

sasolmed



(Registration number: 1234)

ANNUAL FINANCIAL REPORT

for the year ended 31 December 2025

The reports and statements set out below comprise the annual financial report presented to the members of Sasolmed.

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REPORT OF THE CHAIRPERSON

for the year ended 31 December 2025

Dear Members

Embracing Change, Embracing Tomorrow

With the constant increase in the pace of change in so many areas impacting our everyday lives, one should not be surprised to find a world much different from the one we know, just a few years into the future. This is in contrast to the largely stagnant regulatory environment in the South African Healthcare sector where National Health Insurance is mired in legal battles, the Health Market Inquiry recommendations are not finding much traction, the implementation of the Section 59 investigation recommendations remain at the planning stages, and the Low-Cost Benefit Option framework proposed by the Council for Medical Schemes has not yet been approved by the Minister of Health.

The same cannot be said about technology. We are in what feels like the beginning of a major technological revolution, with capabilities like never before to obtain meaningful insight from data and utilise the exponential development of artificial intelligence to leapfrog performance and deliver better results much faster.

Technology is also applied in various aspects of healthcare and closer to home, enables Sasolmed to offer members the ability to make appointments and consult with their doctors from the comfort of their living rooms or offices. Members are also able to obtain prescriptions for medication, which can then be delivered to a nominated address. Advances in wearables and other innovative applications are expected to become increasingly commonplace.

It is the use of technology that has enabled Sasolmed to detect and respond to attempts to defraud the Scheme of its funds, some of these being highly sophisticated. The Board of Trustees extends its appreciation to those members who shared information that supported the actions taken, including the arrests of healthcare providers and members found to be involved in such schemes. The Board of Trustees remains firmly committed to a zero-tolerance approach when it comes to the fraudulent use or misuse of member funds. Members are reminded to review their monthly statements and to report any suspicious activity relating to potential Fraud Waste and Abuse (FWA) to the Sasol Ethics line (0800 016 017) or the Scheme Fraud Hotline (0800 004 500).

Information is power - well-informed members are better able to embrace and utilise the various tools provided to support decision-making when planning to access health care. Communication channels are tailored to meet member preferences and should be used to obtain important information, helping to avoid unexpected outcomes and unnecessary out-of-pocket expenses.

Most people receive an overwhelming volume of communication on a wide range of topics, but personal health and wellbeing must remain a priority.



The true wealth of life – family, friendships, passions, and cherished memories – can only be fully enjoyed and savoured in the presence of good personal health.

Sasolmed offers excellent preventative care benefits aimed at the early detection and subsequent treatment of conditions, before they may require more aggressive intervention and adversely impact quality of life. Technology also provides strong predictive capability, enabling the identification of beneficiaries at the highest risk and those most likely to experience certain undesirable health outcomes.

To support the 39% of beneficiaries suffering from non-communicable diseases, Sasolmed's range of Managed Care Programmes unlocks additional benefits through tailored treatment plans, focused on optimising clinical outcomes and preserving quality of life. For serious interventions, Sasolmed is there to ensure the best possible care while shielding members from catastrophic financial impact.

During 2025, there were 79 events that resulted in claims payments exceeding R1 million, with the highest relating to a member in their thirties amounting to almost R10 million. In short, Sasolmed is there for our beneficiaries in both good and ill health.

The Sasolmed Board consists of an equal number of member-elected and employer-appointed Trustees. All Trustees have a fiduciary duty to act solely in the best interest of Sasolmed and its members and, as Sasolmed members themselves, are also directly impacted by the decisions taken.

REPORT OF THE CHAIRPERSON

for the year ended 31 December 2025



The Board remains steadfast in its commitment to ensuring the affordability and sustainability of Sasolmed in relation to the benefits offered. Decisions are thoroughly investigated and supported by actuarial modelling to assess not only the financial impact on the Scheme as a whole, but also the impact on individual members, ensuring a balanced and considered approach.

With medical inflation consistently tracking well above the Consumer Price Index (CPI headline inflation), and claims exceeding expectations, the Board continuously seeks ways to offer the same or improved quality of care at a reduced cost. These initiatives include transitioning provider reimbursement models from “fee-for-service” to more outcomes-based approaches, changing the way care is accessed to eliminate unnecessary cost, preventing unnecessary duplication of tests, predictive modelling, broadening in-hospital case management, and, of course, ensuring members are provided with the information needed to make prudent decisions when it comes to matters affecting healthcare.

THE NUMBERS

After celebrating our first insurance result surplus of R66 million in 2024, it is disappointing to report a deficit of almost R32 million in 2025. This was mainly due to in-hospital claims substantially exceeding budget by R115 million.

The objective of the Board is to ensure a sustainable operating result that is positive, without relying on uncertain investment returns to offset operating losses. This means that member contributions should be sufficient to cover all claims and operating expenses, allowing investment income to be used to support the Scheme’s solvency and to absorb any unexpected claims experiences.

With this in mind, the Scheme’s strong investment performance made it possible to implement one of the lowest contribution increases in the industry, alongside certain necessary benefit changes aimed at limiting opportunities for fraud, waste and abuse. These changes also encourage members to engage more deliberately when accessing healthcare, helping to protect the Scheme’s shared resources for the benefit of all members.

The Board and its committees continuously monitor a range of key indicators to oversee and maintain the financial health of the Scheme.

Scheme demographics

Membership has remained relatively stable with 28 205 members, which represents a slight reduction of 0.28% from the previous year. Total lives covered saw a similar reduction ending at 74 284 lives, with family size remaining stable. The average age of beneficiaries was 33.4 years compared to 33.1 in 2024. The pensioner ratio of the Scheme increased slightly in 2025 to 9.4% in comparison to 9.0% in 2024 however, there is an indication of future upward pressure on claims.

Healthcare expenditure

The claims ratio, which reflects healthcare expenditure as a percentage of contributions, increased to 101%, compared to a

budgeted number of 99%. At its peak in October 2025, the claims ratio reached 107%, which gave rise to real concern. However, a better-than-expected claims experience in November and December 2025 allowed for a welcome recovery.

Accumulated funds ratio

The accumulated funds ratio (also referred to as the solvency ratio) represents the minimum level of accumulated funds that a medical scheme is required to maintain in order to comply with Regulation 29 of the Medical Schemes Act, No. 131 of 1998. This ratio is expressed as a percentage of gross annual contributions for the financial period under review.

The Board has set a revised target solvency range of between 31% and 41% to ensure that the Scheme is well positioned to absorb any unexpected claims experience without breaching the statutory minimum solvency requirement.

During 2025, the solvency ratio declined from 34.8% in December 2024 to 28.5% in July 2025, primarily due to the elevated claims experience and the exclusion of unrealised investment gains from the solvency calculation. In response, the Board approved the realisation of investment gains to strengthen the Scheme’s solvency position, which closed at 41.6% at the end of the reporting period.

Net healthcare result

After paying all claims, the Scheme recorded an insurance service deficit of R31 870 524 for 2025 compared to a surplus of R66 007 885 in 2024. The objective of the Scheme is to maintain a positive net healthcare result in order to protect the solvency ratio and reduce the impact of any unexpected expenses that may arise.

Strong investment performance over recent years has assisted the Scheme in mitigating the successive operating deficits experienced prior to 2024. However, such favourable investment conditions cannot be assumed to continue indefinitely, and the impact of ongoing tensions in the Middle East is already placing pressure on returns. Reliance on uncertain investment income to offset contribution shortfalls is therefore a risk that the Board does not consider acceptable.

Net surplus

After accounting for all other income, including realised and unrealised gains from investments, as well as all other costs including administration fees and other operational expenditure, Sasolmed experienced a net surplus at year-end of R158 918 119 despite the operational deficit reported above, compared to R172 918 220 in 2024.

Non-healthcare expenses

I am also happy to report that non-healthcare costs continue to be managed rigorously with this expenditure being only 4.3% of total contributions or R131 per beneficiary per month.

REPORT OF THE CHAIRPERSON

for the year ended 31 December 2025



GOVERNANCE

Sasolmed has several committees with delegated responsibilities from the Board to:

- Continuously identify, assess, mitigate and manage risks within the existing operating environment (Audit and Risk Committee);
- Manage the Ex Gratia process (Ex Gratia Committee);
- Oversee the operational aspects of the Scheme namely benefits changes and contribution increases (Operations Committee);
- Manage the investments of the Scheme i.e. investment performance (Investment Committee);
- Assist with the internal controls, financial reporting, risk and governance processes of the Scheme (Audit and Risk Committee); and
- Assess the provision of assurance on the effectiveness of risk responses and mitigating controls by utilising the combined assurance model (Audit and Risk Committee).

The Board is also committed to adopting, as far as reasonably practicable, the King VTM recommendations applicable to Medical Schemes that were issued during the last quarter of 2025. The key focus areas include ethical member-centred governance, as well as strengthened Board accountability and independence.

LOOKING AHEAD

Some of the major focus areas of the Board include:

- Implementing governance practices aligned with the King VTM recommendations.
- Improving member understanding of medical schemes, including Sasolmed benefits and available tools.
- Expanding alternative reimbursement models by moving away from traditional “fee for service” towards more outcomes-based approaches.
- Collaborating with key stakeholders across the healthcare sector to develop and deliver quality cost-conscious solutions that support member health.
- Leveraging the advantages of being a restricted scheme with a geographically concentrated membership base.
- Developing partnerships and initiatives to improve affordability for members without materially compromising benefits, access to care or quality.
- Protecting member interests through the rigorous implementation of measures to detect fraud, waste and abuse, and applying a zero-tolerance approach to inappropriate conduct by both providers and members.

IN CLOSING

I would like to extend my sincere thanks to the Discovery Health team for their support to Sasolmed members, the Sasolmed Office, and the Board of Trustees throughout 2025. Your dedication and commitment are truly valued and appreciated.

My heartfelt appreciation also goes to the current and retired Trustees of the Board for your continued support during another

challenging year. Your thoughtful contributions and significant time commitment in the best interests of Sasolmed are commendable.

A special word of thanks to Mr Freddy Beukes and Ms Merinda Moodie who both stepped into the Acting Principal Officer role during the long-term absence of our Principal Officer, and words cannot express my appreciation for your commitment.

To the dedicated, honest and caring healthcare professionals who support all Sasolmed members through both good and difficult times – we extend our sincere appreciation.

Finally, to my fellow Sasolmed members, we share a special bond as part of one of the leading medical schemes in South Africa. Independent reviews have confirmed that Sasolmed offers exceptional value for money, with comparable benefits in the open market requiring significantly higher financial contributions. You can be proud to be a Sasolmed Member.

Thank you for your compliments, feedback and even the complaints, all of which help us to continue improving Sasolmed for current and future members. Let us embrace change, remain curious about the future, and make full use of the tools and technology available to us as we work together towards a healthier tomorrow.



Mr HL Ernst

Chairperson

The Board of Trustees (the trustees) hereby presents its report for the year ended 31 December 2025.

1 DESCRIPTION OF THE MEDICAL SCHEME

1.1 Terms of registration

Sasolmed ('the medical scheme/the scheme') is a not-for-profit closed medical scheme registered in terms of the Medical Schemes Act 131 of 1998 (the Act), as amended.

1.2 Benefit option within the medical scheme

The medical scheme provides medical scheme benefits and offers one benefit option, the Comprehensive Network Option, with an efficiency-discounted sub-option, the Restricted Network Option, to employees of the Sasol Limited Group (the employer) and Enaex Africa Proprietary Limited (Enaex). The efficiency-discounted sub-option offers a discount on contributions payable by members, for participation in specific designated service provider and medicine arrangements relating to chronic conditions.

Sasol South Africa Limited brokered a joint venture deal with Enaex effective 1 July 2020, which affected about 1 000 employees from different areas of the business. Per the medical scheme's rules: "The Board may, with the approval of the Company and on application from any associated or subsidiary company of the Company, admit such company as an employer and extend the participation in the medical scheme to the employees, principals and partners of such company on the same terms and conditions as applied to the employees, principals and partners of the Company". The participation is limited to Sasol employees who were affected by the joint venture agreement and would be able to remain as contributing members of the medical scheme for as long as they remain in the employ of Enaex, or for as long as Sasol remains a shareholder of Enaex.

2 MANAGEMENT

Details of the Board of Trustees ('the Board/the trustees') in office are provided from 1 January 2025 to the date of this report. Physical and postal addresses are provided as at 31 December 2025.

During the year under review Dr S Smit became unavailable to perform her duties as Principal Officer and Mr F Beukes fulfilled this role until his retirement on 30 November when Ms M Moodie was appointed as acting Principal Officer.

2 MANAGEMENT (continued)

2.1 Trustees in office

Name	Qualifications	Professional Bodies	Designation	Appointed/Elected/Resignation Date
HL Ernst	B.Com (Hons) Marketing Management B.Com (General)	None	Member trustee: Term 1 Vice-Chairperson Acting Chairperson Chairperson Employer trustee: Term 2	Elected 22 April 2015 Elected 1 May 2019 Elected 27 March 2021 Appointed 15 April 2021 Appointed 23 April 2021
AF Botha	BA (Psychology)	None	Member trustee: Term 1	Elected 26 June 2025 Resigned 4 February 2026
LG Claassen	MBA M.Tech.Man B.Eng (Hons) (Tech.Man.) B.Eng (Hons) (Metal.Eng.) B.Eng (Mech.Eng.) (<i>cum laude</i>) GCC	None	Member trustee: Term 1	Elected 30 June 2021
N Cristóvão	BBA Diploma (Business)	None	Employer trustee: Term 1	Appointed 1 May 2024 Resigned 31 January 2025
AP Denyschen	B.Com (Hons)	None	Employer trustee: Term 1	Appointed 1 February 2025 Resigned 11 March 2026
ACJ Fourie	Nursing	None	Member trustee: Term 1	Appointed 28 June 2024 Resigned 27 June 2025
LD Havemann	B.Com (Hons) Industrial Psychology M.Dip (Chem.Eng)	None	Member trustee: Term 1	Elected 26 June 2019 Term ended 26 June 2025
MR Laxa	MBL B.Sc (Chem.Eng.)	Black Management Forum Institute of Directors of Southern Africa (IoDSA)	Member trustee: Term 1 Employer trustee: Term 2	Elected 26 June 2019 Resigned 30 April 2023 Re-appointed 1 November 2024
FEJ Malherbe	MBA B.Sc (Chem.Eng.)	None	Member trustee: Term 1	Appointed 26 June 2025 Resigned 20 November 2025
DC Moloi	LL.M (Regulatory Law) LL.M (Import & Export Law) LL.B B.Com (Law)	Legal Practice Council Corporate Counsel Association of South Africa (Member of the Board) Member: G20Y Leader Circle	Employer trustee: Term 1	Appointed 1 July 2024
MC Mohale	National Diploma (Civil En) B.Tech (Civil Eng) MBA M.Phil Engineering Management		Member trustee: Term 1	Elected 1 February 2026

2 MANAGEMENT (continued)

2.1 Trustees in office (continued)

Name	Qualifications	Professional Bodies	Designation	Appointed/Elected/Resignation Date
LS Mqadi	B.Eng (Hons) Chemical Engineering B.Sc (Hons) Chemical Engineering	None	Member trustee: Term 1	Elected 1 September 2025
AP Naude	B.Com (Hons) Actuarial Science	Fellow of the Actuarial Society of South Africa (FASSA)	Employer trustee: Term 1	Appointed 1 July 2024
R Nienaber	D.Com (Leadership in Performance and Change) M.Com (HR Management) (<i>cum laude</i>) B.Com (Hons) HR Management	Industrial Psychologist registered with the Health Professions Council of South Africa (HPCSA) South African Reward Association (SARA): Master Reward Specialist Member: Institute of Directors of Southern Africa (IoDSA) Remco Forum	Employer trustee: Term 1 Chairperson Employer trustee: Term 2 Employer trustee: Term 3 Employer trustee: Term 3 (continued) Vice-Chairperson	Appointed 1 January 2009 Elected 16 April 2014 Re-appointed 1 January 2015 Re-appointed 1 January 2021 Resigned 26 March 2021 Re-appointed 14 March 2022 Elected 29 August 2024
JHW Potgieter	B.Sc Chemistry and Management B.Sc. Hons. Chemistry M.Sc. Chemistry Ph.D Analytical Chemistry	None	Member trustee: Term 1	Elected 1 January 2026
AM Ratswana	B.Com Post Graduate Diploma (PGDip) Business Admin Executive MBA MCom in Applied Risk Management	None	Employer trustee: Term 1	Appointed 18 March 2026
MF van Wyk	D.Com CA (SA) M.Com Tax MBA	The South African Institute of Chartered Accountants (SAICA) Member of Tax Court of Gauteng	Member trustee: Term 1	Elected 30 June 2021
NJ Verwey	B.Tech (Mechanical Engineering) N.Dip (Mechanical Engineering) Diploma (Project Management) Chartered Industrial Gas Consultant (Gas institute of America) First Aider Level 1	None	Member trustee: Term 1	Elected 30 June 2021 Resigned 28 August 2025
YAM Webb	BA H.Dip (Education) N.Dip (Public Relations)	Member of South African Reward Association (SARA)	Alternate trustee: Term 1 Member trustee: Term 2	Elected 7 April 2016 Designation changed from alternate trustee effective 8 October 2018 Elected 30 June 2022

2 MANAGEMENT (continued)

2.2 Principal Officer

Name	Qualifications	Professional Bodies	Designation	Appointed/Elected/Resignation Date
S Smit	Ph.D (Industrial Psychology) MBA MA (Industrial Psychology) B.Soc.Sc (Hons) Industrial Psychology	Industrial Psychologist registered with the Health Professions Council of South Africa (HPCSA)	Principal Officer (<i>ex officio</i>)	Appointed 1 May 2013 Unavailable to perform the duties of Principal Officer from 26 June 2025
F Beukes	BCompt Master in Business Leadership (MBL)		Acting Principal Officer (<i>ex officio</i>)	Appointed 27 June 2025 Retired 30 November 2025
M Moodie	Baccalaureus Legum Civilium (BLC) Baccalaureus Legum (LLB)	Legal Practice Council (LPC) Admitted Attorney, Notary, Conveyancer	Acting Principal Officer (<i>ex officio</i>)	Appointed 1 December 2025

The Principal Officer is appointed by the Board and is directly accountable to the Board for the rendering of her/his duties as set out in the registered rules of the medical scheme and as stipulated in the Medical Schemes Act and Regulations. Although the Principal Officer is remunerated by the employer, she/he is otherwise free from influence by the employer and is exclusively accountable to the trustees for the fulfillment of her/his duties to the medical scheme.

The Principal Officer is required to attend Board, committee and any other meetings in an *ex officio* capacity.

A performance review is conducted by the Chairperson and the Board to assess the performance of the Principal Officer.

The trustees appoint the Principal Officer to fulfil the duties of the Principal Officer as set out in the registered Rules of the Scheme and any duties of a Principal Officer as provided for in the Medical Schemes Act and Regulations. These duties include, but are not limited to:

- ensure governance of the medical scheme in terms of the Act;
- ensure that trustees discharge their fiduciary duties;
- manage the performance of the administrator and other service providers appointed by the Board of Trustees;
- ensure a communication strategy and plan is in place to effectively communicate to stakeholders at the appropriate time;
- ensure that the strategic and operational objectives of the medical scheme are met;
- supervise any staff employed by the Scheme; and
- report the trustees to the Council for Medical Schemes (CMS) where decisions are made *ultra vires* the Act.

