

LA HEALTH MEDICAL SCHEME

ANNUAL FINANCIAL STATEMENTS

31 December 2025

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2025

The reports and statements set out below comprise the Annual Financial Statements presented to members:

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TRUSTEES' RESPONSIBILITY AND APPROVAL

The Trustees are responsible for the preparation of the Financial Statements, which fairly present the state of affairs of LA Health Medical Scheme, comprising the Statement of Financial Position at 31 December 2025, the Statements of Comprehensive Income and Cash Flows for the year then ended, and the notes to the Financial Statements. These include a summary of material accounting policies and other explanatory notes in accordance with International Financial Reporting Standards, and in the manner required by the Medical Schemes Act of South Africa as amended, and the Regulations thereto. In addition, the Trustees are responsible for preparing the Board of Trustees' report and the Statement of Corporate Governance.

The Trustees are responsible for such internal controls as they deem necessary to enable the preparation of the Financial Statements that are free from material misstatement, whether due to fraud or error. The Trustees ensure the use of appropriate accounting policies and prudent judgements and estimates. The Trustees are also responsible for maintaining adequate accounting records and an effective system of risk management.

The Trustees have made an assessment of the ability of the Scheme to continue as a going concern and have no reason to believe that the Scheme will not be a going concern in the year ahead.

The external auditor is responsible for reporting on whether the Financial Statements are fairly presented in accordance with the applicable financial reporting framework.

Approval of the Financial Statements

The Financial Statements, as identified in the first paragraph, were approved by the Board of Trustees on 23 April 2026 and are signed on its behalf by:



R DENGE
CHAIRPERSON



A VORSTER
TRUSTEE



AM DE KOKER
PRINCIPAL OFFICER

23 April 2026

DATE

STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES

LA Health Medical Scheme is committed to the principles and practice of responsibility, fairness, transparency, integrity and accountability in all dealings with its stakeholders. The Scheme conducts its affairs according to ethical values, and in compliance with a governance framework based on the principles published by the King Commission.

BOARD OF TRUSTEES

The Trustees meet regularly and monitor the performance of the Scheme. They address a range of key issues and ensure that the discussion of items of policy, strategy and performance are critical, informed and constructive. The performance of third party service providers is monitored against contracted service level agreements. The Trustees have adopted, and maintain, a process of risk identification, assessment and management.

All Trustees have access to the advice and services of the Principal Officer and, where appropriate, may seek independent professional advice at the expense of the Scheme.

The Board of Trustees has appointed an Audit and Risk Committee as well as an ad hoc Nominations and Appointment Committee and Recruitment Committee to assist it in executing its duties. The performance of the Board of Trustees, and the appointed sub-committee, is assessed annually against agreed upon terms of reference.

INTERNAL CONTROL

The 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 adequately maintain accountability for its assets. Such controls are based on established policies and procedures and are implemented by trained personnel with the appropriate segregation of duties. The adequacy and effectiveness of the systems are assessed by the Scheme's Internal and External Auditors.

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



R DENGE
CHAIRPERSON



A VORSTER
TRUSTEE



AM DE KOKER
PRINCIPAL OFFICER

23 April 2026

DATE

REPORT OF THE AUDIT & RISK COMMITTEE

The Audit & Risk Committee hereby presents its report for the year ended 31 December 2025.

Audit & Risk Committee members

The Audit & Risk Committee consists of the members listed below and meets at least four times per year, as per the approved terms of reference.

Ms F Mohamed (Chairperson)	Independent
Ms Y Maseko (Deputy Chairperson)	Independent
Mr S Martinus	Independent
Mr H Botha	Trustee
Mr A Vorster	Trustee

Audit & Risk Committee costs are depicted in the annual financial statements. Refer to note 13 of the annual financial statements.

Audit & Risk Committee responsibility

The Audit & Risk Committee reports that it has complied with its responsibilities as contained in the Medical Schemes Act of South Africa (the Act), and the Corporate Governance Guide to Audit & Risk Committees for Medical Schemes as issued by the South African Institute of Chartered Accountants.

The Audit & Risk Committee reports that it has complied with the formal terms of reference/audit committee charter, as approved by the Board of Trustees, regulated its affairs in compliance with the charter and discharged its responsibilities as contained therein.

The effectiveness of internal control

The Audit & Risk Committee has received reports from various assurance providers on the effectiveness of the internal financial control environment and as such has not found any significant or material non-compliance with prescribed policies and procedures.

Further, the Audit & Risk Committee noted that management controls applied during the year of assessment, e.g. the maintaining of an internal audit activity by the Scheme's administrator, has enhanced the overall internal control structure. The Audit & Risk Committee noted specifically the high level of assurance awarded to the Scheme's administrator's financial control environment.

Internal audit - business and IT

The Audit & Risk Committee reviews internal audit reports and the effectiveness of the internal audit function at each meeting. The Committee noted all findings and are comfortable that these are being dealt with accordingly.

The Committee also obtained assurances from the Administrator regarding IT risks and controls, business continuity and data recovery related to IT information security and privacy. The Committee is comfortable with assurances received.

REPORT OF THE AUDIT & RISK COMMITTEE (continued)

Risk management

The Board of Trustees, who is ultimately accountable for the oversight of LA Health's risk, is supported by the Audit & Risk Committee, who has also been appointed as the Scheme's Risk Committee.

LA Health's risk tolerance encapsulates consideration of both the financial and non-financial risks. The key risk categories which include Strategic, Financial, Insurance, Business, Operational and Regulatory, are in place and are actively managed by the Scheme, through ongoing monitoring, assessment, and management of LA Health's risk environment and the effectiveness of the risk management framework. A risk management workshop is convened every two years to review LA Health's approach to risk management, which includes the review of the risk tolerance to ensure that the Scheme remains in line with market best practice and regulatory expectations, whilst adequately addressing the scheme's inherent and residual risk. The next workshop will be held in October 2027, where the Board of Trustees and Audit & Risk Committee will consider whether LA Health's risk tolerance remains aligned to best practices, regulatory expectations, and its strategic objectives.

Evaluation of annual financial statements

The Audit & Risk Committee has:

- Noted and agreed that the financial statements of the Scheme have been prepared in accordance with IFRS and the requirements of the Medical Schemes Act of South Africa;
- Noted and agreed there were no changes in the accounting policy information.
- Reviewed and discussed with the Principal Officer and external auditor the audited financial statements.

Governance

The Board of Trustees has formally adopted the King IV Report on Corporate Governance and is committed to applying its principles in a manner that supports ethical leadership, effective control, and legitimacy. A comprehensive King IV assessment was undertaken using The Governance & Compliance Instrument, providing a detailed analysis of the Scheme's alignment with each of the 17 principles. This assessment confirmed that all principles are well supported by relevant policies, governance structures, and operational activities.

The Audit & Risk Committee is confident that the Scheme's governance framework reflects a strong commitment to accountability and transparency. Further initiatives are currently underway to strengthen compliance with King IV and enhance alignment with emerging best governance practices.

Going concern

The Audit & Risk Committee considered the Going Concern assessment of management and is comfortable that no reason exist for the Scheme not to continue as a going concern.

REPORT OF THE AUDIT & RISK COMMITTEE (continued)

Non-compliance matters

The Audit & Risk Committee takes note of the non-compliance matters as reported in note 20 to the financial statements and of the Board of Trustees' comments as contained in the Board of Trustees Report in this regard and is comfortable that these non-compliance matters have been appropriately addressed.

Annual financial statements

The Audit & Risk Committee concurs and accepts the conclusions of the external auditor on the financial statements and is of the opinion that the audited financial statements be accepted and read together with the report of the external auditor.



MS F MOHAMED CA(SA)
CHAIRPERSON - AUDIT AND RISK



AM DE KOKER
PRINCIPAL OFFICER

23 April 2026

DATE

Independent Auditor's Report

To the Members of LA Health Medical Scheme

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of LA Health Medical Scheme (the Scheme), set out on pages 13 to 65, which comprise the statement of financial position as at 31 December 2025, the statement of comprehensive income, and the statement of cash flows, for the year then ended, and notes to the financial statements, including a summary of material accounting policy information.

In our opinion, these financial statements present fairly, in all material respects, the financial position of LA Health Medical Scheme as at 31 December 2025 and its financial performance and cash flows for the year then ended, in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board 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), as applicable to audits of financial statements of public interest entities, 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.



Managing Partner: ML Tshabalala

A full list of partners and directors is available on request

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

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

In terms of the IRBA Rule on Enhanced Auditor Reporting for the Audit of Financial Statements of Public Interest Entities, published in Government Gazette No. 49309 dated 15 September 2023 (EAR Rule), we report:

Final Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the nature and extent of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality:	R65 million (2024: R57 million).
How we determined it:	1% of Insurance revenue for the year.
Rationale for the materiality benchmark applied:	A key judgement in determining materiality is the determination of the appropriate benchmark to use which should be based on our understanding of the needs of the users of the financial statements. We have determined the users of the financial statements to be the members of LA Health Medical Scheme. We chose insurance revenue as the primary benchmark as it is the benchmark against which the performance of the Scheme is measured by users.

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.

In terms of the EAR Rule, we are required to report the outcome of audit procedures or key observations with respect to the key audit matters and these are included below.

Key audit matter Note 5 of the financial statements	How the matter was addressed in the audit
Valuation of the liability for incurred claims (LIC) included in the insurance contract liability. The carrying amount of the insurance contract liability as per Note 5 of the financial statements is R891 104 340 (2024: R718 935 518) which is made up of the following three components:	We obtained an understanding from the Scheme's actuaries regarding the process followed in calculating the provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme and the risk adjustment for non-financial risk.

<ul style="list-style-type: none"> • The present value of future cash flows of R1 222 533 033 (2024: 1 000 510 733); • The risk adjustment of R5 211 311 (2024: R4 530 039); and • The liability for remaining coverage of -R336 640 005 (2024: -R286 105 255), which is not considered as part of the key audit matter. <p>The provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme (the present value of future cash flows or Incurred But Not Reported – IBNR) and the Risk adjustment (RA), which is a risk adjustment for non-financial risk, are the components that make up the LIC.</p> <p>The determination of the provision for the estimated cost of healthcare benefits that have occurred before the year-end but have not been reported to the Scheme by that date, requires the Scheme’s Trustees to make assumptions in the valuation thereof, which is determined with reference to an estimation of the ultimate cost of settling all claims incurred but not yet reported at the statement of financial position date.</p>	<p>We evaluated the calculations approved by the Board of Trustees and performed procedures which included:</p> <ul style="list-style-type: none"> • Considered the design and implementation of the Scheme’s key controls within the provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme; and RA calculation business process though gaining an understanding of the end-to end claims and LIC business process. • Evaluated the competence, capabilities, and objectivity of the Scheme’s actuary. • We obtained the report of the Scheme’s actuary relating to the LIC at year-end and tested the appropriateness of the estimate as follows: <ul style="list-style-type: none"> ○ Obtained an understanding of the method and models used in calculating the LIC estimate. With the assistance of our actuarial specialists, we assessed the appropriateness of the methodology and assumptions used in determining the provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme and RA components in terms of acceptable methodologies, industry standards, and that they meet the measurement objectives of IFRS 17.
<p>This is an estimate of the future payments to be made on claim events that have taken place during the reporting period but have yet to be reported and paid.</p> <p>The calculation is based on a number of factors which include:</p>	<ul style="list-style-type: none"> ○ Our audit specialists performed an independent calculation of the estimate of the LIC by utilising historical claims data and trends and using this estimate as a basis of assessing the reasonableness of the Board of Trustees’ estimate of the LIC.

- Previous experience in claims patterns;
- Claims settlement patterns;
- Changes in the nature and number of members according to gender and age;
- Trends in claims frequency.
- Changes in the claims processing cycle;
- Variations in the nature and average cost per claim; and
- Other factors such as expectations of future events that are believed to be reasonable to be taken into account in the valuation of the provision for the estimated costs of healthcare benefits that have occurred before the year-end but have not been reported to the Scheme by that date.

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

- Reflects risks and uncertainty as viewed by the Scheme;
- Considers all aspects of non-financial risk and uncertainty; and
- Excludes financial risks, such as investment returns (cash flows not directly tied to contract).

The abovementioned factors require judgement and assumptions to be made by the Scheme's Trustees and therefore accordingly, for the purposes of our audit, we identified the valuation of the provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme and the RA for non-financial risk as representing a key audit matter.

- On a sample basis we tested the integrity of the information used in the calculation of the estimated future cash flows included in the provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme and the RA determined, by performing substantive procedures to test the accuracy and completeness of data used in the determination of the estimation of future cash flows and the RA.
- Assessed the presentation and disclosure in respect of the LIC provision and considered the adequacy of these disclosures against the requirements of IFRS 17 and relevant industry guidance.

Based on the procedures performed as described above, we are satisfied that the methodology and assumptions applied in calculating the provision for the estimated cost of healthcare benefits that had occurred before the year-end, but that had not been reported to the Scheme and RA components of the LIC are appropriate.

Other Information

The Scheme's Trustees are responsible for the other information. The other information comprises the information included in the document titled "LA Health Medical Scheme Financial Statements for the year ended 31 December 2025", which includes the Trustees' responsibility and approval, the Statement of corporate governance by the Board of Trustees, the Report of the Audit & Risk Committee and the Report of the Board of Trustees as required by the Medical Schemes Act of South Africa. 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 that there are no material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa that have come to our attention during the course of our audit.

Audit tenure

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that Deloitte has been the auditor of LA Health Medical Scheme for two years.

The engagement audit partner, Claudette van der Merwe, has been responsible for LA Health Medical Scheme's audit for one year.

DocuSigned by:
 Deloitte & Touche
390CA36F22BE458...

Deloitte & Touche
Per: Claudette van der Merwe
Partner
Registered Auditor

28 May 2026

STATEMENT OF FINANCIAL POSITION
as at 31 December 2025

	Notes	2025 R	2024 R
ASSETS			
Property and equipment	1	17,244	3,965,733
Financial assets at amortised cost	2	3,102,843,455	2,963,908,893
Scheme funds		2,517,843,455	2,378,908,893
Medical Savings Account <i>trust</i> funds		585,000,000	585,000,000
Other financial assets at amortised cost	3	102,360,285	111,490,145
Cash and cash equivalents	4	1,821,841,720	1,449,874,881
Scheme funds		1,536,543,597	1,311,560,365
Medical Savings Account trust funds		285,298,123	138,314,516
TOTAL ASSETS		5,027,062,704	4,529,239,652
LIABILITIES			
Liability to members for future benefits*	5.2	4,126,621,318	3,776,327,777
Liability to members for current benefits**	5.1	891,104,340	718,935,518
Reinsurance contract liabilities	6	2,696,940	-
Post-retirement healthcare funding liability	7	3,242,000	2,882,000
Other financial liabilities at amortised cost	8	3,398,106	31,094,357
TOTAL LIABILITIES		5,027,062,704	4,529,239,652

* This represents the obligation of the Scheme to provide healthcare benefits to its members in the future. It was previously referred to as the Insurance liability for future members.

