



2025

INTEGRATED REPORT

REGISTRATION NUMBER 1512



Bonitas

Medical Aid for South Africa

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OUR AWARDS

Bonitas received multiple awards in 2025, including Best Operational Performance at the BHF Titanium Awards for the third consecutive year, and Number 1 Medical Aid in the Ask Afrika Orange Index for the sixth time.



May 2025
Best Operational Performance at the
BHF Titanium Awards



September 2025
Orange Index Ask Afrika Industry Winner
2025/2026: Best Medical Aid in South Africa



September 2025
New Generation Awards (1) – CRM Strategy:
Best CRM Strategy Campaign



September 2025
New Generation Awards (2) – CRM Strategy:
Best Agency Award for CRM Strategy



October 2025
South Africa's Best Managed Companies:
Best Managed Company in the
Medical Aid Sector



October 2025
Daily Sun Readers' Choice Gold Winner
2025: Readers' Choice Gold Award for
Medical Aid

WHAT DIFFERENTIATES US



NAVIGATING THIS REPORT

We use navigation icons to guide readers through the report by highlighting key themes, stakeholders and strategic pillars. Each icon signals the type of content presented, helping readers understand how the information connects to Bonitas's strategy, governance and performance.

SDGs



Goal 3. Ensure healthy lives and promote wellbeing for all at all ages



Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Stakeholders



Board and employees



Government and regulatory bodies



Members, brokers and agents



Service providers

Strategic pillars



Be a strategic purchaser



Boost business development



Optimise investment returns



Connect with the customer



Integrate the value chain



Create value through innovation



Apply best practice governance

Material matters



Successful and efficient healthcare reform



Trust and confidence in our ability to protect stakeholders' interests



Thought leadership in functional, clinical and specialist areas



Making it easy for members to look after their health



Leveraging our bargaining power, footprint and networks



Protecting our financial sustainability



Preventing fraud, waste and abuse



Cyber and information resilience

ABOUT THIS REPORT

This integrated report covers the period 1 January to 31 December 2025 and outlines the material aspects of our performance, operations, governance and sustainability, and how Bonitas creates and preserves value for its stakeholders.

CONTENT SCOPE AND APPROACH

As a non-profit organisation, Bonitas exists to serve its members. We remain accountable for the responsible, effective and efficient use of the resources entrusted to us.

This integrated report has been prepared to provide members and stakeholders with all material information needed to assess whether we have delivered on this commitment.

The approach used to identify material matters is explained on page 26.

To ensure consistency and comparability, the structure, data and measurements presented here are aligned with prior years' reports. This enables stakeholders to track our performance and progress over time. We introduce our new capabilities-driven strategy in this report, but report on the previous strategic pillars for 2025.

For clarity, we apply the following timeframe references throughout the report:

- Short term: up to one year
- Medium term: one to three years
- Long term: three to 10 years

WE WELCOME FEEDBACK

We aim to continually improve the quality and relevance of our reporting. Please email suggestions for improvement to annualreportqueries@bonitas.org.za.

In addition to this document, we report to members and other stakeholders during annual and special general meetings. Please look out for member invitations to these meetings. Recordings and minutes of past meetings are available on our website.

See page 169 for a list of abbreviations and definitions of terms used in this report.

This report has been compiled with due regard to recognised reporting frameworks and standards, including:

Integrated Reporting Framework, 2021 (<IR> Framework)

This report complies with the <IR> Framework and provides a holistic view of the factors that substantively affect our ability to create value over time.

King IV Report on Corporate Governance™ for South Africa, 2016 (King IV™)¹

We adhere to the King IV™ corporate governance principles and practices. On page 75 we describe how we promote the governance outcomes of an ethical culture, good performance, effective control and legitimacy.

International Financial Reporting Standards (IFRS)

Financial information in this report was compiled using IFRS and was extracted from and agrees with the annual financial statements audited by Deloitte. See page 103 for the unqualified audit opinion of fair presentation and representation.

United Nations Sustainable Development Goals (SDGs)

We have identified the following SDGs as part of our value creation model and highlight our contribution in this report on page 18.



Ensure healthy lives and promote wellbeing for all at all ages



Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Together, these frameworks guide our disclosure, ensuring transparency, comparability and a holistic view of how Bonitas creates and protects value for its members over time.

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Bonitas recognises the growing importance of formal non-financial reporting and the need for standard disclosures. We have taken note of the International Sustainability Standards Board's IFRS S1 and IFRS S2 standards and will follow local regulatory guidance on adoption. IFRS 9 Financial Instruments also has amendments relating to clarifying the classification of financial assets with environmental, social and corporate governance (ESG) and similar features. This was effective from 1 January 2026.

Further, we plan to report according to the IoDSA King V™ Report on Corporate Governance for the 2026 financial year. We are also planning to formalise and expand our future non-financial reporting to align with global standards.

APPROVAL AND SALIENT FEATURES

This report was prepared by the Executive Management team and reviewed by the Audit and Risk Committee. The Bonitas Board and Executive Management approved the integrity of the report, with salient features including the following:

- Strategic focus: A dedicated chapter outlining our approach to delivering affordable, high-quality healthcare to members.
- Performance review: Commentary on progress against our strategy, with insights from the Principal Officer.
- Financial overview: A clear summary of our financial performance, supported by key operational statistics.
- Materiality focus: Identification of material risks and opportunities that influence our long-term resilience and sustainability.
- Governance and remuneration oversight: How the Board exercised and discharged its governance responsibility.

Approved on 25 June 2026 by

Mr OJ Komane
Chairperson of the Board

Mr LR Callakoppen
Principal Officer



2025 PERFORMANCE AT A GLANCE

MEMBERSHIP TRENDS

Principal members

369 147 ↑

(2024: 358 717)

Total beneficiaries

752 875 ↑

(2024: 731 576)

Average beneficiary age

36.2 ↑

(2024: 35.9)

Dependants per principal member

1.04 →

(2024: 1.04)

Pensioner ratio

11.8% ↑

(2024: 11.5%)

Chronic profile

19.9% ↑

(2024: 18.8%)

VALUE CREATED FOR MEMBERS

Percentage of hospital claims paid within 10 days

97.3% ↑

(2024: 89.9%)

Hospital claims processed per day

1 171 ↓

(2024: 1 472)

Hospital authorisations per day

1 532 ↑

(2024: 1 491)

Non-healthcare expenditure as a percentage of risk contributions

9.2% ↓

(2024: 9.4%)

Hospital tariff savings

R566 million ↑

(2024: R532 million)

ENSURING BONITAS REMAINS SUSTAINABLE

Liability to members for future benefits (reserves)

R10.8 billion ↑

(2024: R9.0 billion)

Solvency ratio (minimum legislative requirement is 25%)

36.9% ↓

(2024: 38.6%)

Amounts attributable to members for future benefits

R1.8 billion ↑

(2024: R133.9 million)

Investment income

R2.6 billion ↑

(2024: R1.4 billion)

Total investment portfolio value excluding cash

R12.54 billion ↑

(2024: R10.69 billion)

Insurance service result

R382 million deficit* ↓

(2024: R966 million deficit)
(2024 restated: R832 million deficit)

Return on investment

20.8% ↑

(2024: 13.4%)

Credit rating

AA+ →

(2024: AA+)

Gross recoveries from fraud, waste and abuse (FWA)

R55.3 million ↑

(2024: R46.2 million)

* The deficit recorded in 2024 of R966 million was higher than the deficit of R382 million recorded for 2025.

ABOUT BONITAS

We are dedicated to making quality healthcare accessible and affordable for all South Africans, guided by a commitment to sustainability, accountability and care.

OUR PURPOSE

Our purpose is to align our strategic intent to South Africa, while achieving balance between growth and financial sustainability, thus securing the future of Bonitas Medical Fund.

OUR VALUE PROPOSITION

- We care about our members, so we always act in their best interest.
- We offer a wide range of plans that are easy to use and understand to suit a broad variety of our members' healthcare needs.
- We partner with the best service providers, so our members have access to quality care at affordable rates.
- We are financially stable so we can afford to pay beneficiaries' claims.
- We keep people healthy and assist when they are ill through a range of managed care programmes; we also keep corporates healthier, so they are more productive and engaged.
- We find innovative ways to connect with our members, including our helplines, walk-in centres, website, app, WhatsApp and social media.

HOW WE CARE FOR OUR MEMBERS

We care for our members through:

- Accountability: We accept responsibility for honest and ethical conduct and decisions.
- Collaboration: We harness collective strength to achieve Bonitas's goals with excellence.
- Innovation: We develop new ideas and improve continuously to drive success.
- Commitment: We make a difference by being mindful and responsible in delivering excellence.
- Mutual trust and respect: We care for and respect our members, and enable better values-based healthcare.
- Ethics: We act with integrity, respecting the dignity, diversity and rights of our members.
- Making a difference: We aim to define, measure, analyse, improve and control to make a meaningful difference in the lives of our members.



OUR HEALTHCARE MODEL

Sales, marketing and distribution

Members sign up to Bonitas directly or through a network of brokers who earn commission on their services. Members pay their monthly contributions to Bonitas.

Service providers

- Agile Alternative Business Solutions
- Broker network

Healthcare

Our substantial network of general practitioners (GPs), hospital groups, specialists and pharmacies are specifically chosen to ensure members have access to the highest-quality care while avoiding out-of-pocket expenses.

Service providers

- 471 in-network acute hospitals
- 1 055 in-network day surgery hospitals
- 179 in-network mental health hospitals
- 7 065 in-network GPs
- 4 861 in-network specialists
- 417 in-network anaesthetists
- AZOZA¹ – previously Europ Assistance Worldwide Services (South Africa) Proprietary Limited – EMS¹
- Pharmacy Direct
- Marara Pharmacy²

Investment

We invest members' contributions to generate a return. This protects members' funds and increases our financial reserves, allowing us to keep contributions as low as possible. It also ensures that Bonitas remains able to serve our members in the future.

Service providers

- All Weather, Allan Gray, Aluwani, Catalyst, Fairtree, M&G, Mergence, Sesfikile, Taquanta and Vunani (asset managers)
- RisCura Solutions (investment consultant)

Bonitas has a Business Process Outsourcing (BPO) model that enables us to concentrate on our core capabilities and outsource specialist services to experts. Service providers are carefully selected and managed to ensure they look after our members like we do.

Scheme administration

Administrators provide services such as claims processing, contribution management and customer service.

Service providers

- Medscheme
- Private Health Administrators (PHA)
- Newly appointed administrator effective 1 June 2026 through a Request for Proposal (RFP): Momentum Health

Managed care

Our managed care programmes provide focussed quality care to members with chronic conditions including diabetes, hypertension, cancer, HIV/AIDS, back and neck pain and other ailments. Managed care also includes hospital pre-authorisation and medicine management.

Service providers

- Aid for Aids (Afa)
- AZOZA¹ – previously Europ Assistance Worldwide Services (South Africa) Proprietary Limited – EMS
- CareWorks
- Dental Information Systems (DENIS)¹
- HearConnect
- Medscheme
- PHA¹
- Preferred Providers Negotiators (PPN)
- Scriptpharm¹
- Marara Pharmacy²
- Newly appointed managed care service provider effective 1 June 2026 through a Request for Proposal (RFP): Private Health Administrators (PHA)

Actuarial and audit services

Actuaries assist us to analyse health informatics, develop plans and pricing models, conduct evaluations and review potential amalgamations. Internal audit focuses on processes and controls while external audit focuses on financial reporting.

Service providers

- Deloitte (external audit services)
- Medscheme (actuarial services)³
- NMG Consultants and Actuaries (actuarial services)
- PricewaterhouseCoopers (PwC) (internal audit services)

¹ Risk transfer agreement in place. See page 20 for more information.

² Designated Service Provider (DSP) for: BonCap, Primary, BonPrime (previously Primary Select), BonCore (new option from 2026).

³ Medscheme's contract for actuarial services ended in the 2025 financial year.

OUR KEY RELATIONSHIPS

Bonitas operates within a complex and tightly regulated healthcare environment, with every aspect of our operations influencing the health and wellbeing of our members. We are committed to delivering quality and affordable care through a well-managed network of agents and service providers. Our aim is to do so while upholding regulatory compliance and sound governance at every level.

STAKEHOLDER ENGAGEMENT AND COMMUNICATION FRAMEWORK

The Bonitas Stakeholder Engagement and Communication Framework provides guidance on building and maintaining trust-based relationships that advance shared value creation and a sustainable future for all stakeholders.

Approach

- Leverage existing experience
- Share knowledge and develop joint expertise
- Build partnerships based on mutual values and trust
- Adapt and respond to one another’s needs
- Be purposeful in our work with stakeholders
- Engage timeously with stakeholders

Outcomes

- Communicate our value proposition to stakeholders.
- Build caring, trusting, honest, ethical and open relationships that advance mutual coexistence and shared value creation.
- Promote good corporate citizenship and cooperation in our stakeholder community.
- Manage risk, reputation, legitimacy and relationship-building to create a sustainable future for all stakeholders.
- Maintain and enhance Bonitas’s governance integrity and reputation among stakeholders.

Principles

- Bring about consistency across the value chain on issues relating to stakeholder interests and engagement.
- Raise mutual awareness of Bonitas, our strategy, and our position on strategic issues, industry concerns and stakeholder interests.
- Build trust-based relationships through effective engagements with all key stakeholders while ensuring transparent and honest communication, to understand and address stakeholder issues and concerns.
- Proactively analyse stakeholder needs, interests in relation to Bonitas’s interests, and potential impacts on decision-making, and educe expectation gaps and misunderstandings.
- Create a caring, empowering and consensus-building environment that promotes coexistence and partnership, and contributes to South Africa’s overall healthcare ecosystem.
- Be agile and proactive in all media, business and communication strategies.



OUR STAKEHOLDERS



Board and employees
Govern and manage our operations



Members, brokers and agents
Our principal members and beneficiaries, and those who assist them in the membership process



Service providers
Contracted to provide healthcare and other services



Government and regulatory bodies
Regulate and oversee the healthcare and medical schemes industry



BOARD AND EMPLOYEES

5

Bonitas is managed by the Principal Officer and an Executive Management team, supported by employees, and with oversight from a Board of Trustees and Board Committees. These internal stakeholders are fundamental to the achievement of our value proposition and are the cornerstone of our service to members.

Stakeholders in this group include: Board of Trustees | Board Committees | Employees

How we engage

- Meetings and forums
- Manager–team dialogues
- Formal correspondence
- Employee presentations
- Informal engagements and social activities
- Internal policies and procedures

Their key concerns

- Strong and ethical leadership
- Strategic objectives and implementation

Bonitas response

- The Trustees on our Board are skilled and experienced and are either elected by members or appointed by the Board (a maximum of three Trustees may be appointed by the Board).
- Trustees and employees must adhere to our Code of Ethics and Professional Conduct.
- We conduct biennial independent performance assessments of the Board and its Committees.
- We design our strategy to ensure that we deliver on our purpose.
- We continually monitor progress against strategic objectives.
- We benchmark remuneration against industry practice and view rewards holistically.

Key focus areas for 2025

- Led the review of Bonitas's long-term strategy, including the integration of the new capability framework and alignment of priorities for 2026 to 2029.
- Strengthened strategic planning processes, including the incorporation of clinical risk trends, digital enablement milestones and preventative care insights into future strategy.
- Oversaw readiness for new administration and managed care contracts, including governance controls, transition protocols and independent oversight of the RFP processes.
- Ensured operational preparedness for contract changes, including data integrity measures, service continuity planning and alignment of performance expectations.
- Encouraged employee participation in industry knowledge-sharing platforms, including their contributions to the ACFE Africa Conference and the Managed Care Symposium.
- Actively managed all strategic and operational risks including legal and reputational risk.

How we define the quality of our relationships:

1 Poor or no relationship

2 Transactional or one-way relationship

3 Good relationship but needs to improve to add value to both sides

4 Good relationship with mutual benefit

5 Strong relationship of trust, collaboration and mutual understanding



MEMBERS, BROKERS AND AGENTS

3

Bonitas exists to create and protect value for our members. By understanding members' needs, we are better able to deliver relevant products and services, identify growth opportunities, retain existing members and attract new members. Members can be either direct-paying members (DPMs) who pay contributions directly to Bonitas, or corporate members who obtain membership of Bonitas through their employer.

Our members are advised, assisted and signed up through our distribution network, which includes brokers and direct sales.

Stakeholders in this group include: Members | Brokers | Trade unions | Employer groups and pay points

How we engage

- Integrated report and annual financial statements
- Publications, websites and other material
- Meetings and forums
- Annual General Meetings
- Surveys, focus groups, workshops and roadshows
- Contracts and service level agreements (SLAs)
- Formal correspondence
- Physical and digital touchpoints

Their key concerns

- Membership contributions and affordability
- Plans and benefits
- Claims and benefit queries as well as co-payment queries
- Network access and finding network providers
- Bonitas's position on National Health Insurance
- Customer satisfaction
- Transparency in areas such as trustee remuneration, auditor appointment processes and solvency management

Bonitas response

- We follow a rigorous and data-driven approach to our annual review and adjustment of healthcare plans, benefits and pricing.
- We look for innovative ways to increase member value on our plans, such as through additional benefits, reduced co-payments and innovative managed care programmes.
- We continually evaluate our healthcare provider and hospital networks and negotiate favourable fees so we can pass cost-savings on to our members.
- We address queries through touchpoints including our walk-in centres, call centre, our Bonitas member app and Member Zone portal, WhatsApp channel, corporate portal, brokers' portal and Business Hub.
- We measure customer satisfaction on an annual basis by calculating our net promoter score (NPS), customer satisfaction score and consumer experience score.
- We introduced "Dr B", a chatbot enabled by artificial intelligence (AI), to give members faster answers, clearer guidance and easier access to self-service support.

Key focus areas for 2025

- Expanded stakeholder education and awareness initiatives, including targeted fraud-awareness communication to members and providers, and participation in academic and industry forums to promote ethical conduct.
- We strengthened our online mental health assessments to improve early identification of risk and support timely enrolment into disease management programmes.
- Enhanced the digital experience for members through the redesign of the Bonitas website, with new features deployed ahead of the year-end period.

How we define the quality of our relationships:

1 Poor or no relationship

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SERVICE PROVIDERS

3

We meet members' needs by contracting with a range of service providers. Quality partnerships with these providers are crucial to our ability to offer affordable and high-quality products and services to members.

Stakeholders in this group include: Sales, marketing and distribution partners | Administrators | Healthcare providers | Managed care organisations and service providers | Investment and asset managers | Actuaries and auditors

How we engage

- Integrated report and annual financial statements
- Meetings and forums
- Contracts and service level agreements (SLAs)
- Formal correspondence
- Circulars

Their key concerns

- Contractual roles and responsibilities
- Fees and reimbursements
- Financial and operational performance
- Good governance and transparent contracting processes

Bonitas response

- We implement outcomes-based contracting by ensuring that service providers clearly understand their role, expected deliverables and how they contribute to achieving our strategic objectives.
- We provide detail on contractual roles and responsibilities in service provider contracts and SLAs.
- We monitor the operational performance of our service providers monthly and engage with them as required.
- We review service provider fees as stipulated in the applicable SLA, considering performance and industry benchmarks.
- We aim to create a caring, empowering and consensus-building environment with service providers that promotes coexistence and partnership and contributes to South Africa's overall healthcare ecosystem.

Key focus areas for 2025

- Delivered thought-leadership presentations to healthcare professionals, including a South African Medical Association (SAMA) Continuing Professional Development (CPD) Ethics Webinar attended by more than 700 doctors and specialists, with overwhelmingly positive feedback.
- Improved accuracy in pathology billing through a collaborative project addressing incorrect use of TB testing codes, with corrective action taken by major pathology groups.
- Supported improved integration with healthcare providers through PHA's development of a B2B solution for hospitals, aimed at streamlining data exchange and administrative processes.
- Completed the AfroCentric Data Centre migration, strengthening system stability and ensuring continuity for provider-facing platforms.
- Enhanced provider-related analytics through the ingestion of multi-year datasets into the Bonitas's cloud-based data warehouse.

How we define the quality of our relationships:

1 Poor or no relationship

2 Transactional or one-way relationship

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GOVERNMENT AND REGULATORY BODIES

3

The medical schemes industry is highly regulated and is governed primarily by the National Department of Health and Medical Schemes Act (MSA). We collaborate with all relevant government and regulatory bodies to ensure that members' rights are protected and that our regulatory and governance controls remain of the highest standard.

Stakeholders in this group include: Council for Medical Schemes (CMS), the regulator that controls and coordinates medical schemes, administrators, managed care organisations and brokers | Board of Healthcare Funders (BHF), a representative body of the healthcare funding industry that drives the sustainability of the healthcare ecosystem | Industry associations such as the SAMA, Health Professions Council of South Africa (HPCSA) and Hospital Association of South Africa (HASA)

How we engage

- Integrated report and annual financial statements
- Publications, websites and other material
- Meetings and forums
- Formal correspondence
- Circulars

Their key concerns

- Legal, regulatory and governance compliance
- Fraud, waste and abuse (FWA)
- Access to healthcare
- Anti-competitive behaviour
- National Health Insurance (NHI)

Bonitas response

- We monitor and implement all relevant legislative and regulatory updates and remain abreast of progress regarding applicable CMS and Competition Commission investigations.
- Our approach to managing FWA includes fraud prevention, detection, investigation, risk management and reporting, and the Bonitas FWA Forum meets monthly.
- We aim to make quality healthcare more affordable and accessible and believe that universal healthcare is a right, not a privilege.
- We lobby and engage with relevant stakeholders regarding the importance of an effective, efficient and well-governed NHI and the critical role of the private sector in ensuring universal healthcare.

Key focus areas for 2025

- Participated in CMS Section 59 technical and legal workstreams, contributing to the development of the Codes of Good Practice, the Industry Charter and improved dispute-resolution processes.
- Engaged regularly with the CMS, including responding to CMS complaints and receiving a positive ruling confirming procedural fairness in forensic audits.
- Supported preparations for the 2026 FWA Summit, collaborating with the CMS and industry partners to strengthen ethical conduct, transparency and sector-wide alignment on FWA management.
- Escalated provider-related matters to the appropriate regulatory authorities, including cases referred to the HPCSA, South African Council for Social Service Professionals (SACSSP) and South African Police Service (SAPS), several of which resulted in penalties, suspensions or criminal outcomes.
- Collaborated with SAPS, Special Investigating Unit and the National Prosecuting Authority as part of an industry-wide investigation into irregular renal-care activity, ensuring that systemic risks were addressed through coordinated enforcement.
- Maintained quarterly engagements with the HPCSA, raising overdue matters, escalating concerns and supporting the consistent application of professional standards.
- Shared relevant forensic intelligence with industry bodies, including reporting providers to the Healthcare Forensic Management Unit (HFMU) Portal to support sector-wide risk mitigation and regulatory oversight.

How we define the quality of our relationships:

1 Poor or no relationship

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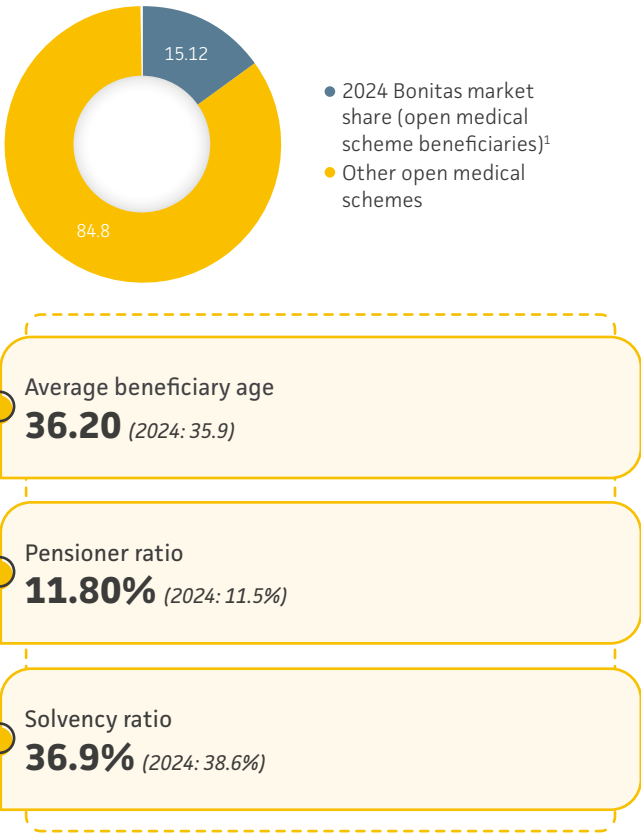
4 Good relationship with mutual benefit

5 Strong relationship of trust, collaboration and mutual understanding

BENCHMARKING BONITAS

For more than 40 years, Bonitas has deepened its understanding of South Africa’s evolving healthcare landscape. Understanding of the diverse needs of our members across communities, income levels and life stages, is what shapes our commitment to quality healthcare in a changing industry.

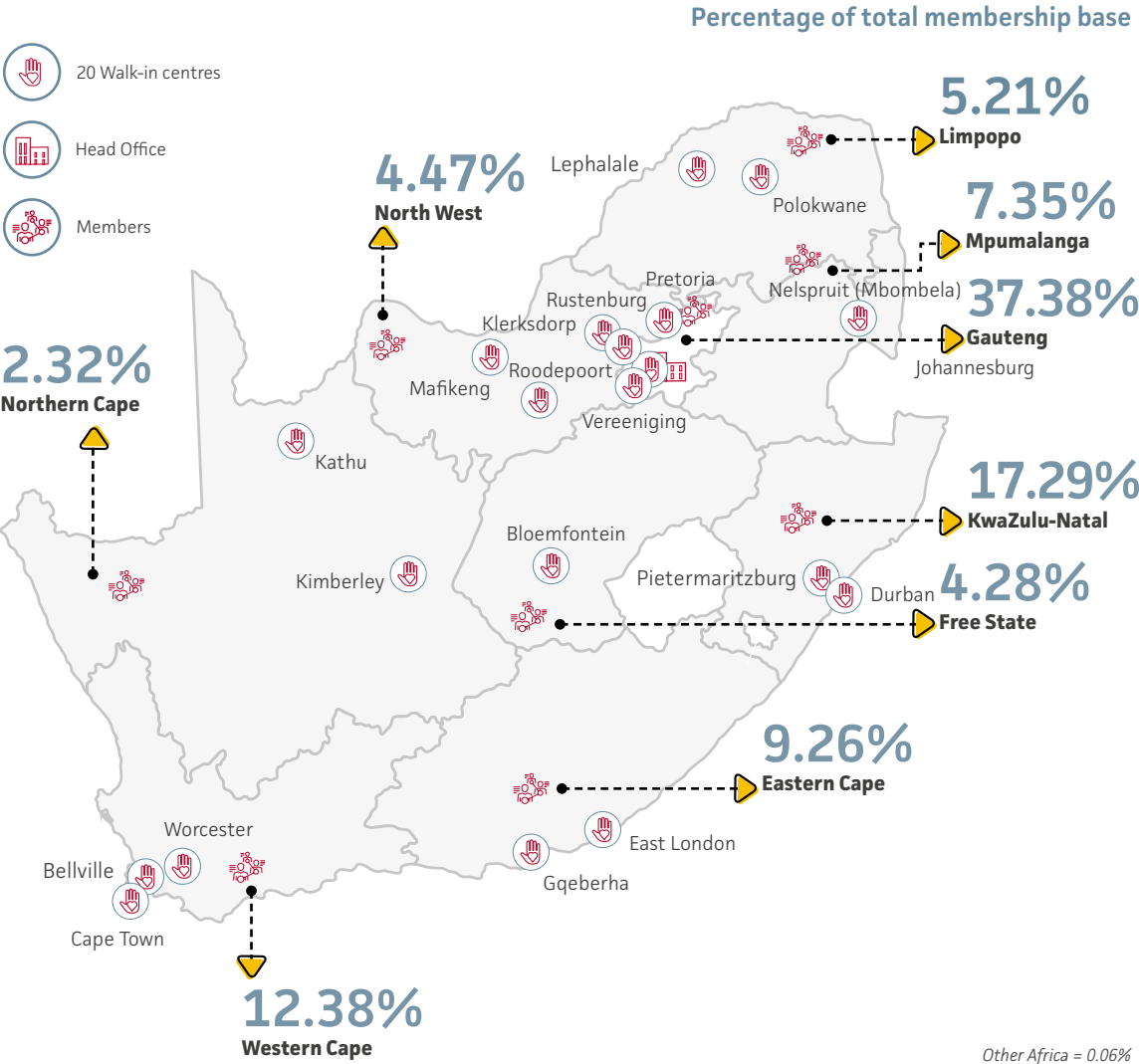
There are currently 16 registered open schemes in operation, a number that has declined from 47 in the year 2000 due to industry consolidation.¹



Source: CMS Industry Report 2024
¹ https://www.medicalschemes.co.za/wp-content/CMSIndustryReport2024_4Dec.pdf

OUR FOOTPRINT

We engage with members through an extensive physical network, supported by a range of digital channels. We have a national presence, and the highest concentration of our membership base is in Gauteng.



BONITAS HEALTHCARE PLANS

Bonitas offers a range of healthcare plans designed to meet the diverse needs of South Africans. Members who choose efficiency-discounted options enjoy added savings when using providers within the Bonitas network. Our Edge plans embrace technology, offering virtual care benefits that support convenient, connected access to healthcare.



TRADITIONAL PLANS

Standard

Rich day-to-day benefits and comprehensive hospital cover

Standard Select (EDO)

Uses a quality provider network to offer rich day-to-day benefits and hospital cover

Primary

Simple day-to-day benefits and hospital cover



EDGE PLANS

BonStart

Technology-driven plan for economically active singles in metros

BonStart Plus

Technology-driven plan for young families and couples planning to expand



SAVINGS PLANS

Personal medical savings accounts (PMSAs) are managed in terms of the Scheme Rules and are repayable in terms of Regulation 10 of the MSA.

For further information on the Scheme Rules adopted for PMSAs, refer to note 11.4 in the annual financial statements.

BonComprehensive

First-class savings plan with ample savings, above-threshold benefit and extensive hospital cover

BonClassic

Generous savings option with wide range of medical benefits, in and out of hospital

BonComplete

Savings option with generous savings, above-threshold benefit and rich hospital cover

BonSave

Savings to use as members choose for medical expenses and extensive hospital cover

BonFit

Basic cover for day-to-day medical needs and essential hospital cover

BonPrime (previously Primary Select)

Designed to enhance flexibility in managing day-to-day healthcare expenditure



HOSPITAL PLANS

BonEssential

Rich hospital benefits with some value-added benefits

BonEssential Select (EDO)

Uses a quality provider network to offer comprehensive hospital benefits with some value-added benefits

Hospital Standard

Extensive hospital benefits with some value-added benefits

BonCore (new option from 2026)

Digitally enabled hospital plan with day-to-day funding for (GP) consultations



INCOME-BASED PLAN

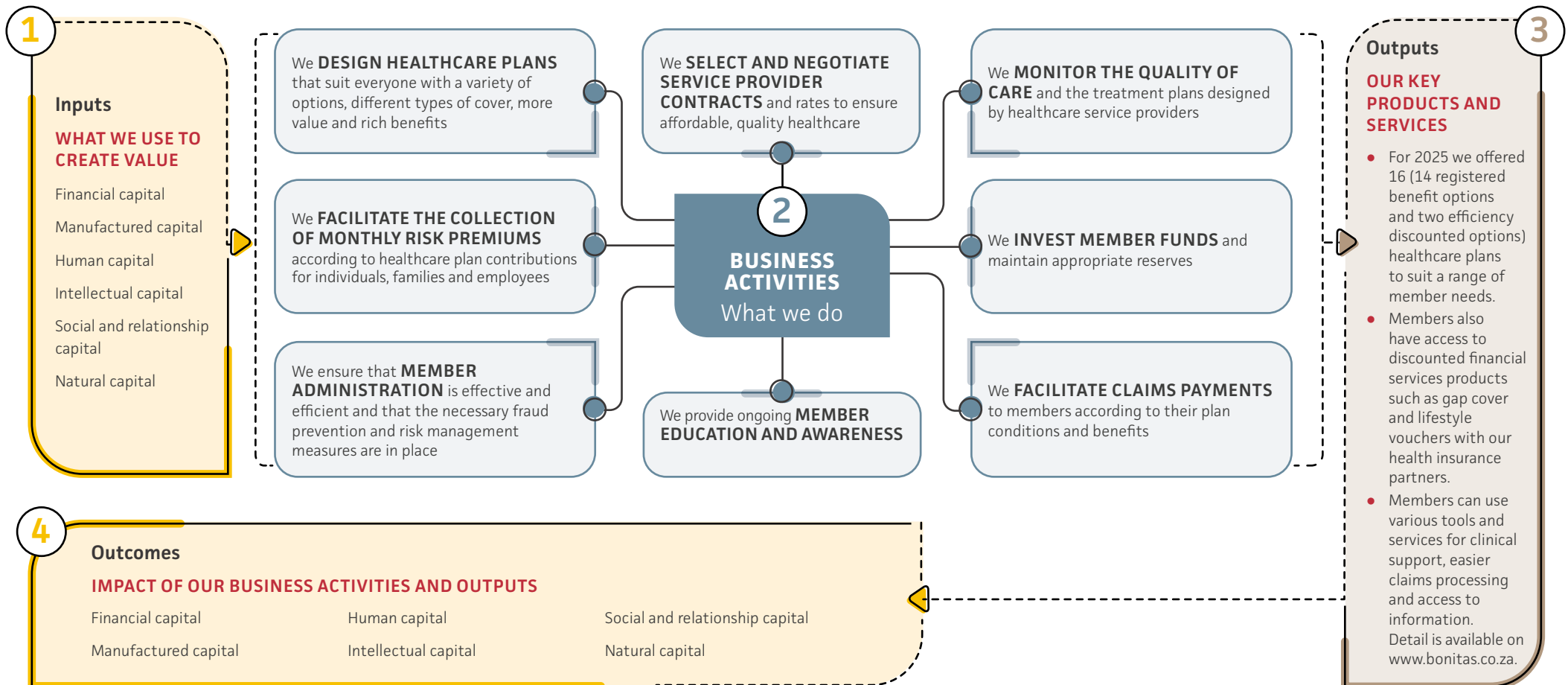
BonCap

Income-based entry-level plan offering basic day-to-day benefits and hospital cover via network providers

HOW WE CREATE AND PROTECT VALUE

We depend on key inputs to provide products and services to members. Bonitas controls some of these inputs while others are controlled by the service providers in our healthcare model (see page 6). This allows us access to more extensive inputs but also requires us to maintain effective relationships with service providers and continually monitor the quality of supplied inputs.

OUR VALUE CREATION MODEL



FINANCIAL CAPITAL

Bonitas is a non-profit organisation that exists and spends funds purely for the benefit of our members. Members' contributions are our primary source of income and are invested to generate further returns. Claims are paid according to members' plans and benefits. We have no shareholders or investors who receive dividends.

Inputs

- 369 147 principal members (2024: 358 717)
- 752 875 total beneficiaries (2024: 731 576)
- 10.2% total weighted contribution increase for 2025 (2024: 6.9%)
- R23.9 billion gross contributions (2024: R22.0 billion)
- R21.3 billion claims (2024: R20.1 billion)

Outcomes

- R23.4 billion insurance expenditure (2024: R22.29 billion) (2024 restated: R22.15 billion)
- 20.8% return on investment (2024: 13.4%)
- 7 loss-making options (2024: 8)
- 36.9% solvency ratio (2024: 38.6%)
- R10.8 billion liability to members for future benefits (reserves) (2024: R9.0 billion)
- R1.8 billion attributable to members for future benefits (2024: R133.9 million)

Value created, preserved or eroded

-  Board and employees ↑
-  Members, brokers and agents ↑
-  Service providers ↑
-  Government and regulatory bodies ↑

Future availability and risk

The sustainability of financial capital relies on membership growth, investment returns, strategic purchasing and effective FWA measures. Bonitas remains responsive to potential shifts in funding and scheme participation under the evolving NHI framework.

↑ Value created

→ Value preserved

↓ Value eroded

MANUFACTURED CAPITAL

We use a range of material goods and infrastructure to meet stakeholder needs and provide affordable and quality healthcare. Our healthcare model provides access to the assets owned, leased or controlled by our service providers.

Inputs

- Head office in Johannesburg
- 20 walk-in centres (2024: 20)
- Call centre
- 24/7 helpline (for medical advice)
- Bonitas member app
- Bonitas Member Zone portal
- WhatsApp channel
- Corporate portal
- Brokers' portal
- Business Hub
- Whistle Blowers hotline
- Bonitas I&T infrastructure

Our broader service provider network comprises facilities such as hospitals, surgeries, clinics, pharmacies, offices and medical equipment.

Outcomes

- 57 879 visits to our walk-in centres (2024: 62 959)
- 1 018 828 calls to our call centre (2024: 1 482 441)
- 1 917 878 logins to the Bonitas member app (2024: 1 533 171)
- 445 075 logins to the Bonitas Member Zone portal (2024: 397 485)
- 2 695 685 Live Chat and chatbot interactions (2024: 1 758 017)
- 196 860 WhatsApp agent chats (2024: 153 238)
- 5 255 498 total digital interactions (2024: 3 841 911)

Value created, preserved or eroded

-  Board and employees ↑
-  Members, brokers and agents ↑
-  Service providers ↑
-  Government and regulatory bodies ↑

Future availability and risk

Manufactured capital relies on national infrastructure and services, such as electricity and water, to function optimally. Physical climate risks and municipal / utilities disruptions may negatively impact essential services.

HUMAN CAPITAL

Our healthcare model enables us to focus on our core capabilities while outsourcing other functions to carefully selected service providers with specialist skills and expertise. Our management and operational team is small, but highly skilled, and oversight is provided by an independent Board of Trustees.

Inputs

- 8 Trustees on our Board as at year-end (2024: 8)
- Skilled Board with extensive experience in governance and the effective management of a medical scheme and healthcare model
- 22 employees (2024: 22)
- Management team with 165 years combined management experience in the healthcare/medical schemes industry
- Our broader service provider network offers us access to experienced agents, brokers, customer service professionals and healthcare professionals such as GPs and medical specialists

Outcomes

- R7.8 million total Trustee remuneration excluding accommodation, travel and training costs (2024: R7.4 million)
- R42.4 million total employee remuneration (2024: R41.0 million)
- 38% black and 13% female Trustees (2024: 38%, 13%)
- 65% black and 60% female employees (2024: 64%, 64%)
- 5% employee turnover (2024: 9%)
- 2 new employee appointments (2024: 1)

Value created, preserved or eroded

-  Board and employees ↑
-  Members, brokers and agents ↑
-  Service providers ↑
-  Government and regulatory bodies ↑

Future availability and risk

Human capital relies on our ability to attract and retain talent as well as ensure high performance. This is a high risk in our value chain where there is, for example, a critical shortage of nursing professionals.

INTELLECTUAL CAPITAL

Bonitas has been operating for more than 40 years. Our core competency is designing and pricing healthcare benefits and managed care plans.

Inputs

- Rich data assets and analytical insights to enable evidence-based decision-making and targeted interventions
- Innovation-driven strategic intent in support of continuous improvement in benefit design, care models and member experience
- Digital enablement to enhance service delivery and product quality through new technologies, digital platforms and automation capabilities
- Governance frameworks, risk management, policies and processes that support disciplined execution, regulatory compliance and responsible innovation

Outcomes

- 2.9% increase in membership (2024: 2.3%)
- Unique and comprehensive healthcare plans covering 334 conditions (2024: 334)
- Protocols and formularies that ensure safe, effective and high-quality treatment
- Digital channels that help members understand and manage health and wellbeing
- Internal risk measurement models and tools that enable us to manage risk effectively

Value created, preserved or eroded

-  Board and employees ↑
-  Members, brokers and agents ↑
-  Service providers ↑
-  Government and regulatory bodies ↑

Future availability and risk

Cyber risk can affect the availability, quality and integrity of data and impact our ability to ensure member privacy.