2 MANAGEMENT (continued)

2.3 Members independent of the trustees

Name	Qualifications
BJ du Plessis (Investment Committee)	CA (SA)
DI Marsberg (Investment Committee)	M.Com (Economics)
M McClintock (Investment Committee)	M.Com (Econometrics) CFA
G Mudoni (Audit and Risk Committee)	CA (SA), FACCAs (UK)
G Pillay (Audit and Risk Committee)	CA (SA)
BJ van Dyk (Audit and Risk Committee)	CA (SA)

2.4 Registered office address and postal address of the medical scheme and Principal Officer

Name and Physical Address	Postal Address
Sasolmed Sasol Place 50 Katherine Street Sandton 2196	P O Box 5486 Johannesburg 2000

2.5 Medical scheme administrator

Name and Physical Address	Postal Address
Discovery Health Proprietary Limited 1 Discovery Place Sandton 2196 CMS accreditation no: 19	P O Box 786722 Sandton 2196

2.6 Investment managers

Name and Physical Address	Postal Address
Old Mutual Wealth Trust Company Proprietary Limited Mutualpark Jan Smuts Drive Pinelands Cape Town 7405 Financial services provider number: 604	P O Box 878 Cape Town 8000

2 MANAGEMENT (continued)

2.6 Investment managers (continued)

Name and Physical Address	Postal Address
Momentum Metropolitan Life Limited 268 West Avenue Centurion 0157 Financial services provider number: 19840	P O Box 7400 Centurion 0157

2.7 Asset consultant

Name and Physical Address	Postal Address
Mentenova Proprietary Limited 3 rd Floor Oxford and Glenhove Building 2 114 Oxford Road Rosebank 2198 Financial services provider number: 43937	P O Box 5653 Rivonia 2128

2.8 Actuary

Name and Physical Address	Postal Address
Jo-Anne Oliver BEconSc (Hons) FASSA FIA 1 Discovery Place Sandton 2196	P O Box 786722 Sandton 2196

2.9 Managed healthcare service providers

Name and Physical Address	Postal Address
Discovery Health Proprietary Limited 1 Discovery Place Sandton 2196 CMS accreditation no: 19	P O Box 786722 Sandton 2196

3 INTERNAL AUDITOR

Name and Physical Address	Postal Address
Discovery Health Proprietary Limited 1 Discovery Place Sandton 2196	P O Box 786722 Sandton 2196

Discovery Health (Pty) Ltd is a subsidiary of Discovery Limited, and all internal audit work related to Discovery Limited and its subsidiaries is the responsibility of Group Internal Audit ("GIA"). The Chief Audit Executive of GIA has overall responsibility for the internal audit function and its activities. GIA is subjected to periodic external quality assurance review in terms of the internal auditing standards (required to be performed once every five years). The last external quality review was performed July 2021 and GIA received the highest rating, namely a generally conformance rating. The GIA Audit Plan is reviewed and approved by the Discovery Limited and Discovery Health Audit Committees and the Audit Plan is ratified by the Sasolmed Audit and Risk Committee. Progress against the approved audit plan is presented, by GIA, at each Sasolmed Audit and Risk Committee meeting. GIA's internal audit work conforms to the International Standards for the Professional Practice of Internal Auditing as published by the Institute of Internal Auditors, GIA Charter, and GIA methodology.

The audit and risk committee has an in committee meeting as a standard agenda item for every meeting. The committee meet in committee, as and when required, and specifically to measure the effectiveness of the internal auditor and internal audit function. Based on this, the audit and risk committee concluded that the internal auditor is effective.

4 INDEPENDENT EXTERNAL AUDITOR

Name and Physical Address	Postal Address
PricewaterhouseCoopers Inc. Registered Auditor 5 Silo Square V&A Waterfront 8002	P O Box 2799 Cape Town 8000

PricewaterhouseCoopers Inc. (PwC) was appointed as the medical scheme's independent external auditor during a formal process concluded during 2025. PwC is effectively the Scheme's auditor from the 2016 financial year. The engagement partner's tenure commenced from the 2023 financial year. PwC, the engagement partner, and audit team are independent of the medical scheme and have no conflict of interest. PwC conducts the audit in accordance with International Standards of Auditing and applicable professional standards, laws, regulations, and PwC internal policies.

Due to the above, the audit and risk committee has concluded that PwC, the engagement partner and audit team are deemed to be independent.

The trustees only appoint reputable auditors accredited by CMS, which are subject to IRBA requirements. The audit and risk committee has an in committee meeting as a standard agenda item for every meeting. The committee meets in committee, as and when required, and specifically to measure the effectiveness of the external auditor and external audit function. Based on this, the audit and risk committee concluded that the external auditor is effective.

5 INVESTMENT STRATEGY OF THE MEDICAL SCHEME

The medical scheme has an Investment Policy Statement, which outlines the investment strategy of the medical scheme, the procedures and processes for implementing the investment strategy and the monitoring and compliance functions of the medical scheme with this policy.

The main objectives of the investment strategy are:

- to ensure that the assets are managed in such a way that the medical scheme maintains a financially sound position;
- to optimise the return within the constraints of the risk profile and capital preservation bias of the medical scheme; and
- to ensure that the assets held comply with the provisions of the Act, specifically Annexure B of the Act.

To enable the effective implementation of the investment strategy, strategic asset allocations have been determined by taking into account:

- the statutory requirements with regard to asset classes allowed for investment;
- the risk and return characteristics of different asset classes; and
- the benefit of diversification.

The medical scheme has set a net investment return objective of Consumer Price Index (CPI) plus 3.0% (after fees) per annum. The total portfolio is measured against the investment objective and weighted performance benchmarks. Emphasis is placed on long-term (3 years or longer) investment performance and consequently the returns and risks of the total portfolio are measured over rolling 3-year periods.

The medical scheme utilises the services of Mentenova Proprietary Limited as an asset consultant.

The performance of the portfolio is monitored on a regular basis and formally reported on at the investment committee meetings on a quarterly basis. Any sustained non-performance of Investment Managers or portfolios over rolling 3-year periods is addressed by considering disinvesting from the portfolio concerned.

During the year, the medical scheme was invested indirectly in a linked policy of insurance consisting of listed bonds, listed equities, unit-linked investments, call accounts and money market accounts with Momentum Outcome-Based Solutions Proprietary Limited to ensure that the concentration of risk is spread and investments are diversified. This portfolio represents 72.4% of the medical scheme's investable assets.

Old Mutual Wealth Management is providing treasury and compliance services and is actively managing the medical scheme's cash to optimise interest income. These cash investments are spread between various call accounts and a short-term fixed deposit. At year-end the cash investments amounted to 27.6% of the medical scheme's investable assets.

6 MANAGEMENT OF INSURANCE RISK

The primary insurance activity carried out by the medical scheme assumes a defined risk of loss from members and their dependants that are directly subject to the risk. This risk relates to costs of healthcare interventions of medical scheme beneficiaries. As such, the medical scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract.

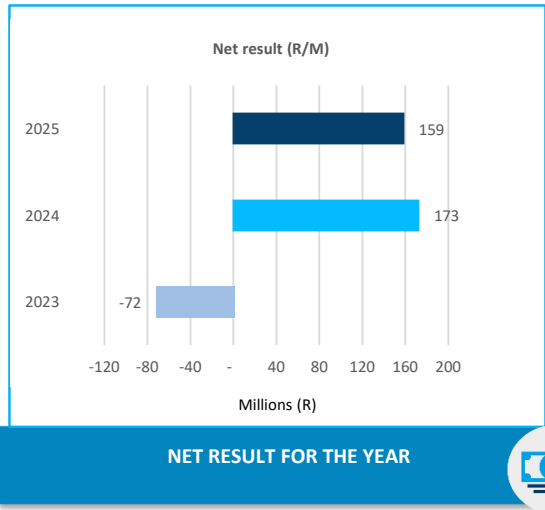
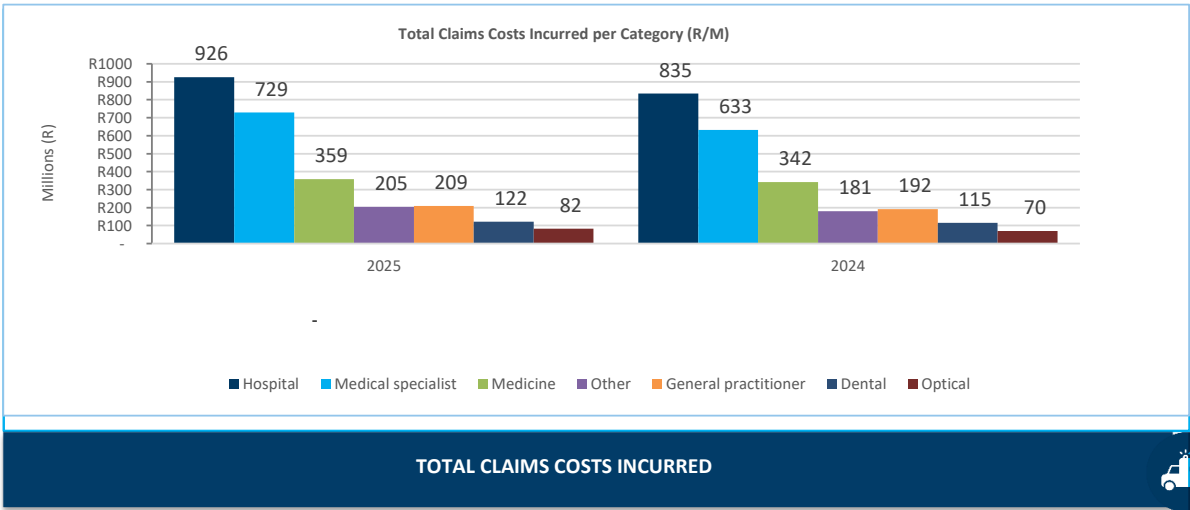
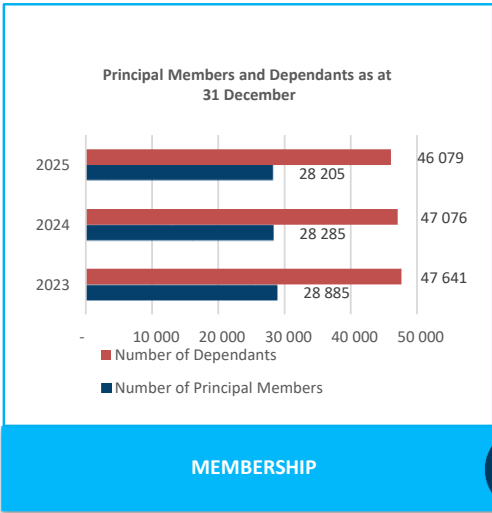
The medical scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, and the monitoring of emerging issues.

The medical scheme uses several methods to assess and monitor insurance risk exposures. 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.

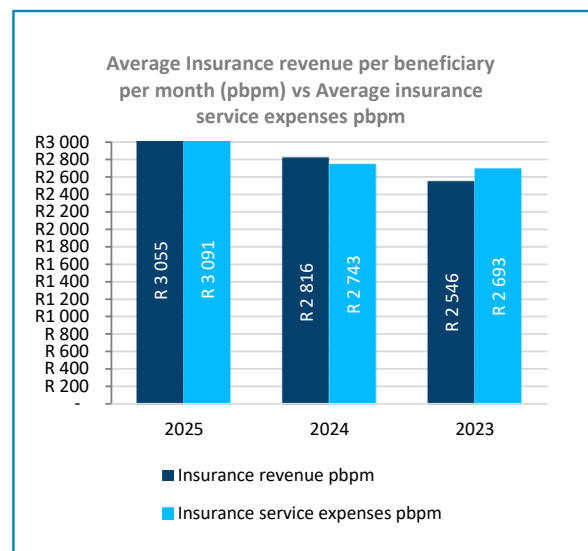
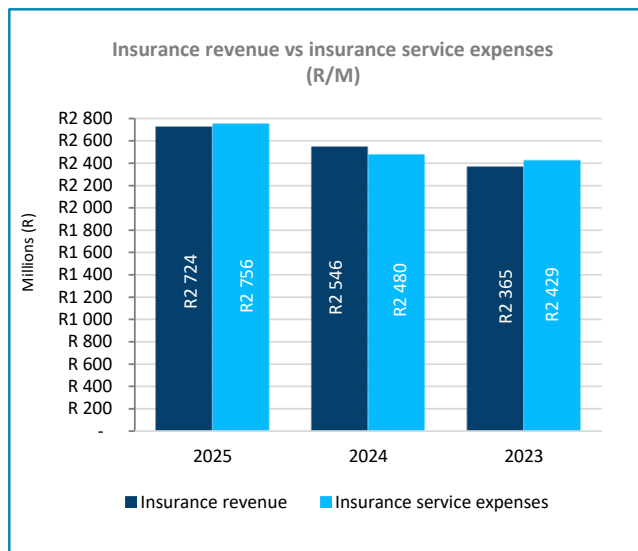
Insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated with established statistical techniques. During the year under review there have been no changes to assumptions used to measure insurance assets and liabilities that have a material effect on the financial statements and there have been no terms and conditions of insurance contracts that had a material effect on the amount, timing and uncertainty of the medical scheme's cash flows.

7 REVIEW OF THE YEAR'S ACTIVITIES

KEY INDICATORS



7 REVIEW OF THE YEAR'S ACTIVITIES (continued)



7.1 Results of operations

The results of the medical scheme are set out in the financial statements and the trustees believe that no further clarification is required.

7.2 Liability for incurred claims

Movements in the liability for incurred claims are set out in note 6 to the financial statements. There have been no unusual movements that the trustees believe should be brought to the attention of the members of the medical scheme. The basis of calculating the provision is consistent with that of previous years.

7.3 Accumulated funds ratio

In terms of Regulation 29(2) of the Act, the medical scheme must maintain accumulated funds expressed as a percentage of annual insurance revenue for the accounting period, which should not be less than 25%.

Accumulated funds ratio

Liability to members for future benefits

Less:

Unrealised gains from investments at fair value through profit or loss

Accumulated funds per Regulation 29(2) of the Act (Members' funds per statement of financial position)

Insurance revenue per the statement of comprehensive income

Accumulated funds ratio

2025 R	2024 R
1 209 902 232	1 050 984 113
(76 014 362)	(164 988 090)
1 133 887 870	885 996 023
2 723 858 579	2 546 443 664
41.6%	34.8%

The trustees' policy is to maintain a strong capital base to ensure sufficient reserves to provide for adverse variations on investment returns and claims experience. The trustees have set as a target percentage of 31% to 41% for reserves, irrespective of the statutory requirement as stipulated by the CMS of 25%.

7 REVIEW OF THE YEAR'S ACTIVITIES (continued)

7.4

Operational statistics	2025		
	Comprehensive network	Restricted network	Total
Number of members at the end of the year (n)	25 637	2 568	28 205
Average number of members for the year (n)	25 613	2 502	28 115
Number of dependants at the end of the year (n)	42 797	3 282	46 079
Average number of dependants for the year (n)	42 981	3 188	46 169
Number of beneficiaries at the end of the year (n)	68 434	5 850	74 284
Average number of beneficiaries for the year (n)	68 594	5 698	74 292
Average age of beneficiaries at the end of the year (yrs)	33.9	27.9	33.4
Dependant ratio to members at the end of the year (n)	1.7	1.3	1.6
Continuation member ratio (beneficiaries > 65 years) (%)	10.1%	1.6%	9.4%
Average insurance revenue per member per month (R)	8 208	6 693	8 074
Average insurance revenue per beneficiary per month (R)	3 065	2 939	3 055
Average insurance service expenses per beneficiary per month (R)	3 166	2 187	3 091
Relevant healthcare expenditure per beneficiary per month (R)	3 097	2 106	3 021
Weighted average attributable, administration and other expenses per beneficiary per month (R)	129	152	131
Insurance service expenses as a percentage of insurance revenue (claims ratio) (%)	103.3%	74.4%	101.2%
Relevant healthcare expenditure as a percentage of insurance revenue (%)	101.1%	71.7%	98.9%
Attributable, administration and other expenses as a percentage of insurance revenue (%)	4.2%	5.2%	4.3%
Accumulated funds per member at year-end (R)			42 897
Return on investment as a percentage of investments (%)			16.0%
Administrator's fees as a percentage of insurance revenue (%)			3.37%
Amounts paid to the administrator - administration fees (R)			91 716 838
Amounts paid to the administrator - accredited managed healthcare services (R)			39 628 902
Amounts paid to the administrator - actuarial consulting fees (R)			2 347 722

7 REVIEW OF THE YEAR'S ACTIVITIES (continued)

7.4

Operational statistics	2024		
	Comprehensive network	Restricted network	Total
Number of members at the end of the year (n)	25 819	2 466	28 285
Average number of members for the year (n)	26 036	2 439	28 475
Number of dependants at the end of the year (n)	43 996	3 080	47 076
Average number of dependants for the year (n)	43 779	3 107	46 886
Number of beneficiaries at the end of the year (n)	69 180	5 596	74 776
Average number of beneficiaries for the year (n)	69 815	5 546	75 361
Average age of beneficiaries at the end of the year (yrs)	33.6	27.8	33.1
Dependant ratio to members at the end of the year (n)	1.7	1.2	1.7
Continuation member ratio (beneficiaries > 65 years) (%)	9.6%	1.6%	9.0%
Average insurance revenue per member per month (R)	7 569	6 210	7 452
Average insurance revenue per beneficiary per month (R)	2 823	2 731	2 816
Average insurance service expenses per beneficiary per month (R)	2 803	1 981	2 743
Relevant healthcare expenditure per beneficiary per month (R) *	2 721	1 885	2 659
Weighted average attributable, administration and other expenses per beneficiary per month (R)	122	144	123
Insurance service expenses as a percentage of insurance revenue (claims ratio) (%)	99.3%	72.6%	97.4%
Relevant healthcare expenditure as a percentage of insurance revenue (%) *	96.4%	69.0%	94.4%
Attributable, administration and other expenses as a percentage of insurance revenue (%)	4.3%	5.3%	4.4%
Accumulated funds per member at year-end (R)			37 157
Return on investment as a percentage of investments (%)			15.0%
Administrator's fees as a percentage of insurance revenue (%)			3.5%
Amounts paid to the administrator - administration fees (R)			89 619 337
Amounts paid to the administrator - accredited managed healthcare services (R)			38 408 288
Amounts paid to the administrator - actuarial consulting fees (R)			1 500 000

* Circular 20 of 2024 and circular 32 of 2025 issued by the Council for Medical Schemes proposed the inclusion of two ratios dealing with relevant healthcare expenditure.

8 ACTUARIAL SERVICES

The medical scheme's actuary has been integral in the determination of the contributions, benefit levels, liability for incurred claims and risk adjustment and there has been no significant disagreement between the trustees and the actuary.

9 EVENTS AFTER REPORTING DATE

There have been no significant events after the reporting date, to the date of the signature of the annual financial report.

10 INVESTMENTS IN AND LOANS TO THE EMPLOYER OF MEMBERS OF THE MEDICAL SCHEME AND TO OTHER RELATED PARTIES

The medical scheme has exposure to shares in Sasol Limited of R2 252 290 (2024: R1 988 210), which equates to 0.2% (2024: 0.2%) of the total portfolio. The medical scheme also has exposure to shares in medical scheme administrators as detailed in note 16.2. The medical scheme received an exemption from Section 35(8)(a) and (c) of the Act from the CMS for a 3-year period until 31 December 2028.

11 BOARD OF TRUSTEES AND COMMITTEES

11.1 Board of Trustees

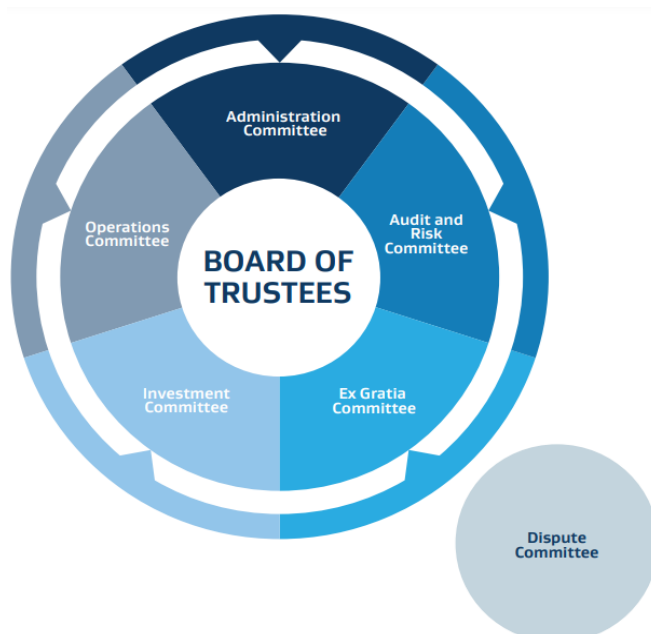
The Board is established to manage the business of the medical scheme in accordance with the Act, and the medical scheme rules, as amended from time to time.

The primary role of the Board is to be responsible for the proper and sound management of the medical scheme in terms of its rules.

The trustees carried out their functions in accordance with an agreed terms of reference, which include the following:

- act in accordance with the rules, with due care, diligence, skill and good faith, taking into account the best interests of the members;
- regularly review the strategy and strategic objectives of the medical scheme;
- consider decisions required in terms of the rules;
- approve and provide mandates for standing, and ad hoc committees, as well as for the Principal Officers allowing them to execute on their role;
- regularly review the key recommendations and decisions taken by committee members and ad hoc or standing committees;
- consider and approve contribution increases;
- consider and approve changes to benefits offered to members;
- stay abreast of, and recognise, changes in the medical scheme landscape, which could potentially impact the sound operation of the medical scheme;
- regularly consider the risk landscape and agree on mitigating actions;
- annually approve the financial statements of the medical scheme; and
- regularly review the Board's performance, composition, structure and succession plan for trustees.

The following committees assist the Board with its responsibilities and provide expert guidance where required:



11 BOARD OF TRUSTEES AND COMMITTEES

11.1 Board of Trustees (continued)

These committees are mandated by the trustees by means of written terms of reference as to their memberships, authority and duties. The terms of reference outlines the key focus areas of the committees to ensure that these committees effectively discharge their duties.

Self-assessments are conducted by the trustees and all other committee members every second year. The self-assessments conducted by the trustees includes a question regarding the efficiency with which meetings are conducted.

11.2 Administration Committee

The committee comprises of six trustees (quorum: three trustees).

The committee carried out its functions in accordance with the terms of reference mandated by the trustees, which include the following:

- monitoring process of service delivery;
- managing service level agreements (SLAs);
- monitoring performance of third party providers;
- ensuring all administrative governance matters are complied with as per the governance checklist;
- monitoring administrative activities;
- reviewing and monitoring the communication strategy, objectives and plan;
- annually reviewing prescribed debt proposed for write-off;
- inviting anyone it chooses to attend meetings to give advice and information as required by the committee;
- compiling, reviewing and implementing policies that pertain to administration matters; and
- conducting constructive review of the risk profiles allocated to the committee, by the audit and risk committee, for the management of risk, to ensure:
 - applicable risks as identified are valid;
 - risk ratings are appropriate;
 - identified risk responses, including critical controls are adequate for identified risks; and
 - there is adequate assurance and controls are appropriate in design and effectiveness.

11.3 Audit and Risk Committee

The committee was established in accordance with the provisions of the Act. The committee consists of a minimum of five members, of which two are trustees, and three are members independent of trustees, including the Chairperson (quorum: one trustee and two independent members).

Name	Designation	Appointment/Resignation Date
N Cristóvão	Trustee	Appointed 1 July 2024 Resigned 31 January 2025
AP Denyschen	Trustee	Appointed 1 February 2025 Resigned 11 March 2026
MR Laxa	Trustee	Appointed 26 June 2019 Resigned 30 April 2023 Re-appointed 1 November 2024
G Mudoni	Independent member	Appointed 1 February 2022
G Pillay	Independent member	Appointed 1 January 2019
BJ van Dyk	Independent member/Chairperson	Appointed 1 December 2020
MF van Wyk	Trustee	Appointed 12 May 2022
S Smit	Principal Officer (<i>ex officio</i>)	Appointed 1 May 2013 - 26 June 2025
F Beukes	Acting Principal Officer (<i>ex officio</i>)	Appointed 27 June 2025 Retired 30 November 2025
M Moodie	Acting Principal Officer (<i>ex officio</i>)	Appointed 1 December 2025

11 BOARD OF TRUSTEES AND COMMITTEES (continued)

11.3 Audit and Risk Committee (continued)

The committee is an advisory committee and not an executive committee. As such it does not perform any management functions or assume any management responsibilities. The committee has an objective, independent role, operating as overseer and a maker of recommendations to the Board for its approval or final decision. The committee does not relieve the trustees of their responsibilities, but assists them to fulfill those responsibilities.

The Principal Officer of the medical scheme, the Fund Manager and the Finance Manager assigned to the medical scheme of the administrator, the internal auditor and the independent external auditor are invited to all committee meetings and have unrestricted access to the chairperson of the committee.

The committee carried out its functions in accordance with the terms of reference mandated by the trustees, which include the following:

- to assist the trustees in their evaluation of the adequacy and efficiency of the internal control systems and accounting practices, information systems and auditing processes applied by the medical scheme and/or its administrator in the day-to-day management of its business;
- to facilitate and promote communication and liaison regarding the matters referred to above or a related matter between the trustees, the Principal Officer, the internal audit staff and the administrator of the medical scheme;
- to consider and recommend the appointment and retention of the independent auditor and to monitor the effectiveness and independence of the internal audit function;
- to examine, review and instruct any changes to the annual financial report, prior to the submission to the trustees;
- to recommend the introduction of measures, which the audit and risk committee believes may enhance the credibility of the financial report and reports concerning the affairs of the medical scheme;
- to advise on any matter referred to the audit and risk committee by the trustees;
- to review and monitor the medical scheme's risk and governance processes; and
- to ensure that a combined assurance model is applied to provide a coordinated approach to all assurance activities to address all the significant risks facing the medical scheme and monitor the relationship between internal and external assurance providers and the administrator, as well as the medical scheme.

The committee has assessed the effectiveness of the combined assurance model and is of the opinion that it incorporates and optimises all assurance services and functions so that, taken as a whole, these enable an effective control environment, support the integrity of information used for internal decision-making by management, the trustees and its committees.

11.4 Dispute Committee

In the event of a dispute arising, the Principal Officer must refer it to the trustees. The trustees shall thereupon appoint a committee of three persons, (which number shall constitute a quorum), at least one of whom shall be a person with legal expertise, and who may not be members of the Board, employees, or officers of the medical scheme or the administrator, to adjudicate such dispute. The trustees did not require the services of this committee during the 2024 and 2025 financial years.

11.5 Ex Gratia Committee

The membership of the committee shall consist of a minimum of four trustees (quorum: three trustees).

The committee carried out its functions in accordance with the terms of reference mandated by the trustees, which include the following:

- review, approve or decline requests from members for ex gratia assistance in funding of relevant healthcare; and
- consider and approve mandates provided to the administrator to expedite applications for ex gratia funding.

Terms of Reference of the Ex Gratia Committee were revised during 2025 to support the Scheme's financial objectives and to ensure that discretionary expenditure remains appropriate, sustainable and aligned to the funding of core healthcare benefits. The Board considered the implications of these changes and remains committed to responsible governance and equitable decision making.

11 BOARD OF TRUSTEES AND COMMITTEES (continued)

11.6 Investment Committee

The membership of the committee shall consist of a minimum of four members, of whom two must be trustees and two must be members independent of trustees (quorum: two trustees and two members independent of trustees). As at year-end, the committee consisted of seven members, of whom four were trustees, and three were members independent of trustees.

Name	Designation	Appointment/Resignation Date
LG Claassen	Trustee	Appointed 30 June 2021
BJ du Plessis	Independent member	Appointed 18 May 2021
MR Laxa	Trustee	Appointed 26 June 2019 Resigned 30 April 2023 Re-appointed 01 November 2024
DI Marsberg	Independent member	Appointed 1 March 2020
M McClintock	Independent member/Chairperson	Appointed 1 December 2020
AP Naude	Trustee	Appointed 1 July 2024
MF van Wyk	Trustee	Appointed 30 June 2021
FEJ Malherbe	Trustee	Appointed 26 June 2025 Resignation 20 November 2025
S Smit	Principal Officer (<i>ex officio</i>)	Appointed 1 May 2013 - 26 June 2025
F Beukes	Acting Principal Officer (<i>ex officio</i>)	Appointed 27 June 2025 Retired 30 November 2025
M Moodie	Acting Principal Officer (<i>ex officio</i>)	Appointed 1 December 2025

The mandate of the investment committee includes the following objectives:

- providing liquidity;
- preserving capital;
- managing investment risk; and
- finding the optimum risk return balance.

11.7 Operations Committee

The membership of the committee shall consist of a minimum of five trustees (quorum: three trustees).

The committee carried out its functions in accordance with the terms of reference mandated by the trustees, which include the following:

- reviewing the monthly management accounts and monitoring the financial position of the medical scheme;
- identifying problems and implement/propose solutions;
- reviewing key strategic and operating matters pertaining to the quality of clinical care and implementing policies that pertain to medical/clinical matters;
- reviewing any, or all, managed healthcare programmes utilised by the medical scheme from time to time and ensure that suitable best practice interventions are utilised taking cognisance of the necessity to, at all times, manage clinical risk for the medical scheme;
- reviewing and recommending to the Board benefit changes and contribution increases for the following year;
- ensuring that industry matters that might impact on the medical scheme are reviewed and that the medical scheme remains informed regarding medical scheme legislation;
- overseeing incidents of fraud;
- reviewing scheme rules and annexures and make recommendations to the Board;
- conducting a constructive review of the risk profiles allocated to the committee, by the audit and risk committee, for management of risk, to ensure:
 - applicable risks as identified are valid;
 - risk ratings are appropriate;
 - identified risk responses, including critical controls are adequate for identified risks; and
 - there is adequate assurance and controls are appropriate in design and effectiveness.
- monitor all risks and matters pertaining to debt within the medical scheme. Debt write-offs will be done in accordance with an approved mandate, and will be reported to the operations committee on a quarterly basis.
- considering all incidents of fraud as identified by the administrator;
- ensuring that all matters are complied with as per the governance checklist;
- manage the member misconduct policy;
- consider matters referred to the operations committee by the other committees for decisions/actions; and
- reviewing and approving all matters relating to the scope of the committee before they are presented to the trustees in order to streamline the activities of the trustees, eg. review new proposed policies, terms of references and any other matters arising.

12 MEMBERSHIP

The total membership was 28 205 with 46 079 dependants at year-end compared to 28 285 members with 47 076 dependants in 2024. The average age of beneficiaries has increased, ending the year on 33.4 years (2024: 33.1 years). The continuation members' ratio (beneficiaries > 65 years) has increased in 2025 to 9.4% (2024: 9.0%).

13 ADMINISTRATION

There is regular interaction with the administrator to encourage ongoing improvement to processes within the administrative and managed healthcare environments of the administrator. The agreement between the Scheme and the Administrator specifies all services provided. The objective is to ensure that members have access to quality and cost-effective healthcare.

Certain of the key focus areas of the administrator are:

- reducing the cost of healthcare without compromising on the quality and outcomes to the members;
- digitalisation of certain functionalities to facilitate the access of members to their medical scheme information/records, and other relevant information available from the medical scheme; and
- integration of healthcare data between the employer and the medical scheme to the benefit of the members.

The technology and information of the medical scheme are governed by the appointed administrator, who reports this to the medical scheme on a regular basis.

The Administrator's control environment is monitored by the operational governance, risk management, compliance and internal audit processes. Significant risks and control deficiencies are raised at the audit and risk committee and remediation or mitigation of issues are monitored by the audit and risk committee.

14 BENEFIT DESIGN

The trustees apply sound business principles when designing benefits and calculating contributions that are in the best interests of the members and to ensure the provision of good quality healthcare at the most affordable cost, whilst taking into account the long-term sustainability of the medical scheme.

15 LEGISLATIVE ENVIRONMENT

15.1 Governance

Governance continues to be an important matter given the fiduciary nature of the responsibilities performed by the trustees. The trustees believe that the initiatives that they have introduced and maintained have created the necessary environment for proper and effective governance of the medical scheme.

During 2025 the trustees unanimously resolved to appoint an independent Chairperson. This decision was taken to enhance objectivity, ensure demonstrable independence from employer and stakeholder interests, and the ability to dedicate focused time and attention to leading the Board and its committees. The resolution was informed by the principles and recommended practices of King V, which emphasise independent leadership as a key component of effective governance, particularly in an increasingly complex medical schemes regulatory, operational and fiduciary environment requiring deep and current industry expertise.

The trustees continue to address areas of possible risk, including fraud to the medical scheme through a comprehensive risk assessment. Other preventative measures, such as requiring declarations of any conflict of interest and having a code of ethics, are also in place.

15.2 King V™

The medical scheme is committed to the implementation of the requirements of King V and is committed to the principles and practices of fairness, openness, integrity and accountability in all dealings with its stakeholders.

15.3 Board of Trustees meetings

The trustees met five times during the year. The trustees confirmed that the medical scheme is a going concern and will remain solvent in the foreseeable future. The medical scheme has various committees to ensure proper governance and compliance with all relevant legislative and regulatory requirements.

15.4 Trustee training

The training and development of trustees is important to the Board. All trustees are expected to stay abreast with developments in the medical schemes' industry and/or other regulatory areas affecting the medical scheme.

15 LEGISLATIVE ENVIRONMENT (continued)

15.5 Irregularities

The Scheme has taken a principled decision not to tolerate the misrepresentation of claims that results in financial loss in any way or form. Where such conduct is identified, whether involving members or healthcare providers, the Scheme investigates all irregularities and, if confirmed, quantifies the amounts for recovery purposes.

Members and healthcare providers are formally notified of the allegations and findings and are afforded an opportunity to respond. This is done through correspondence issued by the Scheme's forensic department. Failure to respond may result in payments being withheld and recovered in order to settle the quantified debt, in line with the Act. The Scheme further reserves the right not to conduct business with members or healthcare providers found to have acted dishonestly or fraudulently.

15.6 Trustee remuneration and reimbursement

The medical scheme has a duly authorised remuneration and reimbursement policy. All trustees, independent committee members and consultants who serve on the Board of Trustees and any of its committees, who are not in the employ of Sasol and therefore do not receive any remuneration from Sasol, are eligible for remuneration and reimbursement of expenses, as approved by the members, as follows:

- R6 555 per meeting for attendance of trustee meetings (including strategy session);
- R5 196 per meeting for attendance of any other committee meetings;
- R1 732 per hour for attendance at an ad hoc meeting; and
- Chairperson fees at 1.5 times the applicable meeting fee.

The above fees were approved by members at the Annual General Meeting (AGM) held on 26 June 2025 up to the next scheduled AGM.

All trustees, independent committee members and consultants who serve on the Board of Trustees and any of its committees, who are not in the employ of Sasol and therefore do not receive any remuneration from Sasol, will be reimbursed for reasonable costs and expenses incurred relating to their duties as such, and the services that they offer to the Board.

15.7 National Health Insurance (NHI) Bill

The medical scheme takes cognisance of the progress made with the implementation of the Bill and the legal challenges against it. The medical scheme supports the objectives of universal health coverage, while recognising the emerging risk of regulatory changes for the medical scheme. The medical scheme will continue to collaborate with the Department of Health, the CMS and other stakeholders on these matters.

16 NON-COMPLIANCE MATTERS

16.1 Claim payments not within thirty days of receipt by the medical scheme

Nature and cause of non-compliance

Section 59(2) of the Act states that:

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

The medical scheme processes and pays claims within thirty days from date of receipt. There are, however, situations beyond the control of the medical scheme that could result in claims being paid later than thirty days, e.g. supporting information may be required from the member or healthcare service provider.

Possible impact of non-compliance

These are isolated cases and thus have not resulted in a material gain or loss to the medical scheme.

Corrective course of action adopted to ensure compliance, including timing of corrective action

The necessary assistance is provided to identified members and healthcare service providers to ensure that these types of isolated cases are minimised.

16 NON-COMPLIANCE MATTERS (continued)

16.2 Investment in an employer group or administrator

Nature and cause of non-compliance

Section 35(8) of the Act states that:

“(8) A medical scheme shall not invest any of its assets in the business of or grant loans to:

- (a) an employer who participates in the medical scheme or any administrator or any arrangement associated with the medical scheme;
- (b) any other medical scheme;
- (c) any administrator; and
- (d) any person associated with any of the abovementioned.”

The medical scheme invests its assets in accordance with an investment policy. These assets are invested in different investment vehicles each having a specific investment mandate, benchmark and chosen investment manager. Some of these mandates may allow exposure to shares or bonds listed in the South African market. The investment manager has full discretion to choose a combination of shares and bonds that will best achieve the benchmark. The representatives of the medical scheme have given discretionary powers in terms of the investment mandate, in accordance with Annexure B to the Regulation to the Act (Annexure B), to the underlying investment manager.

A number of shares are held indirectly, through a policy of insurance with Momentum Investments, in ultimate holding companies of medical scheme administrators and in the medical scheme's employer company, Sasol Limited.

Possible impact of non-compliance

The medical scheme indirectly holds shares in ultimate holding companies of medical scheme administrators and in the medical scheme's employer company Sasol Limited, which is prohibited in terms of Section 35(8)(a) and (c) of the Act.

At year-end the medical scheme held shares indirectly through its linked policy of insurance in:

Company name	31 December 2025 R	31 December 2024 R
Discovery Holdings Limited	3 298 914	547 299
Momentum Group Limited	1 886 953	1 472 503
Sanlam Limited	6 161 401	5 988 516
Sasol Limited (refer to section 10 of the Report of the Board of Trustees)	2 252 290	1 988 210

By applying Section 35(8)(a) and (c) of the Act, the medical scheme will not be able to invest in these companies. The diversification of opportunities is reduced and the medical scheme will be forced to take on additional risk. This is not in the best interest of the members.

Corrective course of action adopted to ensure compliance, including timing of corrective action

The medical scheme received exemption from Section 35(8)(a) and (c) of the Act from the CMS for a 3-year period until 31 December 2028.

In terms of compliance to Annexure B, the medical scheme does perform a comprehensive analysis of the total assets to ensure that the investments do not exceed the limitations set out per Annexure B. Any exposure to the companies in question will be within the limits set out in Annexure B, which will limit the risk to members. It would not be prudent to remove these investment opportunities from the scope of investments available to the underlying investment managers.

16.3 Financial soundness

Nature and impact

In terms of Section 33(2) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance and be financially sound. At 31 December 2025 the Scheme incurred a net insurance service result deficit of R31.9m (2024: surplus of R66.0m). The performance of the Scheme is in line with the Scheme's pricing strategy for the year as the Scheme targets a solvency ratio between 31% and 41%, with the actual solvency ratio at 41.6%, while keeping contributions as affordable as possible.

Cause of non-compliance

The Scheme experienced higher than anticipated claims during 2025.