**Included in the Liability to members for current benefits is the Medical Savings Account *trust* liability to the value of R903,139,293 (2024: R739,676,464). See detail in Notes 5.1 and 5.3.

STATEMENT OF COMPREHENSIVE INCOME
for the year ended 31 December 2025

	Notes	2025 R	2024 R
Insurance revenue	9	6,662,225,073	5,761,334,113
Insurance service expenses**		(6,499,556,407)	(5,561,211,632)
Net claims incurred*	9	(5,828,331,383)	(4,967,285,694)
Accredited managed healthcare services*	9	(139,293,947)	(123,107,953)
Directly attributable expenses	9	(369,592,338)	(325,943,373)
Insurance acquisition cash flows	9	(162,338,739)	(144,874,612)
Net income/(expense) from reinsurance contracts*	9	15,888,475	(1,528,034)
Premiums paid		(58,021,442)	(49,327,024)
Amounts recovered from reinsurance contracts		73,909,917	47,798,990
Insurance service result		178,557,141	198,594,447
Other income***		362,376,396	361,812,669
Investment income	10	361,609,770	360,517,682
Sundry income	11	766,626	1,294,987
Other expenditure***		(190,639,996)	(175,434,560)
Other operating expenditure	13	(126,002,246)	(112,780,409)
Finance expense from insurance contracts	12	(64,637,750)	(62,654,151)
Net surplus for the year before amounts attributable to members for future benefits		350,293,541	384,972,555
Amounts attributable to members for future benefits	5.2	(350,293,541)	(384,972,555)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR****		-	-
Relevant healthcare expenditure*		(5,951,736,855)	(5,091,921,681)

*As required by CMS Circular 32 of 2025, "relevant healthcare expenditure" is presented as a separate line item and comprises net claims incurred, accredited managed healthcare services and net income/(expense) from reinsurance contracts.

**The Scheme expanded its presentation of the Insurance service expense to reflect the breakdown of relevant healthcare expenditure and align with the medical schemes accounting guide issued by the South African Institute of Chartered Accountants. The Insurance service expenses in accordance with IFRS 17: Insurance Contracts include amounts attributable to members for future benefits, the total value of the insurance expenses therefore amounts to R6,849,849,948 (2024: R5,946,184,188).

***Other income and other expenditure disclosure has also been amended to align with the medical schemes accounting guide. Specifically, Net investment income presented in the prior year as Interest from cash and cash equivalents and Interest from investments have now been combined in one line-item Investment income; and presented together with Sundry income under a new sub-total, Other income. Furthermore, Other operating expenditure and Finance expense from insurance contracts (previously called Finance expenses on Personal Medical Savings Account monies) have been presented under a new sub-total, Other expenditure.

****See mutual entity disclosure on page 18

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 and providers		8,326,024,450	7,205,025,178
Cash receipts from members - contributions	5.1	8,326,024,450	7,203,094,409
Cash receipts from members and providers - other	5.3	-	1,930,769
Cash paid to members, employees and providers		(8,190,024,895)	(7,130,561,845)
Cash paid to members and providers - claims and other directly attributable expenses paid	5.1	(7,944,561,893)	(6,936,233,592)
Cash paid to reinsurer	6	(55,324,502)	(49,327,024)
Cash paid to members and providers - other	8	(25,970,378)	-
Cash paid to employees and providers - non-healthcare expenditure	21	(126,815,221)	(112,076,146)
Cash paid to members - Medical Savings Account refunds	5.3	(37,352,901)	(32,925,083)
Net cash generated in operating activities		135,999,555	74,463,333
CASH FLOWS FROM INVESTING ACTIVITIES			
Additions to property and equipment	1	(11,894)	(13,513)
Disposal of property and equipment	1	4,700,000	-
Additions to investments at amortised cost	2	(138,934,562)	(74,236,808)
Interest received	21	370,213,740	343,692,256
Net cash generated from investing activities		235,967,284	269,441,935
Net increase in cash and cash equivalents		371,966,839	343,905,268
Cash and cash equivalents at beginning of the year		1,449,874,881	1,105,969,613
Cash and cash equivalents at end of the year		1,821,841,720	1,449,874,881
Scheme funds		1,536,543,597	1,311,560,365
Medical Savings Account <i>trust</i> funds		285,298,123	138,314,516

ACCOUNTING POLICIES

for the year ended 31 December 2025

GENERAL INFORMATION

The Scheme is a restricted membership medical scheme registered in terms of the Medical Schemes Act No. 131 of 1998, as amended (the Act), and is domiciled in the Republic of South Africa.

LA Health Medical Scheme (the Scheme) is a medical scheme that offers hospital, chronic illness and day-to-day benefits and is administered by Discovery Health (Pty) Ltd, a wholly owned subsidiary of Discovery Limited, listed in the insurance sector of the Johannesburg Stock Exchange (JSE).

BASIS OF PREPARATION

The Financial Statements have been prepared in accordance with IFRS[®] Accounting Standards (IFRS) and IFRIC[®] Interpretations, which are set by the International Accounting Standards Board (IASB). The Financial Statements are also prepared in accordance with the Act, which requires additional disclosures for registered medical schemes.

The detailed accounting policies have been set out in the respective Notes to the Financial Statements, with the general accounting policies applied in the preparation of these Financial Statements set out below. These policies have been consistently applied to all years presented, except for changes required by the mandatory adoption of new and revised IFRS and changes in accounting policies.

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

The Financial Statements are prepared in accordance with the going concern principle using the historical cost basis except for certain financial assets and liabilities, which include:

- Insurance and reinsurance assets and liabilities – measured in terms of IFRS 17.

The Statement of Financial Position is disclosed in the order of liquidity as it provides more reliable information about the transactions and conditions on the financial position of medical schemes, largely due to the uncertainty around the actual identifiable operating cycle, and the asset decisions taken to manage such uncertain operating cycle.

Due to the short-term nature of the Scheme's financial assets and liabilities, all values are shown as current unless otherwise stated.

All monetary information and figures presented in these Financial Statements are stated in South African Rand, which is the Scheme's functional currency, unless otherwise indicated.

ACCOUNTING POLICIES (continued)
for the year ended 31 December 2025

IMPLEMENTATION OF NEW STANDARDS

New standards, amendments and interpretations not yet effective and relevant to the Scheme

The following new standards, amendments and interpretations to the existing standards have been published but are not yet effective for the current financial year. The Scheme has not early adopted them and it is not expected that they will have any material impact on the Scheme's assets, liabilities and results but may result in additional disclosure in the Financial Statements.

Standard	Scope	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.	1 January 2026
Annual improvements to IFRS Accounting Standards – Amendments to: IFRS 1 First-time Adoption of International Financial Reporting Standards; IFRS 7 Financial Instruments: Disclosures and its accompanying Guidance on implementing IFRS7; IFRS 9 Financial Instruments; IFRS 10 Consolidated Financial Statements; IAS 7 Statement of Cash Flows	These amendments, published in Annual Improvements to IFRS Accounting Standards – Volume 11, introduce clarifications and minor revisions to five IFRS standards, effective for annual reporting periods beginning on or after 1 January 2026. The changes address inconsistencies and potential confusion in the application of IFRS 1, IFRS 7, IFRS 9, IFRS 10, and IAS 7. Key amendments include clarifications on hedge accounting for first time adopters, derecognition of lease liabilities, disclosure of deferred differences in fair value, determination of a 'de facto agent' in consolidated Financial Statements, and the use of the term 'cost method' in cash flow statements. These updates ensure consistency and improve the usability of the standards without introducing major policy changes. The Scheme will assess the additional disclosure requirements.	1 January 2026
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.	1 January 2027

None of the new standards, amendments and interpretations effective for the current financial year had any significant impact on the Scheme.

SIGNIFICANT JUDGEMENTS AND ESTIMATES

In the application of the Scheme's accounting policies, which are described below and in the notes, the Board of Trustees is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates. The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Following are the significant judgements, apart from those involving estimations (which are dealt with separately below), that have been made in the process of applying the Scheme's accounting policies and that have the most significant effect on the amounts recognised in the Financial Statements.

Significant Judgements

Classification of the Scheme as a mutual entity

A medical scheme is not legally defined as a mutual entity and the classification of the scheme as a mutual entity was done based on the principles set out in IFRS.

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

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

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

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

SIGNIFICANT JUDGEMENTS AND ESTIMATES (continued)

Significant Judgements (continued)

Classification of the Scheme as a mutual entity (continued)

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

It is therefore expected that the remaining assets of the scheme will be used to pay current and future benefits for members. Based on the above, the Scheme meets the definition of a mutual entity in terms of IFRS.

The Scheme has therefore developed an accounting policy in terms of the IFRS 17 guidance for mutual entities, and the educational material as issued by the IASB, and the Scheme recognises any cumulative profits or losses as part of the Liability attributable to members for future benefits (which forms part of the Insurance contract liabilities on the face of the Statement of Financial Position).

Consequently, the Statement of Comprehensive Income reflects no total comprehensive income for the year.

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

Onerous contract assessment

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

Unit of account

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

The above is demonstrated by the following:

- Hospital claims are managed on a scheme level.
- Chronic conditions are managed on a scheme level, i.e. no matter the option the member will have access to the chronic condition management benefit.
- Reinsurance contracts are based on conditions and not on the benefits of the Options.
- Pricing and benefit option changes are determined at a scheme level to manage member migration between different benefit options to ensure each option is sustainable.
- Risk (utilisation and concentration) is managed holistically.

SIGNIFICANT JUDGEMENTS AND ESTIMATES (continued)

Significant Judgements (continued)

Risk adjustments - liability for incurred claims

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

The risk adjustment was calculated at the portfolio level as the Scheme's ability to set a price based on the individual risk profile of the member is constrained by law. The Risk-Based Solvency methodology was used which calculates the deviations of the recommended provision from the actual using past data and then builds the distribution based on approaches used for Solvency II insurance regulation. 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 *Liability for incurred claims*. The confidence level is set at 75%.

The Scheme will present the changes in the risk adjustment for non-financial risk in the insurance service result. The methods and assumptions used to determine the risk adjustment for non-financial risk were not changed in the current year.

Recoveries from reinsurance

Judgement has been applied to how the Scheme calculates the recoveries from reinsurance contracts. These recoveries represent the value of claims the Scheme would potentially have incurred should the reinsurance agreements not have been in place.

An estimate of the expected similar costs is obtained using other scheme lives not subject to these reinsurance contracts and then multiplied by the lives exposure to these contracts. This amount results in the recoveries from reinsurance.

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.

The sensitivities with regard to the assumptions made that have the most significant impact on measurement under IFRS 17, are detailed in the Insurance Risk Management note in the Financial Statements.

SIGNIFICANT JUDGEMENTS AND ESTIMATES (continued)

Significant estimates (continued)

Estimates of future cash flows to fulfil insurance contracts

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

Method used to measure the insurance contracts

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

Judgement is involved in assessing the most appropriate technique to estimate insurance liabilities for the claims incurred. The 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 applied to cumulative claims data for each period (in the Scheme's case, for the four months post year-end) that is not yet fully developed to produce an estimated ultimate claims cost for each reporting period. 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 *Liability for incurred claims* :

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

FINANCIAL INSTRUMENTS

Recognition

The Scheme recognises a financial instrument when, and only when, it becomes a party to the contractual provisions of the instrument. The Scheme classifies its financial instruments into the following categories: financial assets or financial liabilities at amortised cost.

Classification

The classification depends on the purpose for which the financial instruments are acquired. Management determines the classification of financial instruments at initial recognition. All purchases and sales of financial instruments are recognised on the trade date, which is the date on which the Scheme commits to purchase the financial asset or assume financial liability.

Offsetting financial instruments

This applies where a legally enforceable right to set off exists for recognised financial assets and financial liabilities, and there is an intention and ability to realise the asset and settle the liability simultaneously or to settle on a net basis.

The Scheme will disclose the net asset or liability in the Statement of Financial Position and on a gross basis in the accompanying notes if the above conditions are met.

Derecognition of financial assets and liabilities

The Scheme derecognises a financial asset or part of a financial asset when:

- The contractual right to the cash flows from the asset expires.
- The Scheme retains the contractual right to receive cash flows of the asset, but assumes the obligation to pay one or more third parties the cash flow without material delay.
- The Scheme transfers the asset, while transferring substantially all the risks and rewards of ownership.
- The Scheme neither transfers the financial asset nor retains significant risk and reward of ownership, but has transferred control of the financial asset.

The Scheme derecognises a financial liability when the obligation under the liability is discharged, cancelled or expires.

FINANCIAL LIABILITIES

Financial liabilities are initially recognised at fair value, net of transaction costs incurred. After initial recognition the financial liabilities are measured at amortised cost, using the effective interest method. In addition, the Scheme is not permitted to borrow, in terms of Section 35 (6)(c) of the Act. The Scheme therefore has no long-term financial liabilities.

PROVISIONS

The Scheme recognises a provision when the following conditions are met:

- it has a present legal or constructive obligation as a result of past events;
- it is probable that an outflow of resources embodying economic benefits will be required to settle the obligation;
- and
- a reliable estimate of the amount of the obligation can be made.

Provisions are measured as the present value of management's best estimate of the expenditure required to settle the obligation at the reporting date. Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

CONTINGENT LIABILITIES

The Scheme will disclose a contingent liability if one of the following conditions are met:

- A possible obligation arising from past events, the existence of which will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Scheme.
- A present obligation that arises from past events but not recognised because:
 - It is not probable that an outflow of resources will be required to settle an obligation.
 - The amount of the obligation cannot be measured with sufficient reliability.

INSURANCE CONTRACTS

Definition and classification

Contracts under which the Scheme accepts significant insurance risk from another party (the member) by agreeing to compensate the member or other beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary are classified as insurance contracts. In making this assessment, all substantive rights and obligations, including those arising from law or regulation, are considered on a contract-by-contract basis. The Scheme uses judgement to assess whether a contract transfers insurance risk and whether the accepted insurance risk is significant.

Separating components within insurance contracts

Before the Scheme accounts for an insurance contract it analyses whether the contract contains components that should be separated. There are three categories of components that have to be accounted for separately:

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

The Scheme does not have contracts with specified embedded derivatives. Certain of the contracts with members contain a Medical Savings Account (MSA) component. The MSA, an investment component, and the insurance component of the insurance contract are highly interrelated.

The MSA is a non-distinct investment component with the balances included in Insurance contract liabilities in the Statement of Financial Position. While the cash flows are not recorded in the Statement of Comprehensive Income, they are considered in assessing onerous contracts.

INSURANCE CONTRACTS (continued)

Level of aggregation

The level of aggregation has a significant impact on accounting for the insurance contract, including the measurement of insurance contracts and the extent of offsetting or cross subsidisation to determine onerous contracts. A portfolio comprises contracts subject to similar risks and managed together. Once the group of insurance contracts has been established, it becomes the unit of account.

The contracts issued by the Scheme are subject to similar risks and managed together thus falling into the same portfolio with no further disaggregation into groups. The level of aggregation is assessed to be at a Scheme level.

Contract boundary

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

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

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

In assessing the practical ability to reprice, risks transferred from the member to the Scheme are considered.

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

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

Recognition and derecognition

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

- the beginning of the coverage period; or
- the date when the first payment from the member is due or actually received, if there is no due date; or
- when the 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
- if the terms are modified due to an agreement between the Scheme and its member or by regulation and the modification terms meet the requirements of IFRS 17.

If the modification does not comply with all the requirements of IFRS 17, the Scheme shall treat the changes in cash flow as changes in estimates of fulfilment cash flows.

INSURANCE CONTRACTS (continued)

Initial and subsequent measurement

The coverage period of each contract in the Scheme's portfolio of insurance contracts is one year or less. Therefore, the Scheme has made the accounting policy choice to simplify the measurement of its group of contracts using the Premium Allocation Approach (PAA).

For insurance contracts issued, on initial recognition, the Scheme measures the *Liability for remaining coverage* at the value of contributions received.

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

- the *Liability for remaining coverage* decreased by any investment component paid or transferred to the *Liability for incurred claims*; and
- the *Liability for incurred claims*, comprising the fulfilment cashflows related to past service at the reporting date.

For insurance contracts issued, at each of the subsequent reporting dates, the *Liability for remaining coverage* is:

- increased for contributions received in the period;
- decreased by any investment component paid or transferred to the *Liability for incurred claims*; and
- 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 *Liability for incurred claims* is:

- the probability weighted estimate of the present value of the future cash flows; and
- the risk adjustment for non-financial risk.

Refer to Judgements and Estimates earlier in this note for the significant judgements and estimates used to determine the *Liability for incurred claims* and the estimates to determine the fulfilment cash flow.

Insurance revenue

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

For the group of insurance contracts measured under the PAA, the Scheme recognises insurance revenue based on the passage of time over the coverage period of the group of contracts.

INSURANCE CONTRACTS (continued)

Insurance service expenses

Insurance service expenses include:

- incurred claims and benefits excluding investment components;
- other incurred directly attributable insurance service expenses;
- changes that relate to past service (i.e. changes in the fulfilment cashflows relating to the *Liability for incurred claims*);
- changes that relate to future service (i.e. losses/reversals on onerous groups of contracts from changes in the loss components);
- amounts attributable to members for future benefits; and
- recoveries from third parties (including reimbursement from the Road Accident Fund).

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

Other incurred directly attributable insurance service expenses include:

Accredited managed healthcare services (no risk transfer)

Accredited managed healthcare services (no risk transfer) fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of healthcare services to the members of the Scheme and are expensed as incurred. Accredited managed healthcare services are part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of the Scheme.

Insurance acquisition cash flows

The Scheme includes the 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.

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

Accredited administration services

Expenses for accredited administration services are paid to the Scheme's administrator.

Other operating expenses

Cash flows that are not directly attributable to a group of insurance contracts are recognised in other operating expenses as incurred and include the Scheme's operating expenses and other administration services fees paid to the Scheme's administrator.

INSURANCE CONTRACTS (continued)

Reimbursements from the road accident fund

The Scheme grants assistance to its members in defraying expenditure incurred in connection with the rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made against the Road Accident Fund, administered in terms of the Road Accident Fund Act No 56 of 1996. If the member is reimbursed by the Road Accident Fund, they are obliged, contractually, to cede that payment to the Scheme to the extent that they have already been compensated.

Due to the uncertainty around the confirmation and measurability of the Road Accident Fund amounts, the Scheme accounts for these amounts on a cash basis. These amounts are recognised as a reduction of net claims incurred.

Insurance interest income and expenses

The non-distinct investment component (MSA) accrues interest. This is disclosed as the finance expense on Medical Savings Accounts.

Interest payable on members' Medical Savings Accounts is expensed when incurred.

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.

Classification of Medical Savings Accounts (MSA)

The Scheme has accounted for all MSA transactions that relate to insurance services already rendered in the Liability for Incurred Claims (LIC) at year-end.

Classification of expenditure/income outstanding at year-end

The fulfilment cash flows may include expenditure incurred in accounting standards other than IFRS 17. Where expenditure / income is outstanding at year-end the Scheme has included these payables in the insurance contract liabilities.

REINSURANCE CONTRACTS

Definition

Reinsurance contracts are contractual arrangements entered into by the Scheme with a provider. The provider is paid a fixed fee per member to cover the risk of the number of incidents that occur during a specified period and the cost of providing the service. Reinsurance contracts do not reduce the Scheme's primary obligations to its members and their dependents.

Unit of account

Groups of reinsurance contracts held are assessed for aggregation separately from groups of insurance contracts issued. Applying the grouping requirements to reinsurance contracts held, the Scheme aggregates the reinsurance contracts, which are concluded within a calendar year (annual cohorts), into groups of contracts for which there is a net gain at initial recognition, if any, contracts for which at initial recognition there is no significant possibility of a net gain arising subsequently and remaining contracts in the group, if any.

Reinsurance contracts held are assessed for aggregation requirements on an individual contract basis. The Scheme tracks internal management information reflecting historical experiences of such contracts' performance. This information is used for setting pricing of these contracts such that they result in reinsurance contracts held in a net gain position without a significant possibility of a net cost arising subsequently.

Recognition and derecognition

The reinsurance contract held that covers the losses of separate insurance contracts on a proportionate basis is recognised at the later of:

- the beginning of the coverage period of the group; or
- the initial recognition of any underlying insurance contract.

Initial and subsequent measurement

The coverage period of each reinsurance contract in the Scheme's group of reinsurance contracts, is one year or less. Therefore the Scheme has made the accounting policy choice to simplify the measurement of its group of reinsurance contracts using the PAA.

For reinsurance contracts held, on initial recognition, the Scheme measures the remaining coverage at the amount of reinsurance fees paid.

The carrying amount of a group of reinsurance contracts held at the end of each reporting period is the sum of:

- the *Liability for remaining coverage*; and
- the *Liability for incurred claims*, comprising the fulfilment cashflows related to past service allocated to the group at the reporting date.

Subsequent measurement of the remaining coverage for reinsurance contracts held is:

- increased for the reinsurance fees paid in the period; and
- decreased for the amount of reinsurance fees recognised as reinsurance expenses for the services received in the period.

The Scheme does not adjust the asset for the remaining coverage for reinsurance contracts held for the effect of the time value of money. The reinsurance contributions are due within coverage periods which are one year or less.

REINSURANCE CONTRACTS (continued)

Contract boundary

For groups of reinsurance contracts held, cash flows are within the contract boundary if they arise from substantive rights and obligations that exist during the reporting period in which the Scheme is compelled to pay amounts to the reinsurer or in which the Scheme has a substantive right to receive services from the reinsurer.

The Scheme's reinsurance contracts held have a duration of one year or less.

Net income/(expense) from reinsurance contracts held

The amount that depicts the value the Scheme benefits from entering into a reinsurance contract (i.e. the value of services received from the reinsurance contract provider).

Reinsurance expenses consist of:

- reinsurance premiums; and
- effect of changes in risk of reinsurer non-performance.

Reinsurance expenses are recognised similarly to insurance revenue. The reinsurance expenses recognised in the reporting period depicts the transfer of received services at an amount that reflects the portion of reinsurance fees the Scheme expects to pay in exchange for those services.

All groups of reinsurance contracts held are measured under the PAA. The Scheme recognises reinsurance expenses based on the passage of time over the coverage period of a group of contracts.

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 in accordance with the requirements of IFRS 17, forming part of the fulfilment cash flows of the related group of insurance contracts.

INCOME TAX

In terms of Section 10 (1)(d) of the Income Tax Act 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

STRUCTURED ENTITIES

A structured entity is an entity that has been designed so that voting or similar rights are not the dominant factors 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 agreements. 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 Scheme has determined that some of its investments in pooled funds and in collective investments ("funds") are investments in unconsolidated structured entities. Disclosure of these investments has been made in Note 19 to the Financial Statements. The objectives include achieving medium to long-term capital growth. The investment strategy does not include the use of leverage.

ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT OPTIONS

The following items are directly allocated to benefit options:

- Insurance revenue;
- Insurance service expense; and
- Finance expenses on Medical Savings Accounts

The risk adjustment for non-financial risk is calculated at Scheme level. The allocation to benefit options is based on the proportion of each benefit option's share in the provision for outstanding claims in the Insurance Contract Liability.

The following items are apportioned based on the number of members per benefit option:

- Other operating expenses;
- Investment income, excluding interest on Medical Savings Accounts; and
- Sundry income.

1. PROPERTY AND EQUIPMENT

Accounting policy

Equipment

Equipment is reflected at historical cost less accumulated depreciation and impairments. Depreciation is charged on the straight-line basis over the estimated useful lives of the assets.

The respective depreciation rates used are:

Computer equipment	33%
Office furniture and fittings	10%

Cost includes expenditure that is directly attributable to the acquisition of the asset.

When parts of an item of equipment have different useful lives, they are accounted for as separate items (major components) of equipment. Maintenance and repairs are expensed as incurred.

Gains and losses on disposal of equipment are determined by comparing the proceeds from disposal with its carrying amount. Gains and losses on the disposal of equipment is recognised in profit or loss.

Depreciation methods, residual values and useful lives of equipment are reviewed annually at each reporting date.

Property

As the asset is carried at cost, IFRS requires the building to be assessed for impairment on an annual basis. The decline in value of the building is an indicator of impairment and therefore an entity is required to determine the recoverable amount.

IAS 36 defines the recoverable amount as the higher of (i) fair value less costs to sell and (ii) value in use. Where the recoverable amount is lower than the carrying amount, an impairment must be recognised.

Gains and losses on disposal of property is determined by comparing the proceeds from disposal with its carrying amount. Gains and losses on the disposal of property is recognised in profit or loss.

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

1. PROPERTY AND EQUIPMENT (continued)

Note

	Property	Computer equipment	Office furniture and fittings	Total
	R	R	R	R
As at 31 December 2025				
Cost				
At the beginning of the year	3,920,000	741,634	294,379	4,956,013
Additions	-	7,296	4,598	11,894
Disposals	(3,920,000)	-	(265,901)	(4,185,901)
At the end of the year	<u>-</u>	<u>748,930</u>	<u>33,076</u>	<u>782,006</u>
Accumulated depreciation and impairment				
At the beginning of the year	-	(719,812)	(270,469)	(990,281)
Depreciation charges	-	(16,205)	(10,803)	(27,008)
Depreciation reversal on disposal	-	-	252,527	252,527
At the end of the year	<u>-</u>	<u>(736,017)</u>	<u>(28,745)</u>	<u>(764,762)</u>
Carrying amount at the end of the year	<u>-</u>	<u>12,913</u>	<u>4,331</u>	<u>17,244</u>
As at 31 December 2024				
Cost				
At the beginning of the year	3,920,000	728,121	294,379	4,942,500
Additions	-	13,513	-	13,513
Disposals	-	-	-	-
At the end of the year	<u>3,920,000</u>	<u>741,634</u>	<u>294,379</u>	<u>4,956,013</u>
Accumulated depreciation and impairment				
At the beginning of the year	-	(683,592)	(244,658)	(928,250)
Depreciation charges	-	(36,220)	(25,810)	(62,030)
At the end of the year	<u>-</u>	<u>(719,812)</u>	<u>(270,469)</u>	<u>(990,280)</u>
Carrying amount at the end of the year	<u>3,920,000</u>	<u>21,822</u>	<u>23,910</u>	<u>3,965,733</u>

Details of the equipment are recorded in an asset register which may be inspected at the registered office of the Scheme. No assets have been pledged as security.

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

2. FINANCIAL ASSETS AT AMORTISED COST

Accounting policy

These investments are measured at amortised cost using the effective interest method, less any impairment losses.

The carrying amounts of these investments approximate their fair values due to the short term maturities of these assets. These interest rates are fixed until maturity.

The Scheme's business model is hold to collect contractual cash flows and the contractual cash flow characteristics are such that cash flows constitute solely payments of principal and interest.

Note

The Scheme Funds and Medical Savings Account Trust Funds investments are summarised as follows:

	2025	2024
	R	R
Fixed deposits: Scheme funds	2,517,843,455	2,378,908,893
Fixed deposits: Medical Savings Account <i>trust</i> funds	585,000,000	585,000,000
Current assets	<u>3,102,843,455</u>	<u>2,963,908,893</u>

The weighted average effective interest rate of the Scheme's fixed deposits was 8.23% (2024 - 8.79%). The short term deposits have an average maturity of 365 days (2024 - 365 days).

The weighted average effective interest rate of the Medical Savings Accounts fixed deposits was 8.27% (2024 - 8.87%). The short term deposits have an average maturity of 365 days (2024 - 365 days).

3. OTHER FINANCIAL ASSETS AT AMORTISED COST

Accounting policy

Receivables are initially recognised at fair value, plus transaction costs. The Scheme holds its other receivables with the objective to collect the contractual cash flows and measures them subsequently at amortised cost using the effective interest method.

Impairment of other receivables

The Scheme applies the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for other receivables. To measure the expected credit losses, other receivables are grouped based on shared credit risk characteristics and days past due. There are no impairments of other receivables.

Note

	2025	2024
	R	R
Interest receivable	102,338,066	110,942,037
Prepaid expenses	22,219	548,108
Current assets	<u>102,360,285</u>	<u>111,490,145</u>

The carrying amounts of trade and other receivables approximate their fair values due to the short-term maturities of these assets. Interest is not charged on overdue balances. There were no identified impairment losses.

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

4. CASH AND CASH EQUIVALENTS

Accounting policy

Cash and cash equivalents are short-term, highly liquid instruments that are readily convertible to known amounts of cash and are subject to an insignificant risk of changes in value.

In the Statement of Cash Flows, cash and cash equivalents comprise:

- Current accounts
- Money market instruments

Cash and cash equivalents only include items held for the purpose of meeting short-term cash commitments rather than for investing or other purposes and are carried at amortised cost, which, due to their short-term nature, approximates fair value.

Note

	2025	2024
	R	R
Scheme funds	1,536,543,597	1,311,560,365
Current accounts	183,012,873	126,193,687
Money market instruments	1,353,530,724	1,185,366,678
Medical Savings Account <i>trust</i> funds	285,298,123	138,314,516
Current accounts	4,209,472	5,748,290
Money market instruments	281,088,651	132,566,226
Current assets	1,821,841,720	1,449,874,881

The weighted average effective interest rate on cash and cash equivalents was 7.72% (2024 - 7.90%). There were no identified impairment losses.