↑ Value created → Value preserved ↓ Value eroded

SOCIAL AND RELATIONSHIP CAPITAL

Our relationship with stakeholders has a direct impact on our sustainability and ability to provide quality and affordable healthcare. We are committed to engaging and collaborating with stakeholders to ensure the transformation and longevity of the South African healthcare ecosystem and to combat FWA.

Inputs

- Recognised brand and strong reputation associated with specific attributes and member benefits
- Commitment to transformation, diversity and inclusion
- Healthcare model enables us to partner with service providers who are best able to meet members' needs
- Status as the second-largest open medical scheme (by membership numbers) strengthens our negotiating position
- Active engagement with industry stakeholders such as the CMS, BHF, hospital groups and healthcare practitioners
- Long-standing partnership with Gift of the Givers in 2025, supporting initiatives such as hearing-screening programmes for school children, water-security projects at healthcare facilities and broader social upliftment efforts

Outcomes

- Level 7 Broad-based Black Economic Empowerment (B-BBEE) contributor (2024: Level 7)
- R566 million estimated savings yielded through strategic purchasing (collective bargaining) (2024: R532 million)
- R1.066 billion estimated savings due to managed care and strategic purchasing initiatives (2024: R901.1 million)
- R1.3 billion quantified as a drop in billing behaviour as a result of FWA since 2016 (2024: R1.2 billion)
- R55.3 million gross recoveries due to proactive FWA mitigation (2024: R46.2 million)

Value created, preserved or eroded

Board and employees ↑

Members, brokers and agents ↑

Service providers ↑

Government and regulatory bodies ↑

Future availability and risk

Our partnership with service providers can be at risk when not transacted at arm's length or where fees are not market-related or value-adding.

NATURAL CAPITAL

We do not rely on natural capital to create value, and we have an immaterial impact on natural resource use. We recognise that environmental factors potentially impact individual health and might increase the disease burden through air pollution, water quality and sanitation, or through natural disasters such as flooding and heatwaves.

Inputs

- Our value chain relies on natural inputs, particularly energy and water

Outcomes

- We continue to optimise the use of resources such as energy and water in our head office
- Bonitas partners with Gift of the Givers to support water-security initiatives such as borehole installations at Kalafong Hospital, Sefako Makgatho Health Sciences University, Cwebeni Junior Secondary School, Sibanye Clinic and Tower Hospital, as well as healthcare facility repairs following the KZN floods

Value created, preserved or eroded

Board and employees ↑

Members, brokers and agents ↑

Service providers ↑

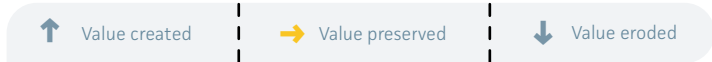
Government and regulatory bodies ↑

Future availability and risk

The healthcare ecosystem remains vulnerable to energy- and water-shedding, and climate change may significantly impact health, wellness and healthcare infrastructure.

OUR VALUE CREATION MODEL CONTEXT

Our external environment and trends in healthcare	Page 21
Progress with the implementation of our strategy	Page 45
The effectiveness of our risk management and ability to identify and capture opportunities for growth	Page 47
Ethical leadership and effective governance structures, processes and controls	Page 74
Strong brand equity in a volatile environment	Page 49
Solid financial performance	Page 4



HOW OUR OUTCOMES CONTRIBUTE TO THE SDGs



Goal 3. Ensure healthy lives and promote wellbeing for all at all ages

Target 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all

Bonitas aims to make quality healthcare more affordable and accessible by growing and retaining membership, prudently investing funds and responding to healthcare trends through strong analytical and purchasing capabilities. Our members benefit from the value of private medical care while being protected against unexpected and high medical costs.

We believe that universal healthcare is a right and support reforms that improve cost, quality and access across the healthcare system. We engage stakeholders on the importance of a well governed and sustainable NHI framework (see page 23) and contribute to the resilience of the healthcare ecosystem through our partnership with Gift of the Givers (see page 43).

Through Scriptpharm and Marara Pharmacy, we strengthen our capability model by combining digital enablement (digital, electronic, and scanned prescriptions), service excellence and a member centred experience. This helps to ensure reliable access to chronic and acute medicines, improve adherence and support continuity of care.

Target 3.B Provide access to affordable essential medicines and vaccines for all

Our healthcare plans meet a wide range of members' needs and cover 334 conditions, including:

- 271 diagnosis and treatment pairs based on the admission categories within hospital benefit management
- 27 prescribed minimum benefit (PMB) chronic conditions for all plans
- 36 additional conditions for certain plans from a chronic medicine management perspective

The Be Better Benefit provides risk funded health assessments and preventative screenings that support early detection and proactive management of health and wellness needs.

All Bonitas plans include preventative care benefits that offer access to selected screenings and vaccinations, although the specific vaccines available differ across the plan range.



Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Target 16.5 Substantially reduce corruption and bribery in all their forms

We have a zero-tolerance approach to FWA as such acts are not only illegal but also increase the cost of healthcare, which translates to increased contribution costs for members. FWA is a primary risk management focus area and we collaborate with all relevant stakeholders to prevent, detect, investigate, manage and report on instances of FWA (see page 43).

Several policies guide ethical practice in Bonitas, including our Anti-Fraud, Waste and Abuse Policy, Code of Ethics and Professional Conduct for Trustees and Independent Members, Code of Ethics and Professional Conduct for Executives and Staff, Gifts Policy and Conflict of Interest Policy.

Target 16.6 Develop effective, accountable and transparent institutions at all levels

Bonitas adheres to the requirements of the MSA together with legislation and regulations published by the CMS and other regulatory bodies. Our Scheme Rules are regulated and registered with the CMS.

We collaborate with the BHF in its endeavour to ensure the sustainability of the healthcare sector and cooperate with this body on areas of mutual interest.

Our focus is on continual improvement of the healthcare value chain. Our Procurement and Contract Management Policy provides guidance on seeking win-win solutions with service providers, that improve healthcare outcomes for members (see page 41). Our Governance, Risk and Compliance (GRC) Framework has been developed in line with the requirements of the MSA, Scheme Rules and King IV™ (see page 84).

MATERIAL TRADE OFFS

Affordable healthcare and long-term sustainability

Bonitas secures long-term sustainability by combining member contributions with investment income to maintain strong reserves and a high solvency ratio, which is currently well above the statutory minimum. These reserves act as a safeguard to ensure claims are always paid, while also providing flexibility to support affordability. By strategically using portions of its reserves to ease contribution increases, Bonitas helps members manage healthcare costs without compromising financial stability, striking a careful balance between protecting our financial future and keeping healthcare accessible.

Bonitas supports long-term sustainability strategically through insight-driven purchasing, digital enablement, innovative care models and disciplined financial management. These capabilities help us manage healthcare inflation, improve value for members and reduce avoidable costs without relying solely on reserves.

From time to time, we may moderate contribution increases to support affordability while keeping solvency within a prudent range. This may include deferring price increases, enhancing benefits or introducing efficiencies that improve member value without compromising long-term resilience.

Reducing loss-making options

Reducing loss-making options is essential to maintaining both affordability and compliance. While certain plans may not be self-sustaining in terms of membership and financial performance, they remain common across the industry. Our focus is on strengthening the financial viability of all options without compromising members' access to healthcare. This is achieved through targeted, plan-specific cost management across the value chain, coupled with ongoing member education and awareness initiatives, ensuring that affordability and sustainability are balanced responsibly.

Towards universal healthcare

The trade-off for Bonitas in the NHI context is between supporting universal healthcare in South Africa and protecting our own sustainability as a medical scheme. Universal healthcare could expand access and equity across the national healthcare system, which aligns with Bonitas's mission. However, the NHI raises concerns about funding, administration and governance. These risks could reduce Bonitas's independence, limit member choice and affect financial stability. To manage this, Bonitas must invest significant resources in engaging with government and regulators. This creates short-term strain but positions Bonitas to remain sustainable in a future where healthcare is potentially centrally funded and managed. (see page 23 for our response to the NHI).

Financial capital ↑
Intellectual capital ↑
Social and relationship capital ↑

Financial capital →
Intellectual capital →
Social and relationship capital →

Financial capital →
Human capital →
Intellectual capital →
Social and relationship capital →

VALUE-ADDED STATEMENT

Description	2025 R'000	%	2024 R'000	%
VALUE CREATED				
Insurance revenue	22 658 292	88.0	20 888 306	92.0
Investment income and other revenue	2 627 057	10.2	1 380 546	6.1
– Investment income	2 610 470		1 385 696	
– Other income	56 590		44 020	
– Loss on disposal of investment property	–		(13 500)	
Less: Asset manager fees	(40 003)		(35 669)	
Net income from risk transfer arrangements/reinsurance	453 826	1.8	433 320	1.9
Total value created	25 649 175	100	22 702 172	100.0
VALUE DISTRIBUTED				
Claims and benefits (to members and providers)	(22 877 518)	89.2	(20 078 903)	88.4
– Hospitals	(8 461 457)		(7 931 341)	
– General practitioners	(950 381)		(896 489)	
– Specialist	(6 632 021)		(6 087 252)	
– Other insurance service expenses	(6 748 927)		(5 078 971)	
– Interest on Personal Medical Savings Account (PMSA) balances	(84 732)		(84 852)	
Insurance acquisition costs (Broker commissions)	(429 145)	1.7	(420 406)	1.9
Administration and managed care benefits	(1 858 040)	7.2	(1 791 159)	7.9
Benefits and remuneration for employees and Trustees	(41 756)	0.2	(39 765)	0.2
Employees	(33 130)		(31 653)	
Trustees	(8 626)		(8 111)	
Social Impact	(7 469)	0.0	(4 960)	0.0
Corporate social investment (CSI)*	(3 300)		(3 300)	
Enterprise development**	(4 169)		(1 660)	
Government	(18 110)	0.1	(16 805)	0.1
Council for Medical Schemes (CMS) levies	(18 110)		(16 805)	
Other operating expenditure (incl amounts attributable to members for future benefits)	(2 212 612)	8.6	(484 061)	2.1
Other operating expenditure	(417 137)		(350 174)	
Amounts attributable to members for future benefits	(1 795 475)		(133 891)	
Retained surplus for members for future benefits (Transferred to Liability to members for future benefits)	1 795 475	(7.0)	133 891	(0.6)
Total value distributed	(25 649 175)	100	(22 702 172)	100.0

* Amount paid to Gift of the Givers, amount paid as part of marketing expense – strategic partnership.

** Enterprise Development (ED) spend with ED beneficiaries, Techplo and Modjaji.

COMMENTARY

Creating and distributing value for sustainable healthcare

As a medical scheme, our core purpose is to create value for our members by ensuring access to quality healthcare while maintaining financial sustainability. Our Value-Added Statement provides transparency on how contributions, investments, and other revenue sources generate value and how this value is distributed to key stakeholders, including members, healthcare providers, employees, regulators, and the broader community.

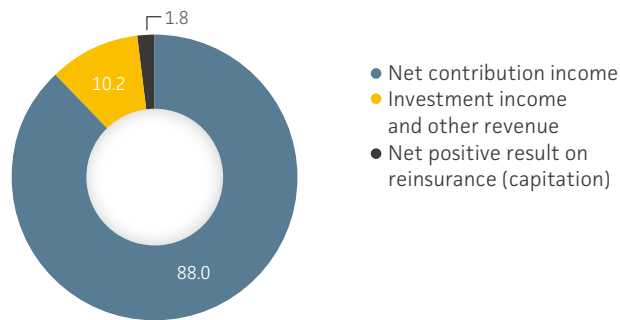
Value creation

During 2025, total value created amounted to R25.6 billion (2024: R22.7 billion), derived primarily from member contributions and strong investment returns captured from the South African equity market. We continue to manage these funds strategically to maximise returns while safeguarding liquidity and long-term financial stability.

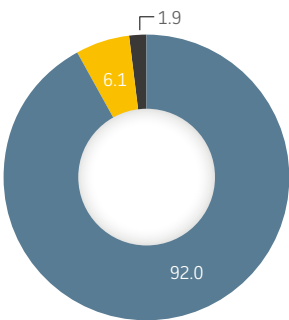
Asset management fees of R40.0 million (2024: R35.4 million) were incurred to provide professional oversight of our investment portfolio. This disciplined investment approach allowed Bonitas to exceed initial targets and bolster the accumulated reserves that protect our members.

A significant component of our value creation continues to stem from reinsurance and capitation agreements, which resulted in a net positive outcome of R454 million (2024: R433 million). These agreements remain a vital tool for reducing claims volatility and improving cost efficiency in high-risk areas, ensuring that the fund remains a stable and resilient home for quality healthcare.

VALUE CREATED (%)
2025



2024



Value distribution

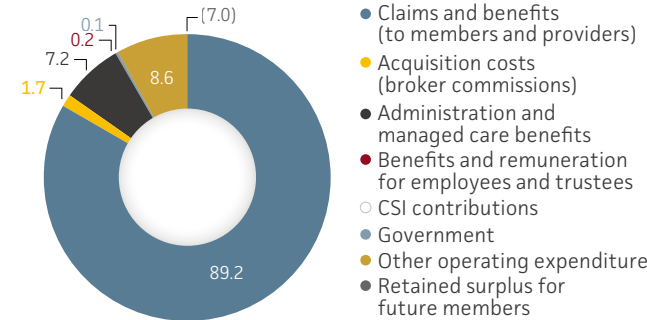
The largest portion of value distributed, representing 89.2% of the total value created (2024: 88.4%), was dedicated to claims and benefits for members and healthcare providers. This allocation ensures that members receive medical care, with payments made directly to providers or as reimbursements to members. The Scheme utilises reinsurance and risk transfer agreements to recover a portion of these costs, which reduces the overall claims burden on the risk pool.

Our focus on operational excellence and governance during the 2025 financial year is demonstrated through our operating expenditure, which is categorised as follows:

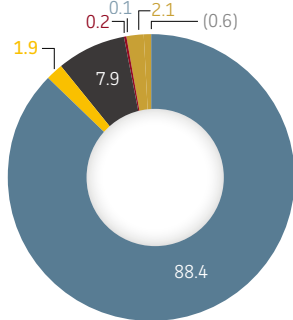
- Administration and Managed Care Costs of R1.9 billion (2024: R1.8 billion). These resources fund scheme administration, claims processing, and managed care initiatives designed to improve healthcare affordability and accessibility.
- Employee and Trustee benefits and remuneration of R42 million (2024: R40 million). This ensures a professional team is in place to deliver value and oversight to the membership base.
- Corporate social investment of R7.4 million (2024: R5 million). These funds support programmes for the broader community, including health and water security initiatives.
- CMS levies of R18 million (2024: R17 million). This expenditure ensures compliance with the regulatory requirements that protect member interests.
- Other operating expenditure of R417 million (2024: R484 million). This covers all remaining operational costs necessary for Bonitas's functioning.

We continued to support our members through broker commissions of R429 million (2024: R420 million), which facilitated access to benefits and ensured that members received expert advice regarding their medical aid options.

VALUE DISTRIBUTED (%)
2025



2024



Securing the future for our members

A portion of the total value created is retained as a surplus and transferred to the insurance liability for future members to ensure long term sustainability. For 2025, this amount reached R1.8 billion, a significant increase from the R133.9 million reported in 2024. This allocation reinforces our ability to absorb unforeseen risks, maintain regulatory solvency requirements, and keep contributions stable while continuously enhancing the benefits available to our community of lives.

OUR MATERIAL MATTERS

We track and respond to members' healthcare needs in the short, medium and long term. This helps us to identify material trends in the healthcare sector and to pivot accordingly to ensure Bonitas's ongoing relevance and sustainability.

TRENDS IN OUR OPERATING CONTEXT

LOW INDUSTRY MEMBERSHIP GROWTH

South Africa's socioeconomic environment continues to exert pressure on affordability and access, with medical scheme coverage remaining structurally low at 14.6% of the population. Financial vulnerability is underscored by a reliance on government support and weak household income growth.

Labour-market pressures intensify membership growth constraints. High unemployment rates, particularly among the youth, weaken the risk pool by reducing the inflow of younger, lower-utilisation members. This contributes to an ageing membership profile, with the average beneficiary age increasing by 0.3 years in 2025. As older members require more frequent and intensive care, this demographic shift drives higher utilisation patterns and costs, making targeted engagement to retain younger members essential for long-term sustainability.¹

These socioeconomic and utilisation dynamics are accelerating consolidation across the medical scheme industry. Financially weaker schemes find it increasingly difficult to sustain benefits and maintain the mandatory 25% solvency ratio in a constrained environment. The long-term trend reflects a significant shrinking of the sector: the total number of schemes has fallen from 146 in 2001 to just 71 in 2024.¹ The open scheme market has been most affected, with only 16 registered open schemes remaining from a high of 49 two decades ago.

Implications for our strategy

Our strategic response focuses on diverse engagement opportunities and building a strong brand by:

- Ensuring our operations have a national footprint to support geographically diverse engagement and multi-sector presence.
- Providing support through our call centre in 11 official languages.
- Actively tracking membership trends and responses to pricing and benefit options.
- Distributing a wide range of public communication, including educational material and an active social media presence.
- Protecting our brand by ensuring consistent, high-quality member experiences and effective reputational management.

Relevant strategic pillar



Connect with the customer



Create value through innovation

Related key risks and opportunities

- Bonitas's sustainability and stability
- Stakeholder management

¹ https://www.medicalschemes.co.za/wp-content/CMSIndustryReport2024_4Dec.pdf.

HEALTHCARE AFFORDABILITY

Global healthcare funding pressures continue to influence pharmaceutical pricing, technology costs and supply chain dynamics worldwide. These pressures contribute to rising input costs for South African medical schemes and form part of Bonitas's key external risks.

Healthcare expenditure in South Africa continues to rise faster than general inflation, placing sustained pressure on the affordability of medical scheme cover. Total benefits paid by schemes increased by 8.52% in 2024¹, driven by higher utilisation, demographic ageing and rising service costs. This growth outpaced average household income increases and headline CPI, widening the affordability gap for members.

Beneficiaries are increasingly subject to out-of-pocket payments to cover differences between scheme tariffs and provider charges, underscoring the financial strain on households. Hospital expenditure remains the dominant cost driver, at 35.95% of total benefits, with the cost per admission increasing by 9.88% despite fewer admissions.¹ These trends reinforce the need for careful benefit design, strong provider-network management and continued investment in preventative and managed-care programmes to maintain long-term sustainability.

Several long-term structural factors continue to drive medical inflation and place pressure on the sustainability of medical schemes in South Africa¹:

- Rising prevalence of chronic and lifestyle diseases continues to increase healthcare utilisation. Sustained growth in chronic disease registrations, with conditions such as hypertension, diabetes and cardiovascular disease remain the most common among beneficiaries.
- Escalating costs of medical technologies, equipment and pharmaceuticals contribute significantly to rising benefit expenditure. Medicine costs, specialist services and hospital-based care remain among the fastest-growing components of total benefits paid.
- Unregulated private healthcare pricing remains a structural challenge. The absence of uniform tariffs and wide variation in provider charges contribute to above-inflation increases in benefit expenditure.

Implications for our strategy

Our strategic response focuses on strengthening the capabilities that improve value, affordability and long-term sustainability:

- Strengthening provider contracting and network optimisation to manage hospital costs and reduce out-of-pocket payments.
- Expanding preventative care, screening and early detection to reduce avoidable utilisation and chronic disease burden.
- Investing in disease-specific managed care programmes to improve clinical outcomes and contain long-term costs.
- Enhancing benefit design to balance affordability with sustainability, focusing on high-value interventions.
- Accelerating digital transformation to support predictive analytics, real-time utilisation monitoring and early risk identification.
- Negotiating preferential rates and applying strategic purchasing to counter medical inflation and pricing variation.
- Monitoring global healthcare funding trends to anticipate input cost pressures and adjust investment and pricing strategies accordingly.

See page 45 for more detail on Bonitas's 2026 – 2029 Strategy.

Relevant strategic pillar



Be a strategic purchaser



Integrate the value chain



Create value through innovation

Related key risks and opportunities

- The impact of increasing or changing regulation
- Bonitas's sustainability and stability
- Service provider partnerships

¹ Council for Medical Schemes (CMS) 2024 Industry Report, <https://www.medicalschemes.co.za/the-2024-cms-industry-report-is-now-available/>.

UNIVERSAL HEALTHCARE AND NATIONAL HEALTH INSURANCE

The NHI is a health-financing system intended to pool public resources to provide universal access to personal health services for all South Africans, based on healthcare needs rather than socio-economic status. The NHI Act of 2024 forms part of South Africa's long-term journey to achieve universal health coverage by creating a unified, equitable and affordable healthcare system. The NHI will establish a centralised national fund that purchases healthcare services from public and private providers, allowing eligible residents to access care without paying at the point of service. The Act will be phased in gradually, using a progressive and programmatic approach based on available financial resources.

Implementation will take place in two phases. Phase 1 commenced in 2023 and will continue until 2026, focusing on establishing the regulatory, governance and administrative foundations of the NHI Fund. Phase 2 will run from 2026 to 2028 and will expand programme rollout and further strengthen system reforms. The Department of Health notes that the NHI is a long-term transformation process that will require many years of continued reform across both the public and private sectors.¹

Given the scale of change required, significant legislative, operational and governance milestones must still be achieved before the NHI becomes fully functional. As a result, private medical scheme membership is not at immediate risk. Bonitas continues to monitor developments closely, particularly in relation to the integration of public and private sectors, the establishment of effective governance structures and the broader reforms needed to ensure that the health system becomes more efficient, equitable and sustainable.

Implications for our strategy

- Lobbying for the importance of a well-governed NHI
- Engaging with legislators and the BHF to shape the NHI model
- Strengthening collaboration with industry stakeholders
- Developing and implementing a comprehensive risk mediation plan
- Continuing to educate and inform members
- Exploring new opportunities and innovative business models

Relevant strategic pillar



Integrate the value chain



Create value through innovation

Related key risks and opportunities

- The impact of increasing or changing regulation
- The impact of NHI on Bonitas's sustainability and structure
- Service provider partnerships

Other regulatory impacts

The CMS published Circular 4 of 2026 in February setting out new requirements for medical scheme auditing and the assessment of audit effectiveness. The CMS adopted a range of audit quality indicators (AQIs) to help audit committees evaluate the reliability of financial reporting. A key focus of the AQIs is the extent of fees paid to external auditors for non-assurance services, a measure intended to eliminate potential threats to auditor independence. These standards are set for implementation during the appointment of auditors for the 2026 financial year. Furthermore, medical schemes classified as Public Interest Entities (PIEs) must now adhere to the enhanced auditor reporting rule, which requires detailed fee disclosures to ensure objectivity.

Bonitas is aware of the adoption of the AQI by CMS with the Audit Risk Committee participating during the CMS consultation process. The Audit Committee will be implementing the standards when appointing auditors for 2026 financial year.

¹ <https://www.health.gov.za/nhi/>

INNOVATION AND TECHNOLOGICAL DISRUPTION

Emerging technologies are accelerating a fundamental shift in how healthcare is delivered, financed and experienced. These advances are reshaping clinical practice, enabling new care models and transforming the way schemes manage risk, quality and cost.

- Next-generation artificial intelligence is moving beyond analytics into real-time clinical decision support, with models that interpret imaging, pathology and biometric data at scale. These tools enable earlier detection of disease, more accurate diagnosis and personalised treatment pathways. They also strengthen risk-stratification, fraud detection and predictive modelling across managed care.
- Generative AI is beginning to automate complex administrative and clinical tasks, including summarising medical records, drafting clinical notes, supporting case management and improving member communication. This reduces the administrative burden, improves turnaround times and frees clinicians to focus on higher-value care.
- Robotic and digitally enhanced surgical technologies are advancing rapidly, offering greater precision, reduced invasiveness and shorter recovery times. Combined with augmented reality and real-time imaging, these innovations are improving clinical outcomes and reducing the length of hospital stays.
- Automation and intelligent workflow orchestration are transforming operational processes, from digital claims adjudication to automated authorisations and real-time utilisation monitoring. These tools reduce manual errors, improve efficiency and support more proactive managed-care interventions.
- Wearables, remote monitoring and continuous biometric sensing are expanding the boundaries of care, enabling early intervention, improved adherence and more personalised chronic-disease management. These technologies support a shift from episodic care to continuous, data-driven health management.
- Virtual care ecosystems are maturing, with telemedicine, digital therapeutics and mobile health applications becoming integrated components of care pathways. These platforms improve access, reduce unnecessary consultations and support behaviour change.
- Interoperability and data-exchange standards are evolving, enabling more integrated care across providers, pharmacies, laboratories and schemes. This supports coordinated care, reduces duplication and strengthens clinical governance.

While these technologies offer significant opportunities to improve outcomes and reduce costs, they also introduce new risks that require strong oversight. Key considerations include data privacy and cyber security, the safety and reliability of AI-driven clinical tools, algorithmic transparency and the need for robust governance frameworks to ensure responsible adoption. The CMS continues to emphasise the importance of strong governance, ethical use of data and appropriate oversight of digital health and managed-care technologies.

Implications for our strategy

- Monitor emerging digital and AI trends to guide future managed-care and operational innovation
- Adopt high-value digital and AI tools that improve outcomes, streamline workflows and enhance member experience
- Strengthen governance for advanced technologies, ensuring clinical safety, ethical data use and transparent algorithms
- Reinforce cyber security and data protection across all digital health platforms
- Support member adoption of digital health solutions through clear communication and education

Relevant strategic pillar



Be a strategic purchaser



Connect with the customer



Create value through innovation



Apply best practice governance

Related key risks and opportunities

- Cyber and information security threats and vulnerabilities
- Technology and innovation
- Stakeholder management

WELLBEING AND MENTAL HEALTHCARE

Globally, mental wellbeing remains at historic lows, with no recovery from the post pandemic decline. South Africa continues to rank among the lowest countries for mental health, with younger generations most severely affected.¹

Poverty, unemployment, inequality, violence and political instability compound the crisis. Children are particularly vulnerable, with 62% experiencing multidimensional poverty and rural children most at risk. These conditions exacerbate mental health challenges, especially among adolescents.²

Among young people, 10% experience depression, 7% live with anxiety, and nearly 18% face post-traumatic stress disorder. Alarming, 12% report suicidal ideation. Contributing factors include peer pressure, exploration of identity, poor home environments, exposure to violence and inadequate living conditions.³

Access to mental healthcare remains uneven. Workplace stress and anxiety dominate employee assistance cases, while rural communities continue to lack adequate facilities and trained professionals. Public health services are overstretched, private care is unaffordable for many, and stigma discourages individuals from seeking help.⁴

Implications for our strategy

- Continuing member education
- Adding mental health solutions to healthcare plans
- Developing disease specific managed care programmes
- Using technology to increase access

Relevant strategic pillar



Connect with the customer



Create value through innovation

Related key risks and opportunities

- Bonitas's sustainability and stability
- Stakeholder management
- Service provider partnerships

¹ The Mental State of the World Report 2025: A Perspective on Internet-Enabled Populations. February.

² United Nations Children's Fund (UNICEF). 2025. Situation Analysis of Children and Adolescents in South Africa 2025. November.

³ Bantjes, J., et al. 2025. Prevalence of Common Mental Disorders Among Children and Adolescents in South Africa: A Systematic Review and Meta-Analysis. South African Journal of Psychiatry, Volume 31.

⁴ The Current State of Mental Health in South Africa: 2025.

MATERIAL MATTERS

Material matters are issues that may significantly affect Bonitas's ability to create value over the short, medium and long term. The matters guide our strategy and influence how we identify and respond to risks and opportunities.

OUR MATERIALITY DETERMINATION PROCESS

The Bonitas Board is responsible for determining, approving and integrating material matters into its oversight process. A structured materiality determination was conducted in 2022, with subsequent reviews in 2023, 2024 and 2025, thereby confirming that all previously identified matters remain material. No new matters have emerged that affect Bonitas's ability to create and preserve value.

1

Review

We identify all matters that could impact our ability to create value by investigating:

- Value drivers that impact the healthcare sector, our members, the Bonitas business model and our strategy
- Feedback from stakeholders
- Strategic risks and opportunities
- Our current and anticipated performance
- Changes in our external operating environment
- Our impact on stakeholders and society at large
- Our previous year's material matters

2

Prioritise

From the list of relevant matters, we identify those that are material by considering the magnitude of their impact on our stakeholders and Bonitas's ability to create value.

3

Integrate

Material matters are integrated to inform strategy and guide disclosures for integrated reporting.



Successful and efficient healthcare reform

Bonitas supports reform that addresses cost and quality while expanding access. While the Constitution guarantees access to healthcare as a basic human right, quality healthcare in South Africa remains unequal. The signing of the NHI Bill into law in May 2024 marks progress, yet its implications for medical schemes are still unclear, with concerns around funding and governance. We advocate for a well-governed NHI and seek clarity on its impact for medical schemes, members and the public. At the same time, we continue to develop future-proof strategies and operating models to ensure we serve our members effectively.

Relevant stakeholders

-  Board and employees
-  Members, brokers and agents
-  Service providers
-  Government and regulatory bodies

Related strategic risk

- The impact of NHI on Bonitas's sustainability and structure
- The impact of increasing or changing regulation
- Bonitas's sustainability and stability
- Service provider partnerships

Related external trend

- Universal healthcare and National Health Insurance

Strategic pillar response

-  Boost business development
-  Create value through innovation

Related strategic opportunity

- Strengthen CMS and regulatory relationships through ongoing engagements and submissions.
- Reinforce the Bonitas value proposition through targeted stakeholder communication.
- Contribute to national healthcare reform through industry participation and policy engagement.
- Improve cohesion within the national healthcare eco-system through collaboration with administrators, managed care partners and industry bodies.
- Secure future-fit administration and managed care partnerships through the RFP process.
- Build future-ready operating models through digital and data-capability enhancements.



Trust and confidence in our ability to protect stakeholders' interests

Growing digital risks, such as compromised data privacy, cyber security, system interruptions, misinformation and higher expectations of transparency make stakeholder trust essential. Stakeholders must be confident that Bonitas delivers affordable, quality healthcare, manages funds responsibly and maintains strong governance. Without this assurance, membership growth, stakeholder confidence and our ability to secure favourable provider rates would be affected.

Member contributions are managed with care and diligence, supported by a Board-approved investment strategy and robust financial controls. Our Stakeholder Engagement and Communication Framework guides how we build relationships that are purposeful, relevant, open, honest, inclusive and responsive. Stakeholder insights inform strategy development, strengthening collaboration and improving our ability to deliver maximum value.

As digital health adoption accelerates, cyber security has become a critical component of stakeholder trust. Protecting member data, safeguarding digital platforms and maintaining resilience against cyber threats are essential to preserving confidence in Bonitas's operations and ensuring uninterrupted access to care.

Relevant stakeholders

-  Board and employees
-  Members, brokers and agents
-  Service providers
-  Government and regulatory bodies

Related strategic risk

- The impact of NHI on Bonitas's sustainability and structure
- Bonitas's sustainability and stability
- The Bonitas brand and reputation
- Stakeholder management
- Service provider partnerships

Related external trend

- Healthcare affordability
- Innovation and technological disruption

Strategic pillar response

-  Connect with the customer
-  Apply best practice governance

Related strategic opportunity

- Build trust through enhanced cyber security and data protection.
- Use stakeholder insights to guide strategy and improve value.
- Demonstrate responsible fund management through disciplined investment practices.
- Strengthen stakeholder relationships through structured engagement.
- Reinforce the Bonitas value proposition through targeted communication.
- Improve transparency and governance through strong oversight.



Thought leadership in functional, clinical and specialist areas

The healthcare sector continues to evolve rapidly as innovations in medical practice, diagnostics and treatment expand the range of products and services available to patients. To deliver quality care, Bonitas ensures that these advances are accessible to members, that members are educated on their use, and that contributions remain affordable. A stronger emphasis is being placed on preventative care, screening and early detection to reduce avoidable utilisation and improve long term health outcomes.

Service provider performance is reviewed monthly, with SLAs incorporating outcomes-based measures to secure tangible healthcare benefits. Managed care programmes offer dedicated support for members living with specific illnesses or conditions, while expanded data and analytics capabilities enable earlier risk identification, more targeted interventions and ongoing refinement of plan benefits to ensure they remain appropriate and responsive to member needs.

Relevant stakeholders

-  Board and employees
-  Members, brokers and agents
-  Service providers
-  Government and regulatory bodies

Related strategic risk

- Bonitas's sustainability and stability
- Stakeholder management
- Service provider partnerships

Related external trend

- Innovation and technological disruption
- Wellbeing and mental healthcare

Strategic pillar response

-  Connect with the customer
-  Apply best practice governance

Related strategic opportunity

- Expand preventative-care leadership through broader screening, wellness and early-detection initiatives.
- Strengthen member education on clinical pathways, healthy behaviours and condition management.
- Strengthen clinical and provider relationships through structured engagement.
- Promote integration across the healthcare value chain.
- Innovate managed care and benefit solutions using data and analytics.
- Reinforce the Bonitas value proposition through member education and preventative care.
- Improve transparency and governance through regular performance reviews.



Making it easy for members to look after their health

Members are better able to manage their health when they are informed and have timely access to the products and services they need. Bonitas engages with members through multiple touchpoints, providing relevant information throughout the healthcare journey, while technology strengthens communication between members and healthcare practitioners.

A stronger focus on preventative care and value-based outcomes is improving quality and cost efficiency by reducing avoidable utilisation, enabling earlier intervention and ensuring that members receive appropriate care.

Relevant stakeholders

-  Board and employees
-  Members, brokers and agents
-  Service providers
-  Government and regulatory bodies

Related strategic risk

- The impact of NHI on Bonitas's sustainability and structure
- Bonitas's sustainability and stability
- Stakeholder management

Related external trend

- Innovation and technological disruption
- Wellbeing and mental healthcare

Strategic pillar response

-  Connect with the customer
-  Integrate the value chain
-  Create value through innovation

Related strategic opportunity

- Strengthen mental-health support through education and early-intervention content.
- Expand family-centred health initiatives to support children, adolescents and parents.
- Promote healthy ageing through targeted education and preventative-care guidance.
- Enhance nutrition and lifestyle support through practical, evidence-based content.
- Improve digital-health literacy to help members use online tools and platforms confidently.
- Expand condition-specific education to support self-management and early intervention.



Leveraging our bargaining power, footprint and networks

Through our business process outsourcing model, Bonitas works with a wide range of service providers to secure competitive rates and ensure that networks evolve in line with member needs. The Board approved a major procurement process and the appointment of Momentum Health (Pty) Ltd as the Medical Scheme's administrator and Private Health Administrators (Pty) Ltd as the Scheme's managed care service provider on 10 December 2025. The new administration and managed care arrangements, which were signed on 28 January 2026, will become effective on 1 June 2026. The contracts have a term of five years, with an option to renew for a further two years.

We also partner with providers offering innovative solutions and collaborate with humanitarian organisation Gift of the Givers to advance health and wellness outcomes for the wider public. Bonitas participates in several industry organisations and associations, including the BHF, which strengthens engagement with legislators and regulators and supports advocacy on behalf of members.

Relevant stakeholders

-  Board and employees
-  Members, brokers and agents
-  Service providers
-  Government and regulatory bodies

Related strategic risk

- The impact of NHI on Bonitas's sustainability and structure
- The impact of increasing or changing regulation
- Bonitas's sustainability and stability
- The Bonitas brand and reputation
- Stakeholder management
- Service provider partnerships

Related external trend

- Low industry membership growth
- Healthcare affordability
- Innovation and technological disruption

Strategic pillar response

-  Be a strategic purchaser
-  Integrate the value chain

Related strategic opportunity

- Strengthen stakeholder relationships to support favourable contracting and network development.
- Promote integration across the healthcare value chain through coordinated provider and partner engagement.
- Innovate solutions with service providers to improve quality, affordability and member experience.
- Reinforce the Bonitas value proposition through strategic partnerships and industry participation.
- Enhance transparency and governance through robust procurement and SLA oversight.
- Use the administration and managed care RFP to secure future-fit partners and improved capabilities.
- Expand collaborative initiatives, including partnerships like Gift of the Givers, to advance public health impact.
- Leverage industry forums such as the BHF to strengthen advocacy and regulatory engagement.



Protecting our financial sustainability

The financial sustainability of a medical scheme depends on membership growth, a balanced profile, responsible investment and operational stability. Without these, solvency may fall below the legislated 25%, placing members' healthcare coverage at risk.

Bonitas structures its plans and contribution increases to attract new members and retain existing ones by balancing benefits with cost. We monitor membership profiles closely and design dedicated programmes to support those with long-term healthcare needs. Member funds are invested responsibly to grow reserves, and strong investment returns contributed meaningfully to financial performance during the year. We also track legislative and regulatory developments and adapt our strategies and models to ensure continued delivery of healthcare benefits.

Relevant stakeholders

-  Board and employees
-  Members, brokers and agents
-  Service providers
-  Government and regulatory bodies

Related strategic risk

- The impact of NHI on Bonitas's sustainability and structure
- Bonitas's sustainability and stability
- The Bonitas brand and reputation

Related external trend

- Low industry membership growth
- Healthcare affordability
- Universal healthcare and National Health Insurance

Strategic pillar response

-  Be a strategic purchaser
-  Optimise investment returns
-  Integrate the value chain

Related strategic opportunity

- Support long-term sustainability through responsible investment and reserve management.
- Use data and analytics to monitor membership profiles and guide pricing and benefit design.
- Adapt strategies in response to legislative and regulatory developments.
- Strengthen stakeholder relationships to support sustainable membership growth.
- Improve cohesion across the healthcare ecosystem to stabilise utilisation and cost.
- Enhance transparency and governance through strong financial oversight and regulatory engagement.
- Innovate benefit and managed care solutions to meet evolving member needs.
- Promote integration across the value chain to improve efficiency and reduce avoidable costs.



Preventing fraud, waste and abuse

FWA in the healthcare sector takes many forms, including false claims, overbilling, unnecessary services, bribery and kickbacks. Beyond being illegal, these practices raise the cost of healthcare and increase member contributions.

Bonitas applies an integrated approach to preventing FWA across the value chain. All service providers must comply with our Anti-Fraud, Waste and Abuse Policy, and the Bonitas FWA Forum meets monthly with primary providers to ensure sound policies and practices. We collaborate with stakeholders to investigate allegations and cases of FWA, working with the SAPS and the Specialised Commercial Crime Unit to uphold accountability and protect member interests.

Relevant stakeholders

-  Board and employees
-  Members, brokers and agents
-  Service providers
-  Government and regulatory bodies

Related strategic risk

- The Bonitas brand and reputation
- Stakeholder management

Related external trend

- Innovation and technological disruption

Strategic pillar response

-  Be a strategic purchaser
-  Optimise investment returns
-  Integrate the value chain

Related strategic opportunity

- Expand member and provider education to reduce avoidable misuse and improve compliance.
- Promote integration across the value chain to improve detection and accountability.
- Innovate FWA-detection tools and analytics to identify risks earlier.
- Enhance provider oversight through structured engagement and monthly FWA Forum reviews.
- Improve collaboration with SAPS and specialised crime units to enforce accountability.