Corrective action

The Board of Trustees carefully monitors the Scheme's performance with the assistance of the Scheme's actuaries. The Trustees are comfortable that the Scheme is in a sound financial position as at 31 December 2025.

16.4 Scheme rules

Nature and impact

In terms of section 32 of the Act, a medical scheme shall be bound by its rules. During the year under review, the Scheme allowed members with co-payments to fund these via the employer's payroll function. This may be seen as a loan to the members, which is not specifically incorporated into the scheme rules.

Cause of non-compliance

The employer assisted members with co-payments, to pay these co-payments via salary deductions.

Corrective action

The Scheme is in the process to update the Rules to allow such a practice. The Scheme is currently investigating this practice.

17 TRUSTEE MEETING ATTENDANCE

The following schedule sets out the various meeting attendances by the members of the Board of Trustees. Trustees' remuneration is disclosed in note 11 to the financial statements. Only Trustees not on the Sasol payroll, are eligible for Trustee remuneration.

Trustees	Board of Trustees meetings		Administration Committee meetings		Audit and Risk Committee meetings		Ex Gratia Committee meetings		Investment Committee meetings		Operations Committee meetings	
	A	B	A	B	A	B	A	B	A	B	A	B
HL Ernst (Chairperson)	6	6	-	-	-	-	7	7	-	-	4	4
A Botha *	2	2	2	1	-	-	4	1	-	-	-	-
LG Claassen	6	4	-	-	-	-	10	6	4	4	-	-
N Cristóvão *	-	-	-	-	-	-	-	-	-	-	-	-
A Denyschen *	6	6	4	4	4	4	4	4	-	-	-	-
ACJ Fourie *	2	2	2	1	-	-	5	5	-	-	-	-
LD Havemann *	3	-	-	-	-	-	5	-	-	-	-	-
MR Laxa	4	3	-	-	4	3	-	-	4	-	-	-
F Malherbe *	3	2	2	2	-	-	2	2	1	1	-	-
DC Molo	6	5	4	3	-	-	-	-	-	-	4	4
L Mqadi *	1	1	1	-	-	-	1	1	-	-	-	-
AP Naude	6	6	-	-	-	-	-	-	4	3	4	4
R Nienaber	6	5	-	-	-	-	-	-	-	-	4	4
MF van Wyk	6	6	-	-	4	4	10	9	4	4	4	4
NJ Verwey *	4	3	3	3	-	-	-	-	-	-	3	3
YAM Webb	6	4	4	4	-	-	-	-	-	-	4	4
S Smit - Principal Officer (ex officio) *	2	2	2	2	2	2	6	5	2	2	2	2
F Beukes - Principal Officer (ex officio)	3	3	2	2	2	2	5	2	2	2	2	2
M Moodie - Principal Officer (ex officio)	-	-	-	-	-	-	1	1	-	-	-	-

The trustees have a mechanism in place to monitor and address low attendance of meetings.

A = Total number of opportunities to attend meetings held during the year.

B = Actual number of meetings attended.

* Resigned/appointed during the year resulting in pro rata attendance being recorded

No disputes were referred to the Dispute Committee and thus no meetings were held during the financial year.

Heinrich Ernst

Chairperson

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES
for the year ended 31 December 2025



The trustees are responsible for the preparation, integrity, and fair presentation of the annual financial report of Sasolmed, and to ensure that proper systems of internal controls are employed by, or on behalf of, the medical scheme. The trustees are fit and proper and have the relevant experience to administer the medical scheme effectively and efficiently. The financial statements presented on pages 33 to 76 have been prepared in accordance with IFRS® Accounting Standards, requirements of the CMS and in the manner required by the Act.

The trustees, in preparing the financial statements, have used the most appropriate accounting policies supported by reasonable and prudent judgments and estimates. Refer to the significant account policies for new standards implemented during the year under review.

The trustees are satisfied that the information contained in the financial statements fairly presents the results of operations for the year and the financial position of the medical scheme at year-end. The trustees also reviewed all other information included in the annual financial report and are responsible for both its accuracy and its consistency with the financial statements.

The trustees are responsible for internal controls, which they determine are necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error and for maintaining adequate accounting records and an effective system of risk management.

The trustees are responsible for ensuring that accurate accounting records are kept. The accounting records disclose with reasonable accuracy the financial position of the medical scheme to enable the trustees to ensure that the financial statements comply with the relevant legislation.

The trustees have outsourced the medical scheme's activities to an accredited medical scheme administrator and managed healthcare services provider, Discovery Health Proprietary Limited, to ensure that the medical scheme continues to operate in a well-established control environment, which is well documented and regularly reviewed. Discovery Health Proprietary Limited incorporates risk management and internal control procedures, which are designed to provide reasonable, but not absolute, assurance that assets are safeguarded and the risks facing the medical scheme are being mitigated.

The financial statements have been prepared on the going concern basis, as the trustees have no reason to believe that the medical scheme will not be a going concern in the foreseeable future based on the members' funds, forecasts and available cash resources.

The medical scheme's independent auditor, PricewaterhouseCoopers Inc., is responsible for auditing the financial statements in terms of International Standards on Auditing and their report is presented on pages 26 to 32. PricewaterhouseCoopers Inc. has unrestricted access to all financial records and related data, including minutes of all meetings, the Board of Trustees and committees of the Board. The trustees believe that all representations made to the independent auditor during its audit were valid and appropriate.

The financial statements were approved and authorised for issue by the Board of Trustees on 7 May 2026 and are signed on its behalf by:

Heinrich Ensr

Chairperson

Romeo Nienaber

Trustee

Herinda Moodie

Principal Officer

for the year ended 31 December 2025

Sasolmed is committed to the principles and practices of fairness, openness, integrity and accountability in all dealings with the medical scheme's stakeholders and conducts the medical scheme's affairs according to ethical values. The member trustees are proposed and elected by the members of the medical scheme and the employer trustees are appointed by the employer.

Board of Trustees

The trustees meet regularly to monitor the performance of the medical scheme, the administrator, and other service providers. They address a range of key issues and ensure that discussions on policy, strategy, and performance are critical, informed, and constructive. The medical scheme conducts its affairs according to ethical values.

All trustees have access to the Principal Officer for advice and consultation on medical scheme matters. Where appropriate, they may seek independent professional advice at the expense of the medical scheme to assist them in their duties.

All newly appointed or elected trustees undergo induction training, and all other trustees are expected to stay updated with developments affecting the medical scheme.

Internal Control

The administrator of the medical scheme maintains internal controls and systems designed to provide reasonable assurance as to the integrity and reliability of the financial statements, and to safeguard, verify and maintain accountability for the medical scheme's assets. Such controls are based on established policies and procedures and are implemented by trained personnel with the appropriate segregation of duties. An independent internal audit function exists within the administrator, with regular reporting to the medical scheme's audit and risk committee.

During the year, there were instances of control failures in the IT General Control environment. However, these incidents did not have a material impact on financial reporting or the annual financial report. The trustees have concluded that there were no significant breakdowns in the functioning of the key internal controls and systems as it relates to Financial Reporting.

Risk Management

The trustees adhere to risk management principles within the Sasolmed Risk Management Framework, ensuring the integration and embedding of risk management in the business activities of the Scheme.

Governance

In terms of good governance practices, the medical scheme complies with a recognised governance framework, which includes regular monitoring of third party service providers and the management of internal controls and their effectiveness.

Heinrich Eans

Chairperson

Ronel Nienaber

Trustee

Helinda Hoodie

Principal Officer

Independent Auditor's Report

To the Members of Sasolmed

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Sasolmed (the Scheme), set out on pages 33 to 76, which comprise the statement of financial position as at 31 December 2025, and the statement of profit or loss and other comprehensive income, and the statement of cash flows for the year then ended, and notes to the financial statements, including material accounting policy information.

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

Basis for Opinion

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

Key Audit Matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period. These matters were addressed in the context of our audit of

the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	How our audit addressed the key audit matter
Valuation of the liability for incurred claims from healthcare events that have occurred but have not yet been reported Refer to the following disclosure in the financial statements as it relates to this key audit matter: • Note 1.5 Methods used to measure the insurance contracts; • Note 1.6 Insurance contracts; • Note 5 Insurance contract liabilities; • Note 6 Liability for incurred claims; and • Note 20 Critical accounting judgements and areas of key sources of estimation uncertainty; As at 31 December 2025 the Scheme recognised insurance contract liabilities amounting to R147 362 927. The Scheme's insurance contract liabilities comprise the liability for remaining coverage (LFRC) and the liability for incurred claims (LIC). In determining the LIC, the Scheme applies significant judgement and estimation uncertainties, due to the Scheme having to determine claims from healthcare events that have occurred but have not yet been reported. The value of the LIC from healthcare events that have occurred but have not yet been reported is the sum of the probability-weighted estimate of the expected future cash flows and the risk adjustment. The LIC reported is calculated by the Scheme's actuaries which is reviewed by management and the Audit and Risk Committee and recommended to the Board of Trustees for approval. The LIC from healthcare events that have occurred but are not yet reported amounts to R98,646,800. The most significant assumptions made in the determination of the LIC are:	Our audit addressed this key audit matter as follows: We obtained an understanding from the Scheme's actuaries regarding the process followed in calculating the LIC from healthcare events that have occurred but have not yet been reported, which included the design and implementation of controls within the process. We obtained the actual claims data from the member administration system covering the year ended 31 December 2025 used in calculating the LIC from healthcare events that have occurred but are not yet reported. We assessed the completeness of the claims data on the member administration system by understanding management's controls. We selected a sample of claim transactions from the claim source and agreed these to the member administration system. No material inconsistencies were noted. We substantively tested a sample of claims received by the Scheme in the financial year, selected from the member administration system, and evaluated the accuracy of the service and process dates and the validity of the claim against the relevant Scheme rules. No material inconsistencies were noted. We assessed the completeness of the claims data in the Scheme's actuarial model by obtaining an understanding of management's controls and testing the reconciliation between the claims data per the member administration system and the claims data per the actuarial model. We also inspected the reported dates of a sample of the claims data used in the Scheme's actuarial model and considered that the data used in the Scheme's actuarial model did not

Key audit matter	How our audit addressed the key audit matter
- the future cash flow projections; and - the risk adjustment for non-financial risk. Future cash flow projections: The future cash flow projections comprise estimates of all future claim payments, receivables from third parties as well as the directly attributable expenses arising from the healthcare events within the boundary of the insurance contracts. The Scheme's actuaries use an actuarial model, based on the Scheme's actual claim development patterns throughout the year, to determine the probability-weighted estimate of expected future cash flows. This model applies a combination of the Basic Chain Ladder ("BCL"), Bootstrapping and Cost Per Event ("CPE") methods. Risk adjustments for non-financial risk: In determining the Scheme's risk adjustment for non-financial risk, the Scheme uses a confidence level technique (value at risk) under IFRS 17, Insurance Contracts (IFRS 17). The Scheme's calibrated risk adjustment (using value at risk) is such that the insurance contract liabilities are held to be sufficient at the 75th percentile of the ultimate loss distribution. We considered the valuation of the LIC from healthcare events that have occurred but have not yet been reported to be a matter of most significance to the current year audit due to the significant judgement and estimation uncertainties applied in determining the future cash flow projections and the risk adjustments for non-financial risk.	include data reported to the Scheme subsequent to year-end. No material inconsistencies were noted. To assess the reasonableness of the Scheme actuaries' estimation process, we compared the actual claim results in the current year to the prior year LIC from healthcare events that have occurred but are not yet reported. We noted no matters for further consideration with respect to the estimation process. We have evaluated management's experts by assessing their competence, capability, and objectivity and noted no aspects requiring further consideration. We performed the following procedures: - We obtained the Provision for outstanding claims as at 31 December 2025 report from the Scheme's actuaries and evaluated the relevance and reasonableness of the actuarial model used by the Scheme's actuaries based on our knowledge of the industry and model used in the prior years. We noted no matters requiring further consideration. - We compared the Best Estimate Liability and Risk Adjustment of the LIC from healthcare events that have occurred but are not yet reported amounts in the report from the Scheme's actuaries to the Best Estimate Liability and Risk Adjustment of the LIC from healthcare events that have occurred but are not yet reported amounts included in Note 5.2 Insurance contract liabilities. We noted no matters requiring further consideration. - We enquired with the Scheme's actuaries whether the IFRS 17 Risk Adjustment methodology (including the confidence level) has changed since the prior year. No changes were noted. - We performed a reasonableness assessment of the risk adjustment amount by recalculating the risk adjustment using the average risk adjustment factor over the past 3 years. No material differences were noted.

Key audit matter	How our audit addressed the key audit matter
	We performed the following procedure(s) to assess the adequacy of the LIC from healthcare events that have occurred but are not yet reported: • We obtained the actual claims run-off report up to 31 March 2026 from the Scheme's administrator and compared the claims paid post year-end to the LIC from healthcare events that have occurred but are not yet reported at year-end as part of subsequent event procedures. No material inconsistencies were noted. • For a sample of claims from the claims run-off report, we tested the occurrence and accuracy of the claims as well as the accuracy of the related service dates by agreeing the claims to underlying supporting documents on the policy administration system and we identified no material inconsistencies. • We inquired from the Scheme's administrator whether there were delays in processing claims at year-end that could possibly impact the claims run-off pattern subsequent to year-end. No such delays were identified. We obtained a list of pre-authorisations approved prior to year-end from the administrator. For a sample of pre-authorisations with a service date before year-end, we requested the related claim documentation and assessed if the related claim had been included correctly in the claims run-off report up to 31 March 2026. No material inconsistencies were noted.

Other Information

The Scheme's trustees are responsible for the other information. The other information comprises the information included in the document titled "Sasolmed Annual Financial Report for the year ended 31 December 2025". The other information does not include the financial statements and our auditor's report thereon.

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

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

Responsibilities of the Scheme's Trustees for the Financial Statements

The Scheme's trustees are responsible for the preparation and fair presentation of the financial statements, in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board and the requirements of the Medical Schemes Act of South Africa, and for such internal control as the Scheme's trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's trustees.
- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists 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 the following material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa, as amended, that have come to our attention during the course of our audit:

- Non-compliance with Section 35(8)(a) and (c) of the Medical Schemes Act – investments in an employer group or administrator.

Audit Tenure

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that PricewaterhouseCoopers Inc. has been the auditor of Sasolmed ten years. The engagement partner, Nicolette Jacobs, has been responsible for Sasolmed's audit for 3 years.

PricewaterhouseCoopers Inc.

Director: NA Jacobs

Registered Auditor

Cape Town, South Africa

STATEMENT OF FINANCIAL POSITION
at 31 December 2025

sasolmed

	Notes	2025 R	2024 R
ASSETS			
Non-current assets		979 205 557	823 861 913
Financial assets at fair value through profit or loss	2	969 093 751	823 861 913
Trade and other receivables	3	10 111 806	-
Current assets		379 595 764	360 134 476
Trade and other receivables	3	10 126 815	12 915 302
Cash and cash equivalents	4	369 468 949	347 219 174
Total assets		1 358 801 321	1 183 996 389
LIABILITIES			
Non-current liabilities			
Liability to members for future benefits	5.3	1 209 902 232	1 050 984 113
Current liabilities		148 899 089	133 012 276
Insurance contract liability to current members	5.1	147 362 927	130 796 740
Trade and other payables	7	1 536 162	2 215 536
Total liabilities		1 358 801 321	1 183 996 389

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME
for the year ended 31 December 2025

sasolmed

	Notes	2025 R	2024 R
Insurance revenue		2 723 858 579	2 546 443 664
Insurance service expenses		(2 755 729 103)	(2 480 435 779)
Claims incurred *	8	(2 653 805 668)	(2 363 016 966)
Third party claims recoveries	16	26 790 133	17 329 416
Accredited managed healthcare services (no transfer of risk) *	9	(39 628 902)	(39 301 364)
Attributable expenses incurred	10	(89 084 666)	(95 446 865)
Insurance service result		(31 870 524)	66 007 885
Other income		218 938 691	123 842 245
Interest income **	13	18 708 916	20 808 922
Sundry income	14	4 997 937	-
(Decrease)/increase in unrealised gains on investments at fair value through profit or loss	13	(88 973 728)	103 033 323
Realised gains	13	284 205 566	-
Net insurance and investment result		187 068 167	189 850 130
Other expenditure		(28 150 048)	(16 931 910)
Administration fees and other operating expenses	11	(15 488 548)	(12 316 115)
Asset management fees	15	(746 966)	(788 084)
Net impairment losses	12	(11 914 534)	(3 827 711)
Surplus for the year		158 918 119	172 918 220
Transfer to liability to members for future benefits	5.3	(158 918 119)	(172 918 220)
Total comprehensive result for the year		-	-

Circular 32 of 2025 issued by the Council for Medical Schemes requires medical schemes to include "Relevant healthcare expenditure as a line item in the annual financial statements.

* Relevant healthcare expenditure 8 and 9 **(2 693 434 570)** (2 402 318 330)

Relevant healthcare expenditure consists of net claims incurred and accredited managed healthcare services.

** This line item was previously reported as "Investment income" and it was renamed to "Interest income" to provide a more accurate description.

STATEMENT OF CASH FLOWS
for the year ended 31 December 2025



	Notes	2025 R	2024 R
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash receipts from members - contributions		2 725 529 037	2 548 328 004
Cash receipts from members and providers - non-contributions		6 425 346	17 329 416
Cash paid to providers, employees and members - claims		(2 674 494 459)	(2 402 359 960)
Cash paid to providers, employees and members - non-healthcare expenditure		(103 966 576)	(112 378 775)
Net cash (utilised)/generated in operating activities		(46 506 652)	50 918 685
Cash flows from investing activities			
Purchase of investments	2	(893 079 389)	-
Proceeds on disposal of investments	2	943 079 389	-
Interest received		18 756 427	20 201 168
Net cash inflows from investing activities		68 756 427	20 201 168
Net increase in cash and cash equivalents		22 249 775	71 119 853
Cash and cash equivalents at the beginning of year		347 219 174	276 099 321
Cash and cash equivalents at the end of the year	4	369 468 949	347 219 174

1 MATERIAL ACCOUNTING POLICIES

The material accounting policies applied in the preparation of the annual financial statements are set out below and are in accordance with IFRS® Accounting Standards. These policies have been consistently applied to all years presented.

1.1 Basis of preparation*Statement of compliance*

The annual financial statements are prepared in accordance with IFRS Accounting Standard and in accordance with the requirements of the Medical Schemes Act (the Act).

Basis of measurement

The financial statements are prepared in accordance with the going concern principle using the historical cost basis, except for financial assets at fair value through profit or loss, which are measured at fair value. Insurance assets and liabilities are measured in terms of IFRS 17 estimates.

Fair Value

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

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

Functional and presentation currency

These financial statements are presented in Rand (R), which is the medical scheme's functional and presentation currency. All the financial information presented in Rand has been rounded to the nearest Rand.

Use of estimates and judgements

The preparation of financial statements, in conformity with IFRS Accounting Standard, requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the medical 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 20 to the financial statements.

Change in terminology

The non-current liability in the Statement of Financial Position was re-named to Liability to members for future benefits. The terminology used in the 2024 financial report referred to Insurance Contract Liability to future members.

1 MATERIAL ACCOUNTING POLICIES (continued)

1.1 Basis of preparation (continued)

a New standards, amendments and interpretations effective in 2025:

There were no new standards, amendments and interpretations effective in 2025.

b New standards, amendments and interpretations issued and not yet effective in 2025 and relevant to the medical scheme

Standard	Summary of requirements	Effective date
Amendments to the Classification and Measurement of Financial Instruments – amendments to IFRS 9 Financial Instruments and IFRS 7 Financial Instruments: Disclosures.	These amendments to IFRS 9 and IFRS 7 address feedback from the post-implementation review of classification and measurement requirements. They clarify the treatment of financial liabilities settled via electronic payment systems and refine the assessment of contractual cash flows, particularly for financial assets with ESG-linked features. Additionally, they enhance disclosure requirements for equity investments designated at fair value through other comprehensive income and introduce new disclosures for financial instruments with contingent features unrelated to basic lending risks and costs. This amendment has no further impact on the scheme.	Annual periods beginning on or after 1 January 2026

Standard	Summary of requirements	Effective date
IFRS 18 Presentation and Disclosure in Financial Statements	The Standard was issued in April 2024 and supersedes IAS 1 Presentation of Financial Statements. The Standard provides additional requirements for the presentation and disclosure of information in the primary financial statements and the notes to improve transparency and comparability of information. IFRS 18 will impact the scheme's Income statement and related note disclosures. The scheme will assess the additional disclosure requirements.	Annual periods beginning on or after 1 January 2027

1 MATERIAL ACCOUNTING POLICIES (continued)**1.2 Financial instruments**

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

The medical scheme classifies its financial assets in the following measurement categories: financial assets at fair value through profit or loss, financial assets at amortised cost, and financial liabilities.

The classification depends on the nature and the purpose of the financial instruments and is determined at the time of initial recognition.

Measurement

Financial instruments are initially measured at fair value plus any directly attributable transaction costs except for financial assets through profit and loss where the directly attributable transaction costs are recognised in profit and loss as incurred. The fair value of financial instruments is determined by reference to published indices on the Johannesburg Securities Exchange (JSE) Ltd.

Impairment

In relation to the impairment of financial assets an expected credit loss model is required. The expected credit loss model requires the medical scheme to account for expected credit losses and changes in those expected credit losses at each reporting date to reflect changes in credit risk since initial recognition of the financial assets. In other words, it is no longer necessary for a credit event to have occurred before credit losses are recognised.

The medical scheme recognises a loss allowance for expected credit losses on trade receivables and insurance contract assets.

The medical scheme measures the loss allowance for a financial instrument at an amount equal to the lifetime expected credit losses (ECL) if the credit risk on that financial instrument has increased significantly since initial recognition, or if the financial instrument is a purchased or originated credit impaired financial asset. However, if the credit risk on a financial instrument has not increased significantly since initial recognition (except for a purchased or originated credit impaired financial asset), the medical scheme is required to measure the loss allowance for that financial instrument at an amount equal to 12 months ECL.

IFRS 9 also allows a simplified approach for measuring the loss allowance at an amount equal to lifetime ECL for trade receivables and insurance contract assets.

Investments

All purchases and sales of investments are recognised on the trade date, which is the date that the medical scheme commits to purchase or sell the asset. Financial assets at fair value through profit or loss are subsequently carried at fair value. Realised and unrealised gains and losses arising from changes in the fair value of financial assets at fair value through profit or loss are included in the Statement of profit or loss and other Comprehensive Income in the period in which they arise.

Trade and other receivables

Trade and other receivables originated by the medical scheme are measured at amortised cost less an appropriate impairment for estimated irrecoverable amounts. For impairment, the medical scheme applies the simplified approach permitted by IFRS 9, which requires expected lifetime losses to be recognised from initial recognition of the receivables.

Cash and cash equivalents

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

Cash and cash equivalents are measured at cost, which approximates fair value.

Trade and other payables

Trade and other payables are recognised at amortised cost, namely original debt less principal payments and amortisations.

1 MATERIAL ACCOUNTING POLICIES (continued)

1.2 Financial instruments (continued)

Gains and losses on disposal of investments

On disposal of an investment, the difference between the net disposal proceeds and carrying amount is recognised in the Statement of Comprehensive Income.

Offset

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.

Derecognition of financial assets and liabilities

The medical scheme derecognises a financial asset only when the contractual rights to the cash flows from the asset expire, or it transfers the financial asset and substantially all the risks and rewards of ownership of the asset to another entity. If the medical scheme neither transfers nor retains substantially all the risks and the rewards of ownership and continues to control the transferred asset, the medical scheme recognises its retained interest in the asset and an associated liability for amounts it may have to pay. Where the risks and rewards of ownership of the financial asset are substantially retained, the financial asset continues to be recognised. The medical scheme derecognises a financial liability when the contractual obligation is discharged or expires.

1.3 Significant judgements

The medical scheme used the confidence level technique to determine the risk adjustment.

1.3.1 Mutual entity assessment

Based on the requirements of IFRS 17, the medical scheme was recognised as a mutual entity, therefore it is expected that the remaining assets of the medical scheme will be used to pay the claims of current and future members. The medical scheme recognised a liability in its statement of financial position to provide coverage to future members.

1.3.2 Unit of account (Level of aggregation)

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

The above is demonstrated by the following:

- hospital claims are managed on a medical scheme level;
- chronic conditions are managed on a medical scheme level, i.e. no matter the option the member will have access to the chronic condition management benefit;
- pricing and benefit option changes are determined at a medical scheme level to manage member migration between different benefit options to ensure each option is sustainable; and
- risk (utilisation and concentration) is managed holistically.

1.3.3 Risk adjustment – liability for incurred claims (LIC)

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

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

1 MATERIAL ACCOUNTING POLICIES (continued)

1.4 Significant estimates

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

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

For the sensitivities with regard to the assumptions made that have the most significant impact on measurement under IFRS 17, refer to note 21.

1.4.1 Estimates of future cash flows to fulfil insurance contracts

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

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

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

1.5 Methods used to measure the insurance contracts

The medical 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 method 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 medical scheme's case, for the four months post-year-end) that is not yet fully developed to produce an estimated ultimate claim cost for each healthcare year. The chain ladder method is the most appropriate for this claim pattern.

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

The following was taken into account when estimating the LIC:

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

1 MATERIAL ACCOUNTING POLICIES (continued)

1.6 Insurance contracts

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

1.6.1 Unit of account

The medical scheme has assessed their portfolio to be at a medical scheme level.

The medical scheme has applied the exemption not to perform profitability groupings as allowed by IFRS 17 and included all contracts in the same group. The medical scheme has further assessed that there are no facts and circumstances to indicate that the group was onerous at the inception date.

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

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

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

Sasolmed does not have any contracts that require separation or combination of insurance contracts.

1.6.2 Contract boundary

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

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

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

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

1 MATERIAL ACCOUNTING POLICIES (continued)

1.6.3 Recognition and derecognition

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

- the beginning of the coverage period;
- the date when the first payment from the member is due or actually received, if there is no due date; and
- when the medical scheme determines that a group of contracts becomes onerous.

An insurance contract is derecognised:

- when it is extinguished (i.e., when the obligation specified in the insurance contract expires or is discharged or cancelled); or
- when the terms are modified due to an agreement between the medical scheme and its member or by regulation and the modification terms meet the requirement in IFRS 17.

If the modification does not comply with all the requirements of IFRS 17 the medical scheme shall treat the changes in cash flow as changes in estimates of fulfilment cash flows (FCF).

1.6.4 Initial and subsequent measurement

The criteria in IFRS 17 should be considered to determine if a medical scheme would be able to use the Premium Allocation Approach (PAA). Sasolmed contracts all have a coverage period of one year or less and are therefore eligible to apply the PAA model.

The medical scheme uses the PAA for measuring contracts with a coverage period of one year or less. This approach is used for all healthcare insurance contracts as each of these contracts has a coverage period of one year or less.

For insurance contracts issued, on initial recognition, the medical scheme measures the Liability for Remaining Coverage (LFRC) at the amount of contributions received, less any acquisition cash flows paid and any amounts arising from the derecognition of the prepaid acquisition cash flows asset.

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

- a. the LFRC; and
- b. the LIC, comprising the FCF related to past service allocated to the group at the reporting date.

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

- a. increased for contributions received in the period;
- b. decreased for insurance acquisition cash flows paid in the period; and
- c. decreased for the amounts of expected contributions received recognised as insurance revenue for the services provided in the period.

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

- a. best estimate of fulfilment cash; and
- b. risk adjustment.

Refer to notes 1.3 and 1.4 for the significant judgements and estimates used to determine the LIC and the estimates to determine the fulfilment cash flow.

1 MATERIAL ACCOUNTING POLICIES (continued)

1.6.4 Initial and subsequent measurement (continued)

Discounting in the PAA

IFRS 17 allows a policy choice whether to adjust the measurement for the impact of the time value of money and other financial risks, if the settlement of the claims is expected within 12 months.

Sasolmed has made the choice not to discount the group of contracts.

If the group of contracts becomes onerous, the medical scheme increases the carrying amount of the LFRC to the amounts of the FCF determined under the general measurement model (GMM) (as described for the LIC above) with the amount of such an increase recognised in insurance service expenses. Subsequently, the medical scheme amortises the amount of the loss component within the LFRC by decreasing insurance service expenses. The loss component amortisation is based on the passage of time over the remaining coverage period of contracts within an onerous group.

1.6.5 Liability for remaining coverage

As the coverage period and the financial year for a medical scheme is the same, there would be no liability for remaining coverage at the year-end reporting date.

1.6.6 Onerous contract assessment

In the consideration of whether facts and circumstances indicate that a group of insurance contracts is onerous, the medical 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.

1.7 Insurance revenue

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

For the group of insurance contracts measured under the PAA, the medical scheme recognises insurance revenue based on the expected pattern of release of risk over the coverage period of the group of contracts.

1.8 Insurance service expenses

Insurance service expenses include:

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

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

The medical scheme includes the following acquisition cash flows within the insurance contract boundary that arise from selling, underwriting and starting a group of insurance contracts and that are costs directly attributable to individual contracts and the group of contracts.

1 MATERIAL ACCOUNTING POLICIES (continued)

1.9 Classification of contribution receivables

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

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

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

1.11 Reimbursements from the Road Accident Fund (the RAF)

The medical scheme grants assistance to its members in defraying expenditures 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 RAF, administered in terms of its Act. If the member is reimbursed by the RAF, they are contractually obliged to cede that payment to the medical scheme to the extent that they have already been compensated. This contractual obligation may be in the form of a separate agreement or by an acknowledgment of a clause to this effect in the rules of the medical scheme.

A reimbursement from the RAF is a possible asset that arises from the claims submitted to the RAF and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the medical scheme. The contingent assets are assessed continually to ensure that developments are appropriately reflected in the financial statements. If it has become reasonably certain that an inflow of economic benefits will arise, the asset and the related income are recognised in the financial statements in the periods in which reasonable certainty occurs.

Receivables are therefore raised for amounts ceded by the members once the medical scheme is notified of the amount to be paid over and the RAF has indicated that the claim is ready for payment, because it is only at this time that the asset can be reliably measured. Receivables from the RAF are still tested for possible impairment despite the RAF's notification of payment of the claim.

1.12 Accredited managed healthcare services

These expenses represent amounts paid or payable to third party administrators, related parties and other third parties for managing the utilisation, costs and quality of healthcare services to the medical scheme. Accredited managed healthcare services are expensed as incurred.

1.13 Investment income

Investment income comprises of dividend income, interest income and gains or losses on financial assets at fair value through profit or loss.

Dividend income from financial assets at fair value through profit or losses recognised when the right to receive payment is established, which is the ex-dividend date for listed equity instruments.

Interest income is recognised on a yield to maturity basis, taking account of the principal amount outstanding and the effective interest method, applicable over the period to maturity, when it is determined that such income will accrue to the medical scheme.

Realised gains arise from the sale of financial assets at fair value through profit or loss and are recognised in the statement of comprehensive income at the time the sale is concluded.

1.14 Expenses for the administration and other operating expenditure

Expenses for the administration and other operating expenditure are expensed as incurred.

1 MATERIAL ACCOUNTING POLICIES (continued)

1.15 Structured entities

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

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

The medical scheme has determined that some of its investments in unit linked investments (Funds) are investments in unconsolidated structured entities. The medical scheme invests in these Funds, whose objectives range from achieving medium- to long-term capital growth and whose investment strategy do not include the use of leverage. The Funds are managed by unrelated asset managers and apply various investment strategies to accomplish their respective investment objectives. The change in fair value of each Fund is included in the statement of financial position.

1.16 Unallocated funds

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

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

A liability for unallocated funds that have not legally prescribed is recognised and disclosed under insurance contract liabilities. The liability is measured at amortised cost using the effective interest rate method.

1.17 Allocation of income and expenditure to benefit options

The following items are directly allocated to benefit options:

- insurance revenue; and
- risk claims incurred.

The remaining items are apportioned based on the number of members on each option:

- third party claim recoveries;
- attributable expenditure;
- administration and other operating
- net impairment losses;
- other income; and
- other expenses.

2 FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS

	2025 R	2024 R
Opening balance	823 861 913	720 828 586
Gross additions	893 079 389	-
Proceeds on disposal of financial assets at fair value through profit or loss	(943 079 389)	-
Realised gains on disposal of investments through profit or loss (note 13)	284 205 566	-
(Decrease)/increase in unrealised gain on revaluation of financial assets at fair value through profit or loss	(88 973 728)	103 033 327
Fair value at the end of the year	969 093 751	823 861 913
Non-current	969 093 751	823 861 913
The investments included above consist of:		
Policy of insurance	969 093 751	823 861 913
	969 093 751	823 861 913

The Scheme disinvested from the policy of insurance in September 2025, and re-invested in a new policy of insurance. An amount of R50m was withdrawn to re-balance the Scheme's investment portfolio. During this process the Scheme realised the unrealised gains in the portfolio. The full growth of the policy of insurance is disclosed as unrealised gains.

The classifications in Note 22 are determined on a look-through basis of the insurance policy. The underlying risk profiles of the instruments are used as a proxy for the financial risk management disclosures.

3 TRADE AND OTHER RECEIVABLES

Non-insurance receivables

Non-current asset

Forensic receivables *

Current asset

Interest receivables

Prepaid expenses

Forensic receivables *

	2025 R	2024 R
Forensic receivables *	10 111 806	-
Interest receivables	1 580 520	1 628 031
Prepaid expenses	87 500	126 949
Forensic receivables *	8 458 795	11 160 322
	10 126 815	12 915 302

* The high value of forensic receivables at 31 December 2025 is due to an increased emphasis on the identification and recovery of fraudulent claims in the scheme. Data for the current and prior years were analysed with enhanced methodologies to identify fraud.

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

4 CASH AND CASH EQUIVALENTS

Call and short term fixed accounts

Current accounts

	2025 R	2024 R
Call and short term fixed accounts	326 442 342	325 851 757
Current accounts	43 026 607	21 367 417
	369 468 949	347 219 174
The weighted average interest on call accounts	7.5%	8.5%
The weighted average interest on current accounts	7.0%	7.9%

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

5 INSURANCE CONTRACT LIABILITIES

Insurance contract liabilities to current members
Liability to members for future benefits

2025 R	2024 R
147 362 927	130 796 740
1 209 902 232	1 050 984 113
1 357 265 159	1 181 780 853

5.1 INSURANCE CONTRACT LIABILITIES TO CURRENT MEMBERS

Reconciliation of the liability for remaining coverage and the liability for incurred claims

	R	R	R	2025 R
	Liability for remaining coverage (LRC)	Liability for incurred claims (LIC)		
		Best estimate liability	Risk adjustment	Total
Opening assets	1 884 339	-	-	1 884 339
Opening liabilities	-	126 722 142	2 190 259	128 912 401
Net opening balance	1 884 339	126 722 142	2 190 259	130 796 740
Insurance revenue	(2 723 858 579)	-	-	(2 723 858 579)
Insurance service expenses		2 754 783 171	945 932	2 755 729 103
Incurred claims and other insurance service expenses	-	2 781 573 304	3 136 191	2 784 709 495
Third party claims recoveries	-	(26 790 133)	-	(26 790 133)
Adjustments to the LIC - changes that relate to past service	-	-	(2 190 259)	(2 190 259)
Insurance service result	(2 723 858 579)	2 754 783 171	945 932	31 870 524
Cash flows				
Premiums received	2 725 529 037	-	-	2 725 529 037
Incurred claims and other insurance service expenses paid	-	(2 740 833 374)	-	(2 740 833 374)
Total cash flows	2 725 529 037	(2 740 833 374)	-	(15 304 337)
Net closing balance	3 554 798	140 671 938	3 136 191	147 362 927
Closing assets	3 554 798	-	-	3 554 798
Closing liabilities	-	140 671 938	3 136 191	143 808 129
Net closing balance	3 554 798	140 671 938	3 136 191	147 362 927

5.1 INSURANCE CONTRACT LIABILITIES - LIABILITY ATTRIBUTABLE TO CURRENT MEMBERS
(continued)

Reconciliation of the liability for remaining coverage and the liability for incurred claims

	R	R	R	2024 R
	Liability for remaining coverage (LRC)	Liability for incurred claims (LIC)		
		Best estimate liability	Risk adjustment	Total
Opening assets	-	-	-	-
Opening liabilities	-	115 654 129	2 553 694	118 207 823
Net opening balance	-	115 654 129	2 553 694	118 207 823
Insurance revenue	(2 546 443 664)	-	-	(2 546 443 664)
Insurance service expenses				
Incurred claims and other insurance service expenses	-	2 497 765 194	2 190 259	2 499 955 453
Third party claims recoveries	-	(17 329 416)	-	(17 329 416)
Adjustments to the LIC - changes that relate to past service	-	-	(2 553 694)	(2 553 694)
Insurance service result	(2 546 443 664)	2 480 435 778	(363 435)	(66 371 321)
Cash flows				
Premiums received	2 548 328 004	-	-	2 548 328 004
Incurred claims and other insurance service expenses paid	-	(2 469 367 765)	-	(2 469 367 765)
Total cash flows	2 548 328 004	(2 469 367 765)	-	78 960 239
Net closing balance	1 884 339	126 722 142	2 190 259	130 796 740
Closing assets	1 884 339	-	-	1 884 339
Closing liabilities	-	126 722 142	2 190 259	128 912 401
Net closing balance	1 884 339	126 722 142	2 190 259	130 796 740

5.2 INSURANCE CONTRACT LIABILITIES

Best estimate of future cash flows

	2025 R	2024 R
Amounts due from members and suppliers	(41 677 044)	(30 823 456)
Provision for impairment	23 593 407	16 893 753
Liability for incurred claims (excluding the risk adjustment)	95 510 609	85 682 024
Unallocated deposits	6 489 225	4 790 985
Amount owing to Mediscor	626 983	-
Contributions received in advance	-	711 068
Amounts owing to members and providers	45 007 355	38 788 768
Amounts owing to the administrator	11 121 403	10 679 000
	140 671 938	126 722 142

5.3 LIABILITY TO MEMBERS FOR FUTURE BENEFITS

	2025 R	2024 R
Opening balance	1 050 984 113	878 065 893
Movement in liability to members for future benefits (note 18)	158 918 119	172 918 220
Closing balance : Non-current	1 209 902 232	1 050 984 113

6 LIABILITY FOR INCURRED CLAIMS

Analysis of movements in liability for incurred claims

	2025 R	2024 R
Balance at the beginning of the year	87 872 283	112 154 315
Payments in respect of prior year	(83 455 503)	(89 164 734)
Over provision in the prior year	4 416 780	22 989 581
Movement in provision for the current year (note 8)	94 230 020	64 882 702
Balance at the end of the year	98 646 800	87 872 283

Process used to determine the assumptions

The process used to determine the assumptions is intended to result in neutral estimates of the most likely or expected outcome. The sources of data used as inputs for the assumptions are internal, using detailed studies that are carried out annually. Greater emphasis is placed on current trends.

Each notified claim is assessed on a separate basis with due regard to the claim circumstances, information available from accredited managed healthcare services and historical evidence of the value of similar claims. However, the ultimate liabilities may vary as a result of subsequent developments. The impact of many of the items affecting the total cost of the claims is difficult to estimate. The provision estimation difficulties also differ by category of claims (i.e. in-hospital, out-of-hospital and chronic benefits) due to differences in the underlying insurance contract, claim complexity, the volume of claims, the individual severity of claims, determining the occurrence date of claim and reporting lags.

The cost of outstanding claims is estimated using a range of statistical methods. These methods extrapolate the development of paid and incurred claims, average cost per claim and ultimate claim numbers for each benefit year based upon observed development of earlier years and expected loss ratios. Run-off periods are used in situations where it takes time after the treatment date until the full extent of the claims to be paid is known. It is assumed that payments will emerge in a similar way in each service month. The proportional increase in the known cumulative payments from one development month to the next can then be used to calculate payments for future development months. The method adopted to calculate the provision is the chain ladder method.

The actual method or blend of methods used varies by benefit year considered, categories of claims and observed historical claims development. To the extent that these methods use historical claims development information, they assume that the historical claims development pattern will occur again in future.

There are reasons why this may not be the case, which insofar as they can be identified, have been allowed for by modifying the methods. Such reasons include:

- changes in processes that affect the processing and recording of claims paid and incurred;
- economic, legal, political and social trends (i.e. resulting in different than expected levels of inflation and/or minimum medical benefits to be provided);
- changes in composition of members and their dependants; and
- random fluctuations, including the impact of large losses.

6 LIABILITY FOR INCURRED CLAIMS (continued)

Movement in liability for incurred claims compared to prior financial year

The table below provides a breakdown of the liability for incurred claims for the 2025 and 2024 financial years:

	Liability for incurred claims	Claims paid after year end (up to February)	Remaining unpaid outstanding claims provision	Remaining unpaid outstanding claims provision as a % of claims incurred
2025	98 646 800	58 803 129	39 843 671	1.5%
2024	87 872 283	67 937 080	19 935 203	0.8%

- an amount of 58.8m of the R98.6m liability for incurred claims has already been paid by end February 2026 for treatment/services in 2025. For comparison, R67.9m of the R87.9m liability for incurred claims was paid by end February 2025; and

- the remaining unpaid liability for incurred claims amounts to approximately 1.7% (0.8% in 2024) of incurred claims (R39.8m in 2025 and R19.9m in 2024).

Taking the above into account, there is a relatively small portion of the provision that is estimated. The estimated portion is only approximately 1.5% of incurred claims.

Assumptions

The assumptions that have the greatest effect on the measurement of the liability for incurred claims are the expected percentages of risk claims settled after each of the first four months of the risk claims run-off period, before the risk claims turn stale.

The percentages used as assumptions are calculated by the Scheme's actuaries based on the Basic Chainladder method which uses historical development patterns to predict future outstanding claims payments for prior service months. The underlying assumption of the Basic Chainladder Method is that the past claims run-off factors (development patterns) are stable over time. Where development patterns have changed over time as a result of changing processes or frequency of payment runs, adjustments have been made to these mechanical estimates and are done in line with actuarial judgement.

Other assumptions:

- the actual demographics of the medical scheme were used including all membership movements for the period;
- the effect of ageing of the population on the utilisation of health services is automatically incorporated; and
- the impact on new technology and the depreciation of the Rand were taken into account.

7 TRADE AND OTHER PAYABLES

Non-insurance payables

Audit fee accrual

Other payables and accruals

2025 R	2024 R
1 337 452	1 246 461
198 710	969 075
1 536 162	2 215 536

Other payables and accruals for the 2024 financial year includes an amount of R601,763 owing to Mediscor for managed care services. The amount owing to Mediscor as 31 December 2025 amounts to R626,983 and is disclosed in note 5.2 as an insurance contract liability. The prior year is not restated as the amount is not material.

8 CLAIMS INCURRED

Net claims incurred

Current year claims

Movement in the liability for incurred claims (note 6)

(2 559 575 648)	(2 298 134 264)
(94 230 020)	(64 882 702)
(2 653 805 668)	(2 363 016 966)

9 ACCREDITED MANAGED HEALTHCARE SERVICES (NO TRANSFER OF RISK)

	2025 R	2024 R
Hospital benefit management	(12 287 117)	(12 167 853)
Pharmacy benefit management	(3 967 610)	(4 053 738)
Disease management	(12 678 147)	(12 456 285)
Network management	(10 696 028)	(10 475 399)
Dental benefit management	-	(100 675)
Human immunodeficiency virus management	-	(47 413)
	(39 628 902)	(39 301 364)

10 ATTRIBUTABLE EXPENSES INCURRED

Actuarial fees (note 17)	(2 347 722)	(1 500 000)
Administration fees paid in respect of accredited services: Previous administrator	-	(8 111 668)
Administration fees paid in respect of accredited services: Current administrator	(85 180 565)	(82 562 454)
- Member record management	(8 784 699)	(8 514 691)
- Contribution management	(7 716 107)	(7 476 813)
- Claims management	(9 715 081)	(9 416 005)
- Financial management	(316 869)	(307 266)
- Information management and data control	(15 745 713)	(15 264 307)
- Customer service	(42 902 096)	(41 583 373)
Member communication	(1 535 920)	(2 887 095)
Third party claims recovery administration fees	(20 459)	(385 648)
	(89 084 666)	(95 446 865)

11 ADMINISTRATION FEES AND OPERATING EXPENSES

Administration fees for other services	(3 192 290)	(3 820 344)
- Internal audit services	(1 304 558)	(1 263 206)
- Forensic investigations and recoveries	(1 631 540)	(1 580 714)
- Governance and compliance	(256 192)	(976 424)
Administration fees for additional services	(3 343 983)	(3 236 538)
- Quality Management and Monitoring Services	(1 230 397)	(1 191 510)
- Advanced Data Analytics	(1 024 769)	(993 494)
- Digital Service Offering	(374 176)	(361 891)
- Enhanced Service Offering	(205 628)	(198 016)
- Enterprise risk management services	(205 628)	(198 016)
- Legal Services	(57 306)	(54 625)
- Product Innovation	(246 079)	(238 985)
AGM cost	(137 903)	-
Audit expense	(2 333 651)	(1 126 472)
Bank charges	(124 887)	(57 996)
Board of Healthcare Funders' subscription	(82 027)	(90 599)
Health Funders Association subscription	(205 575)	(139 847)
Catering	(32 660)	(47 203)
Consulting fees	(1 491 617)	(1 423 121)
Fidelity guarantee and professional indemnity insurance premium	(214 449)	(252 372)
Principal Officer's expenses (note 17)	(2 228 200)	(69 512)
Professional services (Psychiatric services)	-	(7 025)
Legal Fees	(192 257)	(141 438)
Council for Medical Schemes expenses	(1 467 054)	(1 415 659)
Trustees remuneration and consideration expenses (note 11.1)	(373 125)	(342 939)
Other expenses	(68 870)	(145 048)
	(15 488 548)	(12 316 115)

11.1 TRUSTEES REMUNERATION AND CONSIDERATION EXPENSES

	2025 R	2024 R
AF Botha	40 068	-
ACJ Fourie	-	199
DC Moloi	983	-
MF van Wyk	210 231	202 361
YAM Webb	121 843	140 379
	373 125	342 939

12 NET IMPAIRMENT LOSSES

Members' and healthcare service providers' portions that are not recoverable	(11 914 534)	(3 847 951)
Increase in impairment allowance	(6 699 654)	(3 825 368)
Impairment losses recognised in the statement of comprehensive income	(5 214 880)	(22 583)
Impairment losses recovered	-	20 240
	(11 914 534)	(3 827 711)

13 INVESTMENT INCOME

Interest income	18 708 916	20 808 922
Interest on call and money market accounts	15 486 668	18 507 047
Interest on current accounts	3 222 248	2 301 875
Realised and unrealised gains on disposal of financial assets at fair value through profit or loss	195 231 838	103 033 323
Realised gains	284 205 566	-
(Decrease)/increase in unrealised gains on financial assets at fair value through profit or loss	(88 973 728)	103 033 323
	213 940 754	123 842 245

The (decrease)/increase in unrealised gains is now disclosed in this note for completeness and enhanced reporting.

14 SUNDRY INCOME

Contractual recovery on forensic debt	4 997 937	-
	4 997 937	-

15 ASSET MANAGEMENT FEES

Cash management fees	(746 966)	(788 084)
	(746 966)	(788 084)

16 THIRD PARTY CLAIMS RECOVERIES

Forensic recoveries	26 709 266	15 776 690
Road Accident Fund recoveries	80 867	1 552 726
	26 790 133	17 329 416

The high value of forensic recoveries at 31 December 2025 is due to an increased emphasis on the identification and recovery of fraudulent claims in the scheme. Data for the current and prior years were analysed with enhanced methodologies to identify fraud.

17 RELATED PARTY TRANSACTIONS

The administrator and its associates

The information below has been included due to the significance of the outsourcing relationships. The administrator, Discovery Health Proprietary Limited, has significant influence over the scheme, as Discovery Health Proprietary Limited provides financial and operational information, as well as managed healthcare services, but does not control the scheme. Discovery Health Proprietary Limited provides administration and managed healthcare services.

	2025 R	2024 R
Transactions for the year:		
<i>Discovery Health Limited</i>		
Actuarial consulting fees (note 10)	(2 347 722)	(1 500 000)
Administration fees (note 10 and 11)	(91 716 838)	(89 619 337)
Accredited managed healthcare fees (note 9) *	(39 628 902)	(38 408 288)
Total transactions for the year	(133 693 462)	(129 527 625)

In the prior year (2024), the accredited managed healthcare fees mistakenly reported a positive figure (omitted the brackets). This has been reported correctly as an expense in the current financials including the brackets. It had no other effect on the financial statements.

Amounts payable at the end of the year:

<i>Discovery Health Limited</i>		
Investments: Listed equity	3 298 914	5 529 921
Administration and managed healthcare fees	11 121 403	10 679 000
	14 420 317	16 208 921

Terms and conditions of administration agreement

The administration agreement complies with the rules of the medical scheme and is in accordance with instructions given by the trustees. This agreement commenced on the commencement date and shall continue for a period of eight years and thereafter shall continue indefinitely until terminated by either party by giving not less than three months' written notice to the other party of such termination. Notwithstanding the preceding provision, this agreement can be terminated by the scheme upon giving prior written notice to Discovery Health Limited. The administrator shall be entitled to charge interest, at the prime rate, in the event that the administration fee is not paid by the seventh day of the month to which it relates.

Terms and conditions of accredited managed healthcare services agreement

The agreement between Discovery Health Limited and the medical scheme is an agreement whereby Discovery Health Limited, renders managed healthcare services to the medical scheme in accordance with instructions given by the trustees. This agreement shall commence on the commencement date and shall continue for a period of eight years and thereafter shall continue indefinitely until terminated by either party by giving not less than three months' written notice to the other party of such termination. Notwithstanding the preceding provision, this agreement can be terminated by the scheme upon giving prior written notice to Discovery Health Limited. The administrator shall be entitled to charge interest, at the prime rate, in the event that the administration fee is not paid by the seventh day of the month to which it relates.

17 RELATED PARTY TRANSACTIONS (continued)

The employer and participating employer

Sasol Limited is the employer and Enaex Africa Proprietary Limited is a participating employer, due to a joint venture agreement effective 1 July 2020, to the medical scheme. The employer and participating employer:

- appoint 50% of the trustees (not applicable to participating employer);
- do not charge the medical scheme for use of its facilities, nor for time spent by its employees relating to the medical scheme's business;
- subsidises a portion of contributions for certain members of the medical scheme; and
- does not control the medical scheme.

Transactions for the year:

Sasol Limited - Insurance revenue

Enaex Africa Proprietary Limited - Insurance revenue

Total transactions for the year

2025 R	2024 R
2 126 423 578	2 002 313 259
43 378 055	42 645 198
2 169 801 633	2 044 958 457
(2 252 290)	(1 988 210)
3 554 798	1 884 339

Amounts at the end of the year:

Sasol Limited

Investments: Listed equity

Insurance revenue received in advance by the Scheme

The trustees and principal officer, their dependants and close family members

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the medical scheme directly or indirectly. Key management personnel include the trustees and the principal officer. Close family members include close family members of the trustees and the principal officer.

Transactions for the year:

Trustees, Principal Officer, their dependants and close family members

- Insurance revenue billed in terms of the medical scheme's rules
- Claims processed in terms of the medical scheme's rules
- Remuneration and consideration expenses (note 11)
- Principal Officer's expenses (note 11) *

2025 R	2024 R
1 662 059	1 328 999
(1 277 976)	(935 350)
(373 125)	(342 939)
(2 228 200)	(69 512)

* The Principal Officer's expenses increased due to the appointment of a acting Principal Officer.

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

Insurance revenue billed	This constitutes the insurance revenue paid by the related parties as members of the medical scheme in their individual capacities. All insurance revenue were at the same terms as applicable to all members of the medical scheme.
Claims processed	This constitutes amounts claimed by the related parties in their individual capacities as members of the medical scheme. All claims were paid out in terms of the rules of the medical scheme, as applicable to all members of the medical scheme.
Insurance revenue due	This constitutes outstanding insurance revenue receivable. The amounts are due immediately. No provisions for impairment losses 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 medical scheme has two payment runs monthly. The majority of claims are settled within thirty days of being received.
Members' portion due	This constitutes outstanding members' co-payments on claims processed. The amounts are due immediately.

18 NET PROFIT/(LOSS) PER BENEFIT OPTION

For management purposes the medical scheme provides medical scheme benefits and offers one benefit option, the Comprehensive Network Option, with an efficiency-discounted sub-option, the Restricted Network Option.

	Notes	2025		
		Comprehensive network R	Restricted network R	Total R
Insurance revenue		2 522 911 410	200 947 169	2 723 858 579
Insurance service expenses		(2 606 197 747)	(149 531 356)	(2 755 729 103)
Claims incurred	8	(2 513 350 802)	(140 454 866)	(2 653 805 668)
Third party claims recoveries		24 412 801	2 377 332	26 790 133
Accredited managed healthcare services (no transfer of risk)	9	(36 102 871)	(3 526 031)	(39 628 902)
Attributable expenses incurred	10	(81 156 875)	(7 927 791)	(89 084 666)
Insurance service result		(83 286 337)	51 415 813	(31 870 524)
Other income		199 364 060	19 574 631	218 938 691
Investment income	13	17 046 392	1 662 524	18 708 916
Realised and unrealised gains on investments at fair value through profit or loss	2	177 764 936	17 466 902	195 231 838
Sundry income	14	4 552 732	445 205	4 997 937
Other expenditure		(25 644 073)	(2 505 975)	(28 150 048)
Administration fees and other operating expenses	11	(14 110 197)	(1 378 351)	(15 488 548)
Asset management fees	15	(680 557)	(66 409)	(746 966)
Net impairment loss on healthcare receivables	12	(10 853 319)	(1061 215)	(11 914 534)
Net surplus for the year		90 433 650	68 484 469	158 918 119
Number of members at the end of the year		25 637	2 568	28 205
Number of beneficiaries at the end of the year		68 434	5 850	74 284
Average age		33.9	27.9	33.4
Pensioner ratio		10.1%	1.6%	9.4%

Basis of allocations

Except for insurance revenue and claims incurred all other income and expenses are allocated according to membership.

	Notes	2024		
		Comprehensive network R	Restricted network R	Total R
Insurance revenue		2 364 691 862	181 751 802	2 546 443 664
Insurance service expenses		(2 348 564 332)	(131 871 447)	(2 480 435 779)
Claims incurred	8	(2 243 690 249)	(122 062 770)	(2 365 753 019)
Third party claims recoveries		18 333 473	1 731 996	20 065 469
Accredited managed healthcare services (no transfer of risk)	9	(35 936 104)	(3 365 260)	(39 301 364)
Attributable expenses incurred	10	(87 271 452)	(8 175 414)	(95 446 865)
Insurance service result		16 127 530	49 880 355	66 007 885
Other income		113 229 120	10 613 125	123 842 245
Investment income	13	19 027 942	1 780 980	20 808 922
Unrealised gains on investments at fair value through Profit or Loss	2	94 201 178	8 832 145	103 033 323
Other expenditure		(15 483 358)	(1 448 552)	(16 931 910)
Administration fees and other operating expenses	11	(11 261 190)	(1054 926)	(12 316 115)
Asset management fees	15	(720 629)	(67 455)	(788 084)
Net impairment loss on healthcare receivables	12	(3 501 540)	(326 171)	(3 827 711)
Net (deficit)/surplus for the year		113 873 292	59 044 928	172 918 220
Number of members at the end of the year		25 819	2 466	28 285
Number of beneficiaries at the end of the year		69 815	5 546	75 361
Average age		33.6	27.8	33.1
Pensioner ratio		9.6%	1.6%	9.0%

19 CONTINGENT ASSETS

The medical scheme grants assistance to its members in defraying expenditure incurred in connection with a claim that is also made to the RAF, administered in terms of the Road Accident Fund Act. If the member is reimbursed by the RAF, the member is obliged in terms of the medical scheme rules to cede that payment to the medical scheme to the extent that they have already been compensated by the medical scheme.

A reimbursement from the RAF is a possible asset that arises from claims submitted to the RAF and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the medical scheme. If it has become reasonably certain that an inflow of economic benefits will arise, an asset will be recorded and the related income will be recognised in the financial statements.

At year-end the medical scheme had claims against the RAF totalling R131 481 883 (2024: R96 519 856). The claims represent benefits paid by the medical scheme in respect of medical expenses of its members resulting from motor vehicle accidents. The members have ceded their claims against the RAF to the medical scheme. The recoverability of the claims are subject to the outcome of litigation and the liquidity of the RAF.

20 CRITICAL ACCOUNTING JUDGEMENTS AND AREAS OF KEY SOURCES OF ESTIMATION UNCERTAINTY

Certain critical accounting judgements have been made by the trustees in applying the medical scheme's accounting policies and key assumptions concerning the future and other key sources of estimation uncertainty at the reporting date. These have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities in the next financial year and are discussed below:

The ultimate liability arising from claims made under insurance contracts

There are uncertainties that need to be considered when estimating the claims liability of the medical scheme. Initial estimates are made on reported claims and are derived as the claims process develops. All estimates are revised and adjusted at year-end by the medical scheme, if necessary (note 5).

Impairment of financial assets at fair value through profit or loss

The medical scheme determines that financial assets at fair value through profit or loss are impaired when there has been a significant or prolonged decline in the fair value below cost. The determination of the criteria for significant and prolonged impairment requires judgement. The medical scheme evaluates, among other factors, volatility in share price, liquidity uncertainty, financial irregularities or subsequent events affecting the recoverability. Impairment may be appropriate if there is a decline in these factors. Input from the investment managers are also considered.

21 MEDICAL INSURANCE RISK MANAGEMENT

The medical scheme issues contracts that transfer medical insurance risk. This section summarises these risks and the way in which the medical scheme manages them.

Risk management objectives and policies for mitigating insurance risk

The primary insurance activity carried out by the medical scheme assumes the risk of loss from members and their dependants that are directly subject to the risk. The risks relate to the health of the medical scheme's members. As such, the medical scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract. The medical scheme also has exposure to market risk through its insurance and investment activities. The medical scheme takes on the full risk and does not offer a medical savings component.

The medical scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, and monitoring of emerging issues.

The medical scheme uses several methods to assess and monitor insurance risk exposures both for individual types of risk 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 using established statistical techniques.

Historical data shows that the larger the portfolio of similar insurance contracts, the smaller the relative variability about the expected outcome will be. In addition, a more diversified portfolio is less likely to be affected across the board by a change in any subset of the portfolio. The medical scheme has developed its insurance underwriting strategy to diversify the type of insurance risk accepted and within each of these categories to achieve a sufficiently large population of risks to reduce the variability of the expected outcome.

Disclosure regarding the sensitivity of claims to changes in key variables is shown in note 21(a).

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

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

Day-to-day benefits cover the cost (up to 100% of the medical scheme tariff) of out-of-hospital medical requirements, such as visits to general practitioners and dentists, as well as prescribed non-chronic medicines.

The medical scheme's insurance risk 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 this reduces the variability of the outcome.

The medical scheme's strategy specifies that the benefits should be provided at minimum cost and are reflected in the annual benefit guide.

The medical scheme considers its risk to be concentrated in the following areas:

Hospital benefits

Medical inflation has a direct impact on the private hospital costs, which could increase exponentially over time. Hospital claims represent a key risk factor to the medical scheme and the actual claims incurred in respect of hospital costs for any benefit year, could be worse than the expectation.

21 MEDICAL INSURANCE RISK MANAGEMENT (continued)

Risk management objectives and policies for mitigating insurance risk (continued)

Medicine benefits

Medicine claims are affected by continued legislative changes and there is a risk that the actual claims incurred, as a result, may increase or decrease expected medicine costs. An ageing population has a direct correlation and effect on the cost of chronic medication.

Specialist benefits

Based on the Scheme's historical claims experience, the cost and utilisation of specialist services have increased over the reporting period. This trend is attributable to several factors, including:

- Higher billing practices among specialists across various disciplines.
- Increased involvement of multi disciplinary specialist teams (higher numbers of professionals and professional types involved per admission), particularly in hospital based episodes of care.

These drivers collectively resulted in upward pressure on specialist expenditure, influencing the overall claims trajectory for the financial year.

Continuation member ratio

Based on historical data, pensioner members are regarded as the high claimers of medical benefits. Due to the significant number of pensioners through its arrangements with the employer, the pensioner levels could have increased more than anticipated, which could have resulted in greater claims expenditure than expected. The employer implemented strategies to reduce this risk. Post-retirement employer contributions are only available to employees appointed prior to January 1998.

a) Insurance contract liability sensitivity

The effect of the changes in the risk areas identified are set out below. Each change in the criteria represents the impact on the 2026 budget that was approved by the trustees:

	Budget 2026 R	Scenario 1 Increase change	Scenario 2 Decrease change
<i>Inflation assumptions</i>			
In-hospital/ward/theatre/consumables			
Budget scenario – 3.3% average	989 625 773	5%	(2%)
Effect on claims – R		47 900 570	(19 160 228)
Effect on solvency – %		-1.7%	0.7%
<i>Ageing assumptions</i>			
Medicine			
Budget scenario – 5.5%	383 530 584	5%	(2%)
Effect on claims – R		18 563 920	(7 425 568)
Effect on solvency – %		(0.6%)	0.3%
<i>Utilisation assumptions</i>			
Specialist costs			
Budget scenario – 5.0%	458 457 442	5%	(2%)
Effect on claims – R		21 998 918	(8 799 567)
Effect on solvency – %		-0.8%	0.3%

b) Risk adjustment sensitivity

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

	2025 R	2024 R
Risk adjustment with a 75% confidence level – as reported	3 136 191	2 190 259
Risk adjustment with a 80% confidence level	4 145 226	2 931 762

c) Qualitative risk factors

All medical health provider contracts are annual in nature and the medical scheme has the right to negotiate the terms and conditions of the contracts at time of renewal. Management information including investment results, growth in membership, membership ratios, an analysis of claims per speciality and actual versus budgeted financial results are reviewed monthly.

d) Claims development

The claims development tables are not presented since the uncertainty regarding the amount and timing of claim payments is typically resolved within one year. At year-end, a provision is made for those claims outstanding that are not yet reported at that date. Details regarding the subsequent development in respect thereof have been disclosed in note 6.

21 MEDICAL INSURANCE RISK MANAGEMENT (continued)

The following table 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/benefits provided.

2025								
Age grouping (in years)	Medical specialists	General practitioner	Optical	Dental	Medicine	Hospital	Other	Total
	R	R	R	R	R	R	R	R
<26	103 431 893	57 921 513	16 648 509	29 681 869	49 751 317	170 319 661	40 981 534	468 736 297
26 - 35	60 433 544	30 141 096	9 928 102	15 855 012	25 338 596	73 205 881	19 376 188	234 278 418
36 - 50	156 462 584	61 897 629	27 225 333	35 321 121	85 252 274	172 085 846	47 648 110	585 892 897
51 - 65	193 388 897	36 684 450	19 500 289	26 002 172	106 325 768	214 678 569	41 857 321	638 437 466
>65	215 284 311	22 759 942	8 963 466	14 664 858	92 003 152	295 338 762	54 939 975	703 954 466
Total	729 001 229	209 404 630	82 265 699	121 525 032	358 671 107	925 628 720	204 803 128	2 631 299 544

2024								
Age grouping (in years)	Medical specialists	General practitioner	Optical	Dental	Medicine	Hospital	Other	Total
	R	R	R	R	R	R	R	R
<26	95 373 497	54 339 252	16 212 723	27 867 126	48 583 756	158 389 602	38 079 711	438 845 667
26 - 35	54 267 319	30 017 428	10 777 768	16 066 843	25 971 390	72 697 909	20 174 289	229 972 946
36 - 50	133 550 079	54 556 923	21 450 998	32 496 658	81 406 746	159 622 821	44 182 199	527 266 424
51 - 65	172 533 027	34 021 467	14 565 946	25 072 558	105 883 372	191 664 065	35 779 375	579 519 810
>65	177 002 886	19 048 925	6 542 681	13 253 912	80 472 035	252 925 930	42 534 320	591 780 689
Total	632 726 808	191 983 995	69 550 116	114 757 097	342 317 299	835 300 327	180 749 894	2 367 385 535

The tables above reflect the claims paid for each of the disciplines indicated, but do not include provisions for incurred claims or any related claims cost not processed through the system, and should not be compared to Note 8.

22 FINANCIAL RISK MANAGEMENT

The medical scheme's activities expose it to a variety of financial risks, including the effects of changes in the equity market prices, foreign currency exchange rates and interest rates. The medical scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potentially adverse effects on the financial performance of the investments that the medical scheme holds to meet its obligations to its members.

Risk management and investment decisions are made under the guidance and policies approved by the trustees. The investment committee identifies and evaluates financial risks associated with the medical scheme's investment portfolio.

The medical scheme's risk management policies have been established to identify and analyse the risks faced by the medical scheme, to set appropriate risk limits and controls and to monitor risks and adherence to limits. Risk management policies and systems are reviewed regularly to reflect changes in market conditions and the medical scheme's activities. The medical scheme's administrator, through its training and management standards and procedures, aims to develop a disciplined and constructive control environment in which all employees understand their roles and obligations.

The trustees oversee how the administrator monitors compliance with the medical scheme's risk management policies and procedures and reviews the adequacy of the risk management framework in relation to the risks faced by the medical scheme. The trustees are assisted in its oversight role by the administrator's internal audit. Internal audit undertakes both regular and ad hoc reviews of risk management controls and procedures, the results of which are reported to the medical scheme's audit and risk committee.

The financial risks relevant to the medical scheme are set out in notes 22.1.1 to 22.1.8.

The investments as disclosed in note 2 are further classified on a look through basis of the policy of insurance. The underlying risk profiles of the instruments is used as a proxy for the financial risk management disclosures.

22.1 Financial risk factors

22.1.1 Credit risk

Credit risk is the risk of financial loss to the medical scheme if a customer or counterparty to a financial instrument fails to meet its contractual obligations. The medical scheme's principle financial assets are cash and cash equivalents, trade and other receivables and financial assets at fair value through profit or loss. The medical scheme's credit risk is primarily attributable to its trade and other receivables.

Cash and cash equivalents and financial assets at fair value through profit or loss

Funds are invested at various institutions after taking the following criteria into account:

- the medical scheme's mandate requirements;
- regulations as per the Act;
- credit ratings of the various financial institutions; and
- interest offered by the financial institutions.

Financial assets at fair value through Profit or Loss

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

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.1 Credit risk (continued)

Although the medical scheme did not stipulate credit ratings limitations, the medical scheme limits its exposure to credit risk by mostly investing in liquid securities with medium grade moderate risk financial institutions. The medical scheme has a policy of limiting the amount of credit exposure to any one financial institution. Given these credit ratings, the medical scheme does not expect any financial institution to fail to meet its obligations.

Credit risk is mitigated by adhering to the Act, by not investing more than 35% of investable assets in large banks and not more than 10% in smaller banks. The net qualifying capital and reserves are monitored by the appointed asset manager on a monthly basis to determine the split between large and smaller banks.

Credit quality

The table below reflects the medical scheme's exposure to credit risk by reflecting the national scale ratings as per Moody's to indicate credit quality.

Asset class	Ratings	2025 R	2024 R
Cash	Aa1	426 651 362	382 237 702
Debt instruments *	A	13 335 160	-
	A-	5 260 298	-
	A+	988 813	6 915 821
	A1	7 214 826	-
	AA	852 138	1 364 152
	Aa-	14 575 618	2 530 212
	AA+	23 943 146	2 312 051
	Aa1	815 674	-
	Aa2	385 977	-
	Aa3	1 352 445	-
	AAA	447 211 345	381 205 225
	B	509 247	353 342
	B+	-	167 215
	BB-	-	21 838 608
	BBB-	-	11 048 289
	C	-	91 908
	BBB	28 728	-
	Caa2	286 368	-
	Unrated	20 653 972	47 579 153
	Grand Total	537 413 755	475 405 977

* In prior years, this category was designated as 'Listed bonds'. The terminology has been updated to 'Debt instruments' to enhance clarity and improve comprehension of related disclosures.

The table above has been restated to reflect debt instruments (formerly listed bonds) for the 2024 figures, adjusting the total from R267,436,856 to R475,405,977, and the cash balance from R347,219,174 to R382,237,702. Previously, the difference was inadvertently excluded; this has now been corrected to accurately present the full amount of cash and of debt instruments.

The main National Scale Long-term Ratings as per Moody's:

Aaa	Obligations rated Aaa are judged to be of the highest quality, subject to the lowest level of credit risk.
Aa	Obligations rated Aa are judged to be of high quality and are subject to very low credit risk.
A	Obligations rated A are judged to be upper-medium grade and are subject to low credit risk.
Baa	Obligations rated Baa are judged to be medium-grade and subject to moderate credit risk and as such may possess certain speculative characteristics.
Ba	Obligations rated Ba are judged to be speculative and are subject to substantial credit risk.
B	Obligations rated B are considered speculative and are subject to high credit risk.
Caa	Obligations rated Caa are judged to be speculative of poor standing and are subject to very high credit risk.
Ca	Obligations rated Ca are highly speculative and are likely in, or very near, default, with some prospect of recovery of principal and interest.
C	Obligations rated C are the lowest rated and are typically in default, with little prospect for recovery of principal or interest.

Note: Moody's appends numerical modifiers 1, 2, and 3 to each generic rating classification from Aaa through C. The modifier 1 indicates that the obligation ranks in the higher end of its generic rating category; the modifier 2 indicates a mid-range ranking; and the modifier 3 indicates a ranking in the lower end of that generic rating category.

Trade and other receivables

The amounts presented in the statement of financial position are net of allowances for impaired receivables. The medical scheme establishes an allowance for impairment losses that represents its estimate of potential losses in respect of trade and other receivables. The main components of this allowance are a specific loss component that relates to individually significant exposures. This allowance is made where there is an identified loss event which, based on previous experience, is evidence for a reduction in the recoverability of the cash flows.

Trade and other receivables consist of interest receivables, prepaid expenses on non-insurance related expenses and forensic receivables.

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.1 Credit risk (continued)

Credit quality (continued)

Contributions outstanding

Contributions outstanding may arise due to the following:

- addition of dependants;
- non-payment for new members;
- electronic payment rejection; and
- changes in contribution rates.

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

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

Recoveries from members for co-payments

The debt may arise due to the following:

- due to benefit structure, which includes co-payments of 10% or 20%; and
- termination of member or dependants.

The above is managed by applying the medical scheme's approved credit control policy. Members are either suspended or terminated for outstanding co-payments. The application thereof assists in that the medical scheme's financial risk is managed. The procedures as set out in the policy are communicated to the direct paying member prior to suspension or termination of the member. Co-payments for employed members are deducted via the payroll department.

Healthcare service providers debt

The debt may arise due to the following:

- reversals done incorrectly;
- paying the healthcare service providers directly instead of the member;
- overpayment of claims;
- members returning appliances i.e. hearing aids, spectacles, etc.;
- non-dispensing scripts;
- claims erroneously submitted by healthcare service providers;
- healthcare service providers claiming on incorrect membership numbers or incorrect dependants;
- duplicated claims;
- claims paid on incorrect practice numbers;
- incorrect chargeable codes paid; and
- claims paid for treatment after membership had been terminated.

The above is managed by applying the medical scheme's approved credit control policy.

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.1 Credit risk (continued)

Credit quality (continued)

Exposure to credit risk

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

	2025 R	2024 R
Non-current assets		
Financial assets at fair value through Profit or Loss	594 596 167	510 424 505
Trade and other receivables	10 111 806	-
Current assets		
Trade and other receivables	10 126 815	12 915 302
Cash and cash equivalents	369 468 949	347 219 174
	984 303 737	870 558 981

The maximum credit exposure related to financial assets excludes an amount of R375,382,867 (2024: R313,437,408) attributable to equity, which does not entail credit risk. The prior year's figures included the equity component in error; this has been corrected and restated in the current year by removing the equity portion accordingly.

A breakdown of credit risk in relation to impairment and ageing is set out below. From past experience the policy that is applied, in terms of which fully performing receivables past due do not need to be impaired, was determined by the medical scheme:

	Past due not impaired				
	Fully Performing R	Current R	31 to 60 days R	> 60 days R	Total R
2025					
Trade and other receivables	1 668 020	57 408	814 190	17 699 003	20 238 621
2024					
Trade and other receivables	12 915 302	-	-	-	12 915 302

22.1.2 Interest rate risk

The medical scheme's investment contracts during the year included holding investments in interest bearing instruments. The medical scheme's investments were therefore exposed to changes in the market interest rates. This risk is managed by maintaining an appropriate mix between fixed and variable rate deposits within the market.

The table below summarises the medical scheme's exposure to interest rate risks. Included in the table are the medical scheme's investments at carrying amount, categorised by the contractual re-pricing or maturity.

	≤ 1 month R	1 - 12 months R	> 12 months R	Total R
2025				
Fixed rate	116 327 835	46 447 373	407 059 499	569 834 707
Variable rate	369 468 949	-	-	369 468 949
	485 796 784	46 447 373	407 059 499	939 303 656

969 093 751
(374497 584)

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.2 Interest rate risk (continued)

	≤ 1 month R	1 - 12 months R	> 12 months R	Total R
2024				
Fixed rate	17 581 182	44 246 234	364 401 942	426 229 358
Variable rate	347 219 174	-	-	347 219 174
	364 800 356	44 246 234	364 401 942	773 448 532

The table above excludes listed equities.

22.1.3 Capital adequacy risk

This represents the risk that there are insufficient reserves to provide for adverse variations on investments and claims experience. At year-end the accumulated funds ratio computed in terms of the CMS formula was 41.6% (2024: 34.8%). The trustees believe that this cover is appropriate to the medical scheme's needs.

The trustees' policy is to maintain a strong capital base so as to maintain member and market confidence and to sustain future development of the medical scheme. The trustees monitor the return on capital. The trustees have set a lower parameter percentage of 31% for reserves, irrespective of the statutory requirements stipulated by the CMS of 25%.

There were no changes in the medical scheme's approach to capital management during the year. The medical scheme is subject to externally imposed capital requirements by the CMS and the Act.

22.1.4 Liquidity risk

Liquidity risk is the risk that the medical scheme will not be able to meet its financial obligations as they fall due. The medical scheme's approach to managing liquidity is to ensure, as far as possible, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the medical scheme's reputation.

Prudent liquidity risk management implies maintaining sufficient cash and marketable securities. The availability of funding through holding liquid cash positions with various financial institutions ensures that the medical scheme has the ability to fund its day-to-day operations and its obligations as they fall due. The medical scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Act, except for Section 35(8)(a) and 35(8)(c) for which exemption was received from the CMS for a 3-year period until 30 November 2025 and Annexure B and Regulation 30 of the Act relating to equity exposure (category 4).

The medical scheme ensures that it has sufficient cash on demand to meet expected operational expenses for a period of six weeks, including the servicing of financial obligations. This excludes the potential impact of extreme circumstances that cannot reasonably be predicted, such as natural disasters and pandemics.

The table on the next page summarises the medical scheme's exposure to liquidity risk. Included in the table are the medical scheme's liabilities (including insurance liabilities) at carrying amounts, categorised by the contractual repricing or maturity dates.

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.4 Liquidity risk (continued)

Liquidity analysis	≤ 1 month R	1 - 12 months R	> 12 months R	Total R
2025				
Liabilities				
Non-current liabilities				
Liability to members for future benefits	-	-	1 209 902 232	1 209 902 232
Current liabilities	147 561 637	1 337 452	-	148 899 089
Liabilities to members for current benefits	147 362 927	-	-	147 362 927
Trade and other payables	198 710	1 337 452	-	1 536 162
Total liabilities	147 561 637	1 337 452	1 209 902 232	1 358 801 321
Available funding	487 522 213	448 668 405	422 610 703	1358 801 321
Trade and other receivables	1 725 429	2 961 988	15 551 204	20 238 621
Cash and investments	485 796 784	445 706 417	407 059 499	1 338 562 700
Excess/(shortfall)	339 960 576	447 330 953	(787 291 529)	-

	≤ 1 month R	1 - 12 months R	> 12 months R	Total R
2024				
Liabilities				
Non-current liabilities				
Liability to members for future benefits	-	-	1 050 984 113	1 050 984 113
Current liabilities	131 765 815	1 246 461	-	133 012 276
Liabilities to members for current benefits	130 796 740	-	-	130 796 740
Trade and other payables	969 075	1 246 461	-	2 215 536
Total liabilities	131 765 815	1 246 461	1 050 984 113	1 183 996 389
Available funding	377 715 657	441 878 789	364 401 942	1 183 996 388
Trade and other receivables	12 915 302	-	-	12 915 302
Cash and investments	364 800 356	441 878 789	364 401 942	1 171 081 087
Excess/(shortfall)	245 949 843	440 632 328	(686 582 171)	-

22.1.5 Legal risk

Legal risk is the risk that the medical scheme members' will be exposed to contractual obligations, which have not been provided for. The medical scheme's most significant contractual obligation to be provided for is the liability for incurred claims. Refer to note 6 for assumptions used in the calculation of this provision. At 31 December 2025, the medical scheme did not consider that there was any significant concentration of legal risk that had not been provided for.

22.1.6 Market risk

Market risk is the risk that changes in market prices, such as interest rates and equity prices, which will negatively affect the medical scheme's income or the value of its holding of financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the risk return.

All the medical scheme's benefits are Rand denominated and therefore the medical scheme does not have significant net currency

Price risk: the medical scheme is exposed to equity securities price risk because of investments held by the medical scheme. To manage its price risk arising from investments, the medical scheme diversifies its portfolio via the asset consultant in accordance with the mandate set by the medical scheme. Market risk is further mitigated by the limitations placed on equity exposure as per

The different aspects of market risk applicable to the medical scheme are demonstrated as follows:

- interest rate risk: refer to "Sensitivity analysis: Cash";
- interest rate risk and price risk: refer to "Sensitivity analysis: Listed bonds"; and
- price risk: refer to "Sensitivity analysis: Listed equities".

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.6 Market risk (continued)

The concentration, as well as the sensitivities and impact on profit or loss and accumulated funds and reserve, are summarised below:

Concentration of risk and portfolio analysis

Asset class	2025		2024	
	R	% of total	R	% of total
Cash	426 651 361	31.9%	382 237 701	32.6%
Debt instruments	537 413 755	40.1%	475 405 977	40.6%
Equity instruments	374 497 584	28.0%	313 437 408	26.8%
Total	1 338 562 700	100.0%	1 171 081 086	100.0%

Terminology has been updated from 'Listed bonds' and 'Listed equity' to 'Debt instruments' and 'Equity instruments' to improve clarity and enhance understanding of the disclosures.

Investment allocation at 31 December 2025

Asset Manager	Mandate	Investment Vehicle	2025	
			R	% of total
Momentum Investments	Cash/Equity Bonds	Policy of Insurance	969 093 751	72.4%
Old Mutual Wealth Trust Company Proprietary Limited	Liquidity/Cash*	Segregated	369 468 949	27.6%
			1 338 562 700	100.0%

Investment allocation at 31 December 2024

Asset Manager	Mandate	Investment Vehicle	2024	
			R	% of total
Momentum Investments	Cash/Equity Bonds	Policy of Insurance	823 861 913	70.4%
Old Mutual Wealth Trust Company Proprietary Limited	Liquidity/Cash*	Segregated	347 219 174	29.6%
			1 171 081 087	100.0%

* Includes the current account

The table below summarises the primary risks affecting the Scheme's financial assets at fair value through profit or loss exposure to market risk.

2025	Total	Currency risk	Price risk	Interest rate risk
Bills & bonds (included in Debt instruments)	448 380 709			✓
Listed property (included in Equity instruments)	67 846 894		✓	
Listed equities (included in Equity instruments)	306 650 690		✓	
Foreign bonds (included in Debt instruments)	89 033 046	✓		
Cash	426 651 361			✓

2024	Total	Currency risk	Price risk	Interest rate risk
Bills & bonds (included in debt instruments)	397 962 502			✓
Listed property (included in equity instruments)	60 902 377		✓	
Listed equities (included in equity instruments)	252 535 031		✓	
Foreign bonds (included in debt instruments)	77 443 475	✓		
Cash	382 237 701			✓

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.6 Market risk (continued)

Instrument analysis

The table below discloses the top 5 holdings in each of the categories of cash, listed bonds and equities and accounted for 70% of the scheme's investable assets.

Asset Class	Top 5 Holdings - 31 December 2025	% of total portfolio
Cash	Nedbank Ltd	10.8%
	Investec Bank Ltd	10.2%
	Absa Bank Ltd	7.6%
	FirstRand Bank Ltd	2.9%
	The Standard Bank of South Africa Ltd	1.4%
Listed bonds	RSA Bond	20.4%
	USA Bonds	4.1%
	FirstRand Bank Ltd	2.7%
	ABSA GROUP LIMITED	2.2%
	Standard Bank Group Ltd	1.2%
Listed equities	Naspers Ltd	2.0%
	Firststrand Ltd	1.5%
	Standard Bank Group Ltd	0.9%
	ABSA Group Limited	0.9%
	Prosus NV	0.9%

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.6 Market risk (continued)

Instrument analysis

The table below discloses the top 5 holdings in each of the categories of cash, listed bonds and equities and accounted for 65% of the scheme's investable assets.

Asset Class	Top 5 Holdings - 31 December 2024	% of total portfolio
Cash	Nedbank Ltd	10.8%
	Investec Bank Ltd	10.2%
	Absa Bank Ltd	7.6%
	FirstRand Bank Ltd	2.9%
	The Standard Bank of South Africa Ltd	1.4%
Listed bonds	RSA Bond	20.4%
	USA Bonds	4.1%
	FirstRand Bank Ltd	2.7%
	ABSA GROUP LIMITED	2.2%
	Standard Bank Group Ltd	1.1%
Listed equities	Naspers Ltd	2.0%
	Firststrand Ltd	1.5%
	Prosus NV	0.9%
	Standard Bank Group Ltd	0.9%
	ABSA Group Limited	0.9%

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.6 Market risk (continued)

Sensitivity analysis: Cash

Basis:

The sensitivity analysis determines different levels of the closing market value as compared to the actual closing market value based on different levels of interest (see table below) i.e. +1% suggests the closing market value could have been R431 278 806 (2024: R385 760 305) if the interest had been higher by 1% during 2025 as compared to the actual interest rate. A 1% increase in the interest at the reporting date would have increased cash by R4 627 445 (2024 an increase of R3 522 603). An equal change in the opposite direction would have decreased cash by R3 320 581 (2024 a decrease of R3 522 603).

% Change	Index return*	Adjusted closing value - Rand	Rand
2.0%	9.52%	435 252 819	8 601 458
1.0%	8.52%	431 278 806	4 627 445
0.0%	7.52%	426 651 361	-
(1.0%)	6.52%	423 330 780	(3 320 581)
(2.0%)	5.52%	419 356 767	(7 294 594)

*Cash (Short-term Fixed Interest Composite Index)

Sensitivity analysis: Listed bonds

Basis:

The sensitivity analysis determines different levels of the closing market value as compared to the actual closing market value based on different levels of investment performance (see table below) i.e. +1% suggests the closing market value could have been R540 188 363 (2024: R479 463 035) if the investment performance had been higher by 1% during 2025 as compared to the market investment performance. A 1% increase in the investment return at the reporting date would have increased listed bonds by R2 774 608 (2024 an increase of R4 057 057). An equal change in the opposite direction would have decreased listed bonds by R5 852 038 (2024 a decrease of R4 057 057).

% Change	Index return**	Adjusted closing value - Rand	Rand
2.0%	26.24%	544 501 686	7 087 931
1.0%	25.24%	540 188 363	2 774 608
0.0%	24.24%	537 413 755	-
(1.0%)	23.24%	531 561 717	(5 852 038)
(2.0%)	22.24%	527 248 394	(10 165 361)

**Listed bonds (All Bond Index)

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.6 Market risk (continued)

Sensitivity analysis: Listed equities (continued)

Basis:

The sensitivity analysis determines different levels of the closing market value as compared to the actual closing market value based on different levels of investment performance (see table below) i.e. +2% suggests the closing market value could have been R380 654 938 (2024: R318 963 456) if the investment performance had been higher by 2% during 2025 as compared to the market investment performance.

A 2% increase in the investment return at the reporting date would have increased listed equity by R6 157 354 (2024 an increase of R5 526 047). An equal change in the opposite direction would have decreased listed equity by R4 386 788 (2024 a decrease of R5 526 047). The change will have an impact on the revaluation reserve and/or the profit/loss depending on the profit/loss on the investment type. All equity investments are listed on the Johannesburg Stock Exchange.

% Change	Index return***	Adjusted closing value - Rand	Rand
4.0%	46.40%	385 927 009	11 429 425
2.0%	44.40%	380 654 938	6 157 354
0.0%	42.40%	374 497 584	-
(2.0%)	40.40%	370 110 795	(4 386 788)
(4.0%)	38.40%	364 838 724	(9 658 860)

***Listed equities (All Share Index)

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

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

The following is a comparison of the fair value and the carrying amounts of the different classes of financial instruments:

	Financial assets at fair value through profit or loss R	Financial assets at amortised cost R	Cash and cash equivalents R	Liabilities measured at amortised cost R	Total carrying amount R
2025					
Non-current	911,911,339	10,111,806	57,182,413	-	979,205,558
Financial assets at fair value through profit or loss	911 911 339	-	57,182,413	-	969 093 752
Debt instruments	537 413 755	-	-	-	537 413 755
Equity instruments	374 497 584	-	-	-	374 497 584
Cash	-	-	57,182,413	-	57 182 413
Trade and other receivables	-	10,111,806	-	-	10 111 806
Current	-	10 126 815	369 468 949	(148 899 089)	230 696 675
Trade and other receivables	-	10 126 815	-	-	10 126 815
Cash and cash equivalents	-	-	369 468 949	-	369 468 949
Insurance contract liability to current members	-	-	-	(147 362 927)	(147 362 927)
Trade and other payables*	-	-	-	(1 536 162)	(1 536 162)
	911 911 339	20 238 621	426 651 362	(148 899 089)	1 209 902 233

	Financial assets at fair value through profit or loss R	Financial assets at amortised cost R	Cash and cash equivalents R	Liabilities measured at amortised cost R	Total carrying amount R
2024					
Non-current					
Financial assets at fair value through profit or loss	788 843 385	-	35 018 528	-	823 861 913
Debt instruments	475 405 977	-	-	-	475 405 977
Equity instruments	313 437 408	-	-	-	313 437 408
Cash *	-	-	35,018,528	-	35 018 528
Current	-	12 915 302	347 219 174	(133 012 276)	227 122 200
Trade and other receivables	-	12 915 302	-	-	12 915 302
Cash and cash equivalents	-	-	347 219 174	-	347 219 174
Insurance contract liability to current members	-	-	-	(130 796 740)	(130 796 740)
Trade and other payables**	-	-	-	(2 215 536)	(2 215 536)
	788 843 385	12 915 302	347 219 174	(133 012 276)	1 015 965 585

2024

Non-current

Financial assets at fair value through profit or loss

Debt instruments	475 405 977	-	-	-	475 405 977
Equity instruments	313 437 408	-	-	-	313 437 408
Cash *	-	-	35,018,528	-	35 018 528
Current	-	12 915 302	347 219 174	(133 012 276)	227 122 200
Trade and other receivables	-	12 915 302	-	-	12 915 302
Cash and cash equivalents	-	-	347 219 174	-	347 219 174
Insurance contract liability to current members	-	-	-	(130 796 740)	(130 796 740)
Trade and other payables**	-	-	-	(2 215 536)	(2 215 536)
	788 843 385	12 915 302	347 219 174	(133 012 276)	1 015 965 585

Terminology has been updated from 'Listed bonds' and 'Listed equity' to 'Debt instruments' and 'Equity instruments' to improve clarity and enhance understanding of the disclosures.

* The cash portion of the Financial assets at fair value through profit or loss for the 2024 financial year was omitted in error. The disclosure in the table above is now corrected.

** Excludes net contributions received in advance and members' co-payments on claims received in advance.

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.8 Fair value of financial instruments

The carrying amounts of financial assets and financial liabilities in the financial statements approximate their fair values.

a. Valuation techniques and assumptions applied for the purposes of measuring fair value

- the fair values of financial assets and financial liabilities with standard terms and conditions and traded on active liquid markets are determined with reference to quoted market prices (include listed redeemable notes, bills of exchange, debentures and perpetual notes); and
- the fair values of other financial assets and financial liabilities are determined in accordance with generally accepted pricing models based on discounted cash flow analysis using prices from observable current market transactions and dealer quotes for similar instruments.

b. Fair value measurements (fair value hierarchy)

The fair value hierarchy reflects the significance of the inputs used to make the measurements.

Level 1 fair value measurement represents those instruments which are measured using unadjusted quoted prices in active markets for identical instruments. The predominance of market inputs is actively quoted and can be validated through external sources or reliably interpolated if less observable.

At 31 December 2025, investments classified as Level 1 comprised approximately 45% of financial assets measured at fair value on a recurring basis. Fair value measurements classified as Level 1 include exchange traded prices of fixed maturities and equity securities.

Unit linked funds usually have a published price used for the previous day's transactions. Where the valuation of the investment of the medical scheme is based on these observable unit prices with no significant unobservable inputs and there are sufficient transactions to meet the definition of a quoted price in an active market, it is likely to be classified as Level 1. However, if an insurer calculates the liability without reference to the published price, it will fall into Level 2 or 3. Where the valuation of the liability incorporates significant inputs influenced by management's assumptions, such as tax adjustments not reflected in the observable price or underlying assets and liabilities, this is likely to be a Level 3 classification.

Listed debt securities such as government securities and corporate bonds may be classified as Level 1 or 2 depending on trade frequency and data availability.

At 31 December 2025, investments classified as Level 2 comprised approximately 55% of financial assets measured at fair value on a recurring basis. They primarily include government and agency securities and certain corporate debt securities, such as private fixed maturities. As market quotes generally are not readily available or accessible for these securities, their fair value measures are determined utilising relevant information generated by market transactions involving comparable securities. Inputs other than quoted prices that are observable for the assets either directly (as prices) or indirectly (derived from prices) are applied. They are often based on model pricing techniques that effectively discount prospective cash flows to present value using appropriate sector adjusted credit spreads commensurate with the security's duration, also taking into consideration issuer specific credit quality and liquidity. These valuation methodologies have been studied and evaluated by the asset manager and the resulting prices determined to be representative of exit values.

Observable inputs generally used to measure the fair value of securities classified as Level 2 include benchmark yields, reported secondary trades, broker dealer quotes, issuer spreads, benchmark securities, bids, offers and reference data. Additional observable inputs are used when available, and as may be appropriate, for certain security types, such as pre-payment, default and collateral information for purpose of measuring the fair value of mortgage and asset backed securities.

22 FINANCIAL RISK MANAGEMENT (continued)

22.1 Financial risk factors (continued)

22.1.8 Fair value of financial instruments (continued)

b. Fair value measurements (fair value hierarchy) (continued)

Level 3 fair value measurements apply inputs, which are not based on observable market data. Private equity securities usually are priced based on unobservable market data and are not easily tradeable and are therefore likely to be classified as Level 3.

At 31 December 2025, no investments were classified as Level 3.

Fair value measurements

This note provides information about how the medical scheme determines fair values of various financial assets.

Fair value of the medical scheme's financial assets that are measured at fair value on a recurring basis

Some of the medical scheme's financial assets are measured at fair value at the end of each reporting period. The following table gives information about how fair values of these financial assets are determined (in particular, the valuation technique(s) and inputs used).

	Fair value as at 31 December		Fair value hierarchy	Valuation technique(s) and key input	Significant unobservable input(s)	Relationship of unobservable inputs to fair value
	2025 R	2024 R				
Financial assets						
Assets						
Non-current assets						
Financial assets at fair value through profit or loss	969 093 751	823 861 913				
Debt instruments	537 413 755	475 405 977	Level 2	Quoted market price	None	None
Equity instruments	374 497 584	313 437 408	Level 1	Quoted market price	None	None
Cash	57 182 413	35 018 528	Level 1	Quoted market price		
	969 093 751	823 861 913				

The classifications are done on a look through basis of the policy of insurance.

Terminology has been updated from 'Listed bonds' and 'Listed equity' to 'Debt instruments' and 'Equity instruments' to improve clarity and enhance understanding of the disclosures.

This table does not include fair value information for financial assets not measured at fair value if the carrying amount is a reasonable approximation of fair value.

23 EVENTS AFTER REPORTING DATE

There have been no significant events after the reporting date, to the date of the signature of the annual financial report.

24 COMMITMENTS AND OTHER CONTINGENT LIABILITIES

The medical scheme did not have any commitments or other contingent liabilities outstanding at 31 December 2025.

25 NON-COMPLIANCE MATTERS

25.1 *Claim payments not within thirty days of receipt by the medical scheme*

Nature and cause of non-compliance

Section 59(2) of the Act states that:

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

The medical scheme processes and pays claims within thirty days from date of receipt. There are, however, situations beyond the control of the medical scheme that could result in claims being paid later than thirty days, e.g. supporting information may be required from the member or healthcare service provider.

Possible impact of non-compliance

These are isolated cases and thus have not resulted in a material gain or loss to the medical scheme.

Corrective course of action adopted to ensure compliance, including timing of corrective action

The necessary assistance is provided to identified members and healthcare service providers to ensure that these types of isolated cases are minimised.

25.2 *Investment in an employer group or administrator*

Nature and cause of non-compliance

Section 35(8) of the Act states that:

"(8) A medical scheme shall not invest any of its assets in the business of or grant loans to:

- (a) an employer who participates in the medical scheme or any administrator or any arrangement associated with the medical scheme;
- (b) any other medical scheme;
- (c) any administrator; and
- (d) any person associated with any of the abovementioned."

The medical scheme invests its assets in accordance with an investment policy. These assets are invested in different investment vehicles each having a specific investment mandate, benchmark and chosen investment manager. Some of these mandates may allow exposure to shares or bonds listed in the South African market. The investment manager has full discretion to choose a combination of shares and bonds that will best achieve the benchmark. The representatives of the medical scheme have given discretionary powers in terms of the investment mandate, in accordance with Annexure B to the Regulation to the Act (Annexure B), to the underlying investment manager.

A number of shares are held indirectly, through a policy of insurance with Momentum Investments, in ultimate holding companies of medical scheme administrators and in the medical scheme's employer company, Sasol Limited.

Possible impact of non-compliance

The medical scheme received exemption from Section 35(8)(a) and (c) of the Act from the CMS for a 3-year period until 31 December 2028.

25 NON-COMPLIANCE MATTERS (continued)

25.2 *Investment in an employer group or administrator (continued)*

At the year-end the medical scheme held shares at fair value in:

Company name	31 December 2025	31 December 2024
	R	R
Discovery Holdings Limited	3 298 914	547 299
Momentum Group Limited	1 886 953	1 472 503
Sanlam Limited	6 161 401	5 988 516
Sasol Limited (refer to section 10 of the Report of the Board of Trustees)	2 252 290	1 988 210

By applying Section 35(8)(a) and (c) of the Act, the medical scheme will not be able to invest in these companies. The diversification of opportunities is reduced and the medical scheme will be forced to take on additional risk. This is not in the best interest of the members.

Corrective course of action adopted to ensure compliance, including timing of corrective action

In terms of compliance to Annexure B, the medical scheme does perform a comprehensive analysis of the total assets to ensure that the investments do not exceed the limitations set out per Annexure B. Any exposure to the companies in question will be within the limits set out in Annexure B, which will limit the risk to members. It would not be prudent to remove these investment opportunities from the scope of investments available to the underlying investment managers.

25.3 *Financial soundness*

Nature and impact

In terms of Section 33(2) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance and be financially sound. At 31 December 2025 the Scheme incurred a net insurance service result deficit of R31.9m (2024: surplus of R66.0m). The performance of the Scheme is in line with the Scheme's pricing strategy for the year as the Scheme targets a solvency ratio between 31% and 41%, with the actual solvency ratio at 41.6%, while keeping contributions as affordable as possible.

Cause of non-compliance

The Scheme experienced higher than anticipated claims during 2025.

Corrective action

The Board of Trustees carefully monitors the Scheme's performance with the assistance of the Scheme's actuaries. The Trustees are comfortable that the Scheme is in a sound financial position as at 31 December 2025.

25.4 *Scheme rules*

Nature and impact

In terms of section 32 of the Act, a medical scheme shall be bound by its rules. During the year under review, the Scheme allowed members with co-payments to fund these via the employer's payroll function. This may be seen as a loan to the members, which is not specifically incorporated into the scheme rules.

Cause of non-compliance

The employer assisted members with co-payments, to pay these co-payments via salary deductions.

Corrective action

The Scheme is in the process to update the Rules to allow such a practice. The Scheme is currently investigating this practice.