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

5. INSURANCE CONTRACT LIABILITIES

5.1 LIABILITY TO MEMBERS FOR CURRENT BENEFITS

Insurance contracts issued	2025				2024			
	R				R			
	Liability for remaining coverage (LFRC)	Liability for incurred claims (LIC)	Total		Liability for remaining coverage (LFRC)	Liability for incurred claims (LIC)	Total	
	Present value of future cash flows	Risk adjustment			Present value of future cash flows	Risk adjustment		
Net opening balance	(286,105,255)	1,000,510,733	4,530,039	718,935,517	(255,015,841)	921,056,963	4,225,981	670,267,103
Insurance service result	(6,662,225,073)	6,498,875,134	681,272	(162,668,666)	(5,761,334,113)	5,560,907,575	304,058	(200,122,480)
Insurance revenue	(6,662,225,073)	-	-	(6,662,225,073)	(5,761,334,113)	-	-	(5,761,334,113)
Insurance service expense	-	6,498,875,134	681,272	6,499,556,407	-	5,560,907,575	304,058	5,561,211,633
Incurred claims, directly attributable expenses and insurance acquisition costs	-	6,269,718,868	-	6,269,718,868	-	5,392,772,033	-	5,392,772,033
Changes in fulfilment cash flows relating to the liability for incurred claims - past service	-	2,577,522	(4,530,039)	(1,952,517)	-	(20,616,056)	(4,225,981)	(24,842,037)
Changes in fulfilment cash flows relating to the liability for incurred claims - current service	-	226,578,744	5,211,311	231,790,055	-	188,751,598	4,530,039	193,281,637
Finance income from insurance contracts issued	-	64,637,750	-	64,637,750	-	62,654,151	-	62,654,151
Total amounts recognised in the Statement of Comprehensive Income	(6,662,225,073)	6,563,512,884	681,272	(98,030,917)	(5,761,334,113)	5,623,561,726	304,058	(137,468,329)
Investment component - Medical Savings Account (MSA)	(1,714,334,127)	1,714,334,127	-	-	(1,472,849,710)	1,472,849,710	-	-
MSA contributions received	(1,712,978,334)	1,712,978,334	-	-	(1,471,817,122)	1,471,817,122	-	-
Transfers received from other schemes	(1,355,793)	1,355,793	-	-	(1,032,588)	1,032,588	-	-
Total movement	(8,376,559,200)	8,277,847,011	681,272	(98,030,917)	(7,234,183,823)	7,096,411,436	304,058	(137,468,329)
<i>Cash flows</i>								
Contributions received	8,326,024,450	-	-	8,326,024,450	7,203,094,409	-	-	7,203,094,409
Claims and other directly attributable expenses paid	-	(7,944,561,893)	-	(7,944,561,893)	-	(6,936,233,592)	-	(6,936,233,592)
Refunds on death or resignation - MSA	-	(37,352,901)	-	(37,352,901)	-	(32,925,083)	-	(32,925,083)
Total cash flows	8,326,024,450	(7,981,914,794)	-	344,109,657	7,203,094,409	(6,969,158,675)	-	233,935,734
<i>Non cash flows</i>								
Claims related to recoveries from reinsurance (Note 5)	-	(73,909,917)	-	(73,909,917)	-	(47,798,990)	-	(47,798,990)
Net closing balance	(336,640,005)	1,222,533,033	5,211,311	891,104,340	(286,105,255)	1,000,510,733	4,530,039	718,935,518

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

5. INSURANCE CONTRACT LIABILITIES (continued)

5.1 LIABILITY TO MEMBERS FOR CURRENT BENEFITS (continued)	Notes	2025	2024
		R	R
<i>Breakdown of cashflows</i>			
Contributions received		8,326,024,450	7,203,094,409
Risk contributions		6,611,690,323	5,730,244,699
MSA contributions		1,712,978,334	1,471,817,122
Transfers received from other schemes		1,355,793	1,032,588
Claims and directly attributable expenses paid		(7,944,561,893)	(6,936,233,592)
Risk claims		(5,695,180,722)	(4,925,399,964)
MSA claims		(1,578,156,147)	(1,416,907,690)
Directly attributable expenses		(508,886,285)	(449,051,326)
Insurance acquisition costs		(162,338,739)	(144,874,612)
<i>Included in Liability to members for current benefits</i>			
Medical Savings Account monies	5.3	903,139,293	739,676,464
Reported claims not yet paid		74,872,224	50,492,558
Amounts due to administrator - attributable insurance expenses		52,896,145	47,310,514
Liability for incurred claims incurred but not yet reported		231,790,055	193,281,637
Unallocated funds (see Note 8 for more information)		3,999,388	-
Insurance acquisition expenses not yet paid		1,882,208	2,453,030
Less:			
Insurance revenue outstanding		(336,640,005)	(286,105,255)
Member and service provider claims debt		(44,914,067)	(41,752,605)
Provision for impairment		26,945,070	24,882,901
Forensic receivables		(22,865,971)	(11,303,727)
Current liability		891,104,340	718,935,517
5.2 LIABILITY TO MEMBERS FOR FUTURE BENEFITS			
Balance at the beginning of the year		3,776,327,777	3,391,355,222
Amounts attributable to members for future benefits		350,293,541	384,972,555
Balance at the end of the year relating to Liability to members for future benefits		4,126,621,318	3,776,327,777
Non-current liability		4,126,621,318	3,776,327,777

5. INSURANCE CONTRACT LIABILITIES (continued)

5.3 MEDICAL SAVINGS ACCOUNT MONIES

The medical savings account monies, which is managed by the Scheme on behalf of its members, represents savings contributions, and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered rules.

Unspent medical savings at year end are carried forward to meet future expenses for which the members are responsible. In terms of the Medical Schemes Act 131 of 1998, as amended, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Reconciliation of medical savings account monies	2025	2024
	R	R
Balance at the beginning of the year	739,676,464	654,005,376
Plus:		
MSA contributions received	1,712,978,334	1,471,817,122
Transfers received from other schemes	1,355,793	1,032,588
Interest on MSA monies	64,637,750	62,654,151
Less:		
MSA claims	(1,578,156,147)	(1,416,907,690)
Refunds on death or resignation	(37,352,901)	(32,925,083)
Balance at the end of the year	<u>903,139,293</u>	<u>739,676,464</u>

It is estimated that claims to be paid out of members' medical savings accounts in respect of claims incurred in 2025 but not recorded amount to R11,0m (2024: R9,7m).

The mismatch between the MSA trust liability and the MSA trust funds relate to timing differences. These differences are cleared after year-end.

At year end the carrying amount of the MSA trust liability approximates its fair value, since it is payable on demand. These amounts were not discounted to present values due to their demand feature.

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

6. REINSURANCE CONTRACT LIABILITIES

Healthcare Risk – Reinsurance contracts held

	2025				2024			
	R				R			
	Remaining coverage component	Incurred claims for contracts under the PAA		Total	Remaining coverage component	Incurred claims for contracts under the PAA		Total
	Present value of future cash flows	Risk adjustment for non-financial risk			Present value of future cash flows	Risk adjustment for non-financial risk		
Net opening balance	-	-	-	-	-	-	-	-
Net expenses/(income) from reinsurance contracts held	58,021,442	(73,909,917)	-	(15,888,475)	49,327,024	(47,798,990)	-	1,528,034
Reinsurance expenses	58,021,442	-	-	58,021,442	49,327,024	-	-	49,327,024
Claims recovered	-	(73,909,917)	-	(73,909,917)	-	(47,798,990)	-	(47,798,990)
Total amounts recognised in the Statement of Comprehensive Income	58,021,442	(73,909,917)	-	(15,888,475)	49,327,024	(47,798,990)	-	1,528,034
Cash flows								
Premiums paid	(55,324,502)	-	-	(55,324,502)	(49,327,024)	-	-	(49,327,024)
Total cash flows	(55,324,502)	-	-	(55,324,502)	(49,327,024)	-	-	(49,327,024)
Non cash flows								
Recoveries from reinsurance	-	73,909,917	-	73,909,917	-	47,798,990	-	47,798,990
Net closing balance - current liability	2,696,940	-	-	2,696,940	-	-	-	-

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

7. POST-RETIREMENT HEALTHCARE FUNDING LIABILITY

Employees and retired employees who are continuation members of LA Health who qualify for a retirement subsidy participate in the Scheme.

Note

	2025	2024
	R	R
Provision for post-retirement healthcare funding		
<i>Change in liability</i>		
Opening balance	2,882,000	2,603,000
Service cost	46,000	41,000
Interest cost	329,000	334,000
Actuarial loss	145,000	52,000
Benefits paid	(160,000)	(148,000)
Closing balance	3,242,000	2,882,000
Change in benefit assets		
Contributions by employer	160,000	148,000
Benefits paid	(160,000)	(148,000)
	-	-
Statement of comprehensive income		
Service cost	46,000	41,000
Interest cost	329,000	334,000
Amount recognised in profit or loss	375,000	375,000
Other comprehensive income		
Actuarial loss	(145,000)	(52,000)
Amount recognised in profit or loss	(145,000)	(52,000)
Reconciliation of item in statement of financial position		
Opening balance	2,882,000	2,603,000
Employer contribution	(160,000)	(148,000)
Amount recognised in profit or loss	375,000	375,000
Amount recognised in other comprehensive income	145,000	52,000
Closing balance	3,242,000	2,882,000
Current liability	358,000	375,000
Non-current liability	2,884,000	2,507,000
Key valuation assumptions		
Discount rate	10.25%	11.76%
Medical inflation rate	7.07%	8.33%
Sensitivity of results		
1% increase in medical inflation		
Increase in liability	359,000	321,000
Increase in service and interest costs	42,000	46,000
1% decrease in medical inflation		
Decrease in liability	(305,000)	(274,000)
Decrease in service and interest costs	(37,000)	(38,000)

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

8. OTHER FINANCIAL LIABILITIES AT AMORTISED COST

Accounting policy

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. These are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method.

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 below.

Note

	2025	2024
	R	R
Financial liabilities		
Accruals	3,398,106	5,123,979
Unallocated funds	-	25,970,378
Current liability	<u>3,398,106</u>	<u>31,094,357</u>

* Due to the nature of the unallocated funds, this item will be disclosed as an insurance contract liability from the 2025 financial year and going forward. The 2024 value is not re-classified as the value is not material. The accounting policy note for unallocated funds is disclosed in the Accounting Policy section of the Financial Statements.

The carrying amounts of financial liabilities at amortised cost approximate their fair values due to the short-term maturities of these liabilities.

9. INSURANCE REVENUE AND SERVICE EXPENSES

Insurance revenue from contracts measured under the PAA	6,662,225,073	5,761,334,113
Gross contributions	8,375,203,407	7,233,151,235
MSA contributions (note 5.3)	(1,712,978,334)	(1,471,817,122)
Insurance service expenses	(6,499,556,407)	(5,561,211,632)
Net claims incurred	(5,828,331,383)	(4,967,285,694)
Incurred claims	(5,853,640,385)	(4,977,661,260)
Third party recoveries	25,309,002	10,375,566
Directly attributable expenses	(508,886,285)	(449,051,326)
Accredited managed healthcare services (no risk transfer)	(139,293,947)	(123,107,953)
Accredited administration services	(369,592,338)	(325,943,373)
Insurance acquisition costs	(162,338,739)	(144,874,612)
Net income/(expense) from reinsurance contracts held	15,888,475	(1,528,034)
Reinsurance expense	(58,021,442)	(49,327,024)
Reinsurance income	73,909,917	47,798,990
Total insurance service result	<u>178,557,141</u>	<u>198,594,446</u>

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

9. INSURANCE REVENUE AND SERVICE EXPENSES (continued)

Detail of accredited administration services, accredited managed healthcare services and net income/(expense) from reinsurance contracts held has been provided below:

	2025	2024
	R	R
Accredited administration services		
Customer services	183,441,170	161,776,713
Information management and data control	67,335,030	59,382,743
Claims management	41,541,512	36,635,447
Member record management	37,560,377	33,124,485
Contribution management	33,005,463	29,107,508
Broker remuneration management	5,358,202	4,725,397
Financial management	1,350,584	1,191,080
	<u>369,592,338</u>	<u>325,943,373</u>
Accredited managed healthcare services (no risk transfer)		
Disease management	44,574,063	39,394,545
Clinical risk management	41,788,184	36,932,386
Medical provider network management	39,002,307	34,470,227
Pharmacy benefit management	13,929,393	12,310,795
	<u>139,293,947</u>	<u>123,107,953</u>

Net income/(expense) from reinsurance contracts held

Accounting policy

Reinsurance contracts (risk transfer arrangements) held are contractual arrangements entered into by the Scheme and third parties who undertake to indemnify the Scheme against all or part of the loss that the Scheme may incur as a result of carrying on the business of a medical scheme. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependants. The arrangements only decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

Risk transfer arrangement fees are recognised as an expense over the indemnity period on a straight-line basis.

The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the Statement of Comprehensive Income on a gross basis. Amounts recoverable under such contracts are therefore recognised in the same year as the related claims. The claims incurred liability under risk transfer arrangements and the equivalent receivable are also presented in the Statement of Financial Position on a gross basis.

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding claims provisions, and claims reported not yet paid. Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the outstanding claims provision, claims reported not yet paid, and settled claims associated with the risk transfer arrangement.

9. INSURANCE REVENUE AND SERVICE EXPENSES (continued)

Net income/(expense) from reinsurance contracts held (continued)

Accounting policy (continued)

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement.

Note

	2025	2024
	R	R
Made up as follows:		
Discovery Health (Pty) Ltd	(2,312,221)	(1,225,087)
Reinsurance expense	(24,462,961)	(19,294,471)
Claims recovered	22,150,740	18,069,384
Dental Risk Company (Pty) Ltd	18,487,114	(2,639,116)
Reinsurance expense	(31,008,283)	(27,471,126)
Claims recovered	49,495,397	24,832,010
Iso Leso Optics (Pty) Ltd	(286,418)	2,336,169
Reinsurance expense	(2,550,198)	(2,561,428)
Claims recovered	2,263,780	4,897,597
	15,888,475	(1,528,034)

The Scheme has entered into selective risk transfer arrangements with these third party providers to reduce its exposure to claims risk and receive specialist case management. These arrangements form a relatively small component of the total claims cost of the Scheme.

The claims recovered was estimated by calculating Per Life Per Month (PLPM) estimates for services covered under these risk transfer arrangements and multiplying them by the number of members exposed for the period to the respective programmes.

10. INVESTMENT INCOME

Accounting policy

Investment income comprises interest received and accrued on Financial assets at amortised cost and interest on cash and cash equivalents.

