SUREMED HEALTH
(Registration Number 1464)

ANNUAL GENERAL MEETING REPORT 2025

SUREMED HEALTH
REGISTRATION NUMBER 1464

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The report and extracts set out below comprise the Annual General Meeting Report presented to the members of Suremed Health.

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SUREMED HEALTH
REGISTRATION NUMBER 1464

REPORT OF THE BOARD OF TRUSTEES
FOR THE YEAR ENDED 31 DECEMBER 2024

The Board of Trustees hereby presents its report for the year ended 31 December 2024.

1. DESCRIPTION OF THE MEDICAL SCHEME

1.1. Terms of registration

Suremed Health is a not for profit open medical scheme registered in terms of the Medical Schemes Act 131 of 1998 (the Act), as amended.

1.2 Benefit options with Suremed Health

The scheme offers 4 benefit plans to employers and members of the public.

These are:

- Challenger Option
- Navigator Option
- Shuttle Option
- Explorer Option

1.3 Personal medical savings account monies managed by the scheme on behalf of its members

In order to provide a facility for scheme members to set funds aside to meet future healthcare costs not covered in the benefit option, the Trustees have made the savings plan option available to meet this objective.

Members that belonged to the Navigator benefit option during the year under review paid an amount of approximately 20% of their gross contributions into a savings account so as to help pay day to day healthcare costs, up to a prescribed threshold.

Unexpended savings amounts are accumulated for the long-term benefit of the member and interest is paid on balances at a rate determined by the Board of Trustees.

The liability to the members in respect of the savings plan is reflected as a financial liability in the financial statements and is repayable in terms of Regulation 10 of the Act. In terms of the rules of the scheme, the scheme carries the risk.

Savings contributions are refundable when a member leaves the scheme or transfers to an option within the scheme which does not have a savings option. The money will be transferred to the member within six months of the date of the change.

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REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2024

2. MANAGEMENT

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

Mr. AB Vermeulen	Chairman (member elected)
Mr. JLO Fernandes	Trustee (member elected)
Dr. N. Louw	Trustee (employer nominated)

2.2 Principal Officer:

Mr. J Janse van Rensburg

Registered office address and postal address:

c/o Momentum Thebe Ya Bophelo (Pty) Ltd
7 Lutman Street
Richmond Hill
Gqerberha
6001

P.O. Box 1672
Gqerberha
6000

2.3 Registered office address and postal address during the year:

Momentum Thebe Ya Bophelo (Pty) Ltd
7 Lutman Street
Richmond Hill
Gqerberha
6001

P.O. Box 1672
Gqerberha
6000

2.4 Medical Scheme Administrators (Accreditation number Admin:22) during the year:

Momentum Thebe Ya Bophelo (Pty) Ltd
7 Lutman Street
Richmond Hill
Gqerberha
6001

P.O. Box 1672
Gqerberha
6000

2.5 Actuaries (Accreditation number: RSP016/2010) during the year:

Prognosys Actuaries and Consultants
27 Muir Road
Rondebosch
Cape Town
7700

2.6 Auditors during the year:

PricewaterhouseCoopers Inc.
Ascot Office Park
Greenacres
Gqerberha
6045

3. INVESTMENT STRATEGY OF THE MEDICAL SCHEME

The Trustees continue to invest in line with the requirements of the Act. There has been no change in the policy during the current accounting period.

The scheme's investment objectives are to maximise the return on its investments on a long term basis at minimal risk. The investment strategy takes into consideration both constraints imposed by legislation and those imposed by the Board of Trustees. To achieve this, the funds are only invested on short-term and longer-term deposits with major banking institutions.

4. MEDICAL INSURANCE RISK MANAGEMENT

The primary insurance activity carried out by the scheme assumes the risk of loss from members and their dependants that are directly subject to the risk. These risks relate to the health of the scheme members; as such the scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract. The scheme also has exposure to market risk through its investment activities.

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

The scheme uses several methods to assess and monitor insurance risk exposure both for individual types of risk insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing.

The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and severity of claims is greater than expected.

Medical insurance events are, by their nature random, and the actual number and size of events during any one year period may vary from those estimated using established statistical methods.

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

Prescribed Minimum Benefits (PMB's)

In terms of this regulation, a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions. Section 29 (1) (p) of the Act provides that the rules of a medical scheme may, in respect of any benefit option provide that the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition. Payment of these claims is potentially higher than the standard claims at the tariffs agreed by the Scheme.