Cyber and information resilience

Cyber security and information protection and resilience is material to Bonitas as protecting member data and ensuring reliable digital systems are essential to maintaining trust and safeguarding operations.

Bonitas maintains a structured I&T governance framework aligned with King IV™, with oversight from the Board and its committees. Management ensures alignment between business and IT objectives, while service providers are contractually required to manage delivery, ensure compliance and address incidents in line with Bonitas's operating model.

Relevant stakeholders

-  Board and employees
-  Members, brokers and agents
-  Service providers
-  Government and regulatory bodies

Related strategic risk

- Cyber and information security threats and vulnerabilities
- The Bonitas brand and reputation

Related external trend

- Innovation and technological disruption

Strategic pillar response

-  Apply best practice governance

Related strategic opportunity

- Improve digital-health literacy to help members use secure platforms confidently.
- Strengthen cyber-awareness campaigns using simple, member-friendly communication.
- Build trust through clear education on digital safety and responsible data use.
- Embed sound I&T practices and compliance requirements among service providers.
- Elevate service quality through secure, reliable and resilient digital platforms.
- Improve cyber-incident readiness through structured governance and oversight.

OUR STRATEGY

To ensure we deliver on our purpose, Bonitas has a detailed and robust strategy based on five core pillars, supported by governance and innovation – which are relevant to each pillar.



APPLY BEST PRACTICE GOVERNANCE



Be a strategic purchaser

PERFORMANCE AGAINST OUR STRATEGY FOR 2025

Bonitas is concluding the strategic cycle that has guided us over recent years, a period in which the strategic pillars provided clarity, stability and direction. This report reflects performance against those pillars as they applied to the 2025 financial year. Read more about the new strategy on page 45.



Be a strategic purchaser

To ensure that our members have access to affordable healthcare, we contract service providers that offer quality services at value-for-money rates.

Short-term objectives	Long-term objectives
• Create a seamless service experience • Optimise collective bargaining with hospital groups • Reduce co-payments and short payments to create a wallet-free experience for our members • Integrate services to deliver on our new corporate service delivery model • Expand our hospital-at-home initiatives • Enhance outcomes-based measures with managed care providers to improve healthcare outcomes • Implement focused initiatives to improve the performance of loss-making options	• Define and optimise purchasing power with hospital groups • Build more efficient networks of service providers and enhance current networks • Ensure preventative and primary services are available when required • Ensure that secondary and tertiary healthcare only come into play after the first level of relevant care has been accessed
Related material matters • Leveraging our bargaining power, footprint and networks	

Key performance indicators	
Estimated savings yielded through strategic purchasing (hospital negotiations): R566 million ↑ (2024: R532 million)	Estimated savings due to managed care initiatives*: R1.066 billion ↑ (2024: R901.1 million)

* Includes hospital negotiation savings.



Boost business development

Our membership base is key to our sustainability, so we work to acquire new members and retain existing members.

Short-term objectives	Long-term objectives
• Develop a marketing strategy to improve market penetration at an acceptable cost of acquisition • Simplify and streamline the member onboarding process • Implement a focused corporate service delivery model to improve the reporting and servicing experience at paypoints • Develop the Bonitas brand within identified target markets • Improve the ease of doing business for all stakeholders • Use member data to facilitate and support Bonitas's distribution channels to address gaps in member needs • Implement a retention strategy to improve membership terminations and lapses	• Enhance distribution channels • Improve retention (groups and DPMs) • Grow corporate membership and the integration of value-added products • Continue pursuing amalgamation opportunities
Related material matters • Successful and efficient healthcare reform	

Key performance indicators		
Membership acquisitions: 70 393 15% ↑ (2024: 61 290 21%)	Membership terminations: 59 963 13% ↑ (2024: 53 078 2%)	Retention of terminations: 50% ↑ (2024: 46%)



Optimise investment returns

We invest members' contributions for a return and use this money to keep pricing as low as possible.

Short-term objectives

- Achieve a targeted net (of fees and taxes) return in excess of CPI+3.5% per annum over a rolling 36-month period
- Onboard a new asset manager

Long-term objectives

- Preserve capital over a rolling 12- to 18-month period
- Be proactive and reposition Bonitas when there are opportunities to maximise returns while adhering to the set strategic asset allocation parameters
- Manage investment risk to be within tolerable levels
- Challenge the regulator regarding investment constraints in Regulation 30 of the MSA which among other things limits the investment exposure to specific asset classes

Related material matters

- Protecting our financial sustainability



Key performance indicators

Return on investment:
20.8% ↑
(2024: 13.4%)

Investment portfolio value
excluding cash:
R12.54 billion ↑
(2024: R10.69 billion)

% of asset managers
who outperformed their
benchmarks net of fees:
54% →
(2024: 54%)

¹ NPS is a metric to measure customer satisfaction and loyalty. It is calculated by asking the question: "On a scale of one to 10, how likely are you to recommend our product/service to a friend or colleague?" The NPS benchmark varies greatly between industries, and in the South African healthcare sector a healthy NPS is 20 or above.

² Captures member satisfaction with specific interactions.

³ Assesses the ease of the member experience.

⁴ Percentage of calls resolved on first contact without requiring follow-up.



Connect with the customer

Connecting with members helps us provide them with the services they need and gives us insight into evolving trends and requirements.

Short-term objectives

- Meet Bonitas members' needs through all life stages
- Optimise digital platforms and engagements (such as during onboarding) to enhance the Bonitas experience
- Support regular, simplified communication to improve member understanding
- Implement an enhanced stakeholder communication strategy
- Implement a wellness strategy to drive health risk assessments that would create value and competitiveness through activation of the Bonitas Benefit Booster
- Enhance our NPS

Long-term objectives

- Educate and engage patients to take responsibility for their health and conditions
- Form partnerships with doctors, healthcare practitioners and patients
- Actively promote openness and approachability

Related material matters

- Trust and confidence in our ability to protect stakeholders' interests
- Thought leadership in functional, clinical and specialist areas
- Making it easy for members to look after their health



Key performance indicators: Members

Net promoter score:
10.50 ↓
(2024: 11.66)¹

Customer satisfaction score:
93.89% ↑
(2024: 93.19%)²

Consumer experience score:
90.10% ↑
(2024: 74.94%)³

Key performance indicators: Brokers

First call resolution score:
94.31% ↑
(2024: 91.54%)⁴

Consumer experience score:
78.58% ↑
(2024: 75.84%)



Integrate the value chain

We provide members with a complete and integrated solution to their healthcare needs by forming strategic alliances with all stakeholders.

Short-term objectives

- Implement a free-to-member strategy aimed at reducing out-of-pocket expenses
- Implement an integrated product and service strategy and solution to improve member retention, enhance the performance of our distribution channels and complement the Bonitas corporate service delivery model
- Actively build a future for NHI partnerships
- Improve our virtual services

Long-term objectives

- Provide a wallet-free experience for all members
- Integrate our product offering to improve retention
- Brand Bonitas as the future of healthcare in South Africa

Related material matters

- Making it easy for members to look after their health
- Leveraging our bargaining power, footprint and networks



Key performance indicators

Total weighted contribution increase for 2025:
10.2% ↑
(2024: 6.9% after deferral)

Insurance expenditure:
R23.40 billion ↑
(2024: R22.29 billion)
(2024 restated: R22.15 billion)

Insurance loss ratio:
103.70% ↓
(2024: 106.7%)
(2024 restated: 106.1%)



Create value through innovation

We adapt our strategy, processes and products to continue meeting members' needs, ensure Bonitas's sustainability, and increase the accessibility and affordability of healthcare.

Short-term objectives

- Issue communication that is focused on aligning service providers in Bonitas's value chain
- Actively build a future for Bonitas to be part of the NHI in South Africa
- Develop a front-end I&T solution to enhance experience, access and convenience for potential new members

Long-term objectives

- Educate role players to balance the triangle of affordability, quality and cost efficiencies
- Use disruptive strategies to make healthcare technology more readily available to more people

Related material matters

- Successful and efficient healthcare reform
- Thought leadership in functional, clinical and specialist areas



Key performance indicators

Insurance service deficit:
R382.1 million ↓
(2024: R965.7 million)
(2024 restated: R831.8 million)

Non-healthcare expenditure as a percentage of risk contributions:
9.2% ↓
(2024: 9.4%)

Hospital tariff savings:
R566 million ↑
(2024: R532 million)

Loss-making options:
7 ↓
(2024: 8)



Apply best practice governance

We adhere to industry best practices, comply with legislation and regulations, and manage risks to Bonitas's sustainability.

Core elements

- Governance
- Risk management
- Compliance management
- Information and Technology (I&T) governance

Related material matters

- Trust and confidence in our ability to protect stakeholders' interests
- Preventing fraud, waste and abuse
- Cyber and information resilience



Key performance indicators

Amounts attributable to members for future benefits:

R1.8 billion ↑
(2024: R133.9 million)¹

Non-healthcare expenditure as a percentage of risk contributions:

9.2% ↓
(2024: 9.4%)²

Gross recoveries from FWA:

R55.3 million ↑
(2024: R46.2 million)

Solvency ratio:

36.9% ↓
(2024: 38.6%)

¹ Amounts attributable to future members represent the excess over fair value for the current financial period.

² The ratio of non-healthcare expenditure against insurance revenue refers to attributable, non-attributable and acquisition costs as a percentage of insurance revenue.





INITIATIVES SUPPORTING OUR STRATEGIC PILLARS

EXTEND COST-EFFECTIVE AND SPECIALISED SUPPORT AND CARE OFFERINGS

Bonitas has generated savings of over R566 million through strategic hospital negotiations. Contribution increases can be kept to a minimum while securing the best possible rates for members. Bonitas has engaged all major hospital groups to define new networks for the next three years, with a strong focus on maintaining the footprint and size of existing networks.

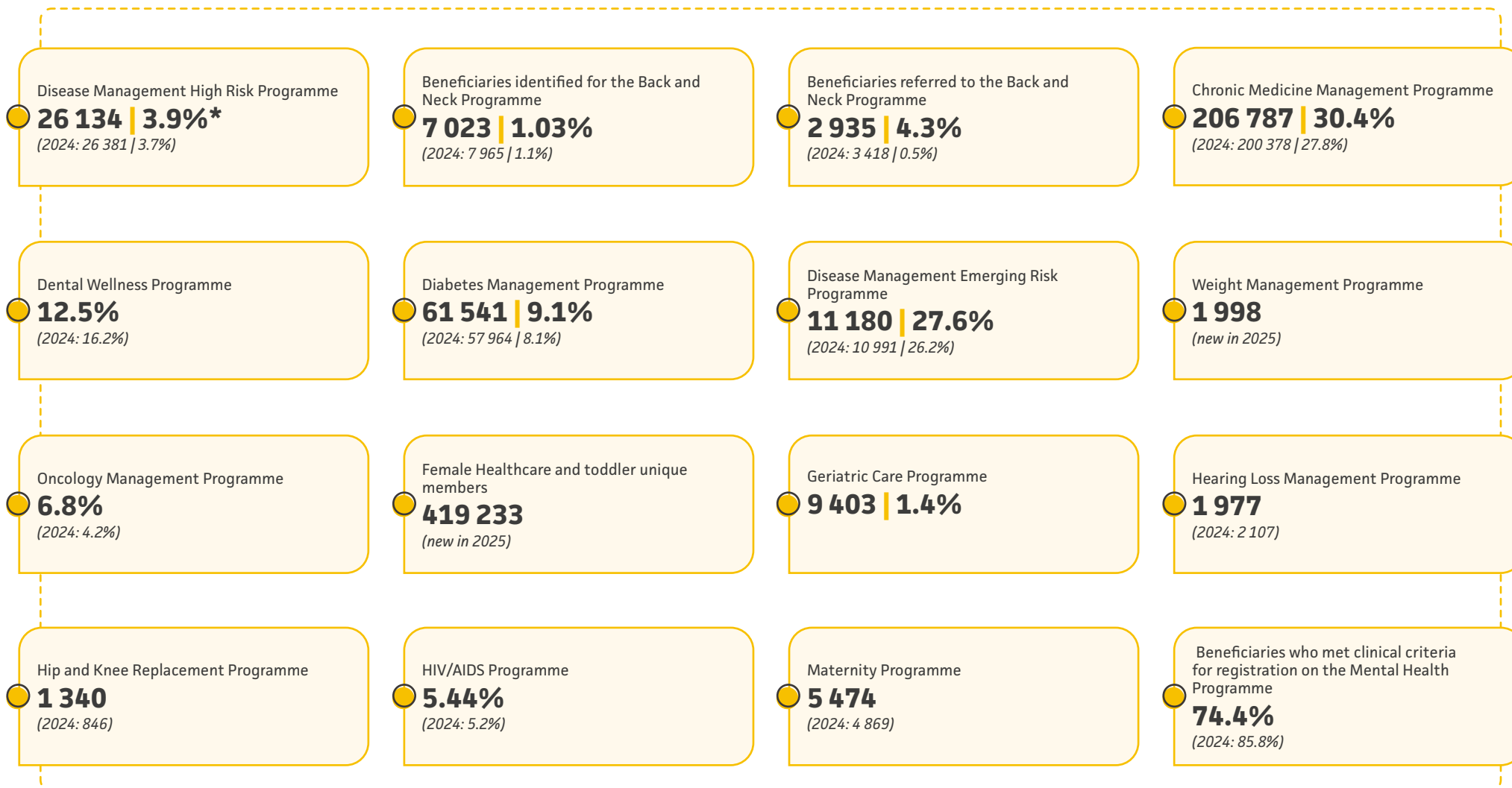
Bonitas continued to expand its managed care offering in 2025, ensuring members receive targeted, cost-effective support across key health conditions and life stages. Each programme focuses on a specific disease or wellbeing area, with preferential rates negotiated through our provider networks.

- The Hearing Loss Management Programme (previously Audiology Benefit Management) was strengthened through our partnership with HearConnect, which now services members on BonComprehensive, BonClassic, BonComplete, Standard and Standard Select. Free online hearing screenings remain available to all South Africans via the Bonitas website.
- Three new programmes were introduced in 2025:
 - » The Female Healthcare Programme, focused on preventative screening and early detection
 - » The Geriatric Care Programme, supporting members aged 70 and older
 - » The Weight Management Programme, targeting lifestyle-linked risk factors
- BonCap HIV prescriptions now require accompanying viral load results. PHA's HIV nurses provide follow-up interventions for members with high viral loads, including treatment regime adjustments and adherence support.
- Clinical risk management was intensified in response to rising claims in mental health (+10.2%) and elective surgery (+2.64%). These trends informed early enrolment into disease management programmes and targeted member engagement.

- A respiratory illness campaign was implemented ahead of the flu season, including the distribution of respiratory care packs and educational messaging across high-risk pay points.
- Between January and December 2025, Bonitas conducted 561 wellness events across 336 pay points, completing 17 921 health risk assessments, 9 064 HIV tests and generating 12 340 clinical referrals. These interventions supported early detection and improved member outcomes.
- Medscheme's tactical plan for 2025 focused on hospital admission risk management, PMB and ex-gratia spend reduction, and early disease programme enrolment – with a targeted savings impact of R200 million. We achieved savings of R221 million.
- Bonitas also piloted a corporate nurse model at Grupo Antolin, offering on-site clinical support and education in members' home languages. Further rollouts are planned across selected pay points.

Strategic pillars

-  Be a strategic purchaser
-  Boost business development
-  Optimise investment returns
-  Connect with the customer
-  Integrate the value chain
-  Create value through innovation
-  Apply best practice governance



* Number of members/beneficiaries

PROMOTE PREVENTATIVE CARE FOR IMPROVED HEALTH AND WELLBEING

Bonitas continued to shift from reactive care to proactive health management in 2025, expanding our preventative care initiatives to support early detection, improve member outcomes and reduce long-term claims exposure. These efforts align with our strategic intent to move from transactional healthcare to outcomes-based managed care.

- Our contraceptives benefit remains available across all Bonitas options, with annual cover ranging from R1 270 to R2 050, depending on the selected plan. This benefit has been widely embraced, especially with the convenience of delivery through our courier pharmacy network.
- The Maternity Programme was expanded to include newborn hearing screening, supporting early detection of sensory impairments and preventing developmental delays.
- The Back and Neck Programme was broadened to include shoulder and knee rehabilitation, enabling earlier intervention for common musculoskeletal conditions and reducing progression to chronic pain.
- The Benefit Booster was increased to up to R5 000 on key options, linking it to wellness and mental health screenings to promote early detection and proactive health management.
- Dr B, a digital health guide, was launched to help members understand their benefits, navigate care pathways and adopt preventative habits.
- The Marara Pharmacy WhatsApp line enabled members to manage prescriptions, deliveries, co-payments and queries through a simple digital channel.

Innovative preventative care initiatives driving outcomes-based managed care

In 2025, Bonitas implemented the following outcomes-based preventative care initiatives to improve member health and manage claims exposure:

- The Benefit Booster was evolved into a proactive risk-identification tool, requiring wellness and mental health screenings to unlock an increased R4 000 in flexible funding for acute medicine and diagnostics.
- AI-enabled retinal screening was introduced across the optical network, allowing optometrists to perform non-invasive early detection of systemic conditions like diabetes and hypertension.
- Support for vulnerable populations was expanded through newborn hearing screenings, respiratory protection for pre-term babies, and structured mental health interventions to reduce avoidable hospitalisations and long-term claims.

Strategic pillars



Boost business development

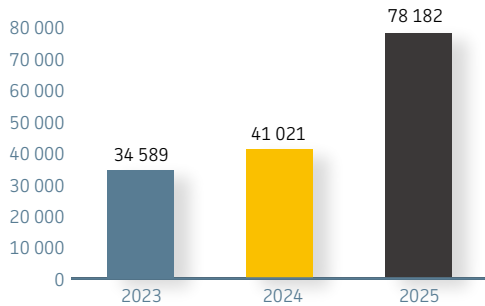


Connect with the customer

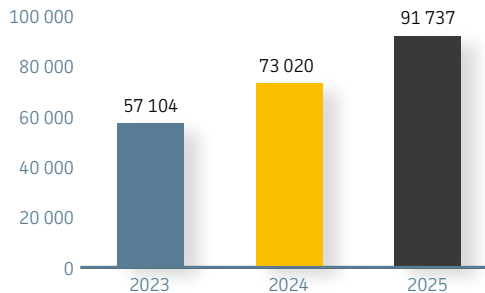


Create value through innovation

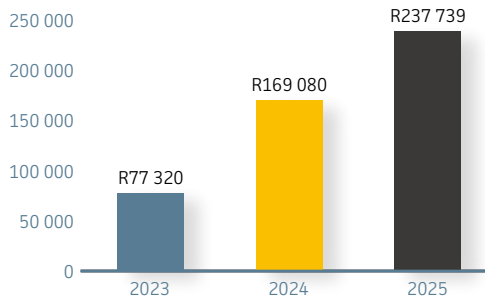
WELLNESS QUESTIONNAIRES COMPLETED



BENEFIT BOOSTER ACTIVATIONS



BENEFIT BOOSTER CLAIMS (R'000)



SIMPLIFY THE ROAD TO HEALTH AND WELLNESS

Bonitas continued to simplify healthcare routines in 2025 by reducing unnecessary complexity, improving member experience and enhancing digital access to care. These efforts support our strategic intent to connect with the customer, create value through innovation and use resources more effectively.

- The Bonitas website was rebuilt and relaunched, improving navigation, responsiveness and access to member tools. Over 300 000 unique users visited the site each month. Enhancements included Quick Find, a tool that helps members locate answers to medical aid-related questions, and a ‘request an ambulance’ function that enables real-time authorisation and location tracking. WhatsApp integration for ambulance tracking is planned for 2026.
- Bonitas launched Dr B, an AI-enabled member engagement tool that supports self-service, education and digital navigation. Dr B forms part of the broader digital enablement roadmap, including Business Hub 2.0 and future super app development.
- In partnership with Pharmacy Direct and Scriptpharm, a doctor portal was implemented to assist with script renewal, formulary compliance and co-payment reduction.
- Bonitas managed emerging reputational risks by implementing targeted interventions to address member concerns, including resolving duplicate debit transactions, engaging with Pharmacy Direct to improve service delivery during the transition to Marara Pharmacy, and streamlining onboarding processes to reduce delays for new members.
- To improve participation in wellness screenings, Bonitas introduced scheduled time-slots with a priority-lane system to reduce queues, as well as targeted SMS and mobilisation messages to remind members of upcoming wellness days.
- Call centre performance remained stable, with over 718 807 calls answered, 83% service level achieved and 93% first-contact resolution. Top query categories included referrals, benefits and education.

Call centre indicators

Total calls answered at the call centre
718 807
(2024:641 152)

Service levels achieved
83%
(2024: 82%)

Top three query categories
Referral, Benefits, Education
2024: Benefits, Education, Referral

Calls resolved on first contact
93%
(2024: 91%)

Strategic pillars

- Be a strategic purchaser
- Boost business development
- Connect with the customer
- Create value through innovation



GROW THE CORPORATE MEMBERSHIP BASE THROUGH AFFORDABLE AND INTEGRATED SOLUTIONS

Bonitas continued to strengthen its corporate value proposition in 2025, focusing on affordability, tailored servicing and sector-specific engagement to drive sustainable membership growth. The organisation's integrated model supports employers, unions and brokers with tools, insights and wellness solutions that align with their workforce needs.

- The broker portal was soft-launched, with over 720 brokers registered, improving onboarding, servicing, quoting and query resolution for employer groups.
- Bonitas's digital roadmap supports customised HR and broker tools, with further integration planned through Business Hub 2.0 and API-enabled platforms to streamline corporate administration and reporting.
- Virtual-first solutions such as BonCore provided corporates with an affordable, digitally integrated option for younger or lower-income employees, reducing barriers to entry and improving workforce coverage.
- Tailored healthcare insight reports were provided to key employers, enabling HR teams to identify workforce health risks, optimise benefits and plan targeted wellness interventions.
- Bonitas implemented sector-specific engagement strategies across several large employer groups, including South African Local Government Association (SALGA), National Union of Metalworkers of South Africa (NUMSA) Free State, Association of Mineworkers and Construction Union (AMCU), National Union of Mineworkers (NUM) and the City of Johannesburg, to stabilise membership and strengthen relationships at pay-point level. These strategies included targeted broker collaboration, improved service levels following the administration transition, and focused support from sector managers and wellness coordinators.

Strategic pillars

-  Boost business development
-  Create value through innovation
-  Apply best practice governance

PROVIDE AFFORDABLE AND HOLISTIC MENTAL HEALTH SOLUTIONS

Bonitas continued to strengthen its mental health offering in 2025, recognising the growing burden of mental illness across South Africa and the increasing impact on members, employers and families. Our approach focuses on affordability, early intervention and integrated support across the care continuum.

- Mental health emerged as a material clinical trend in 2025, with claims tracking 10.2% higher than 2024, prompting focused oversight through the Managed Healthcare Committee.
- Depression remained a key clinical priority, with members able to access chronic benefits for depression across 12 benefit options.
- Bonitas expanded access to digital mental wellbeing tools, including Proudly Panda, which provides free assessments, coping resources and self-guided support.
- High-risk members were prioritised for early enrolment into disease management programmes, supported by Medscheme's tactical plan to reduce hospital admissions and improve adherence.

Bonitas remains committed to providing accessible, affordable and holistic mental health support that meets the evolving needs of members and their families.

Strategic pillars

-  Be a strategic purchaser
-  Boost business development
-  Connect with the customer
-  Create value through innovation

Mental health: what you need to know

- Nearly one in seven people in the world live with a mental disorder.¹
- Depression and anxiety alone cost the global economy an estimated US\$1 trillion each year.²
- Globally, an estimated 5.7% of adults suffer from depression.³
- Globally, one in seven 10-19-year-olds experiences a mental disorder, accounting for 15% of the global burden of disease in this age group.⁴
- 92% of South Africans living with mental health conditions are not receiving the treatment they need.⁵
- 3.64% of Bonitas members are registered for chronic benefits related to depression.



¹ <https://www.who.int/news-room/fact-sheets/detail/mental-disorders>.

² <https://www.who.int/news/item/02-09-2025-over-a-billion-people-living-with-mental-health-conditions-services-require-urgent-scale-up>.

³ <https://www.who.int/news-room/fact-sheets/detail/depression>.

⁴ <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>.

⁵ <https://www.wits.ac.za/news/sources/health-news/2025/new-study-highlights-how-to-improve-mental-health-integration-in-south-african-primary-healthcare.html>.

PROMOTE TRANSPARENCY AND GOOD GOVERNANCE

Bonitas remains committed to transparent decision-making and governance practices that protect member interests, ensure value for money and uphold the integrity of our service provider relationships. In 2025, we strengthened our procurement, oversight and assurance processes, aligning with best practice and regulatory expectations.

- We held our virtual Annual General Meeting (AGM) on 20 August 2025, ensuring member participation and governance continuity.
- Comprehensive RFP processes were initiated for Bonitas's primary administrator and managed care contracts. Governance oversight was of critical importance with independent auditors appointed and due diligence conducted to ensure appropriate outcomes. The process included mandatory briefing sessions, conflict-of-interest controls, and comprehensively evaluating the value provided by all participants with consideration to our strategic objectives and the capacity and capabilities of our providers as well as the expectations of our brokers, members and corporate clients.
- Independent actuarial analysis confirmed that Bonitas achieved R1.85 in value for every R1.00 spent in 2023 (2022: R1.79), excluding BonCap. This reflects the effectiveness of procurement oversight and cost management practices.

The value for money analysis is conducted biennially and was not performed in 2025 due to Competitive RFP Process for the Appointment of an Administration and Managed Care Services Provider.

Strategic pillars



Create value through innovation



Apply best practice governance

How we select and manage service providers

We select and manage service providers in accordance with our Procurement and Contract Management Policy, which is regularly reviewed and approved by the Board.

Criteria for selecting and managing service providers

1

Request for proposal

Open tender processes are followed for major contracts in line with the Procurement and Contract Management Policy. Tenders are advertised in regional and national newspapers. RFP documents and the associated qualification and evaluation criteria are finalised in accordance with the Policy.

2

Briefing session if required

Mandatory briefing sessions are held if required e.g. Mandatory briefing sessions were held for the two RFPs namely Administration and Managed Care RFPs. All participating bidders complete non-disclosure agreements before receiving RFP information.

3

Service provider selection

RFP submissions are assessed and shortlisted by the Evaluation Committee in line with the Procurement and Contract Management Policy. Conflict-of-interest declarations are completed before evaluation. Presentations and comprehensive evaluations are completed in line with the Policy's evaluation requirements. Due diligence, including site visits and financial evaluation are conducted on shortlisted service providers.

4

Contract negotiation

The Evaluation Committee recommends for Board consideration. Final contracts are approved by the Board in line with the Policy.

5

Performance management

Governance oversight of RFP process by independent auditors appointed (for major contracts). Ongoing monitoring includes progress reporting and assurance activities. Contracts are reviewed before expiry to ensure they remain fit for purpose and aligned to Scheme requirements.

CONTRIBUTE TO AN AFFORDABLE AND SUSTAINABLE SOUTH AFRICAN HEALTHCARE ECOSYSTEM

Responding to National Health Insurance

In 2025, the Gauteng High Court ruled that President Ramaphosa must provide a full record of his decision to sign the NHI Act into law. This judgment added fresh momentum to the ongoing debate around the NHI's feasibility, constitutionality and potential impact on both the public and private healthcare sectors. Financial estimates suggest the NHI could cost between R900 billion and R1.3 trillion, raising concerns about long-term affordability and implementation.¹

Bonitas supports universal healthcare and believes that both public and private sectors share responsibility for achieving it. We recognise the infrastructure gaps within the public system and continue to play an active role in strengthening it. Through a long-standing partnership with Gift of the Givers, we have supported public healthcare facilities by improving access to clean running water, refurbishing hospital wards, funding medical bursaries and sponsoring an audiology programme, demonstrating our commitment to practical, community-level healthcare reform.

In response to the NHI developments, Bonitas:

- Engaged with stakeholders including the BHF to lobby for an effective, well-governed NHI that recognises the role of medical schemes
- Monitored risks and opportunities related to the NHI's phased implementation
- Provided members with clear communication on the implications of the NHI, confirming that members remain unaffected at this stage
- Investigated alternative models to ensure Bonitas's long-term sustainability and relevance
- Reaffirmed its support for universal healthcare while emphasising the need for public-private collaboration and financial feasibility

Strategic pillars

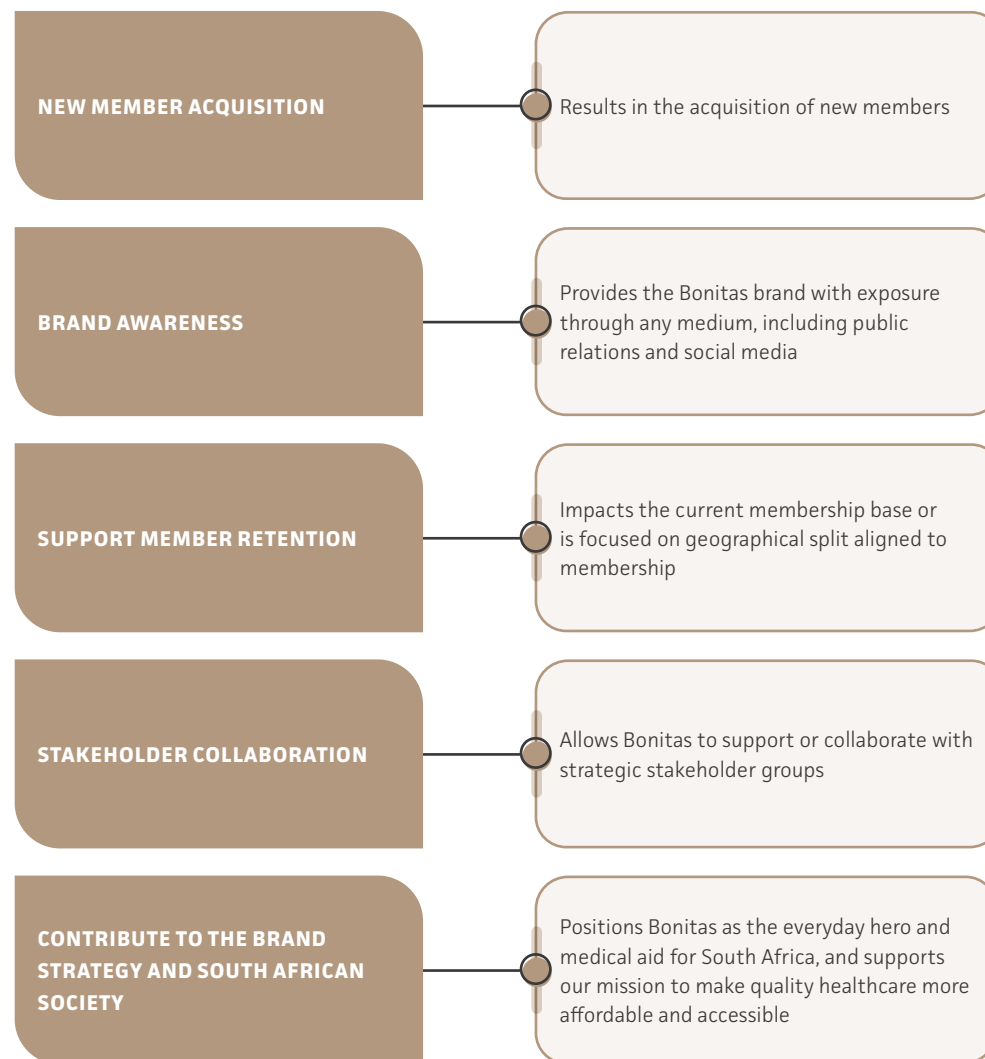
-  Optimise investment returns
-  Create value through innovation
-  Apply best practice governance

¹ <https://dailyinvestor.com/business/65471/nhi-will-cost-every-south-african-taxpayer-an-extra-r43000-per-year/>.

Driving positive healthcare outcomes with Gift of the Givers

Bonitas is guided by a Board-approved Sponsorship and Donations Policy and annual Sponsorship Strategy. Sponsorships are financial in nature, and potential projects are evaluated and approved against the following criteria:

Sponsorship criteria



Fraud, waste and abuse

Bonitas has zero tolerance for FWA-related irregularities. Our Anti-Fraud, Waste and Abuse Policy sets out guidelines for preventing, deterring, detecting, reporting and investigating FWA, as well as the actions and sanctions required under applicable legislation. All providers are required to comply, with non-compliance subject to penalties.

The Bonitas FWA Forum meets monthly with Medscheme, PPN, DENIS and Europ Assistance (now AZOZA) forensic teams to report and discuss operational matters. Together, we engage with service providers to drive preventative and corrective measures. Analytical software is used to identify anomalies or irregularities that may indicate potential FWA, and each step in the forensic process is documented to provide an auditable trail and assurance to stakeholders.

Members can report suspected medical aid fraud through our dedicated Whistle Blowers hotline. Reports may be made anonymously or in confidence via phone, SMS, WhatsApp, email, fax, mail, the Whistle Blowers app or online at <https://www.whistleblowing.co.za/>.

Fraud, waste and abuse management

Fraud prevention	• Industry information sharing • Practice vetting and monitoring • Awareness, training and communication
Fraud detection	• Proactive identification • Tipoffs
Fraud investigation	• Forensic data analysis • Field of work • Practice engagement and communication • Loss assessments
Fraud risk management	• Practice rehabilitation • Payment status change • Recovery mechanisms • Fraud database listing • Regulatory sanctioning • Civil and criminal action
Fraud reporting	• Payment integrity weaknesses • Impact analysis • Service level adherence • FWA Forum



BRINGING CLEAN WATER TO MINING COMMUNITIES

In the North West and Mpumalanga provinces, schools in mining communities experience frequent water outages, disrupting learning and compromising hygiene. In partnership with Gift of the Givers, Bonitas’s funding supported the completion of water infrastructure projects at ten schools. Bonitas funded the installation of reverse osmosis filtration systems and new solar powered borehole installations.

A specific intervention was required at two primary schools in Rustenburg, Ramochana Primary School and Mfidikwe Primary School, which together serve more than 2 500 learners. While Sibanye Stillwater Mining Company had sponsored the drilling of boreholes at both schools, subsequent water testing revealed high levels of nitrates in the water. Excessive nitrate consumption poses serious health risks, particularly for children and pregnant women.

These projects support our strategic objectives by demonstrating a visible commitment to the wellbeing of members and their families in areas where Bonitas has a significant presence. The partnership with Gift of the Givers provides access to an established national network, ensuring effective project implementation and generating positive stakeholder relationships.



Notable 2025 events

- A multi-stakeholder investigation into irregular renal-care claims was initiated across the industry, with Bonitas participating actively to protect members and ensure appropriate action where wrongdoing is identified.
- Several provider-related matters progressed through regulatory and legal channels, including a landmark case in which a healthcare provider was convicted on four counts of fraud and fined R150 000, with additional penalties and suspensions issued by the HPCSA and SACSSP.
- A system enhancement was implemented to strengthen claim validation, evidenced by the September 2025 update that now prevents indirect-payment providers from submitting EDI claims unless accompanied by valid proof of payment, reducing opportunities for collusion and fraudulent submissions.
- An impersonation incident involving a fraudulent individual posing as a forensic team member was identified and addressed, with documented actions including provider notification, a formal risk case opened, escalation to SAMC and Sanlam, and internal forensic investigation to prevent recurrence.
- Forensic monitoring and interventions increased across multiple healthcare disciplines, demonstrated by 7 841 practices on the forensic radar, 1 253 active investigations, 1 640 recovery cases, and 2025 recoveries of R55.3 million, reflecting strengthened oversight and improved billing behaviour.

	Amounts quantified, recovered and saved due to the FWA prevention programme (R'000)									
	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total
Quantified	111 612	106 208	85 881	64 920	75 869	102 037	89 056	74 238	91 819	709 821
Recoveries (gross)	26 469	39 847	39 875	37 060	26 642	44 141	34 236	30 847	35 334	314 451
Change in behaviour	85 000	60 000	165 219	237 309	272 710	200 225	89 200	22 903	48 485	1 181 051
Prepayment										
intervention	6 521	10 942	11 338	14 216	16 989	10 969	17 703	15 030	16 694	120 402
Reversals	371	424	182	401	461	393	343	334	3 270	6 179

FUTURE PRIORITIES

Initiatives planned for the short to medium term include the following:

- Transition to our capabilities-driven strategy for the 2026 to 2029 cycle to link strategic intent directly to internal processes and distinctive competencies.
- Stabilise services with newly appointed providers following the conclusion of the RFP processes for administration and managed care contracts ending in May 2026.
- Execute the digital roadmap which includes the development of a 'super app' and WhatsApp integration for real-time ambulance tracking.
- Address loss-making benefit options through innovative managed care strategies and value-based partnerships.
- Advance the transformation agenda to ensure that the Bonitas economy reflects the demographics of the nation.
- Prepare for the anticipated promulgation of the Conduct of Financial Institutions Bill (COFI Bill)¹ in 2026 and monitor the framework for low-cost benefit options.

¹ <https://www.treasury.gov.za/twinpeaks/Conduct%20of%20Financial%20Institutions%20Bill.pdf>: The Conduct of Financial Institutions Bill (COFI Bill) is a proposed law in South Africa that will create a single, comprehensive framework to regulate how financial institutions behave.

Investigations

Practices under investigation

411 ↓

(2024: 443)

Practices vetted

6363 ↑

(2024: 4 278)

Risk mitigation and remedial action

Practices in recovery

1 640 ↓

(2024: 1 658)

Practices blocked

247 ↑

(2024: 191)

Practices with existing regulatory matters or criminal sanctioning

192 ↑

(2024: 189)

Recoveries

Recovered in 2025, including reversals, recoveries and claim interventions (target of R40 million)

R55.3 million ↑

(2024: R46.2 million;
target of R47.5 million)

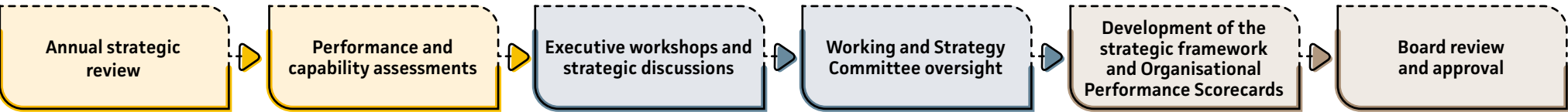
TRANSITIONING TO A CAPABILITIES-DRIVEN STRATEGIC APPROACH

RATIONALE FOR CHANGE

As Bonitas looks ahead, a new multi-year strategy has been developed to build on this foundation and position Bonitas for the next phase of growth and capability development from 2026 to 2029.

The decision to introduce a new strategy is the result of a planned and deliberate transition. The previous cycle strengthened Bonitas’s financial position, enhanced operational performance and deepened member value. However, the healthcare environment continues to evolve, with shifts in member expectations, advances in digital health, regulatory developments and increasing pressure on affordability. These changes require a refreshed strategic focus that enhances and extends the progress already made.

OUR STRATEGY DEVELOPMENT PROCESS



KEY STRATEGIC SHIFTS

As we move from a directional to a operational and structural strategy, Bonitas will enhance our differentiation in the healthcare market. Bonitas will increase investment in capabilities that underpin financial stewardship, more advanced use of data, disciplined operational execution, improved provider alignment and more personalised engagement with members.

The distinguishing feature of the new strategy is its integration and coherence. Strategic direction, operational delivery, member experience and innovation are now connected within a single, unified system. This improves decision-making, resource allocation and the coordination of care. It reinforces the foundations that support quality, affordability, service reliability and proactive health support across the member journey. It also modernises the systems, data and communication capabilities that shape our members’ experiences.

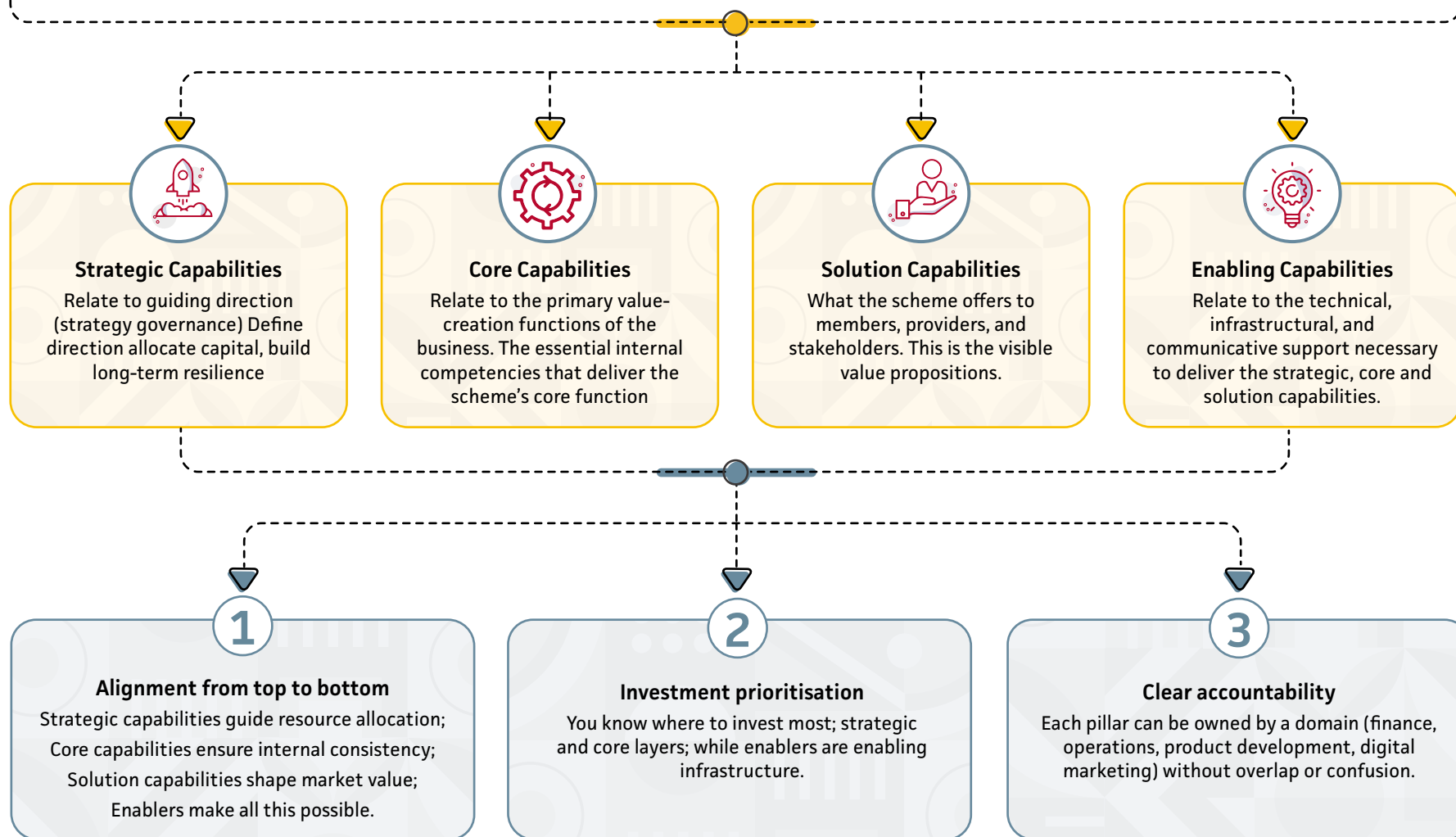
The new strategy builds on the strategy that has guided Bonitas in recent years. The core principles that shaped the seven pillars of the previous period remain central, but each is being strengthened and expanded to support a more integrated and capability-driven strategic approach.

Current strategic pillars (Legacy framework)	New capability framework	Strategic evolution / rationale
 Be a strategic purchaser	Care, quality and efficiency	Strategic purchasing has evolved into a formalised capability around care, quality, and efficiency. We are transitioning from transactional healthcare buying to proactive health management and value-based partnerships supported by data and provider contracting.
 Boost business development	Benefit innovation	Having embedded business development, we are moving the emphasis to innovation as a capability to create new products, refine benefits, and expand value across income segments to drive growth.
 Optimise investment returns	Financial sustainability and reserve management	The focus on investment returns has broadened to holistic financial sustainability, integrating pricing sufficiency, operational performance, and solvency management.
 Connect with the customer	Personalised stakeholder experience	Customer engagement extends beyond members to include brokers, providers, and employers through omni-channel engagement, personalisation, and digital self-service.
 Integrate the value chain	Integrated value model	The concept of "value chain integration" has matured into a structured integrated value model, which aligns incentives between Bonitas, members, and service providers to drive shared outcomes and behavioural change.
 Apply best practice governance	Analytics, data and risk management	Best-practice governance is now embedded in data-driven management of risk, compliance, and insight generation. This transition enhances transparency and accountability across all capabilities.
 Create value through innovation	Operational excellence	Innovation, as a 'structural capability' is now operationalised to continuously improve processes, strengthen cost control, and enhance IT infrastructure.

ADOPTING A CAPABILITIES-DRIVEN STRATEGIC APPROACH

A Capabilities-driven strategic approach advances that sustainable competitive advantage arises from organisational-specific resources and capabilities that are valuable, rare, costly to imitate, and non-substitutable.

In this view, **strategy is not just about choosing markets but about organising and investing internal capabilities to exploit those markets / sectors.**
The Scheme must identify which capabilities drive advantage and build them.



RISKS AND OPPORTUNITIES

The successful implementation of our strategy, and the sustainability of Bonitas, rely on effective risk management, combined with an approach that is in step with emerging opportunities.

The Board is accountable for risk management and is guided by our Risk Management Framework to identify, evaluate and respond to key risks and opportunities consistently, efficiently and effectively. Read more about risk management in the governance section from page 83.

THE IMPACT OF NHI ON BONITAS'S SUSTAINABILITY AND STRUCTURE

Risk definition	Our response and mitigation	Related opportunity
Since it was signed into law in May 2024, the NHI Act is facing nine court challenges. The Act is still in the early stages of implementation, with the first phase running from 2023 to 2026, and the second phase expected to begin in 2026¹, focusing on funding and service coverage. NHI remains a significant risk that can adversely impact the future of private medical schemes and current new membership growth. Key issues include: • Uncertainty around the role of medical schemes and future access to private healthcare • Constitutional and legal implications including infringement of the Bill of Rights • Uncertainty around proposed NHI funding models • Governance implications • Impact of potential corruption and misuse of health funds • Implications around provider reimbursements • Uncertainties around the determination of service benefits	• Ongoing oversight of NHI-related regulatory risks through the Working and Strategy Committee and the Audit and Risk Committee • Continued engagement with CMS, including meetings with the newly appointed CMS Registrar and coordinated submissions on Section 43 and Section 44 matters • Monitoring national legal developments, including BHF litigation and LCBO court challenges, to assess implications for scheme competitiveness • Targeted stakeholder engagement with brokers, corporates, municipal leadership, and industry bodies to manage reputational risk and reinforce Bonitas's strategic positioning • Regular communication to members, brokers, corporates, and healthcare providers on regulatory developments and potential NHI impacts • Strengthening long-term resilience through the administration and managed care RFP processes, ensuring Bonitas has capable partners under future NHI scenarios	• Improve relationships and collaboration between stakeholders • Communicate and entrench the Bonitas value proposition • Contribute to an NHI model that makes a lasting positive impact on South Africans and the healthcare ecosystem Strategic pillars affected  

¹ Phase 1 (2023–2026) focuses on foundational reforms, including drafting regulations, appointing committees, and beginning the integration of public and private healthcare sectors. Phase 2 (2026–2028) will continue these reforms, with full implementation expected to take up to 15 years in total. (South Africa's National Health Insurance Act: Paving the way for universal healthcare and equity – Simeka Health).

THE IMPACT OF INCREASING OR CHANGING REGULATION

Risk definition

Emerging legislation including CMS Circulars, the Medical Schemes Amendment Bill and the Conduct of Financial Institutions (COFI) Bill (expected to be promulgated in 2026) may impact compliance requirements, our business model and our products and services.

Other regulatory matters related to this risk include:

- The low-cost benefit options (LCBOs) framework still has to be finalised by the CMS and is closely monitored. LCBOs represent an immediate, practical and sustainable solution to expand private healthcare. The CMS is currently exempting health insurance providers from compliance with the Medical Schemes Act by imposing a moratorium on medical schemes offering LCBOs.
- The Road Accident Benefit Scheme (RABS) Bill has been revived after the RAF Amendment Bill was abandoned in 2025. This represents a significant shift in South Africa's approach to road accident compensation. Payments towards overdue claims are set to commence, including to medical schemes.
- The CMS established a Clinical Advisory Committee to assist with the development of the Prescribed Minimum Benefits (PMB) Guidelines. The Benefit Definition Guidelines Project aims to clarify PMB entitlements and to offer guidance to all stakeholders in interpreting PMB provisions, starting with the PMB Chronic Disease List and the Diagnostic and Treatment Pairs (DTP) Anatomic Group PMBs.

Our response and mitigation

- Continuous oversight of regulatory developments through the Working and Strategy Committee and the Audit and Risk Committee, with regulatory risks forming part of Bonitas's risk register reviews
- Monitoring and analysing emerging legislation and regulatory frameworks, including the Medical Schemes Amendment Bill, COFI Bill, LCBO developments, and RABS Bill implications
- Tracking LCBO-related court challenges and CMS exemptions to assess competitive impacts and inform strategic positioning
- Monitoring the CMS Benefit Definition Guidelines Project and PMB updates to anticipate changes in benefit design requirements and ensure alignment
- Strengthening governance and compliance readiness through the administration and managed care RFP process, ensuring future partners meet regulatory and audit expectations.

Related opportunity

- Improve affordability and access to healthcare
- Improve cohesion and coherence in the healthcare ecosystem
- Increase transparency and good governance
- Innovate new solutions to meet members' needs
- Protect Bonitas's financial sustainability

Strategic pillars affected



CYBER AND INFORMATION SECURITY THREATS AND VULNERABILITIES

Risk definition

Information security threats and vulnerabilities may arise due to lack of data protection and inadequate user access management or insufficient IT change control and incident management. This could lead to the loss of confidential member healthcare information, financial information or healthcare provider and supplier information, resulting in financial loss, operational disruption and reputational damage.

Our response and mitigation

- IT governance remains a standing agenda item at the Working and Strategy Committee, with regular updates on system performance, cyber risks, and remediation progress
- Data protection and information-security obligations are embedded in the administration and managed care SLAs, ensuring contractual accountability for safeguarding member information
- Administrators maintain established cyber security frameworks, including cyber insurance, endpoint protection, encryption, web application firewalls, vulnerability and penetration testing, and security operations centre monitoring
- Cyber security insurance renewal processes are underway, with updated sufficiency testing and coverage assessments aligned to the dual-administrator environment
- Ongoing monitoring of IT incidents, connectivity issues, and system vulnerabilities is conducted through operational reporting to the Working and Strategy Committee, ensuring early detection and risk mitigation

Related opportunity

- Drive awareness of the confidentiality of personal data
- Insights from quality data can assist to improve the relevance of products and services
- Instil good I&T practices among service providers
- Use big data to improve business Intelligence through analytics-driven modelling and platforms, standardised protocols, predictive analysis etc

Strategic pillars affected



BONITAS'S SUSTAINABILITY AND STABILITY

Risk definition	Our response and mitigation	Related opportunity
We rely on membership growth, retention and affordability for Bonitas's sustainability and stability. Suboptimal design and pricing changes, increasing loss-making options and changes to the membership risk profile might put Bonitas's performance at risk. Increasing healthcare costs and the ineffective management of risk transfer arrangements might further impact resilience, thus affecting our ability to pay claims, serve members and meet solvency requirements.	• Multi-disciplinary product and pricing process supported by actuarial modelling, market research, and option-level financial analysis • Strengthened corporate growth strategy, including targeted acquisition opportunities (e.g., Sizwe Hosmed curatorship) and a diversified distribution channel approach • Monitoring of membership trends, including pensioner ratios, DPM growth, corporate base shifts, and new member claims patterns to inform pricing and benefit design • Implementation of value-added products and wellness programmes (e.g., Benefit Booster, VAPS) to support retention and attract younger, healthier members • Robust procurement and contracting processes, including the 2025 administration and managed care RFPs, supported by independent probity reviews and due-diligence assessments • Ongoing monitoring of option performance, with pricing adjustments aligned to sustainability objectives • Solvency ratio maintained above the statutory 25% requirement, supported by strong investment performance • Independent assurance of financial strength through Global Credit Rating's AA+ (ZA) rating • Regular monitoring of healthcare cost drivers, including hospital utilisation, chronic medicine adherence, and provider network performance	• Improve relationships and collaboration between stakeholders • Improve the quality of service provided to members • Communicate and entrench the Bonitas value proposition • Increase transparency and good governance Strategic pillars affected 

THE BONITAS BRAND AND REPUTATION

Risk definition	Our response and mitigation	Related opportunity
Negative media publicity can lead to the potential loss of stakeholder confidence and brand or reputational damage. Several recent media articles relating to governance and procurement issues raised this risk.	• Ongoing engagement with the CMS on regulatory matters, including Section 43 and Section 44 submissions, and meetings with the newly appointed CMS Registrar • Coordinated communication with brokers and corporate clients • Media communication to ensure consistent, fact-based messaging across all stakeholder groups • Collaboration with legal advisors and public relations partners to manage media queries, ensure accuracy of public statements, and mitigate reputational exposure • Proactive engagement with external auditors to validate fact-based responses and ensure alignment with audited information • Strengthened governance oversight through the Working and Strategy Committee and Audit and Risk Committee, which reviews reputational risks as part of strategic and operational reporting • Active participation in industry forums and regulatory processes	• Improve relationships and collaboration between stakeholders • Increase transparency and good governance • Communicate and entrench the Bonitas value proposition Strategic pillars affected 

STAKEHOLDER MANAGEMENT

Risk definition	Our response and mitigation	Related opportunity
The lack of a stakeholder framework can result in a failure to actively manage the relationship between Bonitas and our key stakeholders. Key stakeholder relationships include those with the CMS, healthcare providers, unions, members and primary service providers. These relationships secure effective governance and efficient operations at Bonitas, and are essential for member retention, risk management and growth.	• Board-approved Stakeholder Engagement and Communication Framework implemented to guide structured engagement with CMS, healthcare providers, unions, corporates, brokers, and members • Targeted communication with brokers and corporates following regulatory or reputational events, supported by formal broker circulars and internal communication packs • Enhanced digital communication channels, including mobile app upgrades, WhatsApp functionality, Live Chat, and improved self-service tools to strengthen member interaction • Website enhancements, including an AI-enabled support bot to improve provider and member engagement • Ongoing operational engagements with administrators and managed care providers to address member concerns, improve service levels, and ensure timely remedial action • Executive-level engagement with key stakeholders such as municipal leadership, major brokerage firms, and industry bodies to reinforce Scheme stability and support growth • Updated communication strategy and templates, including member education materials, the member magazine, and the fortnightly broker newsflash, to ensure consistent and accurate messaging	• Improve relationships and collaboration between stakeholders • Improve the quality of service provided to members • Increase transparency and good governance Strategic pillars affected 

SERVICE PROVIDER PARTNERSHIPS

Risk definition	Our response and mitigation	Related opportunity
Members expect effective and efficient service and administration, including claims processing and payments. Claims paid outside approved benefits and limits or in contravention of the MSA and Scheme Rules are a high risk to Bonitas. Where third parties fail to deliver against contracts or service level agreements, this can lead to member dissatisfaction, terminations, an increase in claims ratios, regulatory compliance issues, a potential increase in loss-making options and reputational damage. Bonitas also has to manage the risks associated with RFP processes to award new administration and managed care contracts, which are expiring at the end of May 2026. The transition to new service providers will have to be proactively managed.	• Chief Operations Officer (COO) oversight of key claims exceptions and Principal Officer sign-off of all non-compliance items to ensure adherence to Scheme Rules and the Medical Schemes Act • Ongoing monitoring of claims processing speed, turnaround times, and year-on-year processing trends, supported by independent monthly actuarial reviews • Formal escalation and remediation processes for service providers who fail to meet contractual obligations, with accountability enforced through SLA performance management • Comprehensive due diligence on shortlisted RFP bidders including financial, legal, operational, IT, HR, and clinical risk assessments • Proactive transition planning for the potential change in service providers, including readiness assessments, infrastructure verification, and system integration risk reviews • Oversight of RFP timelines and risks, including mitigation of delays, documentation of policy deviations, and escalation of risks to the Board • Monitoring of operational risks associated with third-party performance, including IT system stability, connectivity issues, and claims platform reliability • Oversight of the wind down of the process of the current administrator and managed care service providers • Oversight of the transition project for the new administrator and managed care service providers	• Improve relationships and collaboration between stakeholders • Promote integration of the healthcare value chain • Innovate new solutions to meet members' needs • Instil good I&T practices among service providers Strategic pillars affected 

TECHNOLOGY AND INNOVATION

Risk definition	Our response and mitigation	Related opportunity
Failure to keep abreast of new technology and innovation due to rigid structures restricting implementation or execution can reduce our competitiveness. This can result in the ineffective implementation of analytic-driven modelling and platforms whereas a lack of standardised protocols and predictive analysis can result in inefficiencies and poor performance. Competitive benefit design and pricing rely on strong business intelligence and data capabilities.	- Established a central data warehouse and transitioned to an “API-first” architecture¹. This infrastructure does not only safeguard member privacy through enhanced cyber security resilience but also empowers us to leverage big data analytics for more precise clinical risk management - Improved data accessibility for senior management and executives through upgraded reporting tools and structured data-delivery processes - Ongoing oversight of the data-warehouse project through bi-weekly management meetings, with active monitoring of risks, dependencies, and implementation progress - Implementation of digital enhancements to improve member and provider experience, including mobile app upgrades, WhatsApp functionality, Live Chat, and website improvements (CPD modules, interactive formulary, AI bot)	- Business and market intelligence can drive improved benefits, options and member services - Innovation can help address affordability concerns and lead to better healthcare outcomes - Improved data governance can protect and enhance information assets Strategic pillars affected 

MANAGEMENT OF INSURANCE RISK

Bonitas has a portfolio of insurance contracts that covers our risk in terms of member claims, enabling us to manage the healthcare risk exposure of our members and their dependants. Our risk exposure relates to uncertainty around the timing and severity of claims.

Bonitas uses internal risk measurement models, sensitivity and scenario analyses, and stress testing to assess and monitor risk exposure. This applies to both individual and overall risks. We apply probability in pricing and provisioning, and further manage insurance risk through:

- Inclusion of benefit limits and sub-limits
- Approval procedures for transactions that involve pricing guidelines
- Underwriting
- Pre-authorisation and case management
- FWA management
- Monitoring of emerging issues through our Risk Management Framework
- Risk transfer arrangements

Over the past few years, there has been a steady insurance risk migration from systematic to unsystematic in terms of PMBs. This is mainly due to changing legislation that requires Bonitas to pay PMBs at total invoice price and not according to benefit limits and sub-limits. Refer to note 21.1 of the annual financial statements for more.

¹ An API, which stands for application programming interface, is a set of protocols that enable different software components to communicate and transfer data. Developers use APIs to bridge the gaps between small, discrete chunks of code in order to create applications that are powerful, resilient, secure, and able to meet user needs.
<https://www.postman.com/what-is-an-api/>.

RISK TRANSFER ARRANGEMENTS

Certain health risks are outsourced where it is considered beneficial to members – for example, where the cost of procurement, infrastructure or intellectual property would be disproportionate to member benefits. This would only add to rising healthcare and downstream costs such as hospital admissions.

Bonitas has risk transfer arrangements with the following service providers, all of which have a national footprint across South Africa:

Service provider	Risk transfer arrangements
DENIS	Dental benefits: Standard, Standard Select, BonFit Select, BonComplete, BonSave and BonClassic
AZOZA (previously Europ Assistance Worldwide Services (South Africa) Proprietary Limited) – EMS	- Ambulance and emergency services for all plans - International travel benefits: all members except those on BonCap
PHA	Non-hospital costs: BonCap only
PPN	Optometry benefit management: Standard, Standard Select, Primary, Primary Select, BonClassic and BonCap
Scriptpharm	Chronic medicine management for all plans

OUR PERFORMANCE

MESSAGE FROM THE CHAIRPERSON

Our philosophy is that strategic goals are only as effective as the capacity of the partners and systems tasked with delivering them.



STRATEGIC RESILIENCE IN A LANDSCAPE OF CONSOLIDATION

It is my privilege to reflect on a year where Bonitas demonstrated strategic and financial resilience through disciplined execution of our strategy and operational excellence. We operate in an environment where the socioeconomic landscape places sustained pressure on healthcare affordability. The latest CMS Industry Report highlights a clear trend of medical scheme consolidation within our sector: since 2000, the total number of medical schemes in South Africa has fallen from 144 to only 71 in 2024. Open schemes have been hit hardest, with a reduction of roughly two-thirds over the last 25 years, leaving only 16 open schemes remaining.

The following pivotal issues were at the forefront of the Board's strategic oversight throughout the year:

Governance and the strategic rationale for procurement

A defining focus for the Board in 2025 was the oversight of our major administration and managed care procurement processes for the contracts ending May 2026. After 43 years of partnership with our previous provider, it was our fiduciary duty to test the market to ensure our members receive the best possible value.

The Board initiated a formal RFP process, designed in accordance with global best practices to ensure Bonitas's service model remains fit-for-purpose and outcome-based.

We strategically positioned this procurement to identify partners whose values align with our non-profit mission, seeking a value-based approach where the priority is the health of our members. To maintain the highest standards of transparency and integrity, Bonitas appointed independent auditors to strengthen the governance oversight, confirming that the Board of Trustees remains the ultimate and informed decision-maker in the procurement process.

Leadership continuity

The Board remained focused on proactive succession planning and leadership rotation during the financial year. On behalf of the Board, I would like to express our sincere gratitude to Prof DP van der Nest, whose tenure as Chairperson of the Audit and Risk Committee concluded at the end of July 2025, and to Ms Phylicia Kekana, who rotated out of her role as Chairperson of the Remuneration Committee in August 2025. We thank them for their dedicated service and expert stewardship, and we are pleased that Ms Kekana continued to serve as an independent member of the Remuneration Committee until the end of her tenure in January 2026.

We warmly welcome Mr Tshepiso Poho as the new Chairperson of the Audit and Risk Committee and Ms Dudu Msomi as the new Chairperson of the Remuneration Committee.

Regulatory engagement and strategic transparency

Bonitas continues engaging with industry bodies on matters that are in our common interest, or related to regulatory change. One of these relate to the independent section 44 inspection into the affairs of a medical fund by the CMS. While this process is sometimes framed as a 'forensic inspection', the Board views it as a matter of completeness and prudence to provide further assurance of our adherence to governance protocols.

This current inspection is similar to the previous section 43 inquiry where the regulator confirmed they could not arrive at any findings against the prior allegations, validating our commitment to non-profit integrity and long-term sustainability. Our position remains one of absolute transparency and cooperation as we engage with the CMS to conclude this regulatory matter.

Safeguarding our reputation

The Board remains determined to protect the reputation of Bonitas: a brand built through the hard work and contributions of our Trustees, employees, service providers and our members' trust. We decisively addressed media publications featuring incorrect allegations related to procurement processes and governance.

2026 PRIORITIES

As we conclude this strategic cycle, the Board of Trustees has approved a transition toward a capabilities-driven strategy for 2026 to 2029. We are moving beyond a transactional model toward a strategic roadmap grounded in organisational maturity and partnerships aligned with our non-profit mission.

Our priorities for the upcoming year are rooted in this commitment to long-term sustainability:

- Stabilise administration and managed care services with our newly appointed partners, Momentum Health and PHA. Their respective appointments followed a rigorous RFP process and an independent probity review conducted by PwC to ensure the protection of member resources.
- Focus on improving member benefits to ensure affordability in a national landscape where healthcare expenditure growth of 9.03% has outpaced insurance revenue at 8.65%.¹ We remain committed to protecting the healthier purse of our members by demanding specific health outcomes and holding providers strictly accountable to service level agreements.
- Address the challenge of loss-making benefit options, a strategic priority identifying that 57.14% of all options across the industry incurred insurance service losses in 2024.¹ Our new partners are tasked with deploying innovative strategies to manage these risks.
- Continue our transformation agenda to ensure that the Bonitas economy reflects the demographics of our nation.

ACKNOWLEDGEMENTS

In closing, I wish to express my deepest gratitude to Mr R Cowley as he finishes his second term. His deep knowledge of managed healthcare has moved Bonitas forward by miles. I also congratulate Adv RT Monene on her election as Vice-Chairperson: a step that underscores our commitment to transformation.

As I also complete my second term of office, I thank our members and the Board of Trustees for their continued trust. I leave confident that Bonitas remains a resilient and member-focused home for healthcare.

Mr OJ Komane
Chairperson of the Board

Date: 25 June 2026



¹ https://www.medicalschemes.co.za/wp-content/CMSIndustryReport2024_4Dec.pdf.

REPORT FROM THE PRINCIPAL OFFICER

The 2025 financial year was a period of reflection and achievement for Bonitas. I believe that a medical scheme is more than a financial entity. It is a community of lives and a shared risk pool belonging exclusively to its members. This year has demonstrated that a commitment to a non-profit motive is both ethical and practical.



SELECTING NEW SERVICE PROVIDERS

A major focus during 2025 was the oversight of our administration and managed care procurement. After 43 years of service, we conducted a strategic market assessment to ensure members continue to receive the best possible value. This value is measured by the quality of health outcomes for members relative to the costs incurred. It serves as a safeguard against commercial exploitation, ensuring that every rand spent contributes to a sustainable healthcare experience. This duty is necessary to remain competitive in a shrinking market.

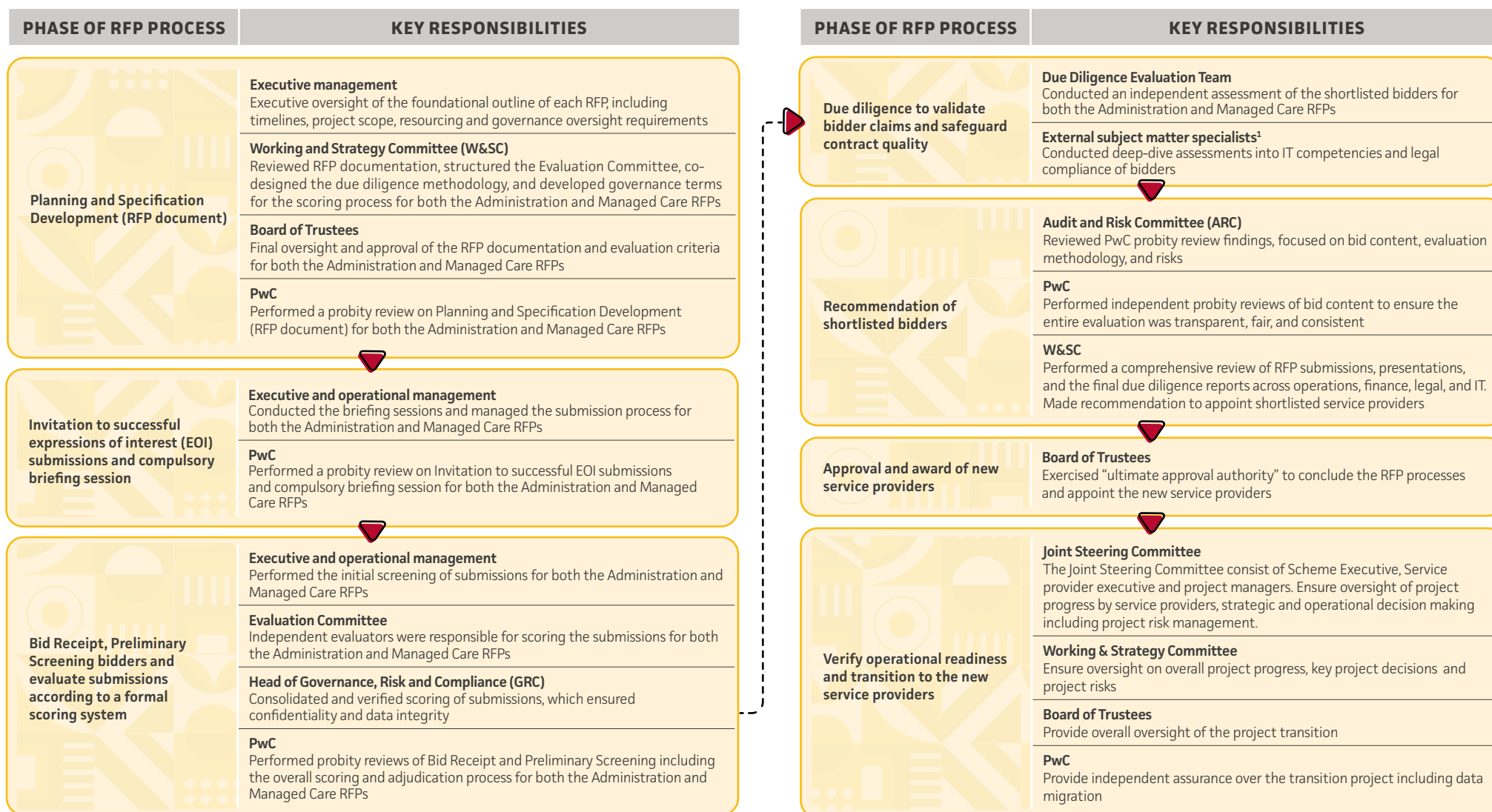
Our administration service contract and managed care service contract both reach their five-year term in May 2026, and we are duty-bound to ensure that the capacity and capabilities of our partners are fit for purpose to deliver outcomes that align with our member-focused mission. While our primary duty is to safeguard the collective resources of our members, profit-oriented organisations are understandably focused on delivering value to their shareholders. We believe that by testing the market, we can identify partners whose strategic goals are most closely aligned with our own commitment to member affordability. We are moving increasingly toward a culture of targeted outcomes and accountability in managing our service contracts.

To ensure transparency, we once again adopted a structured RFP governance framework. We assessed potential partners on four pillars: accreditation, functionality, financial stability, and operational capacity. The process followed a five-stage quality review. At each point, our internal audit team conducted reviews to manage risks and meet strict internal benchmarks.

We remain confident in our adherence to established governance protocols despite a High Court application initiated by an incumbent provider in December 2025 to prevent the conclusion of this process. We believe testing the market for value is an essential duty to our members, and we will not be deterred from seeking the best outcomes for their wellbeing.

ADMINISTRATION AND MANAGED HEALTHCARE RFP GOVERNANCE PROCESS

We applied robust governance oversight across the two RFP processes, which followed similar paths but constituted separate interventions and controls. For example, there were two probity reviews and reports for the Administration and Managed Care RFPs.



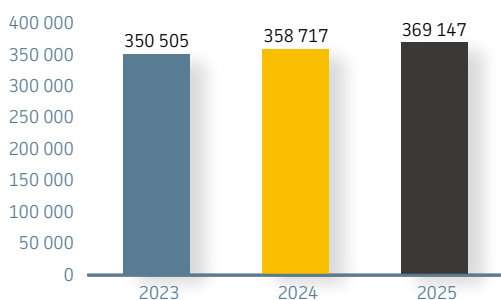
¹ External experts from B2HA and GMI Attorneys

MEMBERSHIP GROWTH

Our operations in 2025 began with a test. In January, the loss of a major paypoint led to the departure of approximately 8 000 members. We recognise that the South African private healthcare market is limited and growth often involves members moving between schemes. We achieved a recovery by executing our strategy and focusing on affordability. From a low of 352 800 members in January, we grew steadily to reach 362 012 by September and ended the 2025 financial year with a total of 369 147 members.

Our resilience is anchored in our ability to innovate for the benefit of members. This financial strength is validated by an AA+ credit rating from GCR Ratings. This independent assessment confirms that Bonitas possesses very strong creditworthiness, high credit quality and strong financial security relative to industry peers.

PRINCIPAL MEMBERS



FINANCIAL RESILIENCE AND CLAIMS TRENDS

Our financial performance this year was steady. We reported a surplus of R1.8 billion, which exceeded our initial target. While a strong South African equity market supported this outcome, our focus remains on the claims loss ratio, which stood at 94.05%.

We are seeing shifts in the burden of disease that reflect broader societal stresses. Notable increases in claims for mental health and spinal disorders remind us that the wellbeing of our members is linked to the socioeconomic environment.

We cannot divorce the burden of the disease from the social constructs in South Africa, including the disparities between public and private healthcare systems. Healthcare in South Africa remains severely under resourced, emphasising the need for healthcare reform that will enable a scheme like Bonitas to attract more members, including younger people, to mitigate the current movement of the same members between schemes.

Despite these challenges, Bonitas remains competitive and managed to achieve R1.6 billion in savings through managed care and strategic purchasing. This effort ensures that we remain resilient and that our funds limit out-of-pocket expenses for members.

STRATEGIC EVOLUTION FOR THE 2026 TO 2029 CYCLE

In this report we close the loop on our previous seven-pillar strategy and introduce our new strategy, which will form the basis of our reporting next year. Bonitas is undergoing a deliberate shift toward a capabilities-driven strategy, which underpinned much of the decision-making in the RFP process, as we sought partners with the capacity and competencies to serve the best interests of our members.

NAVIGATING THE REGULATORY LANDSCAPE

The NHI remains a primary concern. Bonitas supports universal healthcare as a constitutional right, yet we believe the NHI in its current form is not sustainable. We aim to ensure that healthcare reform does not compromise members' quality or freedom of choice.

OUTLOOK

As we look to 2026 and beyond, Bonitas remains focused on protecting our members' interests while navigating an increasingly complex healthcare landscape. Our priorities are clear: safeguarding members' funds, managing costs across the healthcare value chain, and innovating to attract and retain younger members to balance our age profile. This requires showing up to market with technologically driven solutions that resonate with a younger demographic. Our focus on the corporate health space has proven successful, enabling us to not only attract younger members but also partner with employers to create more productive, engaged employees through proactive wellness management.

To ensure the responsible stewardship of members' funds, we maintain robust reserve levels in compliance with statutory requirements and hold all service providers strictly accountable for managing members' resources. The burden of managing both healthcare and non-healthcare costs remains a critical priority. We are actively engaging with hospitals and healthcare providers to reduce what they charge our members, with a particular focus on minimising out-of-pocket expenditure. Our approach is founded on a value-based model rather than vested interests, ensuring that every rand spent delivers maximum benefit to our members.

Looking ahead, our confidence is grounded in our track record. Over the past seven years, we have grown membership from 358 717 in 2024 to 369 147 principal members while improving our solvency ratio from below 24% to over 36%. We have consolidated loss-making options, repositioned our brand, and demonstrated that a steadfast commitment to members can withstand competitive pressures.

Mr LR Callakoppen
Principal Officer

Date: 25 June 2026

FINANCIAL AND OPERATIONAL RESULTS

Our investment returns were particularly vital this year, because they allowed Bonitas's solvency to remain healthy despite significant organic growth.



INVESTMENT PERFORMANCE AND SOLVENCY

We achieved a surplus of R1.8 billion, a result that significantly outperformed our initial target of R41 million and our revised forecast of R612 million. This success was primarily driven by our investment portfolio, which benefited from the strong performance of the South African equity market over the past year.

While we reached a total membership of 369 147, which typically places downward pressure on reserves, the strength of the investment space effectively boosted our solvency levels.

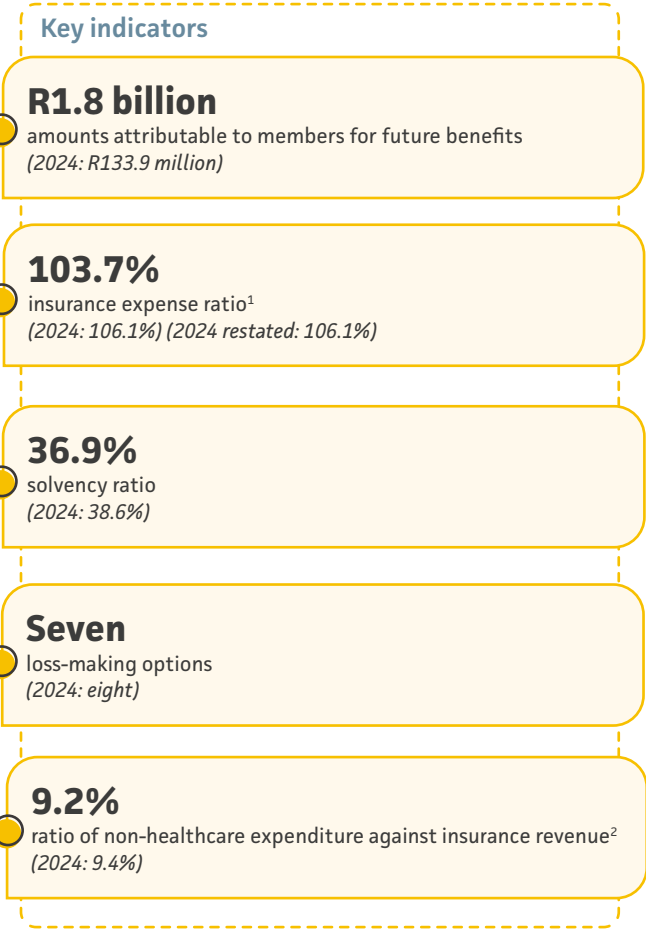
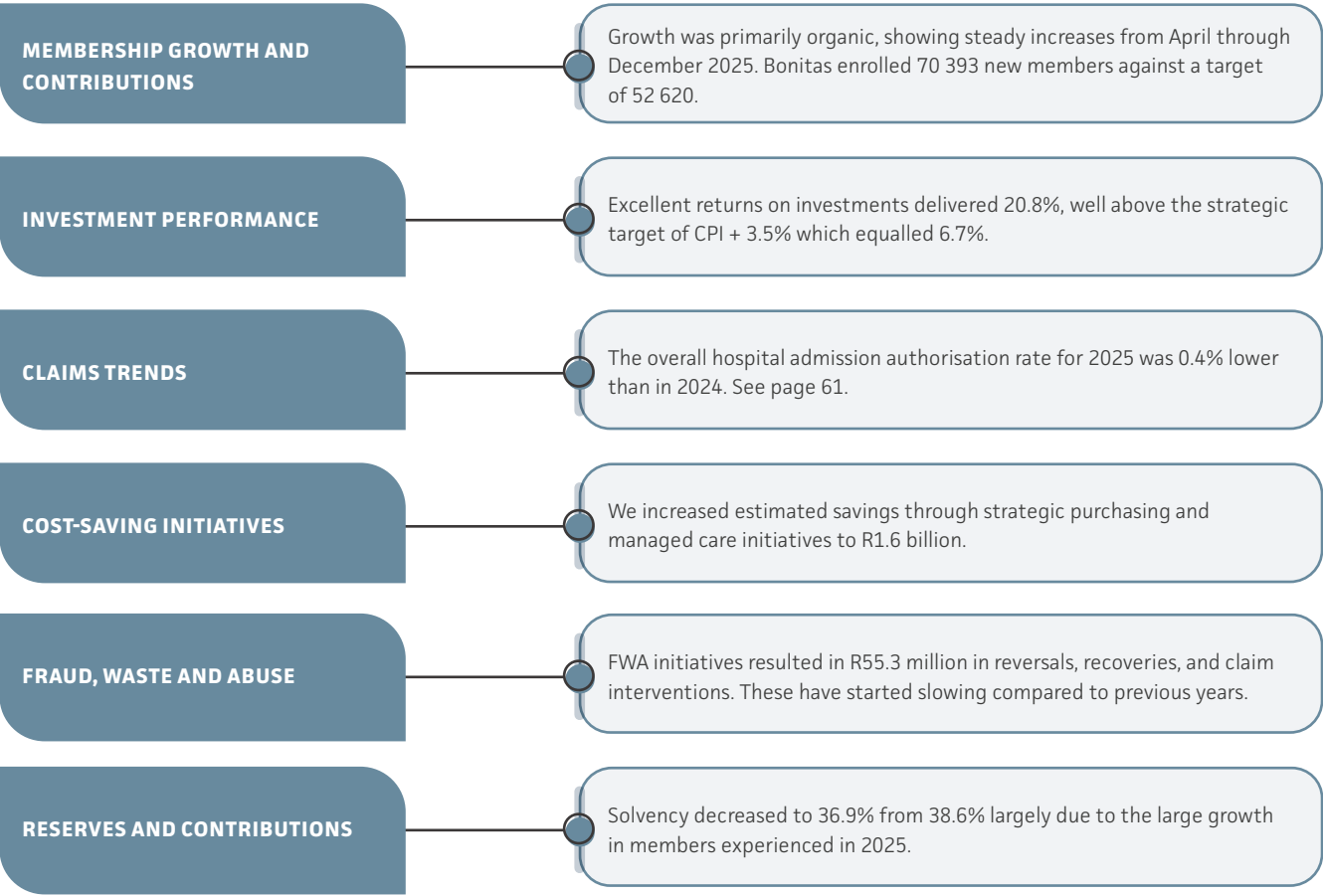
ACTUARIAL METHODOLOGY AND TECHNICAL REFINEMENT

Following the second year of IFRS 17 implementation, Bonitas significantly refined its methodology for calculating the Incurred But Not Reported (IBNR) liability. Under the forward-looking requirements of IFRS 17, the calculation includes a risk adjustment that serves as a buffer against the potential understatement of claims. Since 2023, Bonitas had maintained a highly conservative 90% confidence level for this risk adjustment, which prompted ongoing internal debates and discussions within the Audit and Risk Committee regarding whether this approach was overly conservative.

This internal review was further supported by feedback from the CMS, who noted during a visit in 2025 that Bonitas was likely the only medical aid reporting at such a high confidence level. This period of reflection coincided with a transition in actuarial service providers; while MedScheme handled actuarial services until July 2025, NMG – previously Bonitas's independent reviewing actuaries – took over full end-to-end actuarial services.

NMG recommended shifting to a 75% confidence level for the risk adjustment, noting that while a 90% level was permissible, 75% was the established industry standard. To ensure this change was technically sound, an accounting paper was prepared to assess how Bonitas's IBNR had evolved over previous years. This assessment confirmed that a reduction to 75% confidence level for the risk adjustment was justified based on historical runoff trends and the need for market relevance, ensuring the Scheme remained prudent without being excessively conservative. It reflects new developments in actuarial practice and enhances alignment with the Scheme's risk objectives.

DRIVERS OF FINANCIAL HEALTH



¹ Insurance service expense as a percentage of insurance revenue.
² Attributable, non-attributable and acquisition costs (previously non-healthcare expenditure) as a percentage of insurance revenue.



STATEMENT OF COMPREHENSIVE INCOME: FOR THE YEAR ENDED 31 DECEMBER 2025

	Notes	2025 R'000	2024 R'000
Insurance revenue	15	22 568 292	20 888 306
Insurance service expense**		(23 404 280)	(22 153 413)
Net claims incurred*		(20 997 310)	(19 860 161)
Claims incurred	15.1	(21 281 318)	(20 091 944)
Third party claims recoveries	15.7	67 798	58 387
Changes that relate to past service – adjustments to the LIC	15.2	216 210	173 396
Insurance acquisition cash flows	15.3	(429 145)	(420 406)
Accredited managed healthcare services (no transfer of risk)*	15.4	(702 008)	(664 000)
Directly attributable expenditure	15.5	(1 275 817)	(1 208 846)
Accredited administration service	15.5.1	(1 033 075)	(1 010 512)
Other administration expenditure	15.5.2	(242 742)	(198 334)
Net income from risk transfer arrangement/reinsurance*	15.6	453 826	433 320
An allocation of premiums paid		(2 045 231)	(1 951 687)
Amounts recovered from risk transfer arrangement/reinsurance		2 499 057	2 385 007
Insurance service result**		(382 162)	(831 787)
Other income		2 667 060	1 416 216
Investment income – Scheme	16	2 610 470	1 385 696
Loss on sale of investment property	5	–	(13 500)
Sundry income	17	56 590	44 020
Net insurance finance expenses		(84 732)	(84 852)
Finance expenses from insurance contracts issued – PMSA	11.4	(84 732)	(84 852)
Other expenditure		(404 691)	(365 686)
Administration fees and other operating expenses	18	(364 456)	(324 501)
Asset management fees		(40 003)	(35 669)
Interest expense	4.2	(232)	(322)
Operating expenses on rental of investment property	5	–	(5 194)
Surplus or deficit for the year before amounts attributable to members for future benefits		1 795 475	(133 891)
Amounts attributable to members for future benefits***		(1 795 475)	(133 891)
Total surplus or deficit for the year		–	–
Total comprehensive income for the year		–	–
Relevant healthcare expenditure*		(21 245 492)	(20 090 841)

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

** The prior year comparative for insurance service expense and insurance service result has been represented to exclude amounts attributable to members for future benefits, which is now shown separately after surplus or deficit for the year before amounts attributable to members for future benefit.

*** In accordance with IFRS 17 and recognising the Scheme as a mutual entity, amounts attributable to members for future benefits represents the net surplus earmarked for the future benefit of existing and future members realised in the current financial period. Circular 6 of 2025 issued by the CMS requires medical schemes to present "Amounts attributable to future members" separate from the "Insurance service expenses" and the "Insurance service result". This resulted in a representation of the prior year affected line items as follows: Amounts attributable to future members to the value of R1 795 475 (2024:R133 891) are now being disclosed as a separate line item on the statement of comprehensive income after the surplus for the year.

MEMBERSHIP AND RISK CONTRIBUTION INCOME

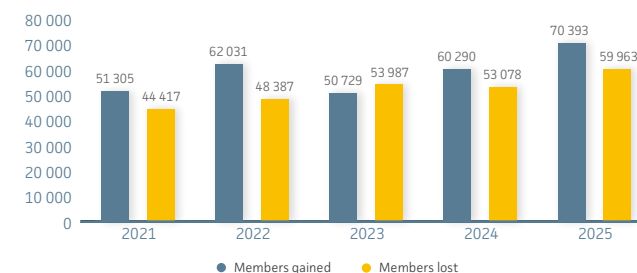
Membership growth was particularly resilient, enrolling 70 393 new members and exceeding the target of 52 620.

This success is attributed to the implementation of the corporate strategy with an effective segmented approach using tailored value-added products and wellness solutions. Additionally, Bonitas remained better placed from a pricing perspective relative to competitors.

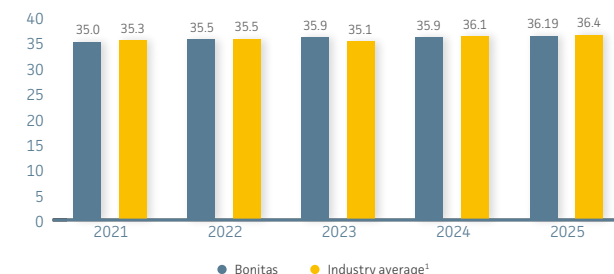
Regarding member movements, the anticipated "buy-downs" expected from the introduction of a network on the Primary option never materialised. Furthermore, the influx of members from the Sizwe Hosmed Medical Scheme curatorship toward the end of the year supplemented organic growth.

Insurance revenue increased by 8.04% to R 22.6 billion (2024: R20.8 billion). Risk contribution income ended the year at 95% (2024: 95%).

MEMBER RETENTION

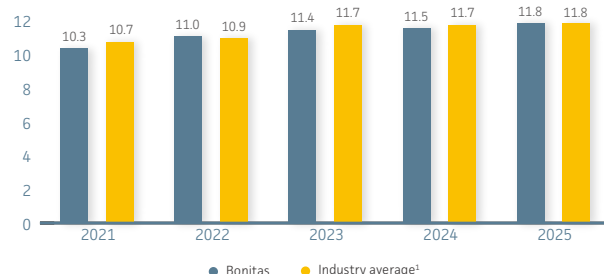


AVERAGE AGE OF BENEFICIARIES



¹ Data based on CMS Industry Reports and refers to open medical schemes only.

PENSIONER RATIO (%)

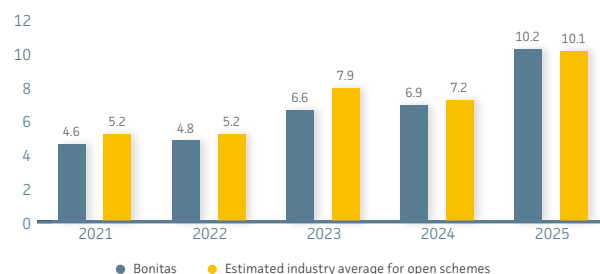


¹ Data based on CMS Industry Reports and refers to open medical schemes only.

HEALTHCARE PLAN PRICING AND AFFORDABILITY

Bonitas follows a structured product development process that considers healthcare trends, member affordability, scheme sustainability and pricing guidelines from the CMS. We continue to use our reserves and solvency to improve benefits while keeping contribution increases as low as possible. For 2026, the weighted average increase in member contributions is 8.8% (2025: 10.2%). Increases range from 6.9% to 11.3% across plans, with the highest increase affecting only 10% of members. The weighted average increase is above the CMS recommendation of 3.3% plus “reasonable” utilisation estimates.

YEAR-ON-YEAR COMPARISON OF WEIGHTED CONTRIBUTION INCREASES (%)



PRODUCT DEVELOPMENT PROCESS

Statistical analysis and research (January – April 2025)

The Board Committees met to review and discuss statistical analyses, industry research and product scenarios.

Proposals (May – June 2025)

The Committees requested and considered input from a variety of stakeholders through independently commissioned research, including brokers, human resources representatives, corporates and local government.

Key focus areas emerging from the research included the need to further integrate managed care into product development, reduce member co-payments and ensure that healthcare plans are easy to understand and benefit alignment.

Board approval (July – August 2025)

The Committees made a final recommendation to the Board on pricing and benefits for evaluation and approval.

Price increases were meticulously calculated by our actuaries, and the Board approved the 2025 pricing and benefits following a rigorous two-day review.

CMS approval (December 2025)

Proposed pricing and benefits were submitted to the CMS for approval.

CLAIMS AND LOSS-MAKING OPTIONS

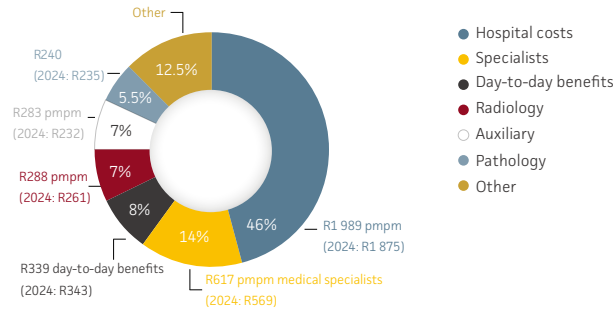
The claims environment for 2025 remained relatively consistent, with notable admission spikes in seizures, spinal disorders, and major digestive diagnoses. Despite these pressures, Bonitas advanced its objective of managing seven loss-making options – Standard, Primary, BonCap, BonComprehensive, BonEssential, BonComplete, and Hospital Standard. Oversight of these options is undertaken by the Managed Healthcare Committee, which draws on finance and actuarial data to identify hospitals or diseases driving losses and to implement targeted healthcare initiatives.

A major achievement was the turnaround of the Primary option, previously one of the largest loss-making plans in 2024. This improvement was driven by a structural transition to a provider network, which secured better rates for planned procedures while maintaining access to any hospital for emergencies. To support these changes, Bonitas prioritised member education to clarify that network-based care is a cost-management tool rather than a reduction in benefits. In contrast, BonCap remains structurally loss-making due to its income-based design, which links contributions to earnings rather than risk. Targeted primarily at the mining industry, this structure makes it difficult to achieve a surplus if the option attracts a high number of sickly members. Bonitas continues to manage this risk through a transfer agreement and will launch BonCore in 2026 – an affordable, non-income-based option designed to attract younger, healthier members and provide a sustainable alternative to BonCap.

At a Scheme level, hospital admission authorisation rates decreased by 0.4% compared to 2024. The five principal diagnosis and procedure groups influencing authorisation rates were cataract procedures (8.7% decrease), major depression (3.9% increase), caesarean deliveries (0.3% increase), major digestive diagnoses with colonoscopy (6.3% increase), and oesophagitis/gastroenteritis (1.2% decrease). Per member per month (pmpm) claims incurred increased by 6% to R4 327 (2024: R4 082), tracking 0.2% below targeted claims of R4 337. The claims ratio decreased by 1.6% to 94.3% (2024: 95.9%), also below target (94.4%).

The largest claims categories for the year include:

LARGEST CLAIMS CATEGORIES



At an insurance service result level, three of the seven loss-making options underperformed relative to our targets. Nevertheless, the Scheme overall performed 0.5% better than expected, recording an insurance service deficit of 1.7% compared to the targeted deficit of 2.2%.

INSURANCE EXPENDITURE

Insurance service expenses increased by 4.9% (based on 2024 restated: 5.4%) to R23.4 billion (2024: R22.3 billion) (2024 restated: R22.2 billion) and the insurance expense ratio ended the year on 103.7% (2024: 106.1%).

The insurance service result excluding amounts attributable to members for future benefits decreased to R382 million deficit (2024: R965 million deficit) largely due to an increase in contributions received due to increased membership during the year.

This year, cost savings were driven primarily through hospital negotiations. Overall, hospital costs pmpm decreased by 2.8% to R1 634 pmpm (2024: R1 681 pmpm).

Accredited administration fees increased by 2.23% to R1.0 billion (2024: R1.0 billion).

Our risk transfer agreements continue to yield benefits, with a net income of R454 million (2024: R433 million) across all arrangements.

The ratio of non-healthcare expenditure against insurance revenue is 9.2% (2024: 9.4%).

Strategic purchasing and managed care initiatives realised an estimated reduction in healthcare costs of R1.066 billion (2024: R901.1 million) which included R566 million (2024: R532 million) in hospital costs.

Cost savings in 2025 as a result of managed care programmes

Hospital negotiations	R566 million
Alternatives to hospitalisation	R26.7 million
Renal dialysis and networks	R79.2 million
High Risk Beneficiary Programme	R48.4 million
Pathology Management Programme	R38.2 million
Specialist Outlier Engagement Programme	R20 million
Emerging Risk Beneficiary Programme	R10.2 million
Arthroplasty Programme	R20 million
Chronic medicine – Risk Management	R36 million
Integrated chronic care network	R13.1 million
Specialist network	R49.8 million
Oncology medicine and consumables	R16 million
Computed tomography (CT) angiogram	R8.3 million
Radiology discounts	R3.5 million
In-room procedures	R44 million
Oncology management programme – Active	R47 million
Oncology treatment	R11.3 million
Oncology PET/CT network	R28.3 million
Anaesthetic network	
Total	R1.066 billion

FRAUD, WASTE AND ABUSE

For 2025, the FWA programme resulted in R55.3 million in reversals and recoveries. Recoveries have started slowing compared to previous years, a trend attributed to the success of long-term mitigation efforts effectively changing provider behaviour since 2016.

CONTRACT MANAGEMENT

We continue to refine our day-to-day contract management. Over the last five years, our SLAs have been updated to include outcome-based objectives, with a focus on critical operational functions. We hold regular monthly meetings to review performance and ensure service providers remain aligned with our requirements.

Our governance framework includes a standardised application of financial penalties where necessary. For instance, providers are expected to meet specific compliance targets, such as the timely delivery of financial reporting. If these benchmarks are not met for two consecutive months without a valid explanation, we apply penalties as a measure of accountability. For more complex issues, such as the IT challenges that originated in 2024, matters are escalated to the Audit and Risk Committee and the Board to ensure appropriate resolution.

STATEMENT OF FINANCIAL POSITION: AS AT 31 DECEMBER 2025

	Notes	2025 R'000	2024 R'000
ASSETS			
Non-current assets			
Property and equipment	4	7 168	3 419
Financial assets held at fair value through profit or loss	6	6 262 992	5 932 586
Total non-current assets		6 270 160	5 936 005
Current assets			
Financial assets held at fair value through profit or loss	6	6 279 456	4 755 629
Reinsurance contract assets	13	112 538	95 384
Trade and other receivables	7	11 481	12 336
Cash and cash equivalents	8	966 466	848 715
Total current assets		7 369 941	5 712 064
Total assets		13 640 101	11 648 069
LIABILITIES			
Non-current liabilities			
Lease liability	4.2	2 555	–
Long-term employee benefit obligation	9	6 443	2 927
Liability to members for future benefits*	10	10 824 568	9 029 093
Total non-current liabilities		10 833 566	9 032 020
Current liabilities			
Insurance contract liabilities	11	2 764 246	2 583 210
Lease liability	4.2	2 957	2 405
Trade and other payables	14	39 332	30 434
Total current liabilities		2 806 535	2 616 049
Total liabilities		13 640 101	11 648 069

* The term "Insurance liability for future members" has been renamed to "Liability to members for future benefits". This represents the accumulated surplus held for the benefit of future members.

CAPITAL MANAGEMENT

The Board remains committed to maintaining a robust capital base to sustain future growth and maintain market confidence, consistently adhering to Regulation 29 of the MSA, which mandates a minimum level of accumulated funds of 25.0%. Despite experiencing unprecedented organic membership growth to 369 147 members, a factor that typically exerts downward pressure on reserves, Bonitas's solvency remains remarkably healthy due to exceptional investment performance.

	2025 R'000	2024 R'000
Liability to members for future benefits	10 824 568	9 029 093
Adjusted for:		
Regulation 29 exclusion of unrealised gains on remeasurement of investments and investment property to fair value*	(2 003 115)	(543 800)
Accumulated funds per Regulation 29	8 821 453	8 485 293
Gross contributions (note 15)	23 865 924	22 003 483
Solvency ratio (%)	36.96%	38.56%
* Cumulative net (losses)/gains on remeasurement to fair value of investments are calculated as follows:		
At beginning of year	543 800	403 544
Movement in unrealised losses on remeasurement to fair value of financial instruments included in accumulated funds (as per Regulation 29 of the Act)	1 459 315	140 256
At end of year	2 003 115	543 800
At beginning of year	–	17 774
Movement in unrealised losses on remeasurement to fair value of financial instruments included in accumulated funds (as per Regulation 29 of the Act)	–	(17 774)
At end of year	–	–
Cumulative net gains on remeasurement of investments and investment property at the end of the year	2 003 115	543 800

LIABILITY FOR INCURRED CLAIMS

The best estimate liability for claims incurred but not yet reported (IBNR) for 2025 was R2.9 billion (2024: R2.7 billion). Provisions have mainly been in the hospital and specialist categories.

Risk adjustment amounted to R92 million (2024: R151 million). This represents 12.7% (2024: 12.2%) of the claims expenditure. The change can be ascribed to the new actuarial methodology explained upfront.

The total of the best estimate provision for incurred claims including risk adjustment is R3.1 billion (2024: R2.9 billion). This is included in liability for incurred claims as part of insurance contract liabilities as per note 11 of the annual financial statements totalling R3.1 billion (2024: R2.9 billion).

The additional components of the liability for incurred claims comprise of the Personal Medical Savings Account (PMSA) liability of R1.6 billion (2024: R1.4 billion) and claims creditor of R255 million (2024: R254 million).

ACTUARIAL VALUATION

In 2025, Bonitas transitioned to NMG for full end-to-end actuarial services, replacing the previous arrangement with Medscheme. NMG now manages the entire process, including monthly risk reporting and the annual evaluation. The actuary plays a critical role in the Managed Healthcare Committee, providing feedback on claims trends and initiatives to turn around loss-making options.

STATEMENT OF CASH FLOWS: FOR THE YEAR ENDED 31 DECEMBER 2025

	Notes	2025 R'000	2024 R'000
Cash flows from operating activities			
Cash receipts from members and providers		23 961 169	22 112 157
Cash receipts from members – contributions		23 851 412	21 967 054
Cash receipts from members and provider – other		109 757	145 103
Cash paid to providers, employees and members		(24 471 425)	(22 800 082)
Cash paid to providers and members	20.1.5	(22 763 113)	(21 151 953)
Cash paid to providers and employees – non healthcare expenditure	20.1.6	(1 624 978)	(1 571 345)
Cash paid to members – savings plan refunds	11.4	(83 334)	(76 784)
Cash utilised in operating activities		(510 256)	(687 925)
Interest paid	11.4	(84 732)	(84 852)
Interest received	16	10 860	19 942
Net cash outflow from operating activities		(584 128)	(752 835)
Cash flows from investing activities			
Acquisition of property and equipment	4	(730)	(696)
Proceeds on disposal of investment property	5	–	61 500
Acquisition of financial assets held at fair value through profit or loss	6	(2 282 731)	(2 414 357)
Disposal of financial assets held at fair value through profit or loss	6	2 515 743	2 733 252
Interest received	20.1.1	293 938	290 231
Dividends received	20.1.2	218 327	192 703
Asset management fees	20.1.3	(39 903)	(35 359)
Rentals received	20.1.4	–	9 324
Net cash inflow from investing activities		704 643	836 598
Cash flows from financing activities			
Lease payments	4.2	(2 765)	(2 649)
Net cash outflow from financing activities		(2 765)	(2 649)
Net increase in cash and cash equivalents		117 751	81 114
Cash and cash equivalents at beginning of the year	8	848 715	767 601
Cash and cash equivalents at end of the year		966 466	848 715

FUTURE PERFORMANCE EXPECTATIONS

Looking ahead to 2026, we expect continued pressure from South Africa's ageing population and the rising burden of non-communicable diseases. Mental health remains an important area of focus as we track its impact on our membership. We also anticipate steady demand for elective healthcare as post-pandemic utilisation patterns continue to settle.

Our investment strategy delivered strong results in 2025, supporting a healthy solvency ratio of 36%.

A key focus for 2026 will be the performance of our pricing strategy. While we believe we are competitively positioned, the real test will unfold over the coming year as we track member retention and claims experience against our assumptions.

The finalisation of our administration and managed care service provider contracts will be a defining milestone for 2026. This process, supported by strong governance and independent assurance at each stage, positions us to enhance operational performance and member value through partnerships aligned with our strategic capabilities model.

As we build on the solid organic growth achieved in 2025, our focus shifts to retention and continued sustainable expansion in the corporate sector. Our preventative care initiatives, managed healthcare programmes and value-based partnerships with healthcare providers will remain central to managing costs while delivering quality care.

We expect our managed care initiatives to continue improving performance across our benefit options, and we will maintain our collective bargaining efforts to secure competitive hospital tariffs that limit out-of-pocket costs for members. Through disciplined financial stewardship, strategic innovation and a firm commitment to member value, we are well positioned to navigate the challenges ahead and deliver sustainable performance for our stakeholders.

Ms V Rikhotso
Chief Financial Officer

Date: 25 June 2026





OPERATIONAL STATISTICS

Bonitas Medical Fund 2025 ("BMF")	Consolidated total	Standard	BonSave	Primary	BonCap	Bon-Classic	BonComp	Bon-Essential	BonFit	Hospital Std	Bon-Complete	BonStart	BonStart Plus
Average number of members during the year (n)	359 796	89 798	43 978	94 525	51 383	6 446	3 280	13 566	26 730	3 311	6 422	12 471	7 887
Number of members at 31 December (n)	369 147	89 707	47 194	94 216	50 838	6 341	3 260	14 002	30 151	3 215	6 344	14 728	9 151
Average number of beneficiaries during the year (n)	734 230	187 447	102 707	216 918	74 852	10 780	5 311	30 480	59 550	5 872	12 053	13 991	14 270
Number of beneficiaries at 31 December (n)	752 875	187 136	110 674	215 984	74 096	10 603	5 266	31 459	66 752	5 687	11 925	16 610	16 683
Proportion of dependants at the end of the year (n)	1.04	1.09	1.35	1.29	0.46	0.67	0.62	1.25	1.21	0.77	0.88	0.13	0.82
Insurance revenue per average member per month (Rands)	5 227	8 258	4 487	5 053	2 171	8 983	12 931	4 002	3 329	5 234	7 572	1 703	2 761
Insurance revenue per average beneficiary per month (Rands)	2 561	3 956	1 921	2 202	1 490	5 371	7 987	1 781	1 494	2 951	4 034	1 518	1 526
Insurance service expense excluding amounts distributable to members per average beneficiary per month (Rands)	2 656	4 145	1 863	2 234	1 850	5 465	8 840	1 926	1 454	3 272	4 136	1 380	1 361
Relevant healthcare expenditure (Net claims incurred, Accredited managed healthcare services and Net income/(expense) from risk transfer arrangement/reinsurance) per average beneficiary per month (Rands)	2 411	3 820	1 646	2 012	1 630	5 068	8 552	1 734	1 264	2 982	3 873	1 212	1 238
Attributable insurance service expenses per average beneficiary per month (Rands)	145	160	141	141	114	200	207	141	145	189	179	142	88
Relevant healthcare expenditure ratio (Net claims incurred, Accredited managed healthcare services and Net income/(expense) from risk transfer arrangement/reinsurance) per average beneficiary per month as a percentage of insurance revenue (%)	94.1%	96.5%	85.7%	91.4%	109.4%	94.4%	107.1%	97.4%	84.6%	101.1%	96.0%	79.9%	81.1%
Attributable insurance service expenses (DAE) ratio as a percentage of insurance revenue (%)	5.7%	4.0%	7.3%	6.4%	7.6%	3.7%	2.6%	7.9%	9.7%	6.4%	4.4%	9.3%	5.7%
Insurance service expense ratio (excluding amounts distributable to members) as a percentage of insurance revenue (%)	103.7%	104.8%	97.0%	101.4%	124.2%	101.7%	110.7%	108.1%	97.3%	110.9%	102.5%	90.9%	89.2%
Non-attributable expenditure as a percentage of gross contributions (%)	1.5%	1.0%	1.4%	1.7%	3.9%	0.8%	0.5%	2.1%	2.2%	1.6%	0.9%	5.0%	3.1%
Attributable, non-attributable and acquisition costs (previously non-healthcare expenditure) as a percentage of risk contributions (%)	9.2%	6.3%	11.8%	10.3%	14.3%	5.5%	4.0%	12.5%	15.3%	9.9%	7.0%	17.5%	11.8%
Average beneficiary age (n)	36.2	41.7	32.6	32.6	36.9	57.2	58.7	38.3	29.7	52.4	48.7	37.1	27.8
Pensioner ratio at 31 December (%)	11.8%	31.8%	10.9%	11.0%	16.4%	61.2%	61.2%	20.8%	5.7%	45.8%	40.2%	5.4%	2.7%
Chronic profile at 31 December (%)	19.9%	31.9%	14.9%	14.9%	20.3%	54.8%	56.3%	12.9%	8.4%	23.4%	37.3%	6.9%	6.2%
Average amounts attributable to members (liability to members) per member at year-end (Rand)	2 444												

Bonitas Medical Fund 2024 ("BMF")	Consolidated total	Standard	BonSave	Primary	BonCap	Bon- Classic	BonComp	Bon- Essential	BonFit	Hospital Std	Bon- Complete	BonStart	BonStart Plus
Average number of members during the year (n)	356 713	95 359	41 155	97 818	53 857	7 070	3 686	13 445	18 616	3 688	7 217	9 309	5 493
Number of members at 31 December (n)	358 717	93 476	41 225	97 515	54 162	6 880	3 592	13 636	20 746	3 584	6 963	10 616	6 322
Average number of beneficiaries during the year (n)	727 946	200 202	95 330	224 519	78 367	11 939	6 030	30 024	41 452	6 597	13 598	10 310	9 577
Number of beneficiaries at 31 December (n)	731 576	196 376	95 584	224 141	78 893	11 573	5 851	30 427	46 220	6 391	13 115	11 850	11 155
Proportion of dependants at the end of the year (n)	1.04	1.10	1.32	1.30	0.46	0.68	0.63	1.23	1.23	0.78	13 115	0.12	0.76
Insurance revenue per average member per month (Rands)	4 880	7 508	4 110	4 556	2 075	8 195	11 323	3 615	3 006	4 806	6 726	1 527	2 587
Insurance revenue per average beneficiary per month (Rands)	2 391	3 576	1 774	1 985	1 426	4 853	6 921	1 619	1 350	2 687	3 570	1 379	1 484
Insurance service expense excluding amounts distributable to members per average beneficiary per month (Rands)	2 539	3 754	1 688	2 166	1 750	4 770	8 686	1 724	1 362	2 738	3 790	1 152	1 337
Relevant healthcare expenditure (Net claims incurred, Accredited managed healthcare services and Net income/(expense) from risk transfer arrangement/re-insurance) per average beneficiary per month (Rands)	2 300	3 450	1 480	1 965	1 519	4 256	8 402	1 535	1 185	2 480	3 489	995	1 219
Attributable insurance service expenses per average beneficiary per month (Rands)	138	152	136	134	105	189	195	135	138	179	170	137	86
Relevant healthcare expenditure ratio (Net claims incurred, Accredited managed healthcare services and Net income/(expense) from risk transfer arrangement/re-insurance) per average beneficiary per month as a percentage of insurance revenue (%)	96.2%	96.5%	83.4%	99.0%	106.5%	87.7%	121.4%	94.8%	87.8%	92.3%	97.7%	72.2%	87.0%
Attributable insurance service expenses (DAE) ratio as a percentage of insurance revenue (%)	5.8%	4.2%	7.7%	6.8%	7.4%	3.9%	2.8%	8.4%	10.2%	6.7%	4.8%	9.9%	4.8%
Insurance service expense ratio (excluding amounts distributable to members) as a percentage of insurance revenue (%)	106.1%	105.0%	95.1%	109.1%	122.7%	95.3%	125.5%	106.5%	100.8%	101.9%	106.2%	83.5%	95.5%
Non-attributable expenditure as a percentage of gross contributions (%)	1.5%	1.0%	1.4%	1.7%	3.7%	0.8%	0.5%	2.1%	2.2%	1.6%	1.0%	5.0%	3.1%
Attributable, non-attributable and acquisition costs (previously non-healthcare expenditure) as a percentage of risk contributions (%)	9.4%	6.6%	12.3%	10.8%	14.2%	5.7%	4.4%	13.2%	16.0%	10.7%	7.7%	18.2%	12.3%
Average beneficiary age (n)	35.9	42.1	32.5	31.9	36.1	56.0	57.7	37.4	29.1	51.2	47.6	35.2	27.3
Pensioner ratio at 31 December (%)	11.5%	18.3%	7.2%	6.1%	9.4%	44.5%	26.8%	12.9%	3.9%	32.9%	26.8%	4.0%	1.6%
Chronic profile at 31 December (%)	18.8%	31.0%	15.3%	14.8%	24.8%	52.5%	56.5%	12.1%	8.5%	22.1%	35.1%	5.0%	5.1%
Average amounts attributable to members (liability to members) per member at year-end (Rand)	2 098												

GOVERNANCE REPORT

BOARD OF TRUSTEES: PROFILES

TRUSTEES AS AT 31 DECEMBER 2025



Mr OJ Komane (60) | Chairperson (Elected Trustee)

Mr OJ Komane is the Independent Chairman of the Mineworkers Investment Trust, the 100% shareholder of the Mineworkers Investment Company. He holds a Master of Science Degree in Engineering Business Management from the University of Warwick (UK). Mr Komane is currently the Managing Director of Accelerated Mining and Engineering Services and served two terms in the office as the Deputy General Secretary of the National Union of Mineworkers. He previously also held several positions on different boards of companies.

Appointed: 1 June 2021

First appointed as Trustee with effect 2 January 2016; appointed as Vice-Chairperson with effect 1 October 2017; appointed as Chairperson with effect 13 March 2019 to 3 December 2020; Trustee term ended with effect 4 January 2021; re-elected as Trustee with effect 1 June 2021 and appointed as Chairperson with effect 28 September 2021; re-appointed as Chairperson with effect 12 August 2022; re-appointed as Chairperson with effect 21 September 2023; re-appointed as Chairperson with effect 18 September 2024, re-appointed Chairperson with effect 25 October 2025.



Adv RT Monene (33) | Vice-Chairperson (Elected Trustee)

Adv RT Monene completed her diploma in Law, LLB, and an additional module in Public International Law at the University of South Africa (UNISA). She joined the Johannesburg Bar in December 2018 after her studies at UNISA and serving on student representative bodies. In 2017, she chaired the Student Representative Council at UNISA. Adv Monene is a general litigator with experience and interest in administrative and public law, medical negligence, constitutional law, human rights law, family law, labour law and regulatory law.

Appointed: 9 September 2022

Appointed as Vice-Chairperson with effect from 25 October 2025.



Mr R Cowlin (71) | (Appointed Trustee)

Mr R Cowlin has over 36 years' experience in the medical aid industry and was involved in several aspects of the industry, including administration, marketing, product design and managed care. He held various top management positions within Medscheme and was the Managing Director of Aid for Aids for 10 years.

Appointed: 5 January 2021

Term ended 4 January 2026

Appointed as Vice-Chairperson with effect 13 March 2019 to 3 December 2020; Trustee term ended with effect 4 January 2021; appointed by the Board with effect 5 January 2021; appointed as Vice-Chairperson with effect 12 August 2022; re-appointed as Vice-Chairperson with effect 21 September 2023; re-appointed as Vice-Chairperson with effect 18 September 2024 until 25 October 2025.



Mr J Bagg (73) | (Appointed Trustee)

Mr J Bagg is a qualified actuary with over 40 years of actuarial, financial management and consulting experience. He served as Statutory Actuary for numerous life insurance companies and is a Trustee of various retirement funds. He also holds directorships at life insurance and reinsurance companies.

Appointed: 5 October 2022

Previous Trustee of Liberty Medical Scheme (LMS) and appointed to the Bonitas Board pursuant to the amalgamation with LMS; re-appointed by the Board as a Trustee with effect 1 April 2019 as part of a casual vacancy (appointment was approved by the members at the AGM held on 19 August 2019); appointed as Vice-Chairperson with effect 4 December 2020; stepped down as Vice-Chairperson on 12 August 2022; Trustee term ended on 31 August 2022; appointed by the Board with effect 5 October 2022.



Mr A Edwards (65) | (Elected Trustee)

Mr A Edwards has over 25 years' experience in financial services and private healthcare funding, with expertise spanning corporate wellness strategy, managed healthcare, clinical risk management, and commercial leadership. He holds a BSc (Zoology/Human Physiology) and a Postgraduate Higher Diploma in Education.

He previously served for a decade as Chief Executive of Liberty Medical Scheme, overseeing healthcare provision for more than 100 000 members annually and gaining extensive experience in healthcare economics, governance, and strategic scheme management. His broader executive involvement in large medical schemes and healthcare mergers reflects strong strategic and operational capability.

Mr Edwards currently leads a coaching and consulting practice focused on executive resilience, leadership performance, and corporate wellbeing, particularly addressing clinical burnout.

Appointed: 1 April 2024

Appointed by the Board as a Trustee with effect from 1 April 2024 as part of a casual vacancy (appointment was approved by the members at the AGM held on 21 August 2024, therefore regarded as an elected Trustee in terms of the Scheme Rules).



Mr PJ Ribbens (54) | (Elected Trustee)

Mr PJ Ribbens started his business in 1997 and has run it for the past 26 years. He has vast experience in marketing and sales and is a director of Ribbens Office National. His responsibilities include overseeing assigned accounts and monitoring and evaluating project activities. He provides guidance to the marketing department by evaluating and developing marketing strategies and planning and coordinating marketing efforts. He positions the company's brand and develops pricing strategies with the sales department. He has completed several Trustee training courses and is well-equipped to support the Board in terms of complex decision-making. He has served for several years on the Managed Healthcare and Investment Committees, and his experience in these areas assists him greatly in serving the Bonitas community.

Appointed: 1 July 2019

Re-elected with effect 17 July 2024.



Mr MG Netshisaulu (49) | (Elected Trustee)

Mr MG Netshisaulu holds an LLB and MCom in Taxation. He is currently studying a PHD in Accounting Science. He is a chartered tax advisor and a member of the Compliance Institute of South Africa. He gained extensive experience in the tax industry with the South African Revenue Service, as well as corporate and non-profit organisations. He completed a CMS Trustee development and inhouse BHF programme. He is currently employed as a Financial Strategic Analyst at UNISA and serves as UNISA member of the Professional Research Committee. He also previously served as Nehawu Branch Chairperson and Deputy Chairperson.

Appointed: 1 September 2017

Re-elected with effect 9 September 2022.



Mr JR Venter (44) | (Elected Trustee)

Mr JR Venter holds a BCom from the University of Pretoria. He has extensive experience in business development, corporate governance, strategic member relationship, retention management and financial management. He is employed by the largest technology service provider in Africa and has more than 16 years of ICT experience. Mr Venter is member-focused and drives SLA adherence from service providers through due diligence on contracts and value creation for members.

Appointed: 1 July 2019

Re-elected with effect 17 July 2024.

EXECUTIVE MANAGEMENT: PROFILES



Mr LR Callakoppen (49) | Principal Officer

Mr LR Callakoppen holds a Master HR Professional (SA Board for People Practices), MPhil (Human Resource) and Industrial Sociology and Information Science Honours Degree from the University of Johannesburg. He also holds a Global Executive Development Qualification (GEDP) from GIBS and completed the Professional Trustee Development Programme at Wits Business School. He also recently completed an Executive and Management Coaching Programme through the University of Cape Town.

He has a wealth of experience at an executive level with specialisation in human capital, transformation and operational management across multiple sectors. He has been involved with Medscheme and the AfroCentric Group in various functions for over 13 years, including heading up the Bonitas business unit.

He served on the BHF Board and was Chairperson of the BHF Finance and Audit Committee.

Appointed: 1 May 2019



Ms V Rikhotso (40) | Chief Financial Officer

Ms V Rikhotso is a chartered accountant registered with the South African Institute of Chartered Accountants. She has 18 years of experience in the public and private sectors with extensive leadership roles in risk, compliance and financial management. She played a vital role in establishing the financial services division within the Auditor-General of South Africa, serving as an audit manager for key entities including the Public Investment Corporation, Development Bank of Southern Africa and South African Revenue Service.

Prior to joining Bonitas, Ms Rikhotso held the position of Senior Specialist: Governance, Risk and Control at Transnet SOC Ltd. She was responsible for establishing and maintaining sustainably effective internal controls across the Transnet Corporate Centre operating division, identifying areas that require financial and operational improvements, and driving the development of appropriate models/solutions to sustainably address risks and compliance with applicable legislation.

She previously served on the Bonitas Board, where she was instrumental in providing strategic oversight and promoting financial stewardship.

Appointed: 1 February 2025



Mr S Perumal (51) | Chief Operations Officer**

Mr Perumal holds an MBA (specialisation in Healthcare Management) and brings over 32 years of progressive experience in the healthcare funding and administration industry. He currently serves as Chief Operations Officer at Bonitas Medical Fund, where he provides strategic oversight of operations, governance, digital transformation, risk management, and outsourced service provider performance. His career includes senior executive leadership roles at Medscheme and within the AfroCentric Group, where he led multi-country operations across several African markets, drove business expansion initiatives, and oversaw large-scale system and operational transformations.

Mr Perumal is recognised for his strong governance acumen, deep understanding of the Medical Schemes Act and regulatory frameworks, and expertise in technology enablement, SLA optimisation, and enterprise risk management. His passion for operational excellence is underpinned by Six Sigma principles and a disciplined, analytical approach to complex problem-solving. He has successfully led strategic projects including digital roadmaps, data warehouse implementation, mobile and customer engagement platforms, benefit design, and major business integrations.

A results-driven executive, Mr Perumal combines strategic thinking with hands-on execution, consistently delivering service excellence, innovation, and sustainable operational performance within highly regulated healthcare environments.

Appointed: 1 January 2018

**** Promoted from Head of Operations to Chief Operations Officer (COO) with effect 1 January 2025.**



Dr T Hadebe (42) | Clinical and Managed Care Executive

Dr T Hadebe is a qualified medical practitioner from Stellenbosch University. He also holds postgraduate qualifications, including in business studies and occupational health, and has a keen interest in global health matters. He has over 13 years of work experience in both the private and public healthcare sectors and has held numerous clinical managerial roles. Dr Hadebe's client-centred and value-based approach to healthcare ensures that he succeeds in his roles whilst delivering optimal healthcare to clients. He currently serves on the BHF Board.

Appointed: 6 November 2023

SENIOR MANAGEMENT: PROFILES



Ms M Marais (46) | Head: Governance, Risk and Compliance

Ms M Marais holds a BCom (Financial Accounting) and BCom Honours (Internal Audit) from the University of Pretoria, and she is a qualified Certified Internal Auditor. Before joining Bonitas, she was a Senior Manager in the Financial Services–Risk Assurance division at PwC. Ms Marais has over 22 years of experience in internal audit, governance, compliance and risk management within the financial services sector, and more specifically, the medical scheme and healthcare industry. She is a member of the Institute of Internal Auditors and, through them, has obtained certification in Risk Management Assurance.

Appointed: 15 October 2018



Ms M Monyatsi (45) | Scheme Secretary

Ms M Monyatsi holds a Professional Advanced Qualification in Governance and Administration, a Postgraduate Diploma in Management Practice from a reputable international business school, and Postgraduate Certificates in Company Law, Advanced Company Law, and Governance, Risk and Compliance from Wits University. Ms Monyatsi has over 21 years of company secretarial experience working directly with Boards in the trade union environment, with nongovernmental healthcare organisations and in the medical schemes industry, and she specialises in Board administration, corporate governance, company law, compliance and King IV™.

Appointed: 14 February 2017



GOVERNANCE STRUCTURE AND PRACTICES

Bonitas is governed by an independent Board of Trustees that oversees the effective implementation of governance principles and practices, financial and operational performance and ensures compliance with applicable laws and regulations.

Corporate governance principles

Although voluntary for medical schemes, Bonitas subscribes to King IV™ for additional governance guidance and leading practice on good governance. King IV™ states that the Board is expected to provide the necessary leadership to realise the following governance outcomes for Bonitas:

- Ethical culture
- Good performance
- Effective control
- Legitimacy

From 1 January 2026, Bonitas will commence the process of adopting the King V Framework which was published on 31 October 2025.

See page 75 for more information on our governance outcomes.

Scheme Rules

Bonitas is governed according to Scheme Rules that are developed and maintained in accordance with the MSA and approved by and registered with the CMS. Among others, these Rules require the Board to:

- Apply sound business principles and ensure Bonitas's financial sustainability
- Ensure that proper control systems are employed by and on behalf of Bonitas
- Ensure that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and duties



OUR GOVERNANCE UNIVERSE

Common law

Bonitas is governed according to relevant South African common law principles, such as fit and proper, public funds, position of trust, etc.

Medical Schemes Act

All medical schemes in South Africa are governed by the MSA and related regulations (the comprehensive Medical Schemes Amendment Bill is still delayed and awaiting alignment with the phased implementation of the NHI Act). The MSA requires the Board to:

- Take all reasonable steps to ensure that the interests of beneficiaries in terms of the rules of the medical scheme and the provisions of the MSA are protected at all times
- Act with due care, diligence, skill and good faith
- Take all reasonable steps to avoid conflicts of interest, and act with impartiality in respect of all beneficiaries
- Develop and adhere to Scheme Rules that are approved by and registered with the CMS



OUR GOVERNANCE BODIES AND ROLES

Board of Trustees

The Board is responsible for the proper and sound management of Bonitas, in the best interest of members, while safeguarding our long-term sustainability. It does this by providing direction, monitoring strategy implementation, guiding decision-making and adhering to the governing legislation and regulation of a medical scheme, including corporate governance principles.

Board Committees

The Board is supported by five Board Committees to effectively fulfil its duties and responsibilities. Each Committee has a work plan and charter. Members consist of Trustees and Independent Members.

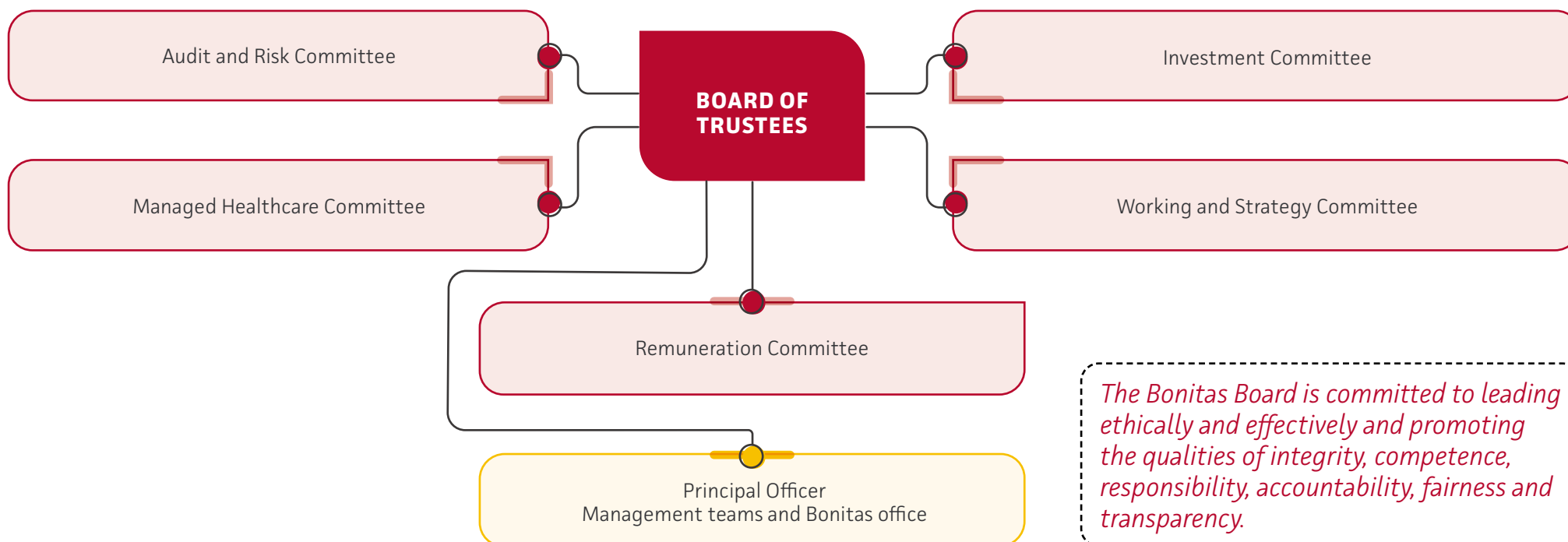
Principal Officer

The Principal Officer is appointed by the Board and must be fit and proper. The Principal Officer is responsible for Bonitas's day-to-day management and is accountable for implementing strategy and any other decisions made by the Board.

Management teams and Bonitas office

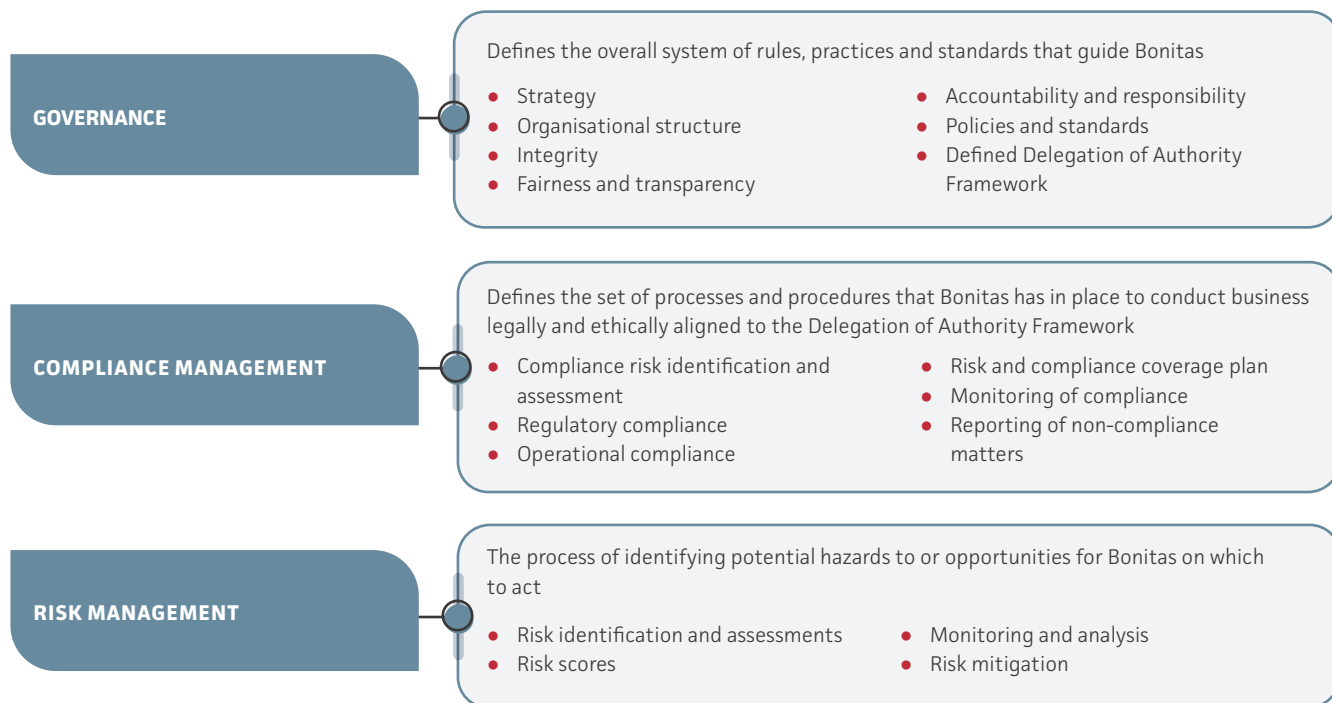
The Principal Officer is supported by:

- Other members of the Executive Management team, namely the CFO, COO and the Clinical and Managed Care Executive
- Senior management team
- Other employees working at the Bonitas office



GOVERNANCE FUNCTIONS AND DEFINITIONS

Bonitas's governance structures and processes are described in the Bonitas GRC Framework, which has been developed in line with the requirements of the MSA, Scheme Rules and King IV™. From 1 January 2026, Bonitas will commence with adopting the King V™ Code which was published on 31 October 2025.



The Board is satisfied that the Delegation of Authority Framework contributes to operational effectiveness and ensures clear definition of the respective roles and decision-making authority of the Board and management.



GOVERNANCE OUTCOMES

The Bonitas GRC Framework aims to achieve four outcomes as defined by King IV™ as we start considering the shift to the King V™ outcomes of an ethical culture, performance and value creation, conformance and prudent control as well as legitimacy. Initiatives related to our current outcomes include the following:

Outcome	Bonitas practices and principles	Board focus areas
Ethical culture	- Bonitas and the Board promote an ethical environment in which employees, Trustees and Independent Members are encouraged to report violations, cooperate with investigations and seek advice when facing a difficult situation. See page 43 for information on FWA reporting and our Whistle Blowers hotline. - Ethics and professional conduct are governed by the following codes, each of which must be acknowledged annually by the target audience: » Code of Ethics and Professional Conduct – Trustees and Independent Members » Code of Ethics and Professional Conduct – Executives and Employees - Bonitas's Gifts Policy defines business courtesy, entertainment, promotional items and invitations that can be considered gifts, and describes the declaration process. - The Board follows established practices to promote ethics and effectiveness in its deliberations. These include declaring any conflicts of interest at all Board and Board Committee meetings (in line with the Conflict of Interest Policy) and ensuring transparency through its communication efforts.	Ensure that all actions and decisions are in the best interest of members
Good performance	- The Board, supported by the Audit and Risk Committee and Investment Committee, reviews Bonitas's financial performance and key performance indicators at the respective meetings, including the going concern status, solvency and investment performance. - The Board conducts a formal annual strategy review to assess the relevance of and progress against Bonitas's strategic pillars. - The Board approves targets for specific strategic indicators, including non-financial aspects. These targets form part of the approved annual Organisational Performance Matrix, which determines employee performance objectives and is implemented according to the Performance Management and Incentive Policies. - The Board ensures regular and transparent performance reporting to members through the AGM and integrated reports.	- Maintain financial sustainability to ensure that members' healthcare costs are covered - Drive membership growth and retention - Promote healthcare affordability, cost efficiency and accessibility - Educate and empower members in terms of healthcare
Effective control	Bonitas has a Combined Assurance Framework that applies the four layers of defence governance model (see page 85). This enables a coordinated approach in which assurance providers work closely, effectively and efficiently towards a control environment where the right assurance is received in the right areas.	- Ensure consistent and sustainable business operations that adhere to the following: » Agreed strategy and risk appetite/tolerance » Agreed business objectives » Agreed policies and processes » Applicable laws and regulations
Legitimacy	- Bonitas exists to serve our members, and therefore, we must maintain their trust and respond to the legitimate concerns of all our stakeholders. See page 7 for more on the nature of our relationships and outcomes of engagements. - We aim to enhance the healthcare ecosystem and psychosocial landscape for all South Africans. In 2025, this included the following: » Expanding our network footprint to broaden member access » Adding new options to provide members with access to more channels » Adopting the B-Value model as a comprehensive, free value-added offering that focuses on holistic health, moving beyond just traditional medical aid benefits » Enhancing member onboarding through system development » Providing affordable and holistic mental health solutions » Promoting transparency and good governance » Contributing to an affordable and sustainable South African healthcare ecosystem » Promoting universal healthcare - We do not sponsor political parties or entities involved in extreme sports that are controversial or disruptive. - As part of our ongoing commitment to sustainable talent development, transformation, and succession planning, Executive Management undertook a review of the current and potential impact of the Learnership Programme versus the Graduate Development Programme. The review assessed alignment to the Bonitas's strategic objectives, operational requirements, cost-benefit considerations, and long-term talent sustainability. Following the assessment, the Executive Management approved the implementation of a structured Graduate Programme, tailored to our specialised operational and governance environment to be implemented in 2026. In 2025, Bonitas supported two learners who completed their business administration qualifications at NQF Level 4 at the SA Business School in November 2025.	- Promote corporate responsibility and position Bonitas effectively as a good corporate citizen - Effectively incorporate environmental, social and governance (ESG) from an investment and Bonitas perspective, with a particular focus on the SDGs we have identified as part of our value creation model (see page 14)

KEY GOVERNANCE MATTERS IN 2025

Annual general meeting

The Bonitas AGM was held on 20 August 2025 in respect of the financial year ending 2024, in line with the Scheme Rules and in compliance with CMS guidelines. 255 principal members attended the virtual meeting, and PwC acted as the independent oversight body.

472 principal members voted on three resolutions:

Resolution 1: To confirm the appointment of Deloitte & Touche as the Scheme's Auditor for the 2025 financial year.

Outcome: Members voted in favour

Resolution 2.1: Trustee Remuneration Policy: To approve an increase in the fees of the Chairperson of the Board above the CPI rate.

Outcome: Members voted against

Resolution 2.2: Trustee Remuneration Policy: To approve an increase in the fees of the Trustee members of the Managed Healthcare Committee above the CPI rate.

Outcome: Members voted against

In relation to Resolution 2.1 and 2.2, the fees defaulted to a CPI increase in line with the prevailing policy.

PwC's report concluded that, based on the oversight procedures performed, the 2025 AGM was carried out in accordance with the applicable provisions of the Scheme Rules.

Policy approvals

The Board reviewed and approved several policies, charters and strategy documents to provide for ongoing process enhancements and an effective governance and control environment. These included:

- Board Charter and all Board Committee Charters
- Internal Audit Charter
- Delegation of Authority
- Investment Policy Statement
- Leave Policy
- Credit Control Policy
- Compliance Policy
- Grievance Policy
- Impairment Policy
- Incentive Scheme Policy
- Employee Remuneration Policy
- Employment Equity and Transformation Policy

Administration and managed care contracts

The Bonitas administration and managed care contracts expire on 31 May 2026. The Scheme embarked on two Request for Proposal (RFP) exercises during June 2025, with full oversight by the Board, namely:

- *Bonitas Administration Services – RFP 006/2025* to appoint a service provider to render the Administration Services of all its options excluding the income-based option – BonCap and its newly launched option BonCore.
- *Bonitas Managed Care Service – RFP 007/2025* to appoint a service provider to render the Managed Care Services for all its options excluding the income-based option – BonCap and its newly launched option BonCore.

The intention of the RFPs was to solicit innovative administration, managed care strategies and risk management intervention proposals respectively to align with the Scheme's target markets in terms of costs, access and value. Furthermore, given the provisions of the Regulations, it would have been deemed to be an undesirable business practice had the Scheme contemplated changing administrators without testing the market. It was also required that the successful provider, when appointed, ensures compliance with all regulatory requirements, the delivery of services and the achievement of the defined strategic objectives of the Scheme. Appointed service providers would need to be able to render the above-mentioned services in accordance with the Medical Schemes Act 131 of 1998, as amended (the Act or MSA), its Regulations and the Scheme Rules as registered by the Council of Medical Schemes (CMS).

The RFP process further reviewed bidders' proposals for controlling health care costs, improving patient outcomes, and managing the use of medical services to ensure the Scheme's long-term sustainability. This exercise will also ensure that the Scheme continues to apply the principles of good corporate governance by evaluating its service providers and alternative models of managed care and administration services at regular intervals. Stringent governance protocols were followed including briefing sessions, presentation sessions, independent oversight and due diligence.

The Scheme appointed the following accredited entities to render these services from 1 June 2026:

- *Bonitas Administration Services – RFP 006/2025 to Momentum Health*
- *Bonitas Managed Care Service – RFP 007/2025 to Private Health Administrators*

The contract period for these services is intended to be for a period of five years, with a possibility of extension for a further two years, provided that the Scheme will be entitled to periodically review the services rendered under the contract at any time.

Other contracts and RFP processes

- An Emergency Medical Services (EMS) and/or International Travel Insurance RFP process was launched during the last quarter of 2025 and will be concluded during quarter two of 2026.
- The Board approved the extension of the DENIS contract for a further 12 months, from 1 January 2026 to 31 December 2026, as well as the extension of the international travel insurance and the emergency medical services contracts under AZOZA for 12 months, while the EMS and/or International Travel Insurance RFP process was underway.
- The Board also approved the extension of the PHA Administration Services contract for BonCap and BonCore for an additional 12 months, from 1 January 2026 to 31 December 2026.
- PwC's internal audit contract was extended by the Board.
- The Board approved the appointment of NMG Actuaries as the Scheme's primary actuary, subject to a three-month transition.

Healthcare plan and option decisions

The Board approved the 2026 pricing and benefits, including:

- A 2026 weighted average contribution increase of 8.8% across all options
- The restructuring of the Primary Select option, transitioning from risk-based to a savings-based model, renamed as BonPrime.
- The introduction of a new hospital option, BonCore.

BOARD FUTURE FOCUS AREAS

- Stabilise the administration and managed care with the new two service providers contracted
- Focus on improving member benefits and ensuring affordability with the best service experience
- Address loss-making options through a new service provider with an innovative strategy
- Continue with our transformation agenda to reflect the South African demographic in Bonitas's profile

OUR BOARD

BOARD COMPOSITION

The Board is responsible for ensuring that Bonitas operates in the best interest of members and maintains long-term sustainability. The Board operates in accordance with a Board Charter that sets out its roles, responsibilities and key governance requirements aligned to the MSA and the Scheme Rules.

Board Trustees are elected by our members or appointed by the Board and must possess the required skills and capabilities to benefit Bonitas in their oversight role. In terms of the Scheme Rules, Trustees must be fit and proper and must be duly elected for a five-year term. In terms of the MSA, section 57(2): "at least 50 per cent of the members of the board of trustees shall be elected from amongst members." Based on the current Scheme Rules, the composition of the Board only represents members of the Scheme whether elected or appointed.

The Board can appoint a maximum of three Trustees without undergoing elections. Such an appointed Trustee must be a member of Bonitas and must possess qualifications or belong to professions such as attorney/advocate, accountant/auditor, actuary, medical practitioner/specialist or any other specialist expertise identified by the Board. The option to appoint specific Trustees allows the Board to source capabilities that will benefit Bonitas and improve race and gender diversity in its composition.

As at 31 December 2025, the Board consisted of eight Trustees: six elected by members and two appointed by the Board.

Changes to the Board during the year included:

- Mr Oupa Komane was re-elected as Chairperson on 25 October 2025.
- Adv Tokologo Monene was elected and appointed as the Vice-Chairperson of the Board on 25 October 2025, replacing Mr Rodney Cowlin, who served on the Board for ten years. His term ended 4 January 2026.
- Adv Tokologo Monene was appointed as a member of the Working and Strategy Committee effective 5 June 2025.

The Board is satisfied that its composition reflects the appropriate mix of knowledge, skills, experience, diversity and independence.

All current Trustees are Bonitas members.

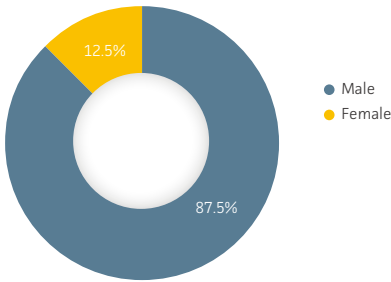
The Board aims to ensure that Trustees have the appropriate skills and experience to effectively govern Bonitas and strives for both racial and gender diversity in order to adequately represent all South Africans.

Board and Executive Management skills profile

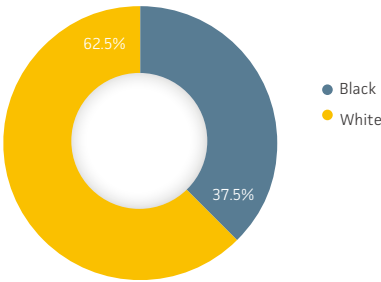
Skills	Trustees							Executive Management				
	Mr J Bagg	Mr R Cowlin	Mr A Edwards	Mr OJ Komane	Adv RT Monene	Mr MG Netshisaulu	Mr PJ Ribbens	Mr JR Venter	Mr LR Callakoppen	Ms V Rikhotso	Dr T Hadebe	Mr S Perumal
Corporate governance	X	X	X	X	X	X		X	X	X	X	X
Medical and retirement funds	X	X	X						X		X	X
Strategy		X	X	X	X	X	X		X	X	X	X
Financial management	X	X	X			X	X	X	X	X		X
Business development		X	X				X	X	X			X
Law					X	X						
Marketing		X	X				X					X
Taxation						X				X		
Skills development	X	X	X	X		X	X	X	X		X	X
Clinical		X	X								X	
Actuarial science	X											
Leadership	X	X	X	X	X	X	X	X	X	X	X	X
I&T								X				X

BOARD DIVERSITY

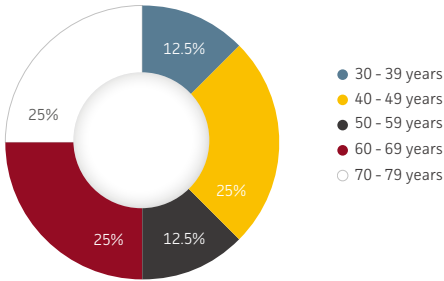
GENDER PROFILE AS AT 31 DECEMBER 2025 (%)



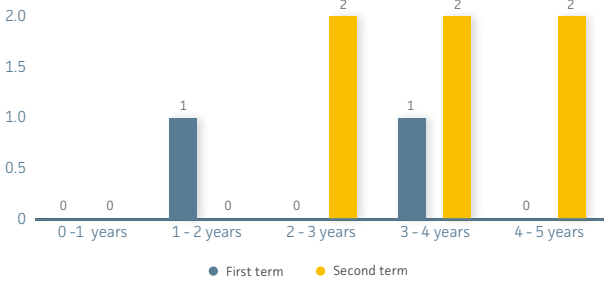
RACE PROFILE AS AT 31 DECEMBER 2025 (%)



AGE PROFILE AS AT 31 DECEMBER 2025 (%)



TENURE AS BOARD MEMBER



BOARD EVALUATION

In line with King IV™ and King V, independent performance assessments of the Board and its Committees are conducted biennially (every two years) to evaluate the effectiveness of their performance against accepted good corporate governance principles and standards.

PwC was appointed by the Board to conduct the independent 2025 performance evaluations of the Board and Committees.

The Board is satisfied that the evaluation process is improving its performance and effectiveness.

The Board of Trustees scored an average rating of 1.10. This suggests that the Board is seen to be performing and functioning well within the desired level and in line with good governance practice. Limited areas of improvement have been noted.

All Committees scored below 2 with an overall average of 1.19. This suggests that for the Committees, minor or no adjustments are required to current processes and practices.

Committee	Average score
1. Audit and Risk Committee	1.11
2. Investment Committee	1.13
3. Managed Healthcare Committee	1.28
4. Remuneration Committee	1.31
5. Working and Strategy Committee	1.12
Average	1.19

KEY BOARD AREAS OF OVERSIGHT

Highlights from the Board’s activities, in fulfilment of the Board Charter, are included below to demonstrate how governance supports value creation and preservation.

Financial

- Evaluated financial performance, including going concern status, loss-making options, unknown and unclaimed deposits, stale claims, the claims ratio, and provision for IBNR claims.

- Approved the annual financial statements and Board of Trustees report, including the Arm’s Length Assertion.
- Reviewed financial forecasts and approved the 2026 budget.
- Appointed the external auditor and approved the audit fee.
- Tracked performance and determined remuneration increases and incentives against the Organisational Performance Matrix.
- Approved yearly fee increases for service providers.
- Participated in the Managed Care workshop and the Investment Committee workshop in February 2025.

Operational

- Reviewed the product development process and considered and approved the pricing and benefit option design for 2026.
- Tracked membership numbers, membership trends, claims history and projections.
- Monitored engagements regarding potential amalgamations.

Stakeholders

- Arranged the virtual AGM, including online voting, with a particular focus on ensuring inclusivity and maximum participation by members.
- Monitored the performance of and engagement with key service providers.
- Approved contract renewals and monitored the process of procuring new service providers.
- Monitored resignations, recruitment and selection – both at Bonitas and at key service providers – to ensure that positions are suitably filled, and that institutional knowledge is retained.

Governance

- Scrutinised reports from the Board Committees and approved their priorities and workplans.
- Approved revised policies, the Board Charter and Charters for the Board Committees.
- Performed oversight over the administration and managed care RFP processes.

Strategy, people and performance

- Approved the 2025 Organisational Performance Matrix.
- Reviewed and approved the Principal Officer's performance rating.
- Approved employee salary increases, the short-term incentive allocation and long-term incentive formulae.
- Evaluated key service provider contracts.

Risk and compliance

- Provided oversight of the key risks facing Bonitas.
- Reviewed and monitored the effectiveness of the compliance management process.
- Considered updates on regulatory matters and legal proceedings.

MEETING ATTENDANCE

The schedule below summarises mandatory Board and Board Committee meetings held during 2025. This includes special meetings and attendance by invitation.

Trustee and/or Independent Member	Board	Audit and Risk Committee	Investment Committee	Managed Healthcare Committee	Remuneration Committee	Working and Strategy Committee
Number of meetings	15 (including 2 days' workshop and 4 special meetings)	8 (including 2 special meetings)	5 (including 1 workshop)	10 (including 1 special meeting and 2 workshops)	4 (including 1 special meeting)	10 (including 2 special meetings)
Mr J Bagg	15/15	2/2	5/5	2/2		9/10
Mr T Bikitsha			5/5			
Dr YO Carrim				10/10		
Mr R Cowlin	15/15		5/5	10/10		10/10
Mr A Edwards	12/12		1/1	10/10	4/4	
Ms P Kekana	2/2				4/4	
Ms W Kirima			3/3			
Mr OJ Komane	15/15	8/8	5/5	10/10	4/4	10/10
Adv RT Monene	15/15		1/1	2/2	4/4	6/6
Ms D Msomi					4/4	
Mr MG Netshisaulu	15/15		1/1	2/2		10/10
Ms S Padayachy		8/8				
Mr T Poho		8/8				
Mr PJ Ribbens	15/15		5/5	10/10		
Prof DP van der Nest	2/2	7/8				
Mr JR Venter	15/15	8/8	1/1	2/2		

BOARD COMMITTEES

The Board is assisted by five Committees consisting of Trustees and Independent Members. The Board and Committees reviewed their performance in terms of their respective mandates and were satisfied that they performed their responsibilities under the relevant charter.

AUDIT AND RISK COMMITTEE

Mandate

In terms of section 36 of the MSA, Bonitas is obliged to have an Audit and Risk Committee. This Committee is duly constituted and functional. The Committee comprises a majority of Independent Members whose mandate is to assist the Board in discharging its duties relating to:

- Safeguarding of assets
- Operation of adequate and effective systems, internal controls and processes
- Preparation of annual financial statements that fairly represent Bonitas's financial position
- Oversight of the external and internal audit appointments and functions
- Oversight of the policies and processes for identifying and assessing business risks
- Oversight of the GRC functions
- Provision of advice on any matter referred to the Committee by the Board

Key activities for 2025

- Assessed financial and investment performance
- Provided oversight of risk management and compliance reporting
- Provided oversight of the re-contracting of internal audit services
- Oversaw the internal and external audit plans, processes and reports
- Approved the scope and fees for the PwC probity review into the administration and managed care RFPs
- Monitored the audit and risk processes of key service providers and followed up on related assessments, reports, action plans and commitments
- Conducted a thorough risk analysis of Bonitas's medium- and long-term strategy
- Oversaw I&T governance matters, processes and reports, particularly the safekeeping of member information
- Provided oversight of combined assurance reporting and approved the revised Combined Assurance Framework
- Considered all matters relating to ethics, contracts and SLAs, legal matters and litigation, FWA and non-compliance with laws and regulations
- Recommended the following to the Board for approval: Audited annual financial statements and related disclosures (including the report of the Board), external audit plan and fees, external auditors' report, going concern status, IBNR methodology, updated Committee Charter, and updated policies

Important disclosures

The Audit and Risk Committee has assessed and is satisfied that our external auditor, Deloitte, is sufficiently independent of Bonitas.

The Committee is satisfied that the tenure of the external auditor and the engagement partner does not impair independence and does not create a risk of familiarity with management. The Committee has reviewed the financial statements and received assurance on key figures, including liability for incurred claims (IBNR claims) and liability to members for future benefits. The Committee received the external audit report from Deloitte as well as the management representation letter. The Committee is comfortable with the assurance provided, the quality of the audit work conducted and the unmodified audit report.

Bonitas has an outsourced internal audit function that is provided by PwC. The Committee approved a risk-based coverage plan that was completed for the financial year and is satisfied with the assurance provided by the internal auditor. In addition, ad hoc Probity reviews relating to the Administration and Managed Care Request for Proposals (RFPs) were conducted by PwC in 2025, at the request of the Committee and approved by the Board of Trustees.

An annual internal audit effectiveness assessment on the outsourced internal auditor was conducted, and the results were satisfactory. The Committee has received assurance on the quality of the system of internal control. The GRC function – including management, internal and external audit – contributes to the Combined Assurance Forum meetings where any possible risk and control matters are dealt with, and quarterly reports and minutes are provided to the Committee as part of the assurance required.

The Committee is satisfied with the capacity and skills of the finance function and the CFO. The annual assessment of the CFO's performance was conducted, and the results were satisfactory.

Members as at 31 December 2025	Capacity	Member since
Prof DP van der Nest*	Independent Member	1 August 2019
Mr MG Netshisaulu**	Trustee Member	28 January 2025
Ms S Padayachy	Independent Member	6 February 2023
Mr T Poho***	Independent Member	1 August 2019
Mr JR Venter	Trustee Member	1 August 2019

* Chairperson term ended 31 July 2025 but continued as an Independent Member. Resigned effective 29 January 2025.

** Appointed to ARC effective 28 January 2025.

*** Appointed as Chairperson of the ARC on 31 July 2025.

INVESTMENT COMMITTEE

Mandate

The Investment Committee manages the investment portfolio in line with the Bonitas Investment Strategy and Policy, and ensures compliance with the regulations of the MSA. The Committee advises the Board on strategic matters relating to the investment of reserves, ensuring investments are made in members' best interest.

Key activities for 2025

- Conducted an Investment Committee workshop in February 2025 to revisit the strategic asset allocation
- Directed a review of the Investment Policy Statement to include a realisation policy
- Reviewed Bonitas's investment mandates, strategic asset allocations, expected risks and returns, and financial position
- Scrutinised the performance of Bonitas's investments, investment consultant and asset managers, and negotiated favourable fees with service providers
- Scrutinised asset managers' due diligence processes
- Recommended the updated Committee charter and the Investment Policy Statement to the Board for approval

Members as at 31 December 2025	Capacity	Member since
Mr R Cowlin**	Trustee Member	30 June 2016
Mr J Bagg	Trustee Member	15 October 2016
Mr TM Bikitsha	Independent Member	1 December 2024
Ms W Kirima*	Independent Member	1 June 2014
Mr PJ Ribbens	Trustee Member	16 November 2019
Mr MG Netshisaulu***	Trustee Member (Chairperson)	10 December 2025

* Term as Independent Member ended 31 May 2025.

** Term as Trustee ended 4 January 2026.

*** Mr MG Netshisaulu replaced Mr R Cowlin as the Chairperson of the IC effective 10 December 2025.

MANAGED HEALTHCARE COMMITTEE

Mandate

The Managed Healthcare Committee provides direction, oversight and guidance on all strategic and operating matters relating to Bonitas's managed healthcare activities to ensure they are managed in the best interest of members. Managed healthcare is about comprehensive care, including preventative, rehabilitative and curative care to promote appropriate care at an optimal cost.

Key activities for 2025

- Monitored the changing healthcare environment and provided advice to the Board on the implications for Bonitas
- Conducted a workshop in February 2025 to consider the performance of healthcare plans, disease management programmes, identify gaps and recommend solutions
- Implemented and evaluated outcomes-based measures through service provider performance audits and analytical reviews
- Reviewed the strategies and operational plans of key service providers, particularly from a managed healthcare organisation perspective
- Considered fee increases and expiring contracts, and recommended renewal or extension where appropriate
- Discussed 2026 healthcare plans and pricing, including the establishment of an open network for data sharing
- Provided oversight of the wellness strategy, including the inclusion of a mental health questionnaire
- Monitored membership and financial data, and loss-making options, to ensure the ongoing relevance of managed care interventions
- Recommended the updated Committee charter to the Board for approval

Members as at 31 December 2025	Capacity	Member since
Mr R Cowlin**	Trustee Member	16 July 2020
Dr YO Carrim	Independent Member	5 October 2022
Mr A Edwards*	Trustee Member (Chairperson)	19 April 2024
Mr PJ Ribbens	Trustee Member	16 July 2020

* Mr A Edwards replaced Mr R Cowlin as the Chairperson of the Managed Care Committee effective 10 December 2025.

** Term as Trustee ended 4 January 2026.

REMUNERATION COMMITTEE

Mandate

The Remuneration Committee provides oversight of the Bonitas Remuneration Strategy and Philosophy and related policies, and ensures compliance with these policies. The Committee oversees the remuneration of Trustees and employees.

Key activities for 2025

- Engaged with independent consultants regarding market-related data and benchmarking to be used in reviewing remuneration practices
- Considered and recommended annual employee salary increases and the overall short-term incentive amount on the basis of the Organisational Performance Score, employee performance scores, affordability, and salary benchmark source data and comparison ratios
- Recommended updates to the Chairperson of the Board and Trustee remuneration where appropriate
- Discussed succession planning for key roles, as well as progress regarding the learnerships offered by Bonitas
- Reviewed the learning and development budget and planned training for the year
- Recommended the updated Committee charter and policies to the Board for approval

Members as at 31 December 2025	Capacity	Member since
Ms P Kekana*	Independent Member	2 January 2016
Mr A Edwards**	Trustee Member	28 January 2025
Adv RT Monene	Trustee Member	5 October 2022
Ms D Msoni***	Independent Member (Chairperson)	1 July 2024
Mr MG M Netshisaulu****	Trustee Member	16 July 2020
Mr L Grubb*****	Independent Member	1 January 2026

* Term ended 3 January 2026.

** Appointed to the Committee with effect from 28 January 2025.

*** Appointed Chairperson from 23 August 2025.

**** Moved to the ARC with effect from 28 January 2025.

***** Appointed to the Committee as an Independent Member with effect from 1 January 2026.

WORKING AND STRATEGY COMMITTEE

Mandate

The Working and Strategy Committee directs and monitors the implementation of Bonitas's strategy and is responsible for overseeing procurement and contract management processes, and recommending the budget to the Board for consideration and approval. In 2024, the Committee's mandate was extended to include oversight of and reporting on organisational ethics, responsible corporate citizenship, sustainable development and stakeholder relationships for implementation during 2025.

Key activities for 2025

- Monitored the performance of key service providers and recommended contract renewals where appropriate, including extensive RFP processes to appoint administration and managed care service providers in 2026
- Reviewed evaluation criteria and briefing documents for service provider RFPs, reviewed evaluation scores and made recommendations to the Board
- Monitored engagements regarding potential amalgamations
- Finalised the 2025 Organisational Performance Scorecard targets
- Conducted the Principal Officer's performance evaluation according to an approved scorecard
- Monitored progress regarding regulatory reports and enquiries, including CMS matters and NHI developments
- Considered key risks relating to succession and the Bonitas membership profile
- Considered I&T governance reports
- Considered FWA reports
- Recommended the updated Committee and Board charters and policies to the Board for approval

Members as at 31 December 2025	Capacity	Member since
Mr OJ Komane*	Trustee Member (Board Chairperson and Chairperson of this Committee)	1 June 2021
Mr R Cowlin**	Trustee Member	1 October 2017
Mr J Bagg	Trustee Member	4 December 2020
Mr MG Netshisaulu	Trustee Member	16 November 2019
Mr LR Callakoppen	Principal Officer	1 May 2019
Dr T Hadebe	Clinical and Managed Care Executive	6 November 2023
Adv T Monene***	Trustee Member (Board Vice-Chairperson)	5 June 2025
Mr S Perumal*^	Chief Operations Officer	1 January 2025
Ms V Rikhotso*^^	Chief Financial Officer	1 February 2025
Mr A Edwards*^^^	Trustee Member	26 February 2026

* Trustee term ended 4 January 2021; re-elected as Trustee with effect from 1 June 2021 and appointed as Chairperson on 28 September 2021; re-elected as Chairperson of the Board with effect from 12 August 2022; term as Chairperson of the Board extended with effect from 21 September 2023, with effect from 18 September 2024 and from 25 October 2025.

** Trustee term ended 4 January 2021 and appointed by the Board with effect from 5 January 2021; re-elected as Vice-Chairperson of the Board with effect from 12 August 2022; term as Vice-Chairperson of the Board extended with effect from 21 September 2023 and again with effect from 18 September 2024. Trustee term ended 4 January 2026.

*** Adv T Monene was appointed with effect 5 June 2025.

*^ Promoted from Head of Operations to Chief Operations Officer with effect 1 January 2025.

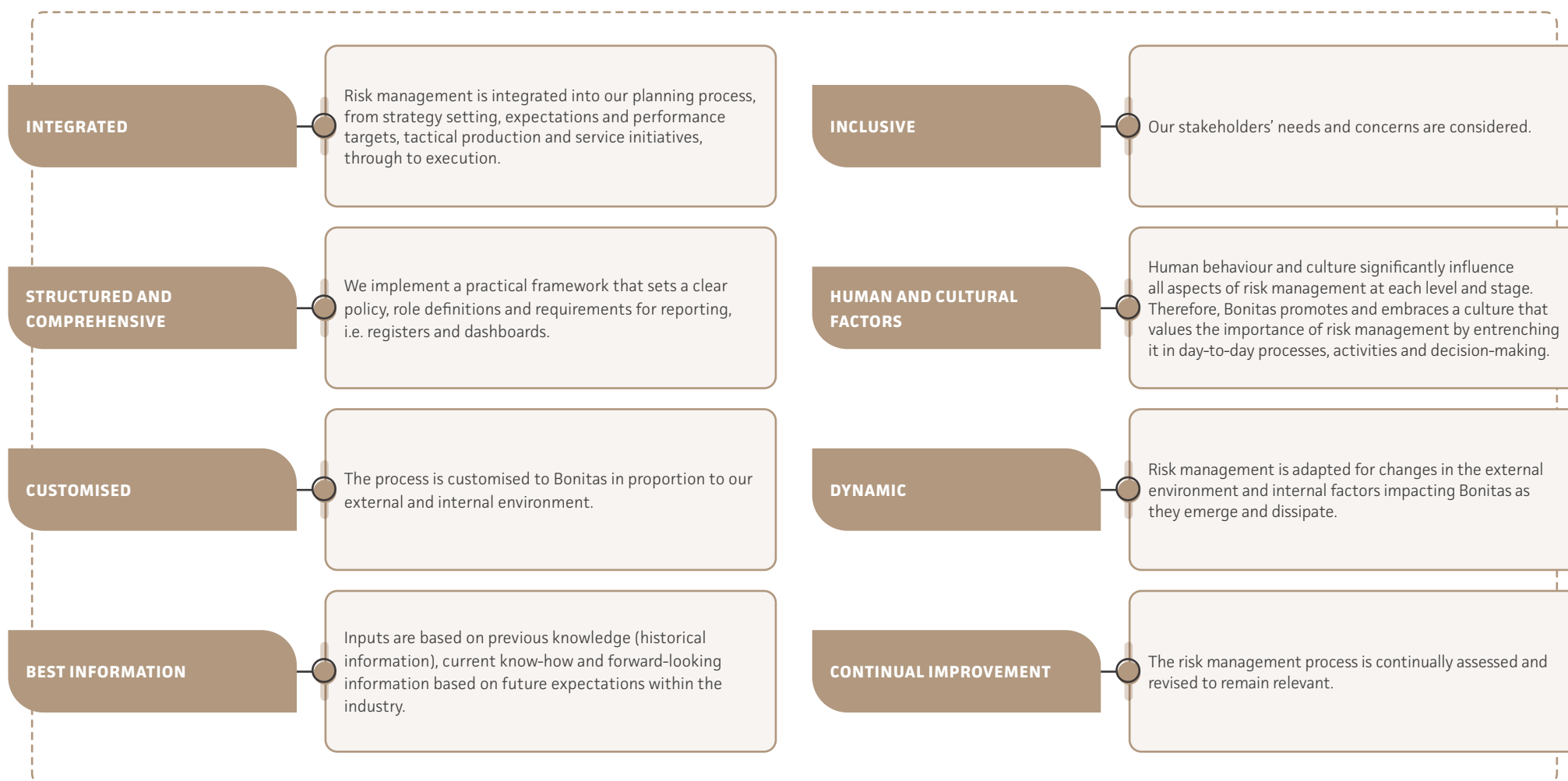
*^^ Appointed as CFO with effect 1 February 2025.

*^^^ Mr A Edwards was appointed with effect 26 February 2026, replacing Mr R Cowlin, whose term ended on 4 January 2026.

RISK MANAGEMENT

Bonitas is committed to identifying, managing and mitigating the risks that we face in the best interest of our members, and ensuring that we comply with all applicable regulations and legislation.

We take a comprehensive approach to risk management based on the following principles:



Risk management is driven by four key role players:



From a risk tolerance perspective in line with the Risk Management Policy, the Scheme is not willing to accept any event (including any instance of material non-compliance with policies and procedures) which, if the event occurred, would result in any one or more of the following:

Financial losses in excess of:

- Operational losses – 2% of solvency (excluding unrealised investment losses)
- Investment losses – 3.5% of solvency (including unrealised investment losses) or 6% of total investment portfolio
- The inability to meet its significant financial obligations (reference to the Compliance requirements in terms of Regulation 29/30 (including Annexure B) of the MSA)
- The loss of its licence to operate
- A severe reprimand from the regulator, which may result in penalties
- Ability to effectively provide services to its members is seriously questioned or threatened
- Inability to generate sufficient profit to sustain its current and future operations
- Extreme reputational and brand damage to the Scheme

Risk management is shaped by formal systems, policies and procedures. The GRC Framework, including the Risk Management Policy, constitute the Bonitas risk management framework, which comprises of the following key components:

Risk Management Policy and Manual	Risk Register, containing high and unacceptable residual risks	Risk Universe, containing a complete list of risks (risk profile of the Scheme)	Risk dashboards	Risk reporting
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The GRC Framework is approved by the Board and ensures that risk management is integrated into significant activities and functions. It provides guidance on identifying, evaluating and responding to key risks and opportunities.

Risk reporting focus areas

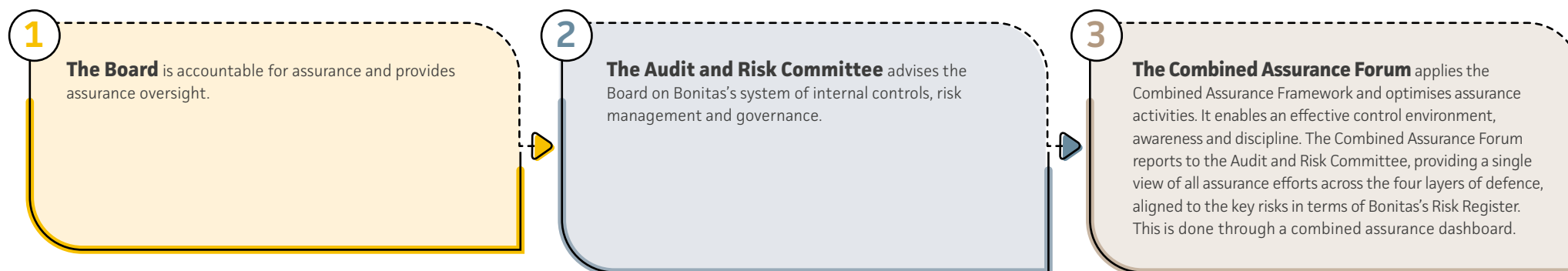
- Emerging risks and risk mitigating actions
- Unacceptable and high risks that remain key focus areas for the Board, Audit and Risk Committee and Executive Management team, and progress regarding their mitigating actions
- Changes in risk ratings where risks become more or less acceptable or tolerable as a result of changing circumstances, either within Bonitas or externally
- Key risk indicators such as membership and financial data

Read more about Bonitas's strategic risks and opportunities on page 47.

COMBINED ASSURANCE

Combined assurance refers to the coordinated activities between internal and external parties to align risk management and assurance processes at Bonitas. For example, instead of the Executive Management and external audit teams working in silos, they communicate and collaborate, together with all other relevant role players, to improve risk management, control, reporting and accountability.

Key role players include:



Combined assurance activities are directed by the Combined Assurance Framework, which is approved by the Board. The Framework ensures integration, coordination and alignment between risk management and assurance processes while seeking to optimise and maximise the level of governance, risk and control oversight based on Bonitas's risk appetite. The Framework is based on the four layers of defence governance model.

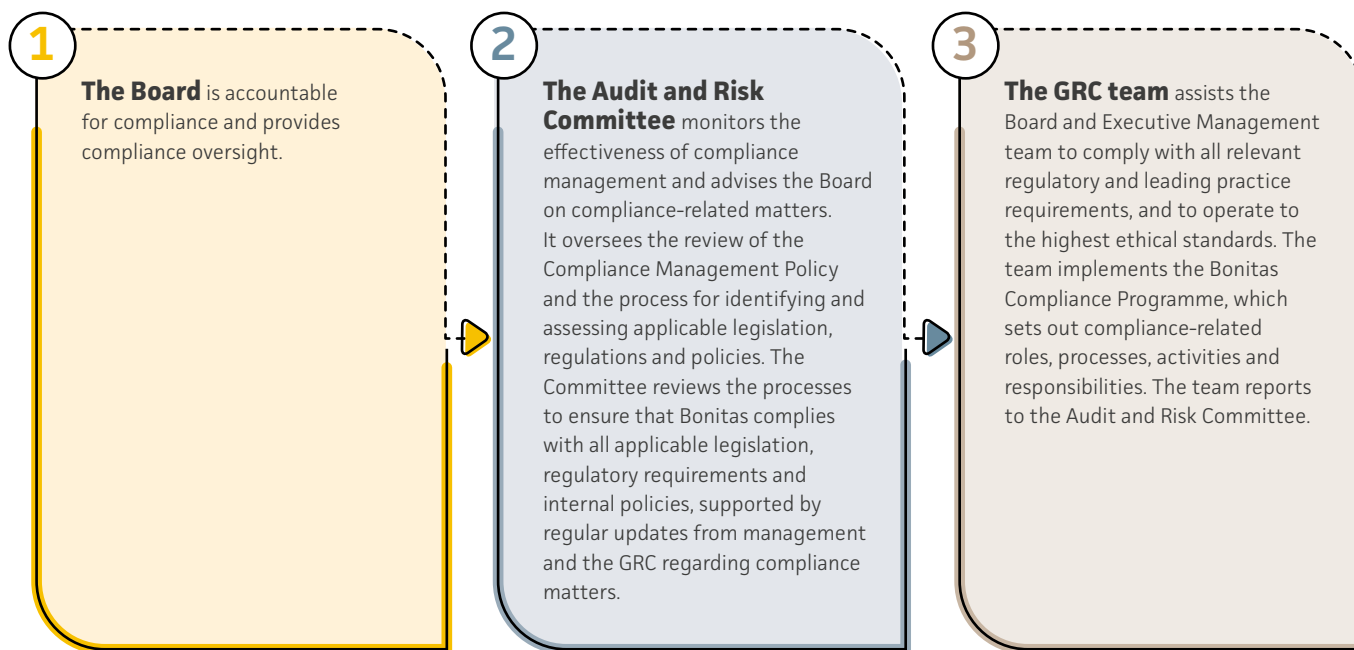
The Audit and Risk Committee is satisfied with the effectiveness of the combined assurance arrangements.

Combined assurance involves four role players constituting different layers of defence:			
First layer of defence	Second layer of defence	Third layer of defence	Fourth layer of defence
Executive Management, management committees, forums and line management	Specialist functions such as GRC and Legal	Internal auditors, i.e. outsourced and at the administrators	Independent external auditors, regulator and others, such as actuaries

COMPLIANCE MANAGEMENT

The South African healthcare sector is complex and highly regulated, and Bonitas has a formal process in place to identify applicable legislation and regulations and ensure compliance. Since we use a BPO healthcare model for our main activities – including administration – we also ensure that our service providers remain compliant.

Key role players include:



Compliance management is directed by the Compliance Management Policy, which is approved by the Board and provides the foundation for compliance at Bonitas. The Policy sets out the principles for compliance management and the expectations for implementing compliance procedures, including the monitoring of regulatory and operational compliance.

The Audit and Risk Committee is satisfied that all regulatory compliance matters have been considered in the preparation of the financial statements.

Our compliance focus areas include the following:

- **Operational compliance:** We monitor operational compliance with the Scheme Rules and policies. Policies are regularly reviewed by the responsible Board Committees, and if amendments are required, these are presented to the Board for approval.
- **Regulatory and legislative compliance:** We ensure compliance with all regulations and legislation that affect Bonitas and our members – specifically the MSA and related regulations – and report on any instances of non-compliance.
- **New and amended requirements:** Bonitas monitors new circulars published by the CMS, as well as progress regarding Acts and Bills that may impact our operations.

Future focus areas

- Ongoing compliance monitoring in line with Bonitas's Regulatory Risk Profile (i.e. prioritised for the legislation identified as primary and rated with a high compliance risk exposure), including the following:
 - » The Medical Schemes Amendment Bill, which was published in 2018 but has not yet been signed into law
 - » NHI Act (see page 47)
 - » CMS circulars, investigations and reports, such as the guidelines on LCBs, and circulars regarding the status of the healthcare sector and recommended contribution increases
 - » Legislation that impacts our operations and members, such as the Road Accident Benefit Scheme (RABS) Bill and Conduct of Financial Institutions (COFI) Bill
 - » Reported instances of FWA and related court proceedings and judgments
 - » Reporting requirements such as IFRS S1 and S2 and King V™
- Ongoing monitoring of implementation plans that address non-compliance matters (as reported in the next section)

NON-COMPLIANCE WITH THE MSA

The following areas of non-compliance with the Medical Schemes Act were identified during the financial year (refer to note 26 of the annual financial statements):

Contravention of Section 33(2) of the Act

Nature and cause

In terms of Section 33(2) of the Act, the Registrar may withdraw the approval of such benefit options which, in his opinion, are not financially sound. For the year ended 31 December 2025, the Scheme reported the following loss-making options as defined by the Council of Medical Schemes on seven (2024: eight) of its benefit options:

	2025 R'000	2024 R'000
Standard	(167 088)	(179 042)
Primary	(1 580)	(434 641)
BonCap	(264 986)	(227 588)
Bonfit	28 659	(8 409)
BonComprehensive	(53 132)	(125 951)
BonEssential	(50 383)	(34 610)
BonComplete	(11 176)	(25 265)
Hospital Standard	(19 416)	(2 983)

Options that are considered loss-making by the Council of Medical Schemes are benefit options that report an insurance service result deficit after excluding amounts attributable to future members.

Possible impact

Loss-making benefit options erode Bonitas's solvency margin. However, due to historical member reserves coupled with an efficient return on investments, we are able to absorb these losses.

Corrective course of action

Bonitas continues to monitor the performance of the seven benefit options listed above on a monthly basis. We have adopted a long-term strategy to correct the loss-making options, and a dedicated task team drives initiatives which will reduce both healthcare and non-healthcare costs over the medium term while improving health outcomes. These measures should have a positive impact across all options. For 2026, Bonitas has budgeted to have eight loss-making options.

Contravention of Section 26(7) of the Act

Nature and cause

Section 26(7) of the Act requires that all subscriptions and contributions be paid directly to a Medical Scheme not later than three days after payment thereof becomes due. The Scheme has aged debtors of up to 120 days for both group and direct paying members and is thus in breach of the three-day rule.

Possible impact

There is a risk of non-compliance with Section 26(7) of the Act. Significant debt with members could affect Bonitas's liquidity and our ability to service members due to the potential non-recoverability of such debtors.

Corrective course of action

It is not possible to receive all contributions within three days of becoming due, as there may be economic circumstances whereby contributions cannot be paid as per Section 26(7). In such instances, members are notified of the breach. In addition, Bonitas has mitigating controls in place to address the non-payment of contributions, which include the enforcement of the Scheme's Credit Control Policy. Other interventions include direct management engagement with affected groups to resolve such concerns.

Exemption of Section 35(8) of the Act

Nature and cause

Section 35(8) of the Act prohibits a medical scheme from investing any of its assets in the business of or granting loans to; (a) an employer group who participates in the medical scheme or any administrator or any arrangement associated with the medical scheme; (b) any other medical scheme; (c) any administrator; and (d) any person associated with any of the above.

Possible impact

Bonitas invested with various entities associated with its administrator and the Scheme's employer groups during the financial year.

Corrective course of action

Bonitas obtained an exemption in terms of Section 35(8) of the Act from the Council for Medical Schemes in respect of the non-compliance noted.

Contravention of Section 59(2) of the Act

Nature and cause

Section 59(2) of the Act states that: "A medical Scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical Scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical Scheme."

Exceptions were noted during the year where claims were delayed when providers exceeded their monthly limit. Providers are screened first by the Forensic team prior to the limit being lifted, resulting in the claims being paid after the 30-day period.

Possible impact

Providers and/or members not settled timeously should be communicated with appropriately to avoid non-compliance.

Corrective course of action

Provider limits are lifted before the next weekly payment run, provided no fraud risk was identified, and are communicated within the 30-day period, where necessary. The system issues related to workflow approval issues were subsequently resolved. Ongoing monitoring of exception reporting is in place to identify any issues proactively and ensure corrective measures are taken. Furthermore, a communication strategy is in place to inform the providers and members of any delays in claim payments outside the 30-day period to reduce the risk of non compliance.

Contravention with Regulation 30 read in conjunction with Annexure B (Item 4(b)) of the Regulations to the Medical Schemes Act, 131 of 1998 – Investments Outside the Republic

Nature and cause

During the financial year ended 31 December 2025, the Scheme held a portion of its investment portfolio classified as “Territories outside the Republic”.

In terms of Regulation 30 of the Regulations to the Medical Schemes Act, read together with Annexure B (Item 4(b)), medical schemes are required to maintain 0% exposure to investments outside the Republic. At year end, the Scheme’s temporary exposure to this category amounted to approximately 0.0004% (R58k) of the total investment portfolio.

The non compliance arose from the look-through classification of an underlying investment exposure and was not the result of a deliberate investment strategy to invest outside the Republic.

Possible impact

The exposure represented an immaterial portion of the Scheme’s total investment portfolio and did not have a material adverse impact on the Scheme’s solvency position, liquidity, or its ability to meet obligations to members. Notwithstanding the immaterial quantum, the exposure constitutes a technical non compliance with the investment limits prescribed in terms of the Medical Schemes Act and its Regulations.

Corrective course of action

Management has reviewed the underlying investment exposure and will ensure strengthened oversight over Regulation 30 and Annexure B classifications, including enhanced monitoring of look through investment exposures.

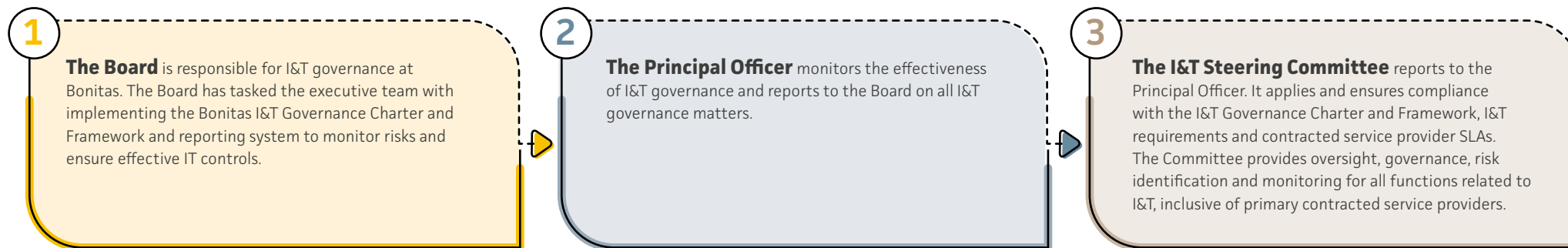
Investment governance and reporting processes will be reinforced to ensure ongoing compliance with the Medical Schemes Act and related Regulations, and compliance will continue to be monitored on an ongoing basis.



INFORMATION AND TECHNOLOGY GOVERNANCE

Effective information and technology governance ensures that we are able to collect, manage and protect healthcare data while optimising IT structures and resources.

Key role players include:



I&T governance is directed by the I&T Governance Charter and Framework, which is approved by the Board. The Charter and Framework adhere to key standards and best practices, and provide guidelines on I&T control and risk monitoring.

The Charter and Framework include the requirements set out in:

- King IV™ (King V™ going forward)
- Control Objectives for Information and Related Technology (COBIT) 2019
- ISO/IEC 38500:2024 Standard for Information Governance
- ISO/IEC 27001: International Standard for Information Security Management Systems (ISMS)

COBIT 2019 is the primary guiding framework as it covers I&T-related governance areas addressed by King IV™ and ISO 38500, as well as links to other commonly used frameworks such as the IT Infrastructure Library (ITIL), PMBOK and InfoSec. We will be updating our I&T Governance Charter and Framework to ensure alignment with King V™ requirements for expanded disclosure and a lifecycle-based approach to data and information governance.

Third-party I&T management

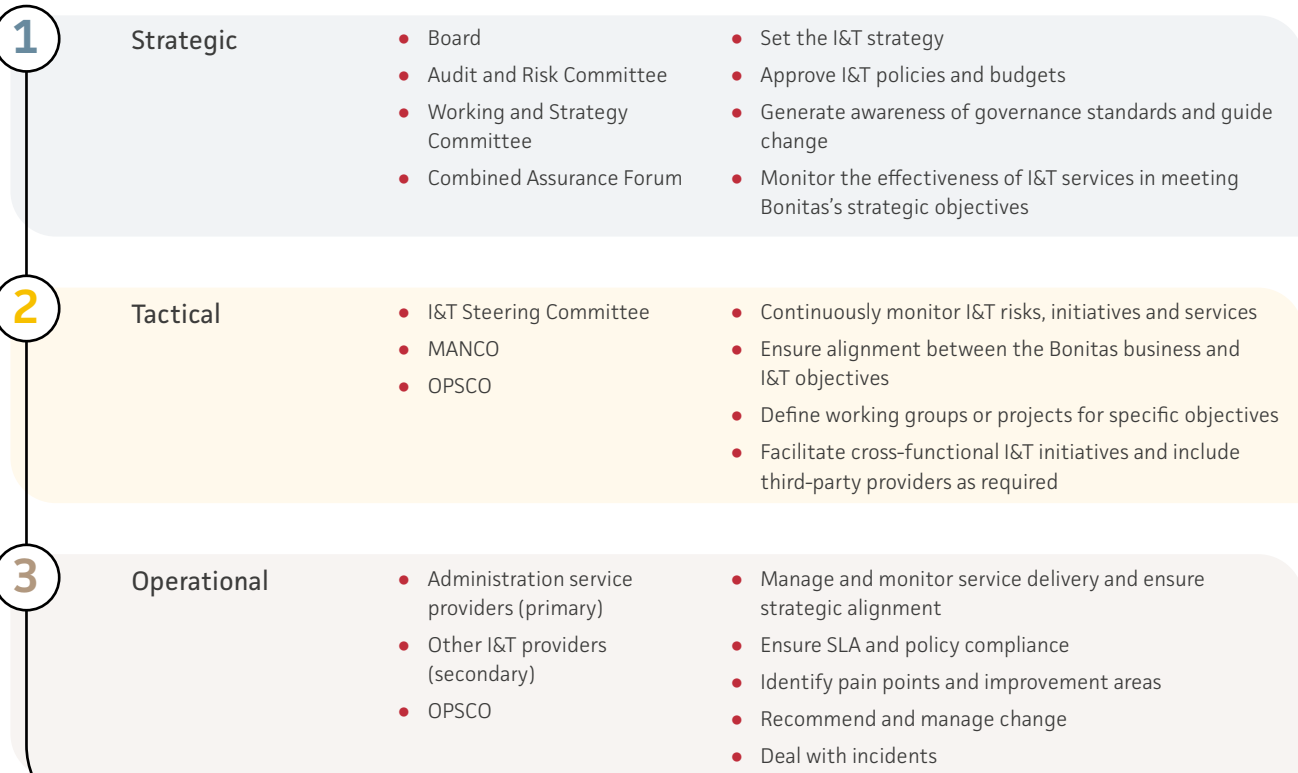
The I&T Steering Committee receives and reviews updates from service providers regarding:

- I&T risks
- Penetration testing
- Vulnerability assessments
- I&T-related audits
- Disaster recovery plans and testing
- Business continuity plans and testing
- Major I&T-related projects

Read more about I&T-related risks in the section on risks and opportunities from page 47.

INFORMATION AND TECHNOLOGY OPERATING MODEL

Bonitas implements I&T governance across all levels and structures, including service providers.



INFORMATION AND TECHNOLOGY PROGRESS IN 2025

- Monitored progress regarding the I&T strategies and plans developed by key service providers
- Monitored I&T incidents and daily system updates provided by key service providers
- Ensured that the root causes of incidents were identified and analysed so appropriate mitigation plans could be put in place where required
- AfroCentric data centre migration was completed in May 2025, and a business continuity test was done in September 2025
- Established a Bonitas AWS cloud environment where a data lake solution is deployed
- Deployed and dimensioned the AWS S3 Cloud Storage as the primary data repository
- Defined and deployed a data backup and archiving solution

FUTURE FOCUS AREAS

- Aligning all Bonitas service providers in a consolidated digital solution
- Further streamline systems, processes and people
- Closely monitor the I&T risks and control environment of key service providers
- Review the results of service provider tests and audits, such as stability, penetration and vulnerability tests
- Review and monitor the digital platforms offered by Bonitas's service providers
- Research and monitor trends relating to cyber security, in particular insurance and coverage
- Review I&T SLAs and revise them as necessary

REMUNERATION REPORT

Our approach to remuneration aims to attract and retain talent, reward performance and align with industry benchmarks and stakeholder expectations. The Board provides leadership on Bonitas’s remuneration approach and implementation.

INTRODUCTION AND BACKGROUND STATEMENT

A Board-approved Remuneration Strategy and Philosophy set out Bonitas’s remuneration strategy, financial reward model and detail on the components of remuneration relevant to all employee levels.

The Remuneration Strategy and Philosophy provide guidance on:

- The strategic intent of remuneration decision-making, thereby enhancing Bonitas’s profile as an employer of choice
- The need for consistency in remuneration decision-making, thereby enhancing internal and external equity
- Corporate governance principles to inform remuneration decisions

The Remuneration Strategy and Philosophy is based on the following principles:

- Ensure alignment with the Bonitas business strategy and purpose
- Attract and retain key talent
- Manage risk and liability, and be financially responsible
- Be externally competitive
- Be internally equitable, fair and supportive of diverse and individual needs
- Offer pay for performance
- Comply with relevant legislation
- Stand up to scrutiny by key stakeholders

The Remuneration Strategy and Philosophy is an important guide to the Remuneration Committee and Board as we evolve our remuneration practices. For example, the philosophy recognises the concept of equal pay for work of equal value and requires adherence. It establishes Executive Management accountability and ownership of the reward process by linking the total reward process to business objectives and managing it in a fair and equitable way that balances affordability and quality of life for employees.

The Board has mandated the Remuneration Committee to provide oversight in terms of remuneration. The Committee’s membership, mandate, key activities, and meeting attendance is set out on page 82.

REMUNERATION CONTEXT AND BENCHMARKING

Bonitas has to attract, retain and develop employees in the context of an industry faced with severe uncertainty, high complexity and high levels of competition. This requires a Board, Committees and employees that are well acquainted with compliance requirements and corporate governance principles while ensuring Bonitas’s sustainability.

Bonitas’s most significant challenge in retaining employees is limited growth opportunities due to the small size of the Scheme and narrow job band structures. Multiple factors, beyond remuneration, therefore, have to be considered in addressing retention.

Bonitas compares its remuneration with a national market of data which is inclusive of other medical schemes and healthcare entities. It further considers research done on the remuneration of non-executives. We gave due consideration to the Guidelines on Trustee Remuneration issued by the CMS, which acknowledge that medical schemes are not-for-profit organisations.

Salary adjustments implemented in April 2025 were benchmarked using the Compa Ratio report provided by 21st Century. The Scheme appointed Remchannel as a new service provider during the last quarter of 2025 to provide remuneration benchmarking and advisory services, and to ensure our remuneration practices remain competitive and relevant.

Our Employee Remuneration Policy and Remuneration Strategy and Philosophy ensure remuneration governance and best practices. The Employee Remuneration Policy is reviewed at least during a two-year cycle for good governance. However, industry salary benchmarking best practices are applied to the annual employee increment process. We continue to work with industry remuneration experts on further updates to the remuneration elements and for salary benchmarking data.

Bonitas endeavours to participate in medical scheme-specific Trustee remuneration benchmarking at least annually.

The Trustee Remuneration Policy is reviewed annually by the Executive Management team and Remuneration Committee. Bonitas members are required to approve the Trustee Remuneration Policy when any material amendments are required, as well as above CPI remuneration fee increases. Such approval must be granted at the AGM, which, as per the Scheme Rules, must be held before 31 August every year. If above CPI remuneration fee increases are approved, fee changes apply from 1 September.

Three policies were reviewed this year, and changes were approved by the Board to:

- The Incentive Scheme Policy
- The Employee Remuneration Policy (including the Remuneration Strategy and Philosophy to ensure alignment)
- The Leave Policy

Our performance management process supports strategy implementation by aligning remuneration with key performance indicators on the Bonitas organisational performance matrix, which serves as a scorecard for overall Scheme performance. This ensures that individual performance is directly linked to organisational objectives.

REMUNERATION IN PRACTICE

Chairperson remuneration

The 2024 and subsequent 2025 benchmarking research conducted by Willis Towers Watson indicated that the fees for the Chairperson of the Bonitas Board were not aligned with the average paid by the peer group, especially when considering that all the medical schemes that formed part of the group were much smaller in size than Bonitas.

The Remuneration Committee, which is an independent body, recommended a staggered approach to align the Chairperson’s fee per meeting over a period of time as opposed to a once-off increase. However, at the 2024 and 2025 AGMs, members voted against an increase above CPI in the Chairperson’s retainer and meeting fee.

Trustee remuneration

Trustee remuneration was increased by 2.8% in 2025 based on the outcome of the voting at the 2025 AGM.

2019 AGM	Members approved the Trustee Remuneration Policy and fees
2020 AGM	Members were not required to vote on the Trustee Remuneration Policy and fees, as there were no material changes to the Policy and fees reflected a CPI increase.
2021 AGM	
2022 AGM	
2023 AGM	Members: • Approved an amendment to the definition of CPI¹ • Approved an increase in the fees of the Chairperson above the CPI rate
2024 AGM	Members: • Voted against an increase in the fees of the Chairperson above the CPI rate • Voted against an increase in the fees of the Trustee members of the Managed Healthcare Committee above the CPI rate
2025 AGM ²	Members: • Voted against an increase in the fees of the Chairperson of the Board above the CPI rate • Voted against an increase in the fees of the Trustee members of the Managed Healthcare Committee above the CPI rate As a result, fees defaulted to a CPI increase in line with the prevailing Policy.

Independent Member remuneration

The Independent Member Remuneration Policy and fees are reviewed annually by the Executive Management team and recommended for approval to the Board if an increase above CPI is considered. As the Remuneration Committee Chairperson and some members are Independent Members, the Committee follows good governance principles and does not participate in this process. Fee changes apply from 1 June every year, following approval and/or adoption at the Board meeting in April if the proposed fee increase is above CPI.

The 2025 benchmarking research conducted by Willis Towers Watson also considered the Independent Member remuneration. It was evident that the Bonitas Independent Member Fee per Meeting is above the Average Fee per Meeting based on the benchmarking analysis performed. The Independent Members received an increase of 2.8% aligned to CPI, with effect 1 June 2025.

Annual increases for employees

Employees are eligible for annual increases in April every year. These are based on performance reviews, of which guidelines, rating scales and definitions are included in the Performance Management Policy, Remuneration Strategy and Philosophy and Employee Remuneration Policy.

Executive and Management performance is measured against an Organisational Performance Scorecard that includes key performance indicators with weightings and targets.

Incentive scheme allocations

Annual incentive awards to employees are based on annual performance reviews and are directly linked to Bonitas’s overall performance. Minimum performance criteria and the calculation of the incentive pool are defined in the Incentive Scheme Policy.

ONGOING FOCUS AREAS

The Bonitas Remuneration Strategy and Philosophy continue to direct future remuneration, reward and employee value proposition decisions based on best practice. The Strategy and Philosophy was reviewed and revised in February 2025 and recommended by the Remuneration Committee to the Board for approval on 27 February 2025.

¹ Bonitas recognises CPI as the annual headline consumer price inflation published by StatsSA as at April of the current year.
² Please refer to AGM 2025 downloads on the website:
[Download the AGM Presentation](#)
[Watch the recording of the AGM](#)
[Download the 2025 Annual General Meeting Q&A](#)

REMUNERATION POLICIES

Bonitas has a holistic rewards approach based on the following:

Elements		Purpose	Related policies and frameworks
Financial rewards			
Total guaranteed remuneration	Basic salary Retirement benefits Medical benefits Death and disability benefits Statutory payments	We aim to be a competitive employer that offers market-related remuneration while managing costs and promoting fairness and pay equity. We want to enable long-term financial security for employees, including support for their individual healthcare needs. While complying with legislation, our intent is to also give employees benefits that will ensure their peace of mind.	• Scheme Remuneration Strategy and Philosophy • Employee Remuneration Policy • Bonitas pension rules • Bonitas medical aid rules • Bonitas risk-benefit rules • Relevant legislative framework
Variable remuneration	Short-term incentives Long-term incentives	Bonitas wants to retain talent by rewarding individual performance through short- and long-term incentives. This will support succession and performance.	• Scheme Remuneration Strategy and Philosophy • Employee Remuneration Policy • Incentive Scheme Policy • Performance Management Policy • Talent and Succession Management Policy and Framework
Non-financial reward			
Learning and development	Performance management Training Workplace learning Career development	We support employee development, performance and productivity through formal and informal learning, including professional development where relevant. We want to create a pipeline of skills for future talent needs while providing employees with opportunities to manage life, career choice, learning and career prospects.	• Employment Equity and Transformation Policy • Diversity, inclusion, engagement and satisfaction initiatives
Work environment	Leadership, climate and culture Core values Job/work design Work-life balance Wellness	We promote a culture of empowerment and leadership that values diversity. We strive to create and maintain a positive working environment that is conducive to productivity, performance, strong relationships, health, and commitment to organisational culture and values.	• Bonitas values • Code of Conduct and Ethics • Leave Policy • Flexible work arrangements • Employee Wellness programme
Other			
Additional benefits and reimbursement	Travel expenses Cellular and data Overtime Acting	We provide employees with tools to perform and reward them for assuming duties that exceed current role requirements.	• Travel and Reimbursement Policy (including Overtime) • Acting Allowance Policy

EMPLOYEE REMUNERATION POLICY

Reviewed and approved by the Board on 23 August 2025. The Policy is reviewed at least every second year, with the next review scheduled for the first quarter of 2027.

This Policy aims to ensure a remuneration system that supports Bonitas's strategy and is linked to business and employee performance.

This Policy aims to ensure a remuneration system that:

- Is an integral part of an overall human resources strategy supporting Bonitas's strategy
- Reflects the competitiveness of the market and alignment with Bonitas's strategic direction
- Is designed to attract and retain high-quality employees with the optimal mix of competencies
- Is aimed at securing employee commitment to Bonitas's purpose and goals
- Is aligned with the anti-discriminatory clause in the Bill of Rights

It seeks to:

- Attract, engage and retain the best talent available, and recognise and reward individual performance against accountabilities set out by Bonitas
- Drive high levels of performance through the provision of fair and competitive remuneration
- Encourage the development of competencies required to meet future business needs
- Motivate and reinforce superior performance amongst employees

Applicable to all Bonitas employees, the Policy aligns with the following regulatory and internal policies:

- Basic Conditions of Employment Act, No 11 of 2002 (as amended)
- Labour Relations Act, No 127 of 1998 (as amended)
- Employment Equity Amendment Act, No 4 of 2002, including provisions on equal pay for equal work
- Leave Policy
- Performance Management Policy
- Recruitment, Selection and Appointment Policy
- Incentive Scheme Policy
- Disciplinary Policy

INCENTIVE SCHEME POLICY

Reviewed and approved by the Board on 23 August 2025. The Policy is reviewed annually, with the next review scheduled for the second quarter of 2026.

This Policy aims to ensure that incentives attract, reward and retain high-performing individuals and create a clear link between performance and strategic objectives.

Short-term incentive

Payment of the short-term incentive (STI) is directly linked to the performance of Bonitas and the employee's performance review outcome. Performance below the set threshold level results in no performance incentive payment.

The Policy sets out the performance cycles, assessment arrangements, STI pool calculation and all conditions for awards, including for new hires, after promotions and during disciplinary proceedings. Bonitas must also achieve a minimum score per the approved Organisational Performance Scorecard to provide for an incentive pool. The STI pool is capped at a maximum of 30% of Bonitas's annual Total Guaranteed Package (TGP) total for the financial year. The incentive pool is the maximum total STI that Bonitas can pay in a financial period. The calculation of the incentive pool and final incentive awards is subject to approval by the Remuneration Committee and the Board.

Long-term incentive

The aim of the long-term incentive (LTI) is to attract, retain, motivate and reward executives and identified employees who can influence Bonitas's performance. It supports our purpose by attracting and retaining the right talent and correlating with our long-term growth plans and financial performance.

The LTI Scheme has a three-year fixed cycle, and the value of the incentive is determined by Bonitas's performance over a three-year period. LTI targets are agreed and approved by the Board. These targets focus on Bonitas's medium- to long-term sustainability.

The new LTI performance targets for January 2024 to December 2026 have been approved by the Board.

Refer to the Remuneration Implementation Report on page 97.

BOARD COMMITTEES' INDEPENDENT MEMBER REMUNERATION POLICY

Approved by the Principal Officer on 4 July 2025.

This Policy is designed to facilitate a fair and responsible remuneration model for Independent Members by ensuring that the level and composition of remuneration is sufficient and reasonable. This includes considering their fiduciary duties and responsibilities towards Bonitas and our members, and the inherent risks and responsibilities associated with such positions of trust.

The Policy aims to remunerate Independent Members appropriately and in line with sound corporate governance principles and based on market-leading practices. The Policy is further based on and relates to:

- Regulations applicable to medical schemes established in terms of the MSA
- Scheme Rules
- King IV™ (King V™ going forward)
- Board and Committee Charters
- Delegation of Authority Policy
- Travel and Reimbursement Policy

This Policy only requires approval by the Board for subsequent years if there are material changes or if remuneration increases are above CPI. The Independent Members received an increase of 2.8% aligned to CPI, and therefore, Board approval was not required.

Our approach and model

In setting fees related to Independent Member remuneration, Bonitas ascribes to the process set out in 2020 by the Institute of Directors South Africa¹. We also consider the requirements of the Companies Amendment Act, No 16 of 2024, and the Companies Second Amendment Act, No 17 of 2024.

Independent Members are appointed by the Board to serve on the various Board Committees, and they do so based on the roles and duties set out in the charters of the relevant Committee to which they are appointed. This includes attending and participating in meetings, preparing for such meetings, conducting research to execute their duties and keeping in touch with industry developments. In accepting their appointment, they also attract possible personal liability as provided for in various legislation. Their remuneration is therefore not different to that of other non-executive directors.

However, as Bonitas is a not-for-profit organisation, Independent Member remuneration is not comparable to that of private companies or those listed on the Johannesburg Stock Exchange. Based on the different remuneration models applied in the healthcare industry, Bonitas elected a Per Meeting Fee model.

The Per Meeting Fee relates to scheduled and special Committee meetings on which an Independent Member is a permanent member, including SGM attendance. Independent Members may also be required to attend specific Board meetings and/or ad hoc meetings, such as interviews or tender evaluations, for which an Independent Member will be entitled to a Per Hourly Meeting Fee that includes preparation time.

Independent Members are not remunerated for attending training and development activities, seminars, functions or meetings with stakeholders or the regulator. No retirement benefits or other forms of bonus or incentive payments are paid to Independent Members.

Independent Members' fees

Fees are reviewed annually. Increases are equivalent to CPI unless extraordinary circumstances justify a higher increase. Fees applicable from 1 June 2024 and 1 June 2025 are as follows:

	Meeting fee from 1 June 2024	Meeting fee from 1 June 2025
Committee meetings		
Audit and Risk Committee: Chairperson	R42 490	R43 680
Audit and Risk Committee: Member	R36 420	R37 440
Investment Committee: Member	R31 564	R32 448
Remuneration Committee: Chairperson	R36 420	R37 440
Remuneration Committee: Member	R31 564	R32 448
Managed Healthcare Committee: Member	R36 420	R37 440

	Hourly meeting fee from 1 June 2024	Hourly meeting fee from 1 June 2025
Ad hoc² meetings		
Ad hoc meeting: Chairperson	R5 706	R5 866
Ad hoc meeting: Invitee	R4 856	R4 992

¹ Institute of Directors South Africa. 2020. 'Managing Conflicts and Tensions at the Remuneration Committee: Remuneration Committee Guidance'. Available on: https://cdn.ymaws.com/www.iodsa.co.za/resource/collection/57F28684-0FFA-4C46-9AD9-EBE3A3DFB101/Paper_3_Managing_conflicts_and_tensions_at_the_Remuneration_Committee.docx.pdf

² Ad hoc meetings are those scheduled in addition to the formal meeting calendar due to specific business requirements and dictated by the Board.

TRUSTEE REMUNERATION POLICY

The Policy was recommended by the Remuneration Committee on 17 July 2025 and adopted by the Board on 23 August 2025.

This Policy aims to remunerate Trustees appropriately, in line with sound corporate governance principles and based on market-leading practices.

The Policy is based on and relates to:

- Regulations applicable to medical schemes established in terms of the MSA
- Scheme Rules
- King IV™ (King V™ going forward)
- Board and Committee Charters
- Delegation of Authority Policy
- Travel and Reimbursement Policy

The Board and Committees focus on Bonitas's long-term strategic direction, overall performance and sustainability. Trustee remuneration is not directly related to short-term results but considers longer-term sustainability and performance.

Trustees are elected from among Bonitas members or appointed by the Board and must be fit and proper to manage Bonitas's business. Trustees carry substantial accountabilities and risks and assume substantial fiduciary duties and responsibilities. As such, it is crucially important to attract and retain suitable and qualified individuals to serve as Trustees who are able to dedicate the appropriate time to serve Bonitas and our members. Trustees are remunerated according to sound corporate governance principles and based on market-leading practices.

In recommending fees for Trustees, Bonitas and the Remuneration Committee acknowledge the process suggested by the Institute of Directors South Africa (IoDSA) in determining the fees of non-executive directors as set out in 2020¹. The Remuneration Committee adheres to this process to ensure conflicts of interest are appropriately managed when determining fees.

Bonitas applies a combination of a Retainer Fee model and Per Meeting Fee model. The rationale is that the Retainer Fee model will enable Bonitas to attract and retain suitable and qualified individuals to serve as Trustees to assume the fiduciary duties and responsibilities associated with such positions, while the Per Meeting Fee will ensure attendance. In other words, the combined model ensures that Trustees dedicate enough time to Bonitas while avoiding unnecessary meetings that could increase costs.

Trustees' fees

Fees are reviewed annually. The fees below demonstrate a comparative analysis of fee increases from 1 September 2024 and 1 September 2025, aligned to Bonitas's Trustee Remuneration Policy.

Name	2024		2025		% variance	2024		% variance
	Retainer fee (monthly) R	Retainer fee (annual) R	Retainer fee (monthly) R	Retainer fee (annual) R		Meeting fee R	Meeting fee R	
Board of Trustees – Chairperson	35 505	426 060	36 499	437 990	2.8%	26 838	27 589	2.8%
Board of Trustees – Trustee	22 747	272 964	23 384	280 607	2.8%	15 924	16 370	2.8%
Audit and Risk Committee – Member						15 924	16 370	2.8%
Investment Committee – Chairperson						19 677	20 228	2.8%
Investment Committee – Member						10 617	10 914	2.8%
Remuneration Committee – Member						7 962	8 185	2.8%
Working and Strategy Committee – Chairperson						19 677	20 228	2.8%
Working and Strategy Committee – Member						10 617	10 914	2.8%
Managed Healthcare Committee – Chairperson						19 677	20 228	2.8%
Managed Healthcare Committee – Member						10 617	10 914	2.8%
Sales and Marketing Committee* – Member						7 962	8 185	2.8%

* Management committee with Trustee members.

¹ (IoDSA) 2020. 'Managing Conflicts and Tensions at the Remuneration Committee: Remuneration Committee Guidance'. Available on: https://cdn.ymaws.com/www.iodsa.co.za/resource/collection/57F28684-0FFA-4C46-9AD9-EBE3A3DFB101/Paper_3_Managing_conflicts_and_tensions_at_the_Remuneration_Committee.docx.pdf

REMUNERATION IMPLEMENTATION REPORT

EXECUTIVE REMUNERATION

Executive remuneration summary (including the Principal Officer)

	2024	2025
Executive remuneration	R11 438 049	R14 346 812
Performance bonus (STI)	R3 407 787	R4 065 195
Performance bonus (LTI)	R2 587 776	R3 153 617
Defined contribution benefits	R681 683	R706 197

The Principal Officer's salary increase of 2.5% was approved by the Board.

Members of the Executive Management team are employed by Bonitas on fixed-term contracts.

The Principal Officer's contract was renewed for a further five years in March 2024. The CFO has a five-year fixed-term contract that commenced on 1 February 2025.

Short-term incentives

- STIs are determined by performance against an agreed Organisational Performance Scorecard and targets. Bonitas met the minimum required organisation score for the purposes of an STI. The total bonus pool was calculated as R7 054 062 million, and the final STI value totalled R7 075 171 million before tax. Surpluses in the bonus pool are not carried over to the next financial period.
- We benchmarked the STI allocations as part of our annual policy review to ensure they are aligned with market and industry benchmarks. Amendments were made to align STI allocations to these benchmarks and to increase the weights applied to organisation performance across all grade levels.

Long-term incentives

- The LTI performance targets for the period January 2024 to December 2026 were implemented and approved by the Board.
- The LTI provision payable to eligible participants in April 2027 for the three-year cycle ending December 2026 is R3 516 392.19 for the 2025 year. The allocation is as follows:
 - » Executives: R3 153 616.55
 - » Employees: R362 775.64

Independent Member fees

- Independent Member fees included fees for attendance at Committee meetings, the AGM and workshops.
- A fee increase of 2.8% was implemented as of 1 June 2025.
- There were no deviations from the Independent Member Remuneration Policy.

Independent Member	Audit and Risk Committee	Investment Committee	Managed Healthcare Committee	Remuneration Committee	Other	Total
Prof DP van der Nest	R287 330				R45 646	R332 977
Mr T Poho	R313 140				R84 742	R397 882
Ms S Padayachy	R294 420					R294 420
Ms W Kirima		R94 692				R94 692
Mr TM Bikitsha		R159 588				R159 588
Dr YO Carrim			R333 900			R333 900
Ms P Kekana				R142 728	R66 289	R209 017
Ms D Msomi				R133 016	R17 598	R150 614

Trustee fees

- The Remuneration Committee confirmed that the effective date of new Trustee fees is 1 September of each financial year. This aligns with the AGM, meaning that Trustees would have completed a 12-month cycle since the date of the previous AGM.
- A fee increase of 2.8% was implemented as of 1 September 2025 for all Trustees. The fees for the 2025 financial year are set out in note 18.2 of the annual financial statements.

Meeting attendance by Trustees and Independent Members is set out on page 80.



ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

2025

Bonitas
Medical Aid for South Africa

ANNUAL FINANCIAL STATEMENTS

STATEMENT OF RESPONSIBILITY OF THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2025

ANNUAL FINANCIAL STATEMENTS

The Board is responsible for ensuring that Bonitas Medical Fund (“the Scheme”) maintains accurate accounting records; the preparation, integrity and fair presentation of the annual financial statements of the Scheme. The annual financial statements comprise the statement of financial position as at 31 December 2025, the statements of comprehensive income, changes in funds and reserves and cash flows for the period ended; and the notes to the financial statements which include a summary of significant accounting policies and other explanatory notes. The annual financial statements presented on pages 98 to 167 have been prepared in accordance with International Financial Reporting Standards (“IFRS”) and in a manner required by the Medical Schemes Act of South Africa, No 131 of 1998, as amended.

In the preparation of the annual financial statements, the Board considers that the most appropriate accounting policies have been used, consistently applied and supported by reasonable and prudent judgements and estimates in line with IFRS. The Board is satisfied that the information contained in the annual financial statements fairly represents the results of operations for the year and the financial position of the Scheme as at year-end. The Board also prepares other information included in the annual report and is responsible for its accuracy and consistency with the annual financial statements.

GOING CONCERN

The going concern basis has been adopted in preparing these financial statements.

The Board has reviewed detailed impact analyses and claims sensitivities to determine the financial impact of adverse and abnormal claiming trends on its reserves, profitability and liquidity and has determined that the Scheme has sufficient reserves and liquidity in place to manage the associated financial risk.

The Scheme’s forecasts support the long-term viability of the Scheme.

ACCOUNTING RECORDS AND CONTROL ENVIRONMENT

The Board is responsible for the Scheme’s system of internal controls which includes risk management and internal control procedures that are designed to provide reasonable, but not absolute assurance that assets are safeguarded and the risks facing the business are being monitored and controlled. Furthermore, the internal controls are designed to enable the preparation of annual financial statements that are free from material misstatement, whether due to fraud or error, and maintaining adequate accounting records and an effective system of risk management.

To the best of its knowledge and belief, based on the above, the Board is satisfied that no material breakdown in the operation of the systems of internal control and procedures has occurred during the year under review.

EXTERNAL AUDITOR’S RESPONSIBILITY

The external auditor, Deloitte, is responsible for reporting on whether the annual financial statements fairly represent the financial position of the Scheme in accordance with the applicable financial reporting framework, and their unqualified audit report is presented on page 103. Deloitte had unrestricted access to all financial records and related data. The Board believes that all representations made to the external auditor during their audit were accurate and appropriate.

OUTSOURCED INTERNAL AUDIT SERVICES

During 2025, the Board approved ad hoc Probity reviews as part of the internal audit plan as recommended by the Audit and Risk Committee to be performed by PricewaterhouseCoopers, who are the outsourced internal auditors of the Scheme. The Probity reviews were performed with regards to the administration and managed care RFPs concluded during 2025. These reviews served to assess adherence to internal policies, applicable legislation, and good governance practices.

APPROVAL OF THE ANNUAL FINANCIAL STATEMENTS

The annual financial statements of the Scheme were approved by the Board on 25 June 2026.

Mr OJ Komane
Chairperson of the Board

25 June 2026

Mr LR Callakoppen
Principal Officer

25 June 2026

Adv RT Monene
Vice-Chairperson of the Board

25 June 2026

STATEMENT OF CORPORATE GOVERNANCE

FOR THE YEAR ENDED 31 DECEMBER 2025

BOARD

The Scheme is committed to the principles and practices of fairness, transparency, responsibility and accountability in all dealings and engagements with its stakeholders. The Trustees are nominated and elected by the members of the Scheme or appointed by the Board in terms of the Rules of the Scheme and in accordance with the Medical Scheme Act of South Africa, No. 131 of 1998, as amended ("the Act"). The Trustees are required to act with due care, diligence and good faith in the best interests of the Scheme and its members. In pursuit of this, the Trustees conduct themselves in accordance with the Rules of the Scheme, the Act and terms of reference of the Board. Although voluntary for medical schemes, Bonitas is committed to subscribing to the King Code of Corporate Governance (King IV™ Report, and recently published King V™ Report) for additional guidance and best practice on good governance.

The Board meets regularly and monitors the performance of the Scheme, the administrator and other third-party service providers. The Trustees address a range of key issues and ensure that engagements, review and assessment of policy, governance, strategy and performance are critical, informed and constructive.

The Board further monitors its performance and that of the Board Committees against an agreed charter and performance targets.

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.

RISK MANAGEMENT AND INTERNAL CONTROLS

The Board, through the Audit and Risk Committee, remains ultimately responsible for oversight and approval of risk management within the Scheme. The governance, risk and compliance function is responsible for co-ordinating, facilitating, monitoring and reporting risk within the Scheme. These roles are executed based on an established risk management policy.

The Board is responsible for overseeing the establishment of effective systems of internal controls in order to provide reasonable assurance as to the integrity and reliability of the annual financial statements and to adequately safeguard the Scheme's assets, mainly through an outsourced model (i.e. administrator). The Scheme's internal controls are based on established policies and procedures and are implemented and exercised by trained personnel with the appropriate segregation of duties.

PricewaterhouseCoopers provides an outsourced internal audit function to the Scheme with a direct functional reporting line to the Audit and Risk Committee of the Scheme. PricewaterhouseCoopers confirmed in an Assessment of the systems of Internal Control, Risk Management and Governance Management Report issued to the Audit and Risk Committee (dated 25 March 2026) for the year ended 31 December 2025 that: "Other than the observations included in individual reports as prepared by PricewaterhouseCoopers and summarised in the Internal Audit status reports submitted to the ARC, nothing additional has come to our attention that would give rise to concern about the internal control environment within Bonitas in the areas reviewed (based on our specific scope and results of sample testing). Although a formal governance assessment was not performed for the year ended 31 December 2025, we conclude that no significant governance matters were noted where governance was addressed as part of the individual reviews."

In addition, internal audit reviews are also conducted by the administrators with regular reporting to Executive Management, including the Audit and Risk Committee of the Scheme.

MEDIA ALLEGATIONS

The Scheme is mindful of the allegations made in the media relating to alleged inappropriate business practices related to certain of its tender processes. In order to ensure that it was fully apprised of all relevant facts relating to these allegations, the Scheme appointed an independent and suitably qualified firm to investigate these allegations. Having considered the outcome of independent review, the Board is satisfied that no evidence which supports these allegations and that would impact the integrity, reliability, or accuracy of the Scheme's financial statements have been identified. The Board remains committed to upholding the highest standards of governance, transparency, and accountability and will continue to monitor and address any matters of concern appropriately.

Mr OJ Komane
Chairperson of the Board

25 June 2026

Mr LR Callakoppen
Principal Officer

25 June 2026

Adv RT Monene
Vice-Chairperson of the Board

25 June 2026

INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF BONITAS MEDICAL FUND



Private Bag X6
Gallo Manor 2052
South Africa

Deloitte & Touche
Registered Auditors
Accounting & Auditing
Deloitte
5 Magwa Crescent
Waterfall City
Waterfall 2090
Docex 10 Johannesburg

Tel: +27 (0)11 806 5200
www.deloitte.com

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Bonitas Medical Fund (the Scheme), set out on pages 104 to 167, which comprise the statement of financial position as at 31 December 2025, and 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 Bonitas Medical Fund as at 31 December 2025, and its financial performance and cash flows for the period then ended, in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board and the requirements of the Medical Schemes Act of South Africa.

Basis for Opinion

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

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:	R225 million (2024: R209 million).
How we determined it:	1% of total insurance revenue for the year
Rationale for the materiality benchmark applied:	A key judgement in determining materiality is the appropriate benchmark to select, based on our perception of the needs of the members of Bonitas Medical scheme, the users of the financial statements. We chose total 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.

INDEPENDENT AUDITOR’S REPORT

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	How the matter was addressed in the audit
Best Estimate Liability – Incurred But Not Reported (IBNR) and Risk Adjustment (RA) components of the Liability for Incurred Claims (LIC) Change in accounting estimate During the financial year ended 31 December 2025, the Scheme refined its actuarial methodology for measuring the LIC under IFRS 17: Insurance Contracts (IFRS 17). The refinement relates to the technique and confidence level applied in determining the RA for non-financial risk. The revised methodology reflects new developments in actuarial practice and enhances alignment with the Scheme’s risk objectives following the appointment of new external actuaries and related governance discussions. Previously, the LIC relied on the Chain Ladder and Adapted Bornhuetter Ferguson methods, with a 15% slower run off sensitivity and a 90% confidence level for the RA. Under the revised approach, the Scheme continues using these projection methods but now calculates the RA using a Weibull distribution and Monte Carlo simulations for best estimate liability – incurred but not reported claims. The confidence level has also been revised to 75%, providing a more appropriate reflection of the Scheme’s risk appetite and diversification benefits. This is regarded as a change in accounting estimate in accordance with IAS 8: Accounting Policies, Changes in Accounting Estimates and Errors (IAS 8). IBNR As disclosed in Note 11.1, the carrying amount of the best estimate liability – incurred but not reported claims at year end is R1 142 903 000 (2024: R1 102 360 000) of which R1 055 648 834 (2024: R1 049 193 619) relates to the Scheme’s computed IBNR, which is the focus of the key audit matter. The determination of the IBNR 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 and related external claims handling expenses. The Basic Chain Ladder (BCL) method, in combination with the Bornhuetter-Ferguson (BF) method, has been used to determine the IBNR as at 31 December 2025. The IBNR calculation is based on several factors, which include: • The level of homogeneity of the data; • Changes in patterns of claims and claims processing; • Changes in the composition of the Scheme i.e. distribution of members and their beneficiaries across various options; • Changes in benefit limits; and • Changes in prescribed minimum benefits. RA As disclosed in Note 11.1, the carrying amount of the risk adjustment relating to insurance contract claims at year end is R91 746 000 (2024: R150 500 000) of which R86 903 400 (2024: R146 288 171) relates to the Scheme’s computed RA, which is the focus of the key audit matter. In terms of IFRS 17, the risk adjustment reflects the compensation that the entity requires for bearing the uncertainty related to the amount and the timing of the cash flows that arise from non-financial risk. The risk adjustment was determined by using a two-parameter Weibull distribution and simulated run-off factors generated through Monte Carlo Simulations. The confidence level has been set at the 75th percentile reflecting the Scheme’s risk attitude towards the level of conservatism considered in its liability reserving, solvency management and pricing practices. We considered the LIC as a key audit matter due to: • The materiality of the liability; and • Significant judgement and estimation uncertainties in determining the future cash flow projections and the risk adjustment.	In evaluating the valuation of the IBNR and RA components of the LIC, we evaluated the calculations approved by the board of trustees and performed procedures which included: • Considered the design and implementation of the Scheme’s controls relating to the preparation of the IBNR and RA calculation though gaining an understanding of the end-to-endclaims and LIC calculation business process; • Obtained the report of the Scheme’s actuaries relating to the LIC at year end and tested the appropriateness of the estimate as follows: » Evaluated the competence, capabilities and objectivity of the Scheme’s actuary; » Obtained an understanding of the methodology and assumptions used in estimating the LIC. With the assistance of our actuarial specialists, assessed the appropriateness of the methodology and assumptions used in determining the IBNR and RA components of theLIC in terms of acceptable methodologies, industry standards, and the measurement objectives of IFRS 17. » Reviewed the changes in methodology applied to the IBNR and RA components of the LIC, including the rationale for these changes and their alignment with actuarial best practice, IFRS 17 and the Scheme’s risk objectives. Assessed whether these changes constitute a change in an accounting estimate as opposed to a prior period error and concluded that they do, based on the refinement of the methodology and related confidence level. » Evaluated the integrity of the information used in the calculation of the LIC by performing substantive procedures to test the accuracy and completeness ofdata used in the valuation of the IBNR and RA components of the LIC; » Our actuarial specialists performed an independent calculation of the estimated LIC by utilising historical claims data and trends. We used this estimate as a basis of assessing the reasonableness of the board of trustees’ estimate of the LIC. • Assessed the presentation and disclosure in respect of the LIC, including the change in accounting estimate disclosure, and considered the adequacy of these disclosures against the requirements of IFRS 17, IAS 8 and relevant industry guidance. Back testing: Considered the Scheme’s assessment of the actual claims processed in 2026 in respect of services provided in the 2025 financial year to determine the need for any subsequent events disclosure. This assessment indicated no material differences between the claims incurred and the IBNR and therefore no subsequent events disclosure is required. Based on the procedures performed, we are satisfied that the valuation of the IBNR and RA components of the LIC is appropriate.

INDEPENDENT AUDITOR'S REPORT

Other Information

The Scheme's trustees are responsible for the other information. The other information comprises the information included in the Integrated Report. 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

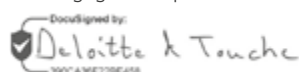
Non-compliance with the Medical Schemes Act of South Africa

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 & Touche has been the auditor of Bonitas Medical Fund for nine years.

The engagement partner, Claudette van der Merwe, has been responsible for Bonitas Medical Fund audit for two years.



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

5 Magwa Crescent
Waterfall City
2090

30 June 2026

STATEMENT OF FINANCIAL POSITION

AS AT 31 DECEMBER 2025

	Notes	2025 R'000	2024 R'000
ASSETS			
Non-current assets			
Property and equipment	4	7 168	3 419
Financial assets held at fair value through profit or loss	6	6 262 992	5 932 586
Total non-current assets		6 270 160	5 936 005
Current assets			
Financial assets held at fair value through profit or loss	6	6 279 456	4 755 629
Reinsurance contract assets	13	112 538	95 384
Trade and other receivables	7	11 481	12 336
Cash and cash equivalents	8	966 466	848 715
Total current assets		7 369 941	5 712 064
Total assets		13 640 101	11 648 069
LIABILITIES			
Non-current liabilities			
Lease liability	4.2	2 555	–
Long-term employee benefit obligation	9	6 443	2 927
Liability to members for future benefits*	10	10 824 568	9 029 093
Total non-current liabilities		10 833 566	9 032 020
Current liabilities			
Insurance contract liabilities	11	2 764 246	2 583 210
Lease liability	4.2	2 957	2 405
Trade and other payables	14	39 332	30 434
Total current liabilities		2 806 535	2 616 049
Total liabilities		13 640 101	11 648 069

* The term "Insurance liability for future members" has been renamed to "Liability to members for future benefits". This represents the accumulated surplus held for the benefit of future members.

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2025

	Notes	2025 R'000	2024 R'000
Insurance revenue	15	22 568 292	20 888 306
Insurance service expenses**		(23 404 280)	(22 153 413)
Net claims incurred*		(20 997 310)	(19 860 161)
Claims incurred	15.1	(21 281 318)	(20 091 944)
Third party claims recoveries	15.7	67 798	58 387
Changes that relate to past service – adjustments to the LIC	15.2	216 210	173 396
Insurance acquisition cash flows	15.3	(429 145)	(420 406)
Accredited managed healthcare services (no transfer of risk)*	15.4	(702 008)	(664 000)
Directly attributable expenditure	15.5	(1 275 817)	(1 208 846)
Accredited administration service	15.5.1	(1 033 075)	(1 010 512)
Other administration expenditure	15.5.2	(242 742)	(198 334)
Net income from risk transfer arrangements/reinsurance*	15.6	453 826	433 320
An allocation of premiums paid		(2 045 231)	(1 951 687)
Amounts recovered from risk transfer arrangement/reinsurance		2 499 057	2 385 007
Insurance service result**		(382 162)	(831 787)
Other income		2 667 060	1 416 216
Investment income – Scheme	16	2 610 470	1 385 696
Loss on sale of investment property	5	–	(13 500)
Sundry income	17	56 590	44 020
Net insurance finance expenses		(84 732)	(84 852)
Finance expenses from insurance contracts issued – PMSA	11.4	(84 732)	(84 852)
Other expenditure		(404 691)	(365 686)
Administration fees and other operating expenses	18	(364 456)	(324 501)
Asset management fees		(40 003)	(35 669)
Interest expense	4.2	(232)	(322)
Operating expenses on rental of investment property	5	–	(5 194)
Surplus or deficit for the year before amounts attributable to members for future benefits		1 795 475	(133 891)
Amounts attributable to members for future benefits***		(1 795 475)	(133 891)
Total surplus or deficit for the year		–	–
Total comprehensive income for the year		–	–
Relevant healthcare expenditure*		(21 245 492)	(20 090 841)

* As required by CMS Circular 32 of 2025, "Relevant healthcare expenditure" is presented as a separate line item and comprises net claims incurred, accredited managed healthcare services (no transfer of risk), and net income/(expense) from risk transfer arrangements/reinsurance. This resulted in a representation of the prior year affected line item as follows: Net claims incurred was added to the value of R20 997 310 (2024: R19 860 161).

** The prior year comparative for insurance service expense and insurance service result has been represented to exclude amounts attributable to members for future benefits, which is now shown separately after surplus or deficit for the year before amounts attributable to members for future benefits.

*** In accordance with IFRS 17 and recognising the Scheme as a mutual entity, amounts attributable to members for future benefits represents the net surplus earmarked for the future benefit of existing and future members realised in the current financial period. Circular 6 of 2025 issued by the CMS requires medical schemes to present "Amounts attributable to members for future benefits" separate from the "Insurance service expenses" and the "Insurance service result". This resulted in a representation of the prior year affected line items as follows: Amounts attributable to members for future benefits to the value of R1 795 475 (2024: R133 891) is now being disclosed as a separate line item on the statement of comprehensive income after the surplus for the year before amounts attributable to members for future benefits.

Insurance service expenses in accordance with IFRS 17 include amounts attributable to members for future benefits, the total value of insurance service expenses therefore amounts to R25 199 755 (2024: R22 287 304).

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2025

	Notes	2025 R'000	2024 R'000
Cash flows from operating activities			
Cash receipts from members and providers		23 961 169	22 112 157
Cash receipts from members – contributions		23 851 412	21 967 054
Cash receipts from members and providers – other		109 757	145 103
Cash paid to providers, employees and members		(24 471 425)	(22 800 082)
Cash paid to providers and members	20.1.5	(22 763 113)	(21 151 953)
Cash paid to providers and employees – non healthcare expenditure	20.1.6	(1 624 978)	(1 571 345)
Cash paid to members – savings plan refunds	11.4	(83 334)	(76 784)
Cash utilised in operating activities		(510 256)	(687 925)
Interest paid	11.4	(84 732)	(84 852)
Interest received	16	10 860	19 942
Net cash outflow from operating activities		(584 128)	(752 835)
Cash flows from investing activities			
Acquisition of property and equipment	4	(730)	(696)
Proceeds on disposal of investment property	5	–	61 500
Acquisition of financial assets held at fair value through profit or loss	6	(2 282 731)	(2 414 357)
Disposal of financial assets held at fair value through profit or loss	6	2 515 743	2 733 252
Interest received	20.1.1	293 938	290 231
Dividends received	20.1.2	218 327	192 703
Asset management fees	20.1.3	(39 903)	(35 359)
Rentals received	20.1.4	–	9 324
Net cash inflow from investing activities		704 643	836 598
Cash flows from financing activities			
Lease payments	4.2	(2 765)	(2 649)
Net cash outflow from financing activities		(2 765)	(2 649)
Net increase in cash and cash equivalents		117 751	81 114
Cash and cash equivalents at beginning of the year	8	848 715	767 601
Cash and cash equivalents at end of the year		966 466	848 715

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

1. GENERAL INFORMATION

The Scheme is a registered non-profit, open medical scheme in terms of the Medical Schemes Act 131 of 1998 (“the Act”) and is domiciled in the Republic of South Africa. The Scheme is administered by Medscheme Holdings Proprietary Limited. Private Health Administrators (PHA) Proprietary Limited handles the Scheme’s benefit option, BonCap. This also includes associated administration and managed care services relating to the BonCap option.

2. MATERIAL ACCOUNTING POLICIES

2.1 Basis of preparation

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

2.1.1 Statement of compliance

The annual financial statements are prepared in accordance with International Financial Reporting Standards (“IFRS”) and interpretations issued by the IFRS Interpretations Committees, as applicable in South Africa, and in the manner required by the Act.

2.1.2 Basis of measurement

These annual financial statements have been prepared on the going concern basis and using the historical cost basis except for fair value through profit or loss financial instruments and investment properties that are held at fair value and insurance and reinsurance assets and liabilities that are measured in terms of IFRS 17 current estimates.

Historical cost is generally based on the fair value of the consideration given in exchange for goods and services.

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

In estimating the fair value of an asset or liability, the Scheme takes into account the characteristics of the asset or liability if market participants would take these characteristics into account when pricing the asset or liability at the measurement date. Fair value for measurement and/or disclosure purposes in these financial statements is determined on such a basis except for leasing transactions that are within the scope of IFRS 16.

2.1.3 Functional and presentation currency

The annual financial statements are prepared in Rand which is the Scheme’s functional and presentation currency. All financial information presented has been rounded to the nearest thousand (R’000), unless otherwise stated.

2.1.4 Presentation changes – comparative reclassification

In the current year, the Scheme reclassified the item previously presented as “Amounts attributable to future members” within insurance service expenses to a separate line named “Amounts attributable to members for future benefits” after the surplus or deficit for the year before amounts attributable to members for future benefits. The comparative figures for 2024 have been reclassified accordingly. This reclassification had no impact on the overall result.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

2. MATERIAL ACCOUNTING POLICIES (CONTINUED)

2.1 Basis of preparation (continued)

2.1.5 New standards, amendments to published standards and interpretations

(a) New standards, amendments and interpretations issued and not yet effective in 2025 and relevant to the Scheme

Standard	Details of amendment	Effective date Periods beginning on or
IFRS 18	IFRS 18 Presentation and Disclosure in Financial Statements: The new IFRS Accounting Standard IFRS 18 Presentation and Disclosure in Financial Statements replaces IAS 1 Presentation of Financial Statements. IAS 1 Presentation of Financial Statements did not have detailed requirements on: a) classification of income and expenses in the statement of profit or loss. b) presentation of subtotals above 'profit or loss' in the statement of profit or loss; or c) aggregation and disaggregation of information presented in the primary financial statements or disclosed in the notes. This lack of detailed requirements led to diversity in practice as entities defined their own subtotals and performance measures. Investors found it difficult to analyse and compare companies' financial performance. IFRS 18 Presentation and Disclosure in Financial Statements, will improve the quality of financial reporting by: a) requiring defined subtotals in the statement of profit or loss; b) requiring disclosure about management-defined performance measures; and c) adding new principles for aggregation and disaggregation of information. The IASB expects these improvements will enable investors to make more informed decisions leading to better allocations of capital that will contribute to long-term financial stability. Application of IFRS 18 is currently being assessed at an industry level.	1 January 2027
IFRS 9 Financial Instruments	Amendments to IFRS 9: Narrow scope amendments to address diversity in accounting practice by making the classification and measurement requirements of IFRS 9 more understandable and consistent, by: a) Clarifying the classification of financial assets with environmental, social and corporate governance (ESG) and similar features; and b) Clarifying the date on which a financial asset or financial liability is derecognised when a liability is settled through electronic payment systems. These amendments also introduce an accounting policy option to allow a company to derecognise a financial liability before it delivers cash on the settlement date if specified criteria are met. Financial instruments are a material balance to the Scheme. The Scheme's investments currently do not contain environmental, social and governance (ESG) or similar features, and the Scheme does not track specific ESG targets. Accordingly, the amendments relating to ESG linked features are not expected to have a material impact. Overall, the amendments are not expected to have a material impact considering no change in business model is anticipated.	1 January 2026

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

2. MATERIAL ACCOUNTING POLICIES (CONTINUED)

2.2 Events after reporting date

Recognised amounts in the annual financial statements are adjusted to reflect events arising after reporting date that provide evidence of conditions that existed at the reporting date. Events arising after the reporting date, that are indicative of conditions that arose after the reporting date, are dealt with by way of a note disclosure.

2.3 Property and equipment

Property and equipment is measured at historical cost less accumulated depreciation and accumulated impairment losses. Costs include expenditure that is directly attributable to the acquisition of the asset.

Depreciation is calculated using the straight-line method to allocate the cost of items of property and equipment to their residual values over their estimated useful lives.

The depreciation rates applicable to each category of property and equipment for the current and comparative periods are as follows:

- Motor vehicles – 5 years
- Leasehold improvements – 5 years
- Computer equipment – 1 to 5 years
- Furniture and fittings – 1 to 5 years
- Right of use asset – amortised over lease term

Depreciation methods, residual values and useful lives are reviewed at each reporting date and adjusted where appropriate. If the carrying amount of the asset is greater than its estimated recoverable amount, the carrying amount is written down immediately to its recoverable amount.

Subsequent costs are included in an asset's carrying amount or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the Scheme and the cost of the item can be measured reliably. All other repairs and maintenance costs are recognised in profit or loss during the financial period in which they are incurred.

Gains and losses on disposals are determined by comparing the proceeds from the disposal with the carrying amount of the relevant asset and these are recognised in profit or loss during the financial period.

2.4 Financial instruments

2.4.1 Classification, recognition and measurement

Regular-way purchases and sales of financial assets and liabilities are recognised on trade date, being the date that the Scheme becomes a party to the contractual rights or obligations of the instrument. The Scheme has the following financial instrument categories: Fair value through profit or loss; Loans and receivables; and Financial liabilities.

A financial asset is any asset that is:

- Financial assets held at fair value through profit or loss;
- Trade and other receivables (non-insurance related); and
- Cash and cash equivalents.

The classification and measurement of the financial assets depend on the objective of the Scheme's business model whether it is to hold assets only to collect cash flows, or to collect cash flows and to sell and whether the contractual cash flows of an asset give rise to payments on specified dates that are solely payments of principal and interest on the principal amount outstanding. Management applies this assessment to financial instruments at initial recognition and re-evaluates this for financial assets when the objective of the Scheme's business model changes.

Financial instruments are initially measured at fair value plus transaction costs that are directly attributable to acquisition or issue of the financial asset or liability. Subsequent to initial recognition, these instruments are measured as set out below.

(i) Financial assets held at fair value through profit or loss

These financial assets are initially recognised at fair value excluding transaction costs, which are immediately expensed.

These financial assets are subsequently measured at fair value. The fair value adjustments are recognised in the statement of profit or loss during the financial period.

(ii) Financial assets held at amortised cost

Financial assets held at amortised cost are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market other than those that the Scheme intends to sell in the short term. Trade and other receivables are classified in this category and are reviewed for impairment as part of the impairment review of financial assets held at amortised cost. They are included in current assets, except for maturities greater than 12 months after the end of the reporting period. These are classified as non-current assets.

Financial assets held at amortised cost comprise of 'Trade and other receivables' (excluding prepaid expenses) and 'Cash and cash equivalents'.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

2. MATERIAL ACCOUNTING POLICIES (CONTINUED)

2.4 Financial instruments (continued)

2.4.1 Classification, recognition and measurement (continued)

(ii) Financial assets held at amortised cost (continued)

Financial assets held at amortised cost are initially measured at fair value plus transaction costs and are subsequently measured at amortised cost using the effective interest rate method, less impairment losses. The effective interest rate method is a method of calculating the amortised cost of a financial asset and of allocating the corresponding interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash flows through the expected life of the financial asset or where appropriate a shorter period.

a) Trade and other receivables (does not include members that are in arrears)

Trade and other receivables balances are reviewed for impairment as part of the impairment review conducted on financial assets held at amortised cost.

b) Cash and cash equivalents

Cash and cash equivalents comprise cash on hand, deposits held at call with banks, and other short-term liquid investments that are readily convertible to a known amount of cash and are subject to an insignificant risk of change in value, and have an original maturity of 90 days or less.

(iii) Financial liabilities

A financial liability is a liability that is a contractual obligation to deliver cash or another financial asset to another entity or to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavourable to the entity. They are included in current liabilities, except for maturities greater than 12 months after the end of the reporting period. These are classified as non-current liabilities.

Financial liabilities comprise trade and other payables.

Financial liabilities are recognised initially at fair value less any directly attributable transaction costs. Subsequent to initial recognition, financial liabilities are measured at amortised cost, using the effective interest rate method.

a) Trade and other payables

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Accounts payable are classified as current liabilities if payment is due within one year or less (or in the normal operating cycle of the business if longer). If not, they are presented as non-current liabilities. Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest rate method.

2.4.2 Impairment of financial assets

(i) Financial assets held at amortised cost

The Scheme's financial assets held at amortised cost do not contain a significant financing component and therefore the loss allowance is measured at initial recognition as the expected credit losses that result from all possible default events over the expected life of a financial asset (ECL) in accordance with IFRS 9. As a practical expedient, IFRS 9 allows a provision matrix to be used to estimate ECL for these financial assets.

The provision matrix is based on historical observed default rates, adjusted for forward looking estimates. At every reporting date, the historical observed rates are updated. Objective evidence that a financial asset or group of assets is impaired includes observable data that comes to the attention of the Scheme about the following events: the Scheme is unable to collect all amounts due according to the original terms of the receivables; significant financial difficulty of the issuer or debtor; a breach of contract, such as a default or delinquency in payments by the debtor; the disappearance of an active market for that financial asset because of financial difficulties; or national or local economic conditions that correlate with defaults on the assets of the Scheme.

If it is determined that a possible impairment loss will be incurred on loans and receivables measured at amortised cost, the amount of the loss is measured as the difference between the present value of the cash flows due under the contract and the present value of the cash flows that the entity expects to receive. These losses are recognised at initial recognition in profit or loss and reflected in an allowance account.

If in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised (such as improved credit rating), the previously recognised impairment loss is reversed directly to profit or loss.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

2. MATERIAL ACCOUNTING POLICIES (CONTINUED)

2.4 Financial instruments (continued)

2.4.3 Derecognition

Financial assets are derecognised when the rights to receive cash flows from the assets have expired, the right to receive cash flows has been retained but an obligation to pay them in full without material delay has been assumed or the right to receive cash flows has been transferred together with substantially all the risks and rewards of ownership.

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

Where the Scheme neither transfers nor retains substantially all the risks and rewards of ownership of the financial asset, the Scheme determines whether it has retained control of the financial asset. If the Scheme has not retained control, it derecognises the financial asset and recognises separately as assets or liabilities any rights and obligations created or retained in the transfer; and if the Scheme has retained control, it continues to recognise the financial asset to the extent of its continuing involvement in the financial asset.

The Scheme derecognises a financial liability when the contractual obligations are discharged, cancelled or expire.

2.4.4 Offset

Financial assets and liabilities are offset and the net amount reported in the statement of financial position only when there is a legally enforceable right to offset the recognised amounts and there is an intention to settle on a net basis, or to realise the asset and settle the liability simultaneously.

2.5 Insurance contