



SUREMED HEALTH
(Registration Number 1464)

ANNUAL GENERAL MEETING REPORT 2026

**SUREMED HEALTH
REGISTRATION NUMBER 1464**

ANNUAL GENERAL MEETING REPORT 2026

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 2025**

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

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 2025**

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	P.O. Box 1672
Richmond Hill	Gqerberha
Gqerberha	6000
6001	

2.3 Registered office address and postal address during the year:

Momentum Thebe Ya Bophelo (Pty) Ltd	
7 Lutman Street	P.O. Box 1672
Richmond Hill	Gqerberha
Gqerberha	6000
6001	

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

Momentum Thebe Ya Bophelo (Pty) Ltd	
7 Lutman Street	P.O. Box 1672
Richmond Hill	Gqerberha
Gqerberha	6000
6001	

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

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**REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2025**

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 Momentum Health (Pty) Ltd.

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 2025, 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.

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**REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2025**

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 Trustees have made an assessment of the ability of the scheme to continue as a going concern for 12 months from the date of approval of the annual financial statements and have no reason to believe that the business will not be a going concern in the year ahead.

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

6.1 Operational statistics per benefit option

	2025				
	Challenger	Navigator	Shuttle	Explorer	Total
Average number of members during the accounting period	116	349	82	110	657
Number of members at the end of the accounting period	114	334	77	103	628
Average number of beneficiaries during the accounting period	232	721	109	153	1 214
Number of beneficiaries at 31 December	227	681	101	141	1 150
Number of dependants at 31 December	113	347	24	38	522
Average number of dependants	116	372	27	43	557
Dependant ratio at 31 December	0.99	1.04	0.31	0.37	0.83
Insurance revenue per average beneficiary per month (R)	5 190.32	2 839.51	1 704.95	1 667.40	3 038.35
Insurance service expenses per average beneficiary per month (R)	5 606.16	3 692.54	2 721.40	4 653.99	4 091.40
Relevant healthcare expenses incurred per average beneficiary per month (R)	5 400.84	3 474.77	2 810.40	4 679.89	3 934.22
Directly attributable insurance service expenses per average beneficiary per month (R)	198.63	211.28	142.66	125.37	191.89
Other expenses per average beneficiary per month (R)	374.69	239.45	124.36	122.74	240.21
Insurance service expenses as a percentage of insurance revenue	108.01%	130.04%	159.62%	279.12%	134.66%
Relevant healthcare expenses incurred as a percentage of insurance revenue	104.06%	122.37%	164.84%	280.67%	129.49%
Directly attributable insurance service expenses as a percentage of insurance revenue	3.83%	7.44%	8.37%	7.52%	6.32%
Other expenses as a percentage of insurance revenue	7.22%	8.43%	7.29%	7.36%	7.91%
Average age per beneficiary	52.85	46.18	43.26	45.47	47.16
Pensioner ratio at 31 December (percentage of beneficiaries > 65 years)	37.89	24.82	24.75	34.75	28.61
Average liability to members for future benefits per member at 31 December (R)	-	-	-	-	58 036
Return on investments as a percentage of investments	-	-	-	-	9.12%

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**REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2025**

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

6.1 Operational statistics per benefit option - continued

	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 liability to members for future benefits per member at 31 December (R)	-	-	-	-	72 157
Return on investments as a percentage of investments	-	-	-	-	10.42%

6.2 Results of operations

The results of the scheme are set out in the Annual Financial Statements. The Challenger option saw 14 high cost cases during the year, Navigator option 31 high cost cases during the year, Shuttle option 3 high cost cases during the year and the Explorer option 7 high cost cases. The high cost case with the highest total hospital cost amounted to R 1.7 million and it was on the Explorer option. These cases have significantly contributed to the negative insurance service results. The Trustees believe that no further clarification is required.

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**REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2025**

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

6.3 Solvency ratio

	2025 R		2024 R
The solvency ratio is calculated on the following basis:			
Liabilities to members for future benefits	36 446 548		51 376 483
Liabilities to members for future benefits excluding unrealised gains	36 446 548		51 376 483
Gross contributions	48 551 765		48 803 775
Ratio of liabilities to members for future benefits to gross annual contribution income	75.07%		105.27%

The scheme is above the statutory requirement of 25%.