Reinsurance contracts

Certain risks are mitigated by entering into risk transfer arrangements - these are in substance, the same as a non-proportional commercial reinsurance contract. In this regard the scheme specifically decided to transfer all risks relating to emergency and ambulance benefits to ER24 and primary care benefits of the Explorer and Shuttle members to Prime Cure Health (Pty) Ltd (terminated 30 April 2024) and Momentum Health (Pty) Ltd (from 1 May 2024).

In terms of the risk transfer arrangements, the suppliers provide certain minimum benefits to all scheme members, as and when required by the members. The scheme does however remain liable to its members with respect to ceded insurance if the suppliers fail to meet the obligations they assume.

When selecting a supplier, the scheme considers its relative security. The security of the supplier is assessed from public rating information and from internal investigations such as capacity and appropriate resources.

5. SCHEME GOVERNANCE

Strategy Plan

The scheme's strategy is determined on an annual basis and approved by the Board of Trustees. Its purpose is to provide direction to the activities of the Principal Officer and management, and to provide a structure through which performance of these individuals can be monitored. It also ensures that the scheme operates effectively and efficiently. During the year under review the trustees gave attention to strategies covering the following:

- Member satisfaction;
- Marketing;
- Communication through website and social media;
- Broker management;
- Health risk management; and
- Risk evaluation and management.

Performance against the scheme strategies is measured by the Board of Trustees at each Board meeting to ensure that the business of the scheme is being managed within the vision and strategies of the scheme.

Risk Management Plan

The management of risk is the responsibility of the Board of Trustees. A risk register, which identifies the risks related to the scheme and the controls in place to address these risks, is approved by the Board of Trustees on an annual basis. The top risks identified for the scheme are:

- Council for Medical Scheme directives;
- Rising medical benefit costs;
- Declining membership numbers;
- Membership declining below sustainable levels;
- Fraud;
- Loss of going concern status;
- National Health Insurance implications;
- Hostile takeover; and
- Service provider delivery.

The risk management plan (RMP) includes appropriate mitigation steps and action plans to manage the risks. The RMP progress is reported on at all Audit Committee and Board of Trustee meetings.

Governance Program

The scheme is committed to following the principles of good corporate governance applicable to Medical Schemes. The scheme's vision, mission and values are reviewed annually by the Board of Trustees to ensure that the Board remains committed to building an ethical organisation. In 2024, these were as follows:

Vision
To be an ethical, sustainable, caring medical scheme providing affordable quality cover to all our members

Mission
To achieve sustainable growth and member loyalty through appropriate quality products, administration services, strong governance and operational excellence

Values

- Integrity;
- Quality services;
- Caring;
- Value for money; and
- Respect for, and loyalty towards, our stakeholders.

Performance of Scheme against Governance structures

The scheme performs an annual review of the King 4 principles, which is approved by the Board of the Trustees. This review sets out whether the scheme applies a specific principle and how this principle is applied. If a principle is not applied, it sets out why it is not applied. In the year under review, all applicable principles were adequately performed and reported.

5. SCHEME GOVERNANCE - continued

Use of Governance structures going forward

The scheme will continue to apply and review the Governance principles and strategies it currently has in place, and will monitor any new developments with a view to implement these, where appropriate and applicable to the scheme.

Future prospects for the scheme

The Board is of the opinion that there is no reason why Suremed Health should not be financially and otherwise sustainable as a going concern in the forthcoming 12 months.

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

6.1 Operational statistics per benefit option

	2024				
	Challenger	**Navigator**	**Shuttle**	**Explorer**	**Total**
Average number of members during the accounting period	126	370	98	176	771
Number of members at the end of the accounting period	122	362	80	123	687
Average number of beneficiaries during the accounting period	255	783	139	228	1 406
Number of beneficiaries at 31 December	244	761	107	173	1 285
Number of dependants at 31 December	122	399	27	50	598
Average number of dependants	129	413	41	52	635
Dependant ratio at 31 December	1.00	1.10	0.34	0.41	0.87
Insurance revenue per average beneficiary per month (R)	4,659.28	2,598.99	1,552.39	1,338.82	2,664.66
Insurance service expenses per average beneficiary per month (R) *	6,231.62	3,275.07	2,207.91	1,916.11	3,485.32
Relevant healthcare expenses incurred per average beneficiary per month (R) *	6,041.65	3,075.81	1,548.17	1,941.54	3,278.52
Directly attributable insurance service expenses per average beneficiary per month (R)	188.86	198.21	127.48	115.58	176.10
Other expenses per average beneficiary per month (R)	332.89	214.46	110.71	100.84	207.23
Insurance service expenses as a percentage of insurance revenue *	133.75%	126.01%	142.23%	143.12%	130.80%
Relevant healthcare expenses incurred as a percentage of insurance revenue *	129.67%	118.35%	99.73%	145.02%	123.04%
Directly attributable insurance service expenses as a percentage of insurance revenue	4.05%	7.63%	8.21%	8.63%	6.61%
Other expenses as a percentage of insurance revenue	7.14%	8.25%	7.13%	7.53%	7.78%
Average age per beneficiary	51.68	44.90	40.57	41.84	45.42
Pensioner ratio at 31 December (percentage of beneficiaries > 65 years)	34.84	22.34	19.63	26.59	25.06
Average insurance contract liability to future members per member at 31 December (R)	-	-	-	-	72 157
Return on investments as a percentage of investments	-	-	-	-	10.42%

* Excluding amounts attributable to future members

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REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2024

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES - continued

6.1 Operational statistics per benefit option - continued

	2023				
	Challenger	**Navigator**	**Shuttle**	**Explorer**	**Total**
Average number of members during the accounting period	136	435	231	235	1 036
Number of members at the end of the accounting period	134	426	261	260	1 081
Average number of beneficiaries during the accounting period	286	928	349	321	1 885
Number of beneficiaries at 31 December	278	904	391	339	1 912
Number of dependants at 31 December	144	478	130	79	831
Average number of dependants	151	493	118	86	848
Dependant ratio at 31 December	1.07	1.12	0.50	0.30	0.77
Insurance revenue per average beneficiary per month (R)	4,252.04	2,375.85	1,499.68	1,207.97	2,299.57
Insurance service expenses per average beneficiary per month (R) *	4,754.14	2,477.77	1,267.10	1,632.16	2,455.18
Relevant healthcare expenses incurred per average beneficiary per month (R) *	4,578.25	2,286.18	1,247.17	1,610.52	2,326.75
Directly attributable insurance service expenses per average beneficiary per month (R)	173.57	189.25	95.47	111.64	156.26
Other expenses per average beneficiary per month (R)	243.39	157.34	85.49	73.02	142.73
Insurance service expenses as a percentage of insurance revenue *	111.81%	104.29%	84.49%	135.12%	106.77%
Relevant healthcare expenses incurred as a percentage of insurance revenue *	107.67%	96.23%	83.16%	133.32%	101.18%
Directly attributable insurance service expenses as a percentage of insurance revenue	4.08%	7.97%	6.37%	9.24%	6.80%
Other expenses as a percentage of insurance revenue	5.72%	6.62%	5.70%	6.04%	6.21%
Average age per beneficiary	50.17	42.95	30.47	33.86	39.84
Pensioner ratio at 31 December (percentage of beneficiaries > 65 years)	32.38	18.75	5.06	13.82	17.06
Average insurance contract liability to future members per member at 31 December (R)	-	-	-	-	57 134
Return on investments as a percentage of investments	-	-	-	-	8.94%

* Excluding amounts attributable to future members

6.2 Results of operations

The results of the scheme are set out in the Annual Financial Statements. The Challenger option saw 20 high cost cases during the year, Navigator option 27 high cost cases during the year, Shuttle option 2 high cost cases during the year and the Explorer option 4 high cost cases. The high cost case with the highest total hospital cost was in excess of R3 million and it was on the Challenger option. These cases are not the norm The Trustees believe that no further clarification is required.

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES - continued

6.3 Solvency ratio

	2024 R		2023 R
The solvency ratio is calculated on the following basis:			
Insurance contract liabilities to future members	51 376 483		61 762 361
Insurance contract liabilities to future members excluding unrealised gains	51 376 483		61 762 361
Gross contributions	48 803 775		56 083 095
Ratio of insurance contract liabilities (future members) to gross annual contribution income	105.27%		110.13%

The scheme is above the statutory requirement of 25%.

7. EVENTS AFTER THE REPORTING PERIOD

The scheme is in the process of investigating potentially merging its operations with a suitable merger partner.

Other than the above, there were no significant events after the reporting period that require disclosure.

8. ACTUARIAL SERVICES

The scheme’s actuaries have been consulted in the determination of the contribution and benefit levels.

9. MARKETING AND DISTRIBUTION SERVICES

Marketing and distribution services are managed directly by the scheme in conjunction with the Administrators.

10. RELATED PARTY TRANSACTIONS

Refer to related parties disclosure in note 24 to the annual financial statements.

12. INVESTMENTS IN AND LOANS TO PARTICIPATING EMPLOYERS OF MEMBERS OF THE MEDICAL SCHEME AND TO OTHER RELATED PARTIES

The scheme holds no investments in participating employers of medical scheme members, or other related parties.

13. NON-COMPLIANCE MATTERS

Section 33 (2)

Each benefit option should be financially sound and self supporting. Non-compliance results in benefit options making a surplus subsidising benefit options making a deficit or where all benefit options incurring a deficit, scheme reserves will be utilised to subsidise the loss-making options. In respect of this scheme the Challenger, Navigator, Shuttle and Explorer options incurred net insurance deficits for the current financial year.

The Challenger option saw 20 high cost cases during the year, Navigator option 27 high cost cases during the year, Shuttle option 2 high cost cases during the year and the Explorer option 4 high cost cases. The high cost case with the highest total hospital cost was in excess of R3 million and it was on the Challenger option. These cases are not the norm. Appropriate adjustments have been made to the Challenger, Navigator, Shuttle and Explorer options for 2025.

Regulation 5(F)

In terms of this regulation diagnostic and such other code numbers that relate to relevant health services, need to be stated on all accounts. Non-compliance results in the scheme not complying with the Act. Certain accounts received from members who do not reside in South Africa do not have diagnostic and such other code numbers that relate to relevant health services. The administrator applies suitable codes where applicable.

Section 26 (7)

In terms of this section all contributions are to be received within 3 days of becoming due. Non-compliance could result in possible cash flow strain and have an impact on interest income. Late payments of contributions by members are not within the scheme’s control, however a credit control policy is in place to address this matter and late payments are followed up by the administrator.

Section 59 (2)

Certain claims were paid in excess of 30 days after receipt by the administrator as a result of queries to be investigated/audited in relation thereto. Non-compliance could impact on the relationship with members and providers. Procedures and policies are in place to manage late payment of claims, including a weekly report of claims held for investigation which is checked and signed by management to ensure that the 30 day limit is not exceeded. This practice ensures accurate claims processing and is in the interest of the risk management of the scheme

13. NON-COMPLIANCE MATTERS - continued

Regulation 30 and Annexure B of the Regulations

In terms of this regulation and the annexure, medical schemes may not have more than 10% of its investable assets invested in a bank inside the Republic with net qualifying capital and reserve funds per the Reserve Bank DI900 return greater than R 100 million and less than R 5 billion. In this respect, the scheme held 10.60% of its investable assets in a fixed deposit with GBS Mutual Bank. Non-compliance results in the scheme not complying with the regulations to the Act. It was considered whether an early withdrawal would be beneficial to the scheme, however, the early withdrawal fee and lost interest would not have been to the scheme's benefit. This particular fixed deposit matures in May 2025, at which time an appropriate amount will be withdrawn to ensure compliance.

The Trustees do not consider that these non-compliance matters have had a significant impact on the operations of the scheme or on the Financial Statements.

14. MEETING ATTENDANCE AND REMUNERATION

The following schedule sets out the attendance at meetings of the Board of Trustees and remuneration received.

	BOARD MEETINGS		AUDIT COMMITTEE MEETINGS		OTHER MEETINGS		FEES	EXPENSES	
NAME	A	B	A	B	A	B	R	R	
AB Vermeulen (BoT Chairman)	6	6	3	3	1	1	607 925	14 774	C
J Janse van Rensburg (Principal Officer)	6	6	3	3	1	1	760 800	10 429	
JLO Fernandes (BoT Trustee)	6	6	3	3	1	1	347 765	8 752	
N Louw (BoT Trustee)	6	6	-	-	1	1	349 110	7 402	
Total	24	24	9	9	4	4	2 065 600	41 357	

A = Total possible number of meetings that could have been attended
B = Actual number of meetings attended.
C = This amount includes expenses paid by the Chairman on behalf of the scheme

15. AUDIT COMMITTEE

Please refer to the attached report of the Audit Committee which summarises the roles, responsibilities and activities of the committee.

AB VERMEULEN

AB Vermeulen
Chairman

Date: 22-04-2025 | 14:17 SAST

SUREMED HEALTH
REGISTRATION NUMBER 1464
EXTRACT FROM ANNUAL FINANCIAL STATEMENTS

STATEMENT OF FINANCIAL POSITION
AS AT 31 DECEMBER 2024

	2024 R	2023 R
ASSETS		
Non-current assets		
Financial assets at amortised cost	38 409 495	51 799 507
Current assets	24 562 337	18 268 744
Financial assets at amortised cost	16 303 231	12 413 793
Trade and other receivables	61 308	29 035
Cash and cash equivalents	8 197 798	5 825 916
Total assets	62 971 832	70 068 251
LIABILITIES		
Non-current liability		
Insurance contract liabilities	51 376 483	61 762 361
Current liabilities	11 595 349	8 305 890
Trade and other payables	255 185	269 074
Reinsurance contract liabilities	82 424	28 024
Insurance contract liabilities	11 257 740	8 008 792
Total liabilities	62 971 832	70 068 251

SUREMED HEALTH
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EXTRACT FROM ANNUAL FINANCIAL STATEMENTS

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION
FOR THE YEAR ENDED 31 DECEMBER 2024

	2024 R Challenger	2024 R Navigator	2024 R Shuttle	2024 R Explorer	2024 R Total
Insurance revenue	14 262 046	24 425 320	2 597 154	3 663 002	44 947 522
Insurance service expenses (excluding amounts attributable to future members)	(19 074 988)	(30 779 101)	(3 693 841)	(5 242 471)	(58 790 400)
Net income from reinsurance contracts held	3 401	9 820	890 480	(385 834)	517 867
Reinsurance expenses from reinsurance contracts held	(51 048)	(151 990)	(1 355 091)	(1 152 817)	(2 710 946)
Reinsurance income from reinsurance contracts held	54 449	161 810	2 245 571	766 983	3 228 813
Insurance service result (net healthcare result)	(4 809 541)	(6 343 961)	(206 207)	(1 965 303)	(13 325 011)
Interest income from financial assets	1 875 284	3 204 225	338 993	480 714	5 899 216
Net investment income	1 875 284	3 204 225	338 993	480 714	5 899 216
Finance expenses from insurance contracts issued - PMSA	-	(87 596)	(172)	-	(87 768)
Net insurance finance expenses	-	(87 596)	(172)	-	(87 768)
Net result after investment income and finance expenses	(2 934 257)	(3 227 331)	132 614	(1 484 588)	(7 513 563)
Sundry income	43 046	559 899	9 286	11 034	623 265
Other operating expenses	(1 018 961)	(2 015 497)	(185 223)	(275 899)	(3 495 580)
Net surplus/(deficit) for the year	(3 910 173)	(4 682 930)	(43 323)	(1 749 453)	(10 385 878)
Members at 31 December 2024	**122**	**362**	**80**	**123**	**687**

	2023 R Challenger	2023 R Navigator	2023 R Shuttle	2023 R Explorer	2023 R Total
Insurance revenue	14 612 331	26 438 370	6 298 100	4 648 879	51 997 680
Insurance service expenses (excluding amounts attributable to future members)	(16 337 561)	(27 573 291)	(5 323 129)	(6 282 838)	(55 516 819)
Net expense from reinsurance contracts held	7 996	26 064	(316 678)	(346 665)	(629 283)
Reinsurance expenses from reinsurance contracts held	(50 668)	(167 459)	(5 228 150)	(1 401 249)	(6 847 526)
Reinsurance income from reinsurance contracts held	58 664	193 523	4 911 472	1 054 584	6 218 243
Insurance service result (net healthcare result)	(1 717 234)	(1 108 857)	658 293	(1 980 624)	(4 148 422)
Interest income from financial assets	1 652 568	2 990 023	712 278	525 761	5 880 629
Net investment income	1 652 568	2 990 023	712 278	525 761	5 880 629
Finance expenses from insurance contracts issued - PMSA	-	(89 005)	(217)	-	(89 222)
Net insurance finance expenses	-	(89 005)	(217)	-	(89 222)
Net result after investment income and finance expenses	(64 666)	1 792 161	1 370 354	(1 454 863)	1 642 985
Sundry income	60 073	682 139	33 897	19 112	795 221
Other operating expenses	(836 286)	(1 751 997)	(358 378)	(281 258)	(3 227 919)
Net surplus/(deficit) for the year	(840 880)	722 303	1 045 873	(1 717 009)	(789 713)
Members at 31 December 2023	**134**	**426**	**261**	**260**	**1 081**

Note: Expenses have been allocated between the various options based on membership figures.

The Annual Financial Statements were approved by the board on 14 April 2025 and signed on its behalf by Messrs AB Vermeulen (Chairman), JLO Fernandes (Trustee) and J Janse van Rensburg (Principal Officer).

The full audited annual financial statements will be available at the Annual General Meeting. Further copies may be obtained from the Fund Co-ordinator at loren.erasmus@momentum.co.za.

Independent Auditor's Report

To the Members of Suremed Health

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Suremed Health (the Scheme), set out on pages 10 to 56, which comprise the statement of financial position as at 31 December 2024, and the statement of comprehensive income and the statement of cash flows for the year then ended, and notes to the financial statements, including material accounting policy information.

In our opinion, these financial statements present fairly, in all material respects, the financial position of Suremed Health as at 31 December 2024, and its financial performance and cash flows for the year then ended, in accordance with IFRS Accounting Standards and the requirements of the Medical Schemes Act of South Africa.

Basis for Opinion

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

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

The scope of our audit was influenced by our application of materiality. An audit is designed to obtain reasonable assurance whether the financial statements are free from material misstatement. Misstatements may arise due to fraud or error. They are considered material if individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

Based on our professional judgement, we determined certain quantitative thresholds for materiality, including the final materiality for the financial statements as a whole as set out in the table below. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and in aggregate on the financial statements as a whole.

Final materiality	R450,000
How we determined it	1% of insurance revenue
Rationale for the materiality benchmark applied	We chose insurance revenue as the benchmark because, in our view, it is the benchmark against which the performance of the Scheme is most commonly measured by users, and is a generally accepted benchmark in the industry. We chose 1% which is consistent with quantitative materiality thresholds used for non-profit orientated entities in this sector.

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 and Council of Medical Schemes' Circular 65 of 2015, *Auditor's Reports: Key Audit Matters* (as applicable), we are required to report key audit matters and the outcome of audit procedures or key observations with respect to the key audit matters, and these are included below.

Key audit matter	***How our audit addressed the key audit matter***
Valuation of the liability for incurred claims from healthcare events that have occurred but have not yet been reported Refer to the following disclosure in the financial statements as it relates to this key audit matter: ● Note 3: Significant estimates; ● Note 4: Principal accounting policies; ● Note 10: Insurance contract liabilities; and ● Note 10.1: Liability attributable to current members As at 31 December 2024 the Scheme recognised Insurance contract liabilities - Current liability attributable to current members amounting to R11,257,740. The Scheme's insurance contract liabilities comprise the liability for remaining coverage (LFRC) and the liability for incurred claims (LIC).	Our audit addressed this key audit matter as follows: We obtained an understanding from the Scheme's administrator regarding the process followed in calculating the LIC from healthcare events that have occurred but have not yet been reported, which included the design and implementation of controls within the process. We obtained the actual claims data from the member administration system covering the year ended 31 December 2024 used in calculating the LIC from healthcare events that have occurred but are not yet reported.

In determining the LIC, the Scheme applies significant judgement and estimation uncertainties, due to the Scheme having to determine claims from healthcare events that have occurred but have not yet been reported. The value of the LIC from healthcare events that have occurred but have not yet been reported is the sum of the probability-weighted estimate of the expected future cash flows and the risk adjustment. The LIC reported is calculated by the Scheme's actuaries which is reviewed by the Audit Committee and recommended to the Board of Trustees for approval. The LIC from healthcare events that have occurred but are not yet reported amounts to R5,327,730 (Note 10.1). The most significant assumptions made in the determination of the LIC are: • the future cash flow projections; and • the risk adjustment for non-financial risk. *Future cash flow projections* The future cash flow projections comprise estimates of all future claim payments, receivables from third parties as well as the directly attributable expenses arising from the healthcare events within the boundary of the insurance contracts. The Scheme's actuaries use an actuarial model, based on the Scheme's actual claim development patterns throughout the year, to determine the probability-weighted estimate of expected future cash flows. This model applies the Bornheutter-Ferguson method. *Risk adjustments for non-financial risk* In determining the Scheme's risk adjustment for non-financial risk, the Scheme uses a confidence level technique (value at risk) under *IFRS 17 Insurance Contracts*. The Scheme's calibrated risk adjustment (using value at risk) is such that the insurance contract liabilities are held to be sufficient at the 75th percentile of the ultimate loss distribution.	We substantively tested a sample of claims received by the Scheme in the 2024 financial year, selected from the member administration system, and evaluated the accuracy of the service and process dates and the validity of the claim against the relevant Scheme rules. No material inconsistencies were noted. We assessed the completeness of the claims data in the Scheme's actuarial model by obtaining an understanding of management's controls and testing the reconciliation between the claims data per the member administration system and the claims data per the actuarial model. No material inconsistencies were noted. To assess the reasonableness of the Scheme actuaries' estimation process, we compared the actual claim results in the current year to the prior year LIC from healthcare events that have occurred but are not yet reported. We noted no matters for further consideration with respect to the estimation process. We have evaluated management's experts by assessing their competence, capability, and objectivity and noted no aspects requiring further consideration. We performed the following procedures: • We obtained the LIC from healthcare events that have occurred but are not yet reported from the Scheme's administrator and evaluated the relevance and reasonableness of the actuarial model used by the Scheme's actuaries based on our knowledge of the industry and model used in the prior years. We noted no matters requiring further consideration. • We compared the Best Estimate Liability and Risk Adjustment of the LIC from healthcare events that have occurred but are not yet reported amounts in the report from the Scheme's actuaries to the Best Estimate Liability and Risk Adjustment of the LIC from healthcare events that have occurred but are not yet reported amounts included in Note 10. We noted no matters requiring further consideration.

We considered the valuation of the LIC from healthcare events that have occurred but have not yet been reported to be a matter of most significance to the current year audit due to the significant judgement and estimation uncertainties applied in determining the future cash flow projections and the risk adjustments for non-financial risk.	• We enquired with the Scheme's administrator whether the IFRS 17 Risk Adjustment methodology (including the confidence level) has changed since the prior year. No changes were noted. • We performed a reasonableness assessment of the risk adjustment amount by recalculating the risk adjustment using the average risk adjustment factor over the past 3 years. No material differences were noted. We performed the following procedures to assess the adequacy of the LIC from healthcare events that have occurred but are not yet reported: • We obtained the actual claims run-off report up to 31 March 2025 from the Scheme's administrator and compared the claims paid post year-end to the LIC from healthcare events that have occurred but are not yet reported at year-end as part of subsequent event procedures. No material inconsistencies were noted. • For a sample of claims from the claims run-off report, we tested the occurrence and accuracy of the claims as well as the accuracy of the related service dates by agreeing the claims to underlying supporting documents on the policy administration system and we identified no material inconsistencies. • We inquired from the Scheme's administrator whether there were delays in processing claims at year-end that could possibly impact the claims run-off pattern subsequent to year-end. No such delays were identified.

Other Information

The Scheme's trustees are responsible for the other information. The other information comprises the information included in the document titled "Suremed Health's Annual Financial Statements for the year ended 31 December 2024". 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 and the requirements of the Medical Schemes Act of South Africa, and for such internal control as the Scheme's trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

From the matters communicated with the Scheme's trustees, we determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit

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

Report on Other Legal and Regulatory Requirements

Non-compliance with the Medical Schemes Act of South Africa

As required by the Council for Medical Schemes, we report the following material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa, as amended, that have come to our attention during the course of our audit:

1. Section 33(2): Each benefit option should be financially sound and self-supporting. In respect of this scheme, the Challenger, Navigator, Shuttle and Explorer options incurred deficits at the net insurance result level.

Audit Tenure

As required by the Council for Medical Schemes' Circular 38 of 2018, Audit Tenure, we report that PricewaterhouseCoopers Inc. has been the auditor of Suremed Health for 14 years.

The engagement partner, Mr A. Rathan, has been responsible for Suremed Health's audit for 6 years.

PricewaterhouseCoopers Inc.

PricewaterhouseCoopers Inc.
Director: A. Rathan
Registered Auditor
Gqeberha, South Africa
16 April 2025

www.suremed.co.za

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