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

Note

	2025	2024
	R	R
Interest earned on cash and cash equivalents	4,161,205	4,449,018
Interest earned on Financial assets at amortised cost	292,810,815	293,414,514
Interest earned on MSA <i>trust</i> funds	64,637,750	62,654,151
Investment income	<u>361,609,770</u>	<u>360,517,683</u>

11. SUNDRY INCOME

Accounting policy

Amounts due by the Scheme that have legally prescribed, that is funds older than three years, are reversed and included under Sundry income.

Note

Prescribed amounts written back	-	1,294,987
Profit on sale of property and equipment	766,626	-
	<u>766,626</u>	<u>1,294,987</u>

12. INSURANCE FINANCE EXPENSES

Accounting policy

Interest payable on members' Medical Savings Accounts is expensed when incurred.

Note

Interest allocated on Medical Savings Accounts	<u>64,637,750</u>	<u>62,654,151</u>
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NOTES TO THE FINANCIAL STATEMENTS (continued)
for the year ended 31 December 2025

13. OTHER OPERATING EXPENSES

Accounting policy

Other operating expenses are expensed as incurred.

Note

	2025	2024
	R	R
Administration fees	98,054,210	86,473,977
Other services		
Marketing services	67,229,101	59,289,324
Forensic investigations and recoveries	6,964,780	6,142,237
Internal audit services	5,587,713	4,927,802
Distribution services	2,824,752	2,491,148
Governance and compliance	1,094,592	965,320
Additional services		
Quality management and monitoring services	5,252,273	4,631,978
Advanced data analytics	1,624,232	1,432,410
Digital service offering	4,387,193	3,869,064
Product innovation	1,041,628	918,611
Enhanced service offering	891,563	786,269
Enterprise risk management services	891,563	786,269
Legal services	264,820	233,545
Actuarial fees	1,089,259	1,033,669
Association fees	1,483,696	1,139,345
Audit and Risk Committee expenses	171,290	144,991
Bank charges	653,840	643,048
Depreciation	27,011	62,030
Election costs	-	162,833
External audit fees	1,351,497	1,724,081
Audit services - current year*	1,383,500	1,409,004
Audit services - (over)/under provision prior year	(48,503)	300,409
Other services (agreed-upon procedures)	16,500	14,668
Fidelity guarantee and professional indemnity insurance premium	12,310	12,310
Insurance fees	42,680	52,969
Legal fees	1,139,703	284,829
Levies - Council for Medical Schemes	5,602,350	4,947,582
Managed care: management services (non-accredited)	409,332	392,076
Medical emergency call centre fees	693,523	619,091
Meeting facility costs	171,877	186,966
Other expenses	1,340,905	1,518,364
Public relations and communication expenses	260,336	305,393
Staff costs	10,203,554	9,527,953
Trustee remuneration and disbursements (note 14)	3,294,873	3,548,902
	126,002,246	112,780,409

*This fee relates to the opinions on the annual financial statements (R1,260,000), annual statutory returns audit (R81,000) and compliance report (R42,000) in accordance with the requirements of Sections 36(1), 36(5) and 36(8) of the Act as required by the Council for Medical Schemes.

14. TRUSTEE REMUNERATION AND DISBURSEMENTS

Trustee name	Location	Retainer fee		Subsistence and accommodation		Travelling		Conference and other fees		Training		Telephone		Strategic session		Total	
		2025 R	2024 R	2025 R	2024 R	2025 R	2024 R	2025 R	2024 R	2025 R	2024 R	2025 R	2024 R	2025 R	2024 R	2025 R	2024 R
Barnard, RC	Gqeberha	196,992	185,148	13,241	9,549	11,356	16,457	31,436	701	-	-	-	-	8,964	6,306	261,989	218,161
Bennett, AJ	Johannesburg	-	92,574	-	4,980	-	11,837	-	1,368	-	-	-	-	-	6,215	-	116,974
Beukman, GJ	Langebaan	-	111,078	-	5,700	-	3,429	-	2,247	-	-	-	1,800	-	8,901	-	133,155
Bosman, RG	Johannesburg	-	92,574	-	6,510	-	17,357	-	1,071	-	-	-	-	-	6,162	-	123,674
Botha, HF	Mossel Bay	196,992	185,148	13,134	6,527	22,384	13,396	-	5,329	-	-	-	-	13,318	7,778	245,828	218,178
Chidi-Manganye, MN	Pretoria	196,992	185,148	7,226	10,595	8,858	32,370	-	2,414	45,035	-	-	-	11,380	4,769	269,491	235,296
De Bruyn, R	Plettenberg Bay	196,992	185,148	16,512	25,507	32,191	33,178	31,361	2,307	-	2,467	-	-	8,355	12,000	285,411	260,607
Denge, R	Johannesburg	236,376	211,355	14,123	19,721	14,621	31,288	-	160,526	-	877	3,600	3,600	8,477	5,672	277,197	433,039
Deysel, HA	Queenstown	-	92,574	-	5,952	-	5,159	-	5,620	-	-	-	-	-	-	-	109,305
Dlamini, MAV	Johannesburg	196,992	185,148	6,217	8,896	11,335	26,046	-	1,379	-	-	-	-	8,206	7,500	222,750	228,969
Field, RJ	Cape Town	-	92,574	-	6,509	-	459	-	726	-	-	-	-	-	7,862	-	108,130
Joseph, AD	Johannesburg	196,992	92,574	11,275	13,199	5,492	10,481	34,400	-	45,762	843	-	-	8,814	-	302,735	117,097
Koen, J	Pretoria	65,664	-	2,672	-	3,534	-	29,815	-	-	-	-	-	-	-	101,685	-
Komapi, GM	Johannesburg	196,992	92,574	12,155	11,411	9,211	10,883	37,828	-	44,985	2,269	-	-	5,700	-	306,871	117,137
Lemmer, A	Gqeberha	-	61,716	-	2,820	-	4,708	-	-	-	-	-	-	-	2,915	-	72,159
Mabunda, S	Johannesburg	196,992	185,148	9,610	10,436	7,809	28,248	-	1,698	-	-	-	-	12,036	6,491	226,447	232,021
Mavuso, CL	Johannesburg	-	169,719	-	19,721	-	20,870	-	1,146	-	1,088	-	-	-	5,833	-	218,377
Nel, CS	Pretoria	216,670	192,853	11,979	13,925	17,639	29,965	34,032	1,353	-	1,388	3,600	1,500	7,834	6,336	291,754	247,320
Vorster, A	Cape Town	196,992	92,574	5,281	2,948	9,932	5,728	-	-	-	-	-	-	6,464	-	218,669	101,250
Yamba, S	East London	196,992	185,148	24,106	32,409	18,891	32,916	35,742	507	-	1,241	-	-	8,315	5,834	284,046	258,055
		2,488,630	2,690,775	147,531	217,315	173,253	334,775	234,614	188,392	135,782	10,173	7,200	6,900	107,863	100,574	3,294,873	3,548,904

15. RELATED PARTY TRANSACTIONS

Key management personnel and their close family members

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the non-executive Board of Trustees and the Principal Officer of the Scheme. The disclosure deals with the full-time Principal Officer and staff of the Scheme who are compensated on a salary basis, and non-executive Board of Trustees who is compensated on a fee basis.

Close family members include close family members of the Board of Trustees, Principal Officer and staff of the Scheme.

Parties with significant influence over the Scheme

Discovery Health (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions, but does not control the Scheme. Discovery Health (Pty) Ltd provides administration and managed care services. The Scheme furthermore has a reinsurance contract with Discovery Health (Pty) Ltd. As Discovery Health (Pty) Ltd is a related party, its subsidiaries and fellow subsidiaries within the Discovery Ltd group are related parties to the Scheme. Discovery Ltd's Annual Report provides detail of its group structure.

The Scheme contracted with Discovery Third Party Recovery Services (Pty) Ltd (DTPRS), a wholly-owned subsidiary of Discovery Health (Pty) Ltd, to manage the identification and collection of third party recoveries from the Road Accident Fund.

Transactions with related parties

The following provides the total amount in respect of transactions, which have been entered into with related parties for the relevant financial year. All amounts are disclosed as absolute numbers.

Transactions with key management personnel and their close family members, which includes Trustees, the Principal Officer and staff of the Scheme:

	2025	2024
	R	R
<i>Statement of Comprehensive Income</i>		
Compensation		
Principal Officer and staff of the Scheme	6,155,682	5,790,205
Trustee remuneration (note 14)	3,294,873	3,548,904
Contributions and claims		
Insurance revenue	1,412,042	922,997
Incurred claims	1,176,121	859,264
Interest paid on Medical Savings Accounts	4,982	4,649
<i>Statement of Financial Position</i>		
Liability attributable to current members (MSA balances)	67,256	59,632

15. RELATED PARTY TRANSACTIONS (continued)

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

Transactions	Nature of transactions and their terms and conditions
Compensation	This constitutes remuneration and consideration paid to Trustees, the Principal Officer and the staff of the Scheme.
Insurance revenue	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms as applicable to other members.
Incurred claims	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members.
Medical Savings Accounts	The amounts owing to the related parties relate to Medical Savings Account balances to which the parties have a right. Interest is earned on positive MSA balances. The amounts are all current and would need to be payable on demand as applicable to other members.

	2025	2024
	R	R
Transactions with entities that have significant influence over the Scheme		
Statement of Comprehensive Income		
Administration fees	467,646,548	412,417,350
- Accredited administration services (Note 9)	369,592,338	325,943,373
- Other administration fees (Note 13)	98,054,210	86,473,977
Managed care: management services (Note 9)	139,293,947	123,107,954
Medical emergency call centre fees	693,523	619,091
Reinsurance expenses	24,462,961	19,294,471
Statement of Financial Position		
Amounts due to administrator (Note 5.1)(Administration fees due)	52,896,145	47,310,514
Amounts due to administrator (Note 6)(Reinsurance fees due)	2,179,993	-

The terms and conditions of the transactions with entities with significant influence over the Scheme were as follows:

Terms and conditions of the administration and managed care agreements

The administration and managed care agreements are in accordance with instructions given by the Trustees of the Scheme. Notwithstanding the signature date, the agreements are effective from the Commencement Date (1 January 2023) and shall endure for an initial period of five calendar years, with an option to renew for a further five calendar years, subject to earlier termination in accordance with the provisions of the agreements. The Scheme has the right to terminate these agreements on 6 months notice.

Terms and conditions of the third-party collection services

The third-party collection service agreement is in accordance with instructions given by the Trustees of the Scheme. The agreement will endure indefinitely until terminated by either Party giving the other Party not less than 6 (six) months' prior written notice.

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

16. NET RESULT PER BENEFIT OPTION

2025	LA CORE R	LA COMPREHEN- SIVE R	LA FOCUS R	LA ACTIVE R	LA KEYPLUS R	CONSOLIDATED R
Insurance revenue	322,819,394	111,403,723	1,229,101,144	4,793,447,136	205,453,676	6,662,225,073
Insurance service expense	(358,299,486)	(135,395,517)	(1,226,456,632)	(4,566,902,418)	(212,502,354)	(6,499,556,407)
Claims incurred	(340,862,937)	(130,166,144)	(1,062,683,393)	(4,106,205,370)	(188,413,539)	(5,828,331,383)
Accredited managed healthcare services	(3,853,108)	(1,093,592)	(33,701,790)	(93,827,582)	(6,817,875)	(139,293,947)
Other directly attributable insurance services expenses	(10,419,325)	(2,957,173)	(91,133,530)	(253,721,627)	(11,360,683)	(369,592,338)
Insurance acquisition costs	(3,164,116)	(1,178,608)	(38,937,919)	(113,147,839)	(5,910,257)	(162,338,739)
Net income/(expense) from reinsurance contracts held	(236,607)	(52,743)	15,387,133	(1,768,757)	2,559,449	15,888,475
Insurance service result	(35,716,699)	(24,044,537)	18,031,645	224,775,961	(4,489,229)	178,557,141
Other income	10,032,321	2,848,586	87,635,076	244,131,610	17,728,803	362,376,396
Other expenses	(5,433,810)	(1,542,450)	(47,504,670)	(132,285,957)	(3,873,109)	(190,639,996)
Amounts attributable to members for future benefits	(31,118,188)	(22,738,401)	58,162,051	336,621,614	9,366,465	350,293,541
Number of members	3,213	887	29,340	80,052	5,938	119,430
Number of beneficiaries	4,481	1,127	73,727	208,981	13,822	302,138
Average age	68.44	69.30	27.23	30.05	29.12	30.03
Pensioner ratio	71.55%	71.37%	1.23%	3.51%	1.82%	4.14%
Relevant healthcare expenditure	(344,952,652)	(131,312,479)	(1,080,998,050)	(4,201,801,709)	(192,671,965)	(5,951,736,854)

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

16. NET RESULT PER BENEFIT OPTION (continued)

2024	LA CORE	LA COMPREHEN- SIVE	LA FOCUS	LA ACTIVE	LA KEYPLUS	CONSOLIDATED
	R	R	R	R	R	R
Insurance revenue	310,680,450	115,236,286	1,013,208,716	4,126,195,755	196,012,906	5,761,334,113
Insurance service expense	(350,544,779)	(124,721,776)	(918,224,737)	(3,981,684,674)	(186,035,666)	(5,561,211,632)
Claims incurred	(333,204,620)	(118,940,061)	(780,254,122)	(3,572,442,593)	(162,444,298)	(4,967,285,694)
Accredited managed healthcare services	(3,819,129)	(1,174,820)	(28,376,343)	(83,055,226)	(6,682,435)	(123,107,953)
Other directly attributable insurance services expenses	(10,326,326)	(3,176,529)	(76,725,181)	(224,565,741)	(11,149,596)	(325,943,373)
Insurance acquisition costs	(3,194,704)	(1,430,366)	(32,869,091)	(101,621,114)	(5,759,337)	(144,874,612)
Net income/(expense) from reinsurance contracts held	(138,559)	(34,667)	(2,889,710)	(920,034)	2,454,936	(1,528,034)
Insurance service result	(40,002,888)	(9,520,157)	92,094,269	143,591,047	12,432,176	198,594,447
Other income	10,798,384	3,285,319	85,437,206	242,308,334	19,983,426	361,812,669
Other expenses	(5,426,150)	(1,662,836)	(41,205,111)	(119,282,486)	(7,857,977)	(175,434,560)
Amounts attributable to members for future benefits	(34,630,654)	(7,897,676)	136,326,364	266,616,895	24,557,625	384,972,555
Number of members	3,241	986	25,650	72,736	5,999	108,612
Number of beneficiaries	4,563	1,231	65,048	192,015	14,075	276,932
Average age	67.82	69.88	27.07	29.41	28.90	29.65
Pensioner ratio	70.48%	71.81%	1.25%	3.36%	0.86%	4.19%
Relevant healthcare expenditure	(337,162,308)	(120,149,548)	(811,520,175)	(3,656,417,853)	(166,671,797)	(5,091,921,682)

17. EVENTS AFTER THE REPORTING PERIOD

There have been no other events that have occurred subsequent to the end of the accounting period that materially affect the Financial Statements, and that the Trustees consider should be brought to the attention of the members of the Scheme.