7. EVENTS AFTER THE REPORTING PERIOD

During the course of 2025, the scheme initiated a process to explore a potential merger with a suitable partner. This decision was taken by the Board of Trustees after a directive received from the Council of Medical Schemes (CMS). It is based on an assessment of the scheme's current and anticipated operating environment, including:

- The scheme's recent financial performance;
- The size and sustainability of the membership base;
- Expected levels of medical inflation; and
- The scheme's capacity to increase member contributions to ensure long-term sustainability while maintaining affordability.

The scheme has identified and engaged with a potential merger partner and has commenced a merger process, with an estimated effective merger date of 1 January 2027.

As at the date of approval of these financial statements, an Exposition Document had been completed and submitted for actuarial review. Submission of the Exposition Document to the CMS is expected during early May 2026.

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 25 to the annual financial statements.

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**REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2025**

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 are 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 14 high cost cases during the year, Navigator option 31 high cost cases during the year, Shuttle option 3 high cost cases during the year and the Explorer option 7 high cost cases. The high cost case with the highest total hospital cost amounted to R1.7 million and it was on the Explorer option. These cases are not the norm. Appropriate adjustments have been made to the Challenger, Navigator, Shuttle and Explorer options for 2026.

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

**SUREMED HEALTH
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**REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2025**

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 their 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 R5 billion. In this respect, the scheme held 11.45% of its investable assets in a fixed deposit with GBS Mutual Bank as at 30 April 2025. Non-compliance results in the scheme not complying with the regulations to the Act. This fixed deposit matured in May 2025 and the appropriate reduction was made to ensure compliance. There was no non-compliance with Regulation 30 and Annexure B from May 2025.

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.

NAME	BOARD MEETINGS		AUDIT COMMITTEE MEETINGS		OTHER MEETINGS		FEES	EXPENSES
	A	B	A	B	A	B	R	R
AB Vermeulen (BoT Chairman)	5	5	3	3	1	1	648 750	12 831 C
J Janse van Rensburg (Principal Officer)	5	5	3	3	1	1	796 500	16 226
JLO Fernandes (BoT Trustee)	5	5	3	3	1	1	376 650	-
N Louw (BoT Trustee)	5	5	-	-	1	1	365 350	-
Total	20	20	9	9	4	4	2 187 250	29 057

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
Chairman

Date: 21-04-2026 | 14:37 SAST

SUREMED HEALTH
REGISTRATION NUMBER 1464
EXTRACT FROM ANNUAL FINANCIAL STATEMENTS

STATEMENT OF FINANCIAL POSITION
AS AT 31 DECEMBER 2025

	2025	2024
	R	R
ASSETS		
Non-current assets		
Financial assets at amortised cost	10 707 877	38 409 495
Current assets	36 993 556	24 562 337
Financial assets at amortised cost	23 735 240	16 303 231
Trade and other receivables	30 402	61 308
Cash and cash equivalents	13 227 914	8 197 798
Total assets	47 701 432	62 971 832
LIABILITIES		
Non-current liability		
Liability to members for future benefits	36 446 548	51 376 483
Current liabilities	11 254 884	11 595 349
Trade and other payables	301 643	255 185
Reinsurance contract liabilities	77 685	82 424
Insurance contract liabilities	10 875 557	11 257 740
Total liabilities	47 701 432	62 971 832

SUREMED HEALTH
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EXTRACT FROM ANNUAL FINANCIAL STATEMENTS

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION
FOR THE YEAR ENDED 31 DECEMBER 2025

	2025 R	2025 R	2025 R	2025 R	2025 R
	Challenger	Navigator	Shuttle	Explorer	Total
Insurance revenue	14 418 714	24 558 961	2 228 366	3 059 675	44 265 716
Insurance service expenses	(15 573 924)	(31 936 755)	(3 556 875)	(8 540 073)	(59 607 627)
<i>Claims incurred</i>	(15 022 143)	(30 109 410)	(3 370 420)	(8 310 019)	(56 811 992)
Net claims incurred	(14 851 058)	(29 615 797)	(3 324 270)	(8 248 767)	(56 039 893)
Accredited managed healthcare services (no transfer of risk)	(171 085)	(493 613)	(46 150)	(61 252)	(772 099)
<i>Directly attributable insurance service expenses</i>	(551 781)	(1 827 345)	(186 455)	(230 054)	(2 795 635)
Fees paid in respect of accredited administration services	(494 162)	(1 482 485)	(137 984)	(182 351)	(2 296 982)
Insurance acquisition cash flows expenses	(57 619)	(344 860)	(48 471)	(47 703)	(498 653)
Net income from reinsurance contracts held	18 604	56 142	(302 768)	(277 584)	(505 606)
Reinsurance expenses from reinsurance contracts held	(49 257)	(149 087)	(582 235)	(814 626)	(1 595 205)
Reinsurance income from reinsurance contracts held	67 861	205 229	279 467	537 042	1 089 599
Insurance service result	(1 136 606)	(7 321 652)	(1 631 278)	(5 757 982)	(15 847 517)
Interest income from financial assets	1 364 768	2 344 740	210 189	288 562	4 208 259
Net investment income	1 364 768	2 344 740	210 189	288 562	4 208 259
Finance expenses from insurance contracts issued - PMSA	-	(82 291)	(174)	-	(82 465)
Net insurance finance expenses	-	(82 291)	(174)	-	(82 465)
Net result after investment income and finance expenses	228 162	(5 059 203)	(1 421 262)	(5 469 420)	(11 721 723)
Sundry income	69 951	184 772	21 959	14 790	291 472
Other operating expenses	(1 040 902)	(2 071 012)	(162 542)	(225 228)	(3 499 684)
Net deficit for the year before mutualisation	(742 789)	(6 945 443)	(1 561 846)	(5 679 857)	(14 929 935)
Amounts attributable to members for future benefits	742 789	6 945 443	1 561 846	5 679 857	14 929 935
Total comprehensive income for the year	-	-	-	-	-
Members at 31 December 2025	114	334	77	103	628
	2024 R	2024 R	2024 R	2024 R	2024 R
	Challenger	Navigator	Shuttle	Explorer	Total
Insurance revenue	14 262 046	24 425 320	2 597 154	3 663 002	44 947 522
Insurance service expenses	(19 074 988)	(30 779 101)	(3 693 841)	(5 242 470)	(58 790 400)
<i>Claims incurred</i>	(18 496 884)	(28 916 285)	(3 480 571)	(4 926 230)	(55 819 970)
Net claims incurred	(18 316 910)	(28 409 779)	(3 451 903)	(4 856 093)	(55 034 684)
Accredited managed healthcare services (no transfer of risk)	(179 974)	(506 506)	(28 668)	(70 137)	(785 286)
<i>Directly attributable insurance service expenses</i>	(578 104)	(1 862 816)	(213 270)	(316 240)	(2 970 430)
Fees paid in respect of accredited administration services	(521 125)	(1 504 889)	(151 113)	(261 508)	(2 438 635)
Insurance acquisition cash flows expenses	(56 979)	(357 927)	(62 157)	(54 732)	(531 795)
Net expense 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	(4 809 541)	(6 343 961)	(206 207)	(1 965 302)	(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)	(3 227 332)	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 deficit for the year before mutualisation	(3 910 173)	(4 682 930)	(43 323)	(1 749 452)	(10 385 878)
Amounts attributable to members for future benefits	3 910 173	4 682 930	43 323	1 749 452	10 385 878
Total comprehensive income for the year	-	-	-	-	-
Members at 31 December 2024	122	362	80	123	687

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

The Annual Financial Statements were approved by the board on 21 April 2026 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 Medical Scheme

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 57, 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, as well as 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 2025, and its financial performance and cash flows for the year then ended, in accordance with IFRS Accounting Standards and the requirements of the Medical Schemes Act of South Africa.

Basis for Opinion

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

Key Audit Matters

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

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Chief Executive Officer: L S Machaba

The Company's principal place of business is at 4 Lisbon Lane, Waterfall City, Jukskei View, where a list of directors' names is available for inspection.

Reg. no. 1998/012055/21, VAT reg.no. 4950174682

Key audit matter	How our audit addressed the key audit matter
<p>Valuation of the liability for incurred claims from healthcare events that have occurred but have not yet been reported</p> <p>Refer to the following disclosures in the financial statements as it relates to this key audit matter:</p> <ul style="list-style-type: none"> • Note 3: Significant estimates; • Note 4: Principal accounting policies; • Note 10: Insurance contract liabilities; and • Note 10.1: Liability attributable to current members <p>As at 31 December 2025 the Scheme recognised Insurance contract liabilities - Current liability attributable to current members amounting to R10 875 557.</p> <p>The Scheme's insurance contract liabilities comprise the liability for remaining coverage (LFRC) and the liability for incurred claims (LIC). In determining the LIC, the Scheme applies significant judgement and estimation uncertainties, due to the Scheme having to determine claims from healthcare events that have occurred but have not yet been reported.</p> <p>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 administrator which is reviewed by management and 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 R4 707 805.</p> <p>The most significant assumptions made in the determination of the LIC are:</p> <ul style="list-style-type: none"> • the future cash flow projections; and • the risk adjustment for non-financial risk. • Future cash flow projections <p>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 administrator uses an actuarial model, based on</p>	<p>Our audit addressed this key audit matter as follows:</p> <p>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.</p> <p>We obtained the actual claims data from the member administration system covering the year ended 31 December 2025 used in calculating the LIC from healthcare events that have occurred but are not yet reported.</p> <p>We assessed the completeness of the claims data on the member administration system by understanding management's controls. We tested the integration of claim transactions from the claim source to the member administration system. No material inconsistencies were noted.</p> <p>We substantively tested a sample of claims received by the Scheme in the 2025 financial year. We selected from the member administration system and evaluated the accuracy of the service and process dates as well as the validity of the claims against the relevant Scheme rules. No material inconsistencies were noted.</p> <p>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.</p> <p>We also inspected the reported dates of a sample of the claims data used in the Scheme's actuarial model and considered that the data used in the Scheme's actuarial model did not include data reported to the Scheme subsequent to year-end. No material inconsistencies were noted.</p> <p>To assess the reasonableness of the Scheme administrator's 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.</p>

Key audit matter	How our audit addressed the key audit matter
<p>the Scheme's actual claim development patterns throughout the year, to determine the probability-weighted estimate of expected future cash flows. This model applies a combination of the Basic Chain Ladder ("BCL") and Bootstrapping methods.</p> <p><u>Risk adjustments for non-financial risk</u></p> <p>In determining the Scheme's risk adjustment for non-financial risk, the Scheme uses a confidence level technique (value at risk) under <i>IFRS 17, Insurance Contracts (IFRS 17)</i>. 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.</p> <p>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.</p>	<p>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:</p> <ul style="list-style-type: none"> • We obtained the LIC calculation 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 10.1 (Liability attributable to current members). We noted no matters requiring further consideration. • 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. <p>We performed the following procedure(s) to assess the adequacy of the LIC from healthcare events that have occurred but are not yet reported:</p> <ul style="list-style-type: none"> • We obtained the actual claims run-off report up to 28 February 2026 from the Scheme's administrator and compared the claims paid post year-end to the LIC from healthcare events that have occurred but are not yet reported at year-end as part of subsequent event procedures. No material inconsistencies were noted.

Key audit matter	How our audit addressed the key audit matter
	<ul style="list-style-type: none"> • 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. <p>We obtained a list of pre-authorisations approved prior to year-end from the administrator. For a sample of pre-authorisations with a service date before year-end, we requested the related claim documentation and assessed if the related claim had been included correctly in the claims run-off report up to 28 February 2026. No material inconsistencies were noted.</p>

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 Annual Financial Statements for the year ended 31 December 2025". The other information does not include the financial statements and our auditor's report thereon.

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

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

Responsibilities of the Scheme's Trustees for the Financial Statements

The Scheme's trustees are responsible for the preparation and fair presentation of the financial statements, in accordance with IFRS Accounting Standards 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. firm has been the auditor of Suremed Medical Plan for 15 years.

The engagement partner, Mr A Rathan, has been responsible for Suremed Medical Plan's audit for 7 years.

PricewaterhouseCoopers Inc.

PricewaterhouseCoopers Inc.

Director: A Rathan
Registered Auditor
Gqeberha, South Africa
22 April 2026



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