18. INSURANCE RISK MANAGEMENT REPORT

Nature and extent of risks arising from insurance contracts

The Scheme issues contracts that transfer insurance risk. The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event, in accordance with the Scheme Rules and legislative requirements.

This note summarises these risks and the way in which they are managed.

Insurance risk

The risk under any insurance contract can be expressed as the probability that an insured event occurs multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The principal risk that the Scheme faces under its insurance contracts is that the actual claims payments exceed the projected amount of the insurance liabilities. This could occur because the frequency and severity of claims are greater than estimated. A larger number of members will result in smaller variability of the actual claims experience relative to expected levels. This is because an adverse experience is diluted by a larger group of members whose claims are stable and thus predictable.

Factors that aggravate insurance risk include unanticipated demographic movements, adverse experience due to an unexpected epidemic, changes in members' disease profiles, unexpected price increases, prevalence of fraud, supplier induced demand and the cost of new technologies or drugs.

The risks that the Scheme face can be discussed for the different benefits offered. The three main types of benefits offered by the Scheme in return for monthly contributions are indicated below:

Major Medical Expenses

The hospital benefits cover medical expenses incurred arising from admissions to hospital. This includes accommodation, theatre, professional fees, medication, equipment and consumables.

Day-to-day benefits

Day-to-day benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines. The day-to-day benefits include both the Medical Savings Account (MSA) and an insurance risk element. The Scheme does not carry risk for MSA benefits.

18. INSURANCE RISK MANAGEMENT REPORT (continued)

Insurance risk (continued)

Chronic illness benefits

The Chronic Illness Benefit (CIB) covers approved medication and treatment for a list of conditions which includes the 27 Prescribed Minimum Benefit (PMB) chronic conditions. These include conditions such as HIV / AIDS, high blood pressure, cholesterol and asthma.

The Scheme also covers additional chronic illness conditions (on specific Options).

The risks associated to the Scheme with the types of benefits offered to members are addressed below:

Major medical risk

The main factors impacting the frequency and severity of hospital claims are the number of admissions and the cost per event. An increase in the frequency and severity of claims result in an increase in the cost of claims.

An increase in the admission rate is often linked to increases in the number of beneficiaries at older ages or with chronic conditions. The increase in cost per event is driven by annual tariff and other cost increases. An increased cost per event can also be caused by an increased case-mix, severity of admissions and the introduction of new hospital-based technologies.

The following table shows various factors that impact hospital claims:

Key indicators	2025	2024	% increase / decrease
Length of stay (days)	4.45	4.34	2.53%
Average hospital cost per admission (R)	39,317	36,349	8.17%
Total cost per event (R)	63,580	58,615	8.47%
Total cost per life per month (R)	739	665	11.13%
Admissions per 1 000 lives	226.00	234.00	-3.42%

Day-to-day benefits risk

The day-to-day claims risk is influenced by the demographics and disease burden of members across the various benefit options, and required levels of PMB-related cover. Increased frequency and cost of these claims during the year increase the day-to-day risk costs for the benefit options that provide cover once the MSA benefits have been exhausted.

Chronic illness benefits risk

The main factors impacting the frequency and severity of chronic illness claims are the number of claimants and the cost per claimant respectively.

18. INSURANCE RISK MANAGEMENT REPORT (continued)

Insurance risk (continued)

Chronic illness benefits risk (continued)

Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. Increases in the regulated prices for chronic medication, the Single Exit Price, and increases in dispensing fees will also result in an increase in costs per claim. The mix between the various chronic conditions will also have an impact on the frequency and severity of the claims.

Certain factors that impact chronic cost are shown below:

Key indicators	2025	2024	% increase / decrease
Claimants per 1 000 lives	15.86	15.41	2.92%
Total cost per life per month (R)	56.55	55.42	2.04%

Risk management

The Scheme has various initiatives that are used to manage the risk associated with claims experience. These include:

- Members have to be referred by a doctor prior to an elective admission.
- All hospital admissions have to be pre-authorised.
- Case managers monitor hospital stays that are longer than expected, to ensure length of stay is managed appropriately.
- The work of the Centre for Clinical Excellence, which evaluates the effectiveness of new technologies and recommends whether the Scheme should cover these.
- The development of protocols around various high cost conditions, such as lower back surgery.
- A dedicated unit to focus on reducing surgical consumable spend.
- Peer review and statistically profiling significant outlier doctors on admission rate and generated costs.
- A Coordinated Care Programme to ensure direct coordination of care to high risk beneficiaries for whom multiple admissions are indicated, if not managed.
- An Advanced Illness Benefit Programme dedicated to managing care during the end of life stage for patients who are terminally ill.
- A disease management unit dedicated to managing high risk beneficiaries with complex diseases.
- Alternative reimbursement contracts exist with hospitals to mitigate the risk of additional utilisation above that which is expected for the demographics of the Scheme and severity of admissions.
- The Scheme manages and mitigates the risks associated with chronic illness benefits through an extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, all of which comply with the Regulations on Prescribed Minimum Benefits. In addition, the Centre for Clinical Excellence is involved in evaluating the effectiveness of new drugs and recommends whether the Scheme should cover these drugs or not.

18. INSURANCE RISK MANAGEMENT REPORT (continued)

Concentration of insurance risk

The Scheme is not exposed to a significant degree of concentration risk due to the various employers being located throughout the country. The Scheme also offers several benefit options to meet a variety of members' needs. This results in the Scheme being representative of the medical scheme market and, as such, it experiences limited variability of the outcome.

An annual actuarial valuation is performed, which specifies the contributions to be charged in return for the benefits to be provided given the expected demographic profile of each benefit option.

Reinsurance contracts held

The Scheme has reinsurance contracts in which suppliers are paid to provide certain minimum benefits, as and when it is required by the members. These arrangements are also known as capitation arrangements and fix the cost to the Scheme of providing these benefits.

The Scheme does, however, remain liable to its members to provide the benefits. If any supplier fails to meet the obligations of the reinsurance contract, the Scheme will cover the cost of the benefit.

When selecting a supplier, the Scheme assesses their ability to provide the relevant service. This is to mitigate against the reputational and operational risks that the Scheme faces should a supplier not meet its obligations. The Scheme also monitors the performance of the suppliers, checks the quality of care provided and has access to data on the underlying fee-for-service claims covered by the arrangement.

Claims development

At year-end, a probability weighted best estimate is made for those claims that have not yet been reported. Detailed claims development tables are not presented as the uncertainty regarding the amount and timing of claims payments are typically resolved within one year; in most cases within four months.

The methodology followed in setting this estimate is the actuarial methodology of chain ladder estimation. This methodology is the most objective, but the accuracy of the estimate is sensitive to changes in the average time from treatment to payment of claims. For hospital claims in the latest service month, a blend of the chainladder method and another method using the estimated cost per event and pre-authorized admissions is also followed.

18. INSURANCE RISK MANAGEMENT REPORT (continued)

Claims development (continued)

The December 2025 probability weighted best estimate of future cash flows for claims incurred but not yet reported and risk adjustment was made in accordance with Advisory Practice Note 304 of the Actuarial Society. In accordance with this practice note, the following factors are considered to determine whether they would have any impact on the probability weighted best estimate of the claims incurred but not yet reported and risk adjustment estimates:

- The homogeneity of claims data.
- The credibility of claims data.
- Changes in emergence and settlement patterns.
- The impact of seasonality.
- The impact of re-opened or adjusted claims.
- The impact of benefit limits and changes.
- External influences.
- The demographic profile of the Scheme.

Based on the processing patterns and claims development up to the end of December 2025 in respect of treatment dates during 2025, the recommended probability weighted best estimate of the claims incurred but not yet reported as at December 2025 is R226.6 million (2024: R188.8 million).

The recommended risk adjustment for non-financial risk, the compensation required for bearing uncertainty about the amount and timing of the cash flows that arise from non-financial risk as the Scheme fulfils insurance contracts, as at 31 December 2025 is R5.2 million (2024: R4.5 million).

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

	2025		2024	
	R		R	
	LIC as	Impact on	LIC as	Impact on
	at 31 December	SOCI*	at 31 December	SOCI*
Insurance contract liability	891,104,340	-	718,935,518	-
Change in LIC provision - 1% change in claims cost	-	57,866,323	-	49,563,666

*Statement of Comprehensive Income

Sensitivity of risk adjustment	2025	2024
	R	R
Risk adjustment with a 75% confidence level - as reported	5,211,311	4,530,039
Risk adjustment with a 90% confidence level	11,194,670	9,731,196

18. INSURANCE RISK MANAGEMENT REPORT (continued)

Claims development (continued)

Liquidity risk

One of the main components of the Scheme's insurance contract liabilities is the probability weighted best estimate of the claims incurred but not yet reported. These are generally settled in a short period of time; approximately 95% of this balance is settled within three months after the claim was incurred and the balance is expected to be settled within six months. The remaining insurance liabilities are generally settled within 30 days from year-end.

The MSA contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a MSA must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit plan and enrolls in another benefit plan or medical scheme without a savings account or does not enrol in another medical scheme. Therefore, the carrying values of the members' MSA are deemed to be equal to their fair values, which is the amount payable on demand.

Liquidity risk can also arise when the Scheme's investment mix does not match the nature of the liabilities. However, investments are managed by finance professionals who ensure that investments, including cash and cash equivalents, are always sufficiently liquid to meet current liabilities while excess reserves are invested to maximise investment return within the scope of the Regulations to the Act.

Assumption risk

The Liability attributable to members for future benefits and therefore the Scheme's solvency is sensitive to changes in claims development patterns. Another relevant assumption is medical inflation. Other assumptions that are considered include utilisation trends, the impact of new technology and the expected demographic profile of the Scheme membership.

19. FINANCIAL RISK MANAGEMENT REPORT

Overview

The Scheme is exposed to financial risk through its financial assets, financial liabilities and insurance contract liabilities. In particular the financial risk is that the proceeds, for any reason, from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of financial risk include market risk, interest rate risk, credit risk and liquidity risk.

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

The Board of Trustees has overall responsibility for the establishment and oversight of the Scheme's risk management framework.

The Scheme manages these risks through various risk management processes to ensure that the investment return on assets supporting the insurance liabilities is sufficient to contribute towards funding members' reasonable benefit expectations.

Market risk

Market risk is the risk that changes in market variables, such as foreign exchange rates, interest rates and equity prices will affect the Scheme's income or the value of its holdings in financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on risk.

The Scheme's insurance liabilities are settled within one year and the Scheme does not discount insurance liabilities. Consequently, changes in market interest rates would not affect the Scheme's net result arising from changes in the insurance liability.

Currency risk

All of the Scheme's benefits are rand-denominated and therefore the Scheme does not have significant net currency risk.

Price risk

All of the Scheme's investments are held in cash and money market funds therefore the Scheme does not have any price risk.

19. FINANCIAL RISK MANAGEMENT REPORT (continued)

Market risk (continued)

Interest rate risk

Interest rate risk is the exposure that the Scheme has to changes in interest rates. As the Scheme holds no debt with the exception of the savings liability on which interest is paid, the main exposure to the Scheme would be a reduction in interest income on investments if interest rates were to decrease.

The sensitivity of interest rate change is presented below.

<i>Interest rate risk sensitivity analysis</i>	2025	2024
	R	R
Change in Liability attributable to members for future benefits due to 1% change in prime lending interest rate	<u>44,002,056</u>	<u>44,137,838</u>

Legal risk

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. At 31 December 2025, the Scheme did not consider there to be any significant concentration of legal risk and no provision has been raised.

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

19. FINANCIAL RISK MANAGEMENT REPORT (continued)

Investment risk

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities.

The following table compares the fair value and carrying amounts of assets and liabilities per class of assets and liabilities. The carrying amounts approximate the fair value amounts.

	Financial assets at amortised cost	Insurance contract liability	Financial liabilities at amortised cost
	R	R	R
31 December 2025			
Investments	3,102,843,455	-	-
Other financial assets at amortised cost	102,360,285		
Cash and cash equivalents	1,821,841,720	-	-
Liability to members for future benefits	-	(4,126,621,318)	-
Liability to members for current benefits	-	(891,104,340)	-
Reinsurance contract liabilities	-	(2,696,940)	-
Post-retirement healthcare funding liability	-	-	(3,242,000)
Other financial liabilities at amortised cost	-	-	(3,398,106)
	5,027,045,460	(5,020,422,598)	(6,640,106)
31 December 2024			
Investments	2,963,908,893	-	-
Other financial assets at amortised cost	111,490,145	-	-
Cash and cash equivalents	1,449,874,881	-	-
Liability to members for future benefits	-	(3,776,327,777)	-
Liability to members for current benefits	-	(718,935,518)	-
Reinsurance contract liabilities	-	-	-
Post-retirement healthcare funding liability	-	-	(2,882,000)
Other financial liabilities at amortised cost	-	-	(31,094,357)
	4,525,273,919	(4,495,263,295)	(33,976,357)

19. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk

Credit risk is the risk of financial loss resulting from a counterparty's failure to meet their contractual obligations. The Scheme does not have significant credit risk arising from reinsurance contract assets or insurance assets. The reinsurance agreements are used to manage insurance risk. This does not, however, discharge the Scheme's liability as the primary insurer. If a reinsurer fails to pay a claim for any reason, the Scheme remains liable for the payment to the member. Exposures to individual members are managed by adhering to the requirements of Section 26(7) of the Medical Schemes Act i.e actively pursuing all contributions not received within three days of becoming due, suspending benefits for all members where contributions have not been received for 30 days and terminating benefits for all members where contributions have not been received for 60 days. The credit risk is taken into account when the expected contribution is calculated.

Key areas where the Scheme is exposed to credit risk are:

- Financial assets at amortised cost comprise fixed deposits. The risks associated with these deposits are managed by monitoring the Scheme's exposure to external financial institutions against approved deposit limits per institution.
- Insurance contract assets and other receivables. The main components of insurance contract assets are in respect of contributions due from members and amounts recoverable from members and suppliers in respect of claims debt.
- Cash and cash equivalents comprise of fixed deposits, deposits held on call with banks and other short-term liquid investments. The risks associated with these deposits are managed by monitoring the Scheme's exposure to external financial institutions against approved deposit limits per institution.

Exposure to credit risk

The carrying amount of Insurance contract assets, as included in the Insurance contract liabilities, and Financial assets at amortised cost represents the maximum credit exposure.

The Scheme ages and pursues unpaid accounts in terms of the Scheme's approved debt policy. The tables below highlight Insurance contract assets which are due, past due (by number of days) and are used to project the insurance contract cash flows that are not recoverable.

	2025	2024
	R	R
Insurance contract asset		
Not past due	333,367,011	287,527,410
Past due 1 - 30 days	6,316,678	4,038,515
Past due 31 - 90 days	12,928,506	5,715,679
91 days to more than 1 year	28,941,876	30,574,034
	<u>381,554,071</u>	<u>327,855,638</u>
Expected credit loss based on debt policy	<u>26,945,070</u>	<u>24,882,901</u>

19. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Credit quality

The credit quality of insurance contract assets as presented above can be assessed by reference to historical information about counterparty default.

Insurance revenue outstanding

The Scheme collects over 98% of outstanding contributions in the month following the contributions being due. Therefore, the Scheme can establish that the credit quality of contribution debtors is high and no additional disclosure of the credit quality is provided.

Withdrawn member claims debtors

These amounts are due from members that have withdrawn from the Scheme. The Scheme estimates that 81% (2024: 81%) of these receivables are not recoverable. This has been taken into account in the insurance contracts fulfilment cash flows.

Service provider claims debtors

These debtors are the healthcare providers of the Scheme. The amounts due to the Scheme are offset against future payments to be made to these providers. This has been taken into account in the insurance contracts fulfilment cash flows.

Forensic receivables

Forensic debt recovery mechanisms primarily include Acknowledgement of Debt (AOD), reversals, and cost adjustments. AOD amounts are recovered through various means such as debit orders, Electronic Fund Transfers (EFTs) or direct deposits into the bank account, which undergo continuous monitoring.

Financial assets at amortised cost

The Scheme has no significant concentration of credit risk. Cash transactions are limited to financial institutions with a high credit rating. The Scheme has a policy of limiting the amount of credit exposure to any one financial institution.

The Scheme limits its exposure to credit risk by investing only in liquid securities and only with counterparties that have high credit ratings. Given their high credit ratings, the Trustees do not expect any counterparty to fail to meet its obligations. Annexure B of the Regulations to the Act, prescribes the credit limits per institution, which reduces the individual risk per institution. The exposure to these credit limits are regularly monitored.

Cash and cash equivalents are only placed with reputable financial institutions with a high credit quality.

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

19. FINANCIAL RISK MANAGEMENT REPORT (continued)

The following table discloses the Scheme's asset credit ratings using official long-term credit ratings where available:

	GCR AA+	GCR AA	Not rated
31 December 2025			
Financial assets at amortised cost	1,175,000,000	1,927,843,455	-
Other financial assets at amortised cost	38,417,390	63,920,676	22,219
Cash and cash equivalents	1,814,310,472	7,432,036	-
31 December 2024			
Financial assets at amortised cost	1,155,000,000	1,808,908,893	-
Other financial assets at amortised cost	41,980,670	68,961,367	548,108
Cash and cash equivalents	1,420,183,987	29,690,893	-

Unconsolidated investment structures

The Scheme has involvement with investment funds in which it invests but it does not consolidate. The investment funds meet the definition of structured entities because:

- The voting rights in the funds are not dominant rights in deciding who controls them because they relate to the administrative tasks only;
- each fund's activities are restricted by prospectus; and
- the funds have narrow and well-defined objectives to provide investment opportunities.

The monies are invested in reputable funds which generate returns for the Scheme. The Scheme views these funds as unconsolidated structured entities. The Scheme monitors the performance of the funds closely to ensure the Scheme earns high returns without unnecessary exposure to risk.

The Scheme has investments in certain pooled portfolios and collective investment schemes (the Funds) as listed in the table below. The exposure the Scheme has to these Funds is also listed in the table. The Scheme's maximum exposure is limited to the total value of its investments in the Funds.

Fund	2025		2024	
	Fair value of fund assets held R	% Fund exposure attributable to Scheme	Fair value of fund assets held R	% Fund exposure attributable to Scheme
Nedbank Corporate Money Market Fund C1	467,175,650	2.19%	359,726,279	0.84%
Ninety One Corporate Money Market Fund A	744,364,903	3.00%	554,925,053	2.48%
Stanlib Corporate Money Market Fund B	423,078,823	0.66%	403,281,572	0.60%

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

19. FINANCIAL RISK MANAGEMENT REPORT (continued)

Liquidity risk

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due. The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, 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 Scheme's reputation.

Members of the Scheme are required to submit their claims within 4 months of the service date.

An expected maturity analysis for all assets and liabilities is provided below:

	Up to 3 months	>3 - 12 months	> 12 months	Total
	R	R	R	R
31 December 2025				
Assets	2,344,045,460	2,683,000,000	-	5,027,045,460
Financial assets at amortised cost	419,843,455	2,683,000,000	-	3,102,843,455
Other financial assets at amortised cost	102,360,285	-	-	102,360,285
Cash and cash equivalents	1,821,841,720	-	-	1,821,841,720
Liabilities	(896,254,232)	(1,320,154)	(2,867,000)	(900,441,386)
Liability to members for current benefits	(890,065,436)	(1,038,904)	-	(891,104,340)
Reinsurance contract liability	(2,696,940)	-	-	(2,696,940)
Post-retirement medical aid benefit liability	(93,750)	(281,250)	(2,867,000)	(3,242,000)
Financial liabilities at amortised cost	(3,398,106)	-	-	(3,398,106)
Net liquidity	1,447,791,228	2,681,679,846	(2,867,000)	
Liability to members for future benefits	-	-	(4,126,621,318)	(4,126,621,318)
31 December 2024				
Assets	1,935,273,919	2,590,000,000	-	4,525,273,919
Financial assets at amortised cost	373,908,893	2,590,000,000	-	2,963,908,893
Other financial assets at amortised cost	111,490,145	-	-	111,490,145
Cash and cash equivalents	1,449,874,881	-	-	1,449,874,881
Liabilities	(747,940,498)	(2,464,377)	(2,507,000)	(752,911,875)
Liability to members for current benefits	(716,752,391)	(2,183,127)	-	(718,935,518)
Post-retirement medical aid benefit liability	(93,750)	(281,250)	(2,507,000)	(2,882,000)
Financial liabilities at amortised cost	(31,094,357)	-	-	(31,094,357)
Net liquidity	1,187,333,421	2,587,535,623	(2,507,000)	
Liability to members for future benefits	-	-	(3,776,327,777)	(3,776,327,777)

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

19. FINANCIAL RISK MANAGEMENT REPORT (continued)

Capital risk management

Capital adequacy risk is the risk that there may be insufficient reserves to provide for adverse variations on actual or expected future experience.

The Scheme's objective is to manage its capital in such a way that the annual contribution increase to members is as low as possible and to remain a going concern. The Scheme therefore uses investment income and the investments to fund any possible deficit that might occur as a result of operational losses.

The calculation of the regulatory capital requirement is set out below.

	2025	2024
	R	R
Liability to members for future benefits (Note 5.2)	4,126,621,318	3,776,327,777
Accumulated funds per Regulation 29 of the Act	<u>4,126,621,317</u>	<u>3,776,327,777</u>
Gross annual contributions	8,375,203,407	7,233,151,235
Insurance revenue (Note 9)	6,662,225,073	5,761,334,113
MSA contributions received (Note 9)	1,712,978,334	1,471,817,122
Solvency margin	49.27%	52.21%

The accumulated funds ratio above compares favourably to the minimum prescribed accumulated funds ratio of 25%.

20. NON-COMPLIANCE MATTERS

Circular 11 of 2006 (the Circular) issued by the Council for Medical Schemes (the CMS) deals with issues to be addressed in the audited Financial Statements of medical schemes. This includes the requirement that all instances of non-compliance be disclosed in the audited Financial Statements, irrespective of whether the auditor considers them to be material or not.

During 2025, the Scheme did not comply with the following Sections and Regulations of the Act.

20. NON-COMPLIANCE MATTERS (continued)

20.1 Non-compliance with Section 33(2)(b) and Section 33(2)(c) - Financial performance and soundness of the LA Health Medical Scheme benefit options

Nature and impact

In terms of Sections 33(2)(b) and 33(2)(c) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance and be financially sound. The LA Core, LA Comprehensive and LA Keyplus benefit options incurred insurance service result deficits for the year ended 31 December 2025, thereby contravening Section 33(2)(b) and Section 33(2)(c) of the Act.

Causes of failure

The Scheme offers multiple benefit options to provide benefits suited to the specific healthcare needs of the varying demographic groups within the Scheme's overall membership. The benefit design process, however, must also consider the overall financial impact on the Scheme of providing such benefits. This takes into account the Scheme's financial stability, reserve levels and ultimate sustainability. To achieve both objectives, it may be necessary to incur losses on certain options, which are then offset by surpluses on other options. These losses are anticipated in the annual budget, which is approved by the Council for Medical Schemes (CMS).

Corrective action

The Board of Trustees addresses the sustainability of all benefit options during their annual strategic conference, and subsequent budgetary process, taking into consideration the required annual contribution increases. Fair consideration was given to the affordability of the benefits in these benefit options for their registered beneficiaries.

20.2 Non-compliance with Section 26(7) – Late payment of contributions

Nature and impact

Contributions due from a number of participating employers were received more than three days after becoming due in certain months during 2025, which is in contravention of Section 26(7) of the Act.

Causes of failure

Due to internal process delays by some participating employers, the contributions paid on behalf of members were not paid within three days of becoming due. As a result the Scheme is in contravention of Section 26(7) of the Act.

Corrective action

Scheme management continues to engage any employer group that pays late, and appropriate action is taken as and when necessary. Continuous improvements have been instrumental in timeous payment of contributions by employer groups. The Trustees consider the impact of the non-compliance to be immaterial.

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

20. NON-COMPLIANCE MATTERS (continued)

20.3 Non-compliance with Section 59(2) – Payment of claims within 30 days

Nature and impact

A medical scheme shall, in the case where an account has been rendered, subject to the provisions of the 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 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

Causes of failure

A small number of claims were paid later than 30 days of the date of receipt. Delays occur when accounts are referred for clinical audit or other investigations. These are however exceptions and claims are generally paid within the prescribed time.

Corrective action

The Scheme continues to comply as far as possible. It is however inherent to the industry that the adjudication of a small number of complex or problematic claims may result in payment thereof exceeding the standard 30-day period.

21. RECONCILIATION OF MOVEMENTS IN THE STATEMENT OF CASH FLOWS

	Notes	2025 R	2024 R
Cash paid to providers - non-healthcare expenditure		(126,815,221)	(112,076,146)
Depreciation	1	27,008	62,030
Movement in prepaid expenditure	3	525,889	(160,512)
Other operating expenses	13	(126,002,246)	(112,780,409)
Movement in post-retirement healthcare funding liability	7	360,000	279,000
Movement in accruals	8	(1,725,872)	523,745
Interest received		370,213,742	343,692,256
Interest earned	10	361,609,770	360,517,683
Movement in interest receivable	3	8,603,972	(16,825,427)

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

1 DESCRIPTION OF THE MEDICAL SCHEME

1.1 Terms of registration

LA Health Medical Scheme is a not-for-profit restricted Scheme registered in terms of the Medical Schemes Act, No 131 of 1998 (the Act), as amended.

1.2 Benefit options within the Scheme

In terms of its rules, the Scheme offered five benefit options during 2025:

LA Core
LA Comprehensive
LA Focus
LA Active; and
LA Keyplus

1.3 Medical Savings Account trust liability

On all benefit options except LA KeyPlus, members pay an agreed sum, less than or limited to 25% of their gross contributions, into a medical savings account (MSA). The full annual amount is made available for use on 1 January of each year although members only contribute towards this monthly. The MSA provides members with adequate cover for medical expenses they may incur outside of hospital, up to a prescribed limit, for different types of medical treatment such as dental care, optometry and acute medicine.

The balance remaining in the MSA at the end of each calendar year is carried over to the following year for the benefit of the member.

Actual interest earned, net of related expenses, is paid on Medical Savings Accounts.

Investment of MSA trust monies, managed by the Scheme on behalf of its members, have been separately disclosed as a current asset in the financial statements.

1.4 Reinsurance contracts (risk transfer arrangements)

The Scheme had the following reinsurance contracts in place during 2025:

- Discovery Health (Pty) Ltd - To provide specialised diabetes and cardiometabolic management services to members on all benefit options, except LA Keyplus.
- Iso Leso (Pty) Ltd - To manage optometry costs for members on the LA Keyplus and LA Focus options.
- Dental Risk Company (Pty) Ltd - To manage dental costs for members on the LA Keyplus and LA Focus options.

2 MANAGEMENT

2.1 Board of Trustees in office during the year under review

Name	Status	Date elected	Date term ends
Mr R Denge	Chairperson	Jul-2018	Jun-2030
Ms CS Nel	Deputy Chairperson	Jul-2015	Jun-2027
Mr RC Barnard		Jul-2009	Jun-2027
Mr HF Botha		Jul-2015	Jun-2027
Ms MN Chidi-Manganye		Jul-2021	Jun-2027
Mr R de Bruyn		Oct-2009	Jun-2027
Mr MAV Dlamini		Jul-2018	Jun-2030
Ms AD Joseph		Jul-2024	Jun-2030
Mr BJ Koen	Appointed 1 September 2025	Sep-2025	Jun-2027
Ms GM Komapi		Jul-2024	Jun-2030
Mr S Mabunda		Jul-2021	Jun-2027
Mr CL Mavuso	Resigned 29 April 2025	Jul-2021	Apr-2025
Mr A Vorster		Jul-2024	Jun-2030
Mr S Yamba		Jul-2021	Jun-2027

2.2 Principal Officer

Mr AM De Koker 1 Discovery Place Sandton 2196	PO Box 786722 Sandton 2146
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2.3 Registered office address and postal address

1 Discovery Place Sandton 2196	PO Box 786722 Sandton 2146
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2.4 Medical scheme administrator

Discovery Health (Pty) Ltd 1 Discovery Place Sandton 2196	PO Box 786722 Sandton 2146
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2.10 External auditor

Deloitte & Touche 5 Magwa Crescent Waterfall City 2090	PO Box 1986 Johannesburg 2000
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REPORT OF THE BOARD OF TRUSTEES (continued)

3 REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

3.1 Operational statistics

	LA Core		LA Comprehensive		LA Focus		LA Active		LA Keyplus		Consolidated	
	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024
Number of members at year end	3,213	3,241	887	986	29,340	25,650	80,052	72,736	5,938	5,999	119,430	108,612
Number of beneficiaries at year end	4,481	4,563	1,127	1,231	73,727	65,048	208,981	192,015	13,822	14,075	302,138	276,932
Average number of members for the year	3,197	3,333	907	1,025	27,966	24,762	77,858	72,476	5,658	5,885	115,586	107,481
Average number of beneficiaries for the year	4,461	4,709	1,142	1,285	70,729	63,075	204,051	191,306	13,213	13,862	293,596	274,237
Dependant-to-member-ratio at year end	1.39	1.41	1.27	1.25	2.51	2.54	2.61	2.64	2.33	2.35	2.53	2.55
Pensioner ratio (65 Years +)	71.55%	70.48%	71.37%	71.81%	1.23%	1.25%	3.51%	3.36%	1.82%	0.86%	4.14%	4.19%
Average age of beneficiaries	68.44	67.82	69.30	69.88	27.23	27.07	30.05	29.41	29.12	28.90	30.03	29.65
Avg Insurance revenue per member per month (pmpm)(R)	8,415	7,769	10,236	9,367	3,662	3,410	5,131	4,744	3,026	2,776	4,803	4,467
Avg Insurance revenue per beneficiary per month (pbpm)(R)	6,030	5,498	8,129	7,475	1,448	1,339	1,958	1,797	1,296	1,178	1,891	1,751
Avg Insurance service expense pmpm (R)	9,339	8,765	12,440	10,138	3,655	3,090	4,888	4,578	3,130	2,634	4,686	4,312
Avg Insurance service expense pbpm (R)	6,693	6,203	9,880	8,090	1,445	1,213	1,865	1,734	1,340	1,118	1,845	1,690
Relevant healthcare expenditure incurred pbpm (R)	6,444	5,967	9,582	7,792	1,274	1,072	1,716	1,593	1,215	1,002	1,689	1,547
Directly attributable insurance service expenses pbpm (R)	267	250	296	282	147	139	142	134	115	107	144	136
Insurance service expense as a percentage of insurance revenue	111%	113%	122%	108%	100%	91%	95%	97%	103%	95%	98%	97%
Relevant healthcare expenditure as a percentage of insurance revenue	107%	108%	118%	104%	88%	80%	88%	89%	94%	86%	89%	89%
Directly attributable insurance service expenses as a percentage of insurance revenue	4.42%	4.55%	3.64%	3.78%	10.16%	10.37%	7.25%	7.46%	8.85%	9.10%	7.64%	7.79%
Attributable and non-attributable expenses as a percentage of net contributions	5.52%	5.70%	4.54%	4.73%	12.68%	12.98%	9.06%	9.33%	10.73%	11.34%	9.53%	9.75%
Average broker fees per member (R)	82	80	108	116	116	111	121	117	87	82	117	112
Amounts paid to administrator (R'000)	17,037	16,883	4,835	5,193	149,013	125,442	414,862	367,159	21,193	20,848	606,940	535,525
Liability attributable to members for future benefits per member at 31 December (R)	-	-	-	-	-	-	-	-	-	-	34,553	34,769
Average Healthcare management expense pmpm (R)	100	96	100	96	100	96	100	96	100	96	100	96
Average Healthcare management expense pbpm (R)	72	68	80	76	40	37	38	36	43	41	40	37
Return on investments	-	-	-	-	-	-	-	-	-	-	8.23%	8.17%

3 REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES (continued)

3.2 Results of operations

The financial results of the Scheme are clearly set out in the Financial Statements accompanying this report.

3.3 Solvency ratio

	2025	2024
Liability to members for future benefits per the Statement of Financial Position	<u>4,126,621,318</u>	<u>3,776,327,777</u>
Accumulated funds per Regulation 29 of the Act	<u>4,126,621,318</u>	<u>3,776,327,777</u>
Gross annual contributions	8,375,203,407	7,233,151,235
Insurance revenue (Note 9)	6,662,225,073	5,761,334,113
MSA contributions received (Note 9)	1,712,978,334	1,471,817,122
Solvency ratio	49.27%	52.21%

The Scheme's solvency ratio exceeds the statutory reserve requirement of 25% of gross annual contribution income.

3.4 Provision for outstanding claims

At year-end, a provision is made for those claims outstanding that have been incurred but not yet reported. Movements in this provision is included in the Insurance contract liabilities and are set out in Note 5 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 Scheme.

4 INVESTMENT AND FIXED ASSET POLICY

The Board of Trustees continue to invest excess funds in line with the requirements of Annexure B of the Regulations of the Act. There has been no change in the policy during the current year.

5 COMMITTEES

5.1 AUDIT COMMITTEE

An Audit & Risk Committee, established in accordance with the provisions of the Act, is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. The Committee consists of five members of which two are members of the Board of Trustees. The majority of the members, including the Chairperson, are not officers of the Scheme or its third party administrator. The Committee met four times during 2025.

The Chairperson of the Board, the external auditor and the internal auditors of the Administrator are invited to attend all Audit & Risk Committee meetings and have unrestricted access to the Chairperson of the Committee.

In accordance with the provisions of the Act, the primary responsibility of the Committee is to assist the Board of Trustees in carrying out its duties relating to the Scheme's accounting policies, internal control systems and financial reporting practices. The external auditor formally reports to the Committee on critical findings arising from audit activities.

5.2 NOMINATIONS & APPOINTMENTS COMMITTEE

The Board of Trustees appointed a Nomination and Appointments Committee to review the structure, size and composition (including skills, knowledge, experience and diversity) of the Board of Trustees and make recommendations to the Board of Trustees with regard to any changes. The Nomination and appointments Committee has also been mandated to consider board continuity and its recommendations will be considered at the Board of Trustees 2026 strategic conference. Members of the Nomination and Appointments Committee are not remunerated.

5.3 SPECIAL COMMITTEE

An ad-hoc Special Committee was appointed to ensure the Board of Trustees acts in a fair, transparent and ethical manner, serving the best interests of the LA Health membership. Members of the Special Committee are not remunerated.

5.4 RECRUITMENT COMMITTEE

The Recruitment Committee advises and makes recommendations to the Board of Trustees on the succession of the Principal Officer. Its purpose is to ensure the long-term stability and effectiveness of the organisation's leadership and governance structure. Members of the Recruitment Committee are not remunerated.

6 MEETING ATTENDANCE

The following schedule sets out trustee meeting attendances where column A indicates the total number of meetings that could have been attended and B the actual number of meetings attended.

Trustee	Board of Trustees		Audit & Risk Committee		Risk Assessment Workshop		Strategic conference		Annual General Meeting		Product launches	
	A	B	A	B	A	B	A	B	A	B	A	B
Mr R Denge (Chairperson)	6	6	-	-	1	1	1	1	1	1	1	1
Ms CS Nel (Deputy Chairperson)	6	6	-	-	1	1	1	1	1	1	1	1
Mr RC Barnard	6	4	-	-	1	1	1	1	1	1	1	1
Mr HF Botha	6	5	4	4	1	1	1	1	1	1	1	1
Ms MN Chidi-Manganye	6	5	-	-	1	1	1	1	1	1	1	1
Mr R de Bruyn	6	6	-	-	1	1	1	1	1	1	1	1
Mr MAV Dlamini	6	5	-	-	1	1	1	1	1	1	1	1
Ms AD Joseph	6	5	-	-	1	1	1	1	1	1	1	1
Mr B Koen	2	1	-	-	1	0	-	-	-	-	1	0
Ms GM Komapi	6	5	-	-	1	1	1	1	1	1	1	1
Mr S Mabunda	6	5	-	-	1	1	1	1	1	1	1	1
Mr CL Mavuso	2	0	-	-	-	-	-	-	-	-	-	-
Mr A Vorster	6	4	4	4	1	0	1	1	1	1	1	0
Mr S Yamba	6	6	-	-	1	1	1	1	1	1	1	1
Independent members: Audit												
Ms F Mohamed (Chairperson)	-	4	4	4	1	1	-	-	-	-	-	-
Y Maseko (Deputy Chairperson)	-	-	4	4	1	1	-	-	-	-	-	-
S Martinus	-	-	4	4	1	1	-	-	-	-	-	-

7 NON-COMPLIANCE MATTERS

7.1 Non-compliance with Section 33(2)(b) and Section 33(2)(c) - Financial performance and soundness of LA Health benefit options

Nature and impact

In terms of Sections 33(2)(b) and 33(2)(c) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance and be financially sound. The LA Core, LA Comprehensive and LA Keyplus benefit options incurred insurance service result deficits for the year ended 31 December 2025, thereby contravening Section 33(2)(b) and Section 33(2)(c) of the Act.

Causes for the failure

The Scheme offers multiple benefit options to provide benefits suited to the specific healthcare needs of the varying demographic groups within the Scheme's overall membership. The benefit design process, however, must also consider the overall financial impact on the Scheme of providing such benefits. This takes into account the Scheme's financial stability, reserve levels and ultimate sustainability. To achieve both objectives, it may be necessary to incur losses on certain options, which are then offset by surpluses on other options. These losses are anticipated in the annual budget, which is approved by the Council for Medical Schemes (CMS).

7 NON-COMPLIANCE MATTERS

7.1 Non-compliance with Section 33(2)(b) and Section 33(2)(c) - Financial performance and soundness of LA Health benefit options

Corrective action

The Board of Trustees addresses the sustainability of all benefit options during their annual strategic conference, and subsequent budgetary process, taking into consideration the required annual contribution increases. Fair consideration was given to the affordability of the benefits in these benefit options for their registered beneficiaries.

7.2 Non-compliance with Section 26(7) – Late payment of contributions

Nature and impact

Contributions due from a number of participating employers were received more than three days after becoming due in certain months during 2025, which is in contravention of Section 26(7) of the Act.

Causes for the failure

Due to internal process delays by some participating employers, the contributions paid on behalf of members were not paid within three days of becoming due. As a result the Scheme is in contravention of Section 26(7) of the Act.

Corrective action

Scheme management continues to engage any employer group that pays late, and appropriate action is taken as and when necessary. Continuous improvements have been instrumental in timeous payment of contributions by employer groups. The Trustees consider the impact of the non-compliance to be immaterial.

7.3 Non-compliance with Section 59(2) – Payment of claims within 30 days

Nature and impact

A medical scheme shall, in the case where an account has been rendered, subject to the provisions of the 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 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

Causes for the failure

A small number of claims were paid later than 30 days of the date of receipt. Delays occur when accounts are referred for clinical audit or other investigations. These are however exceptions and claims are generally paid within the prescribed time.

Corrective action

The Scheme continues to comply as far as possible. It is however inherent to the industry that the adjudication of a small number of complex or problematic claims may result in payment thereof exceeding the standard 30-day period.

8 MEMBERSHIP

The total number of lives on the Scheme increased by 9.1% to 302,138 at the end of 2025, when compared to 276,932 at the end of 2024. The Board of Trustees continues to monitor and manage membership movements and the matter is receiving appropriate attention in terms of both risk management and future strategic planning. At the end of 2025, the Scheme's average beneficiary age was 30.03 years (2024: 29.65 years). The pensioner ratio decreased from 4.19% at the end of 2024 to 4.14% at the end of 2025.

9 BENEFIT OPTIONS

Benefit design is a dynamic process and aimed at fulfilling the needs and healthcare benefit requirements of the Scheme's members. For this reason, the Scheme offered five benefit options during 2025 which are reviewed on an on-going basis in terms of affordability, financial viability, membership choice and legislative compliance.

10 SERVICE AND ADMINISTRATION

The Scheme's administration is outsourced to Discovery Health (Pty) Ltd. The Scheme regularly reviews its service level agreements. The Scheme also ensures that effective service delivery and service levels are monitored and evaluated on an on-going basis.

11 FINANCIAL OVERVIEW

11.1 Review of financial results

The overall claims for 2025 were 2.13% higher than that budgeted for the year.

Incurred claims expenditure, expressed as a percentage of insurance revenue, was 87.48% for 2025 (2024: 86.22%).

The Scheme generated a net surplus for the year amounting to R350.3m. This compares very favourable against a budgeted surplus of R258.6m for 2025, with an actual surplus of R385.0m in 2024.

11.2 Administration expenditure

Administration expenditure (attributable and non-attributable to insurance contracts) remained stable at 9.53% of gross insurance revenue in 2025 (2024: 9.75%). The overall administration expenditure compares well with that of other medical schemes (as obtained from the latest available CMS annual report) in the healthcare industry.

11.3 Investments

Net investment income during 2025 amounted to R297.0 million, which is slightly down from the R297.9 million generated in 2024. This is due to the decrease in interest rates in the South African market during 2025.

12 COMMUNICATION

Scheme communications continue to be aimed at the education and empowerment of members, and elevating the profile of the LA Health brand to retain the current membership and attract new members. Ongoing evaluation of communication tools and channels has ensured continuous improvement of the impact of the marketing and communication messages and strategies.

13 ROAD ACCIDENT FUND (RAF) CLAIMS

The Scheme has the right to recover medical expenditure incurred on by members who have been involved in motor vehicle accidents (MVAs), from those members, if the value of the medical expenditure is reimbursed by the RAF. Usually a portion of the award to a claimant by the RAF is compensating for medical expenditure incurred. LA Health members, on joining the Scheme, agree to reimburse the Scheme for medical expenses paid by the Scheme, in the event that such expenses are reimbursed by the RAF.

The Scheme has no legal right to these funds until a court order has been issued instructing the RAF to reimburse the member for the medical costs incurred as a result of the MVA. Due to the significant uncertainty surrounding the outcomes of these claims, the Scheme cannot, from an accounting perspective, recognise an amount owing or a contingent asset until an award has been made by the court. As at the 31 December 2025, the Scheme had potential reimbursements of medical expenditure incurred on members involved in MVA's who had pending claims against the RAF, of R152.5 million.

The RAF has frequently (notably since August 2022) refused to pay past medical expenses for accident victims whose costs were covered by medical schemes, arguing that no actual loss was suffered by the member. The RAF effected its refusal to pay past medical expenses through directives that it had issued. Legal battles in this regard are ongoing, and this will be resolved in superior courts.

14 MANAGED CARE

The Scheme constantly reviews the manner in which it mitigates its clinical and financial risks while at the same time ensuring the provision of the highest quality of care to members. The Managed Care programmes will continue to undergo improvement and development to cater for the prevailing conditions in the industry, and the interest of the members.

15 EVENTS AFTER THE REPORTING DATE

There have been no significant events that have occurred subsequent to the end of the accounting period that affect the Financial Statements, and that the Trustees consider should be brought to the attention of the members of the Scheme.

16 GOING CONCERN

The Trustees have no reason to believe that the Scheme will not be a going concern in the year ahead.

17 VOTE OF APPRECIATION

On behalf of LA Health, the Board would like to express its thanks to:

- All members of LA Health and their employers.
- Independent members of the Board committees for their support.
- The Executive team and staff of LA Health for the diligent manner in which they have managed the affairs of the Scheme.
- The Registrar of Medical Schemes and his staff for their co-operation and assistance.
- Our contracted service partners, industry associations and healthcare service providers.

18 CONCLUSION

The Scheme is well positioned to meet the current industry challenges, as well as future changes in the legislative framework. The Scheme continues to be financially strong and its products are competitive in terms of pricing, benefits and service levels.



R DENGE
CHAIRPERSON



A VORSTER
TRUSTEE



AM DE KOKER
PRINCIPAL OFFICER

23 April 2026

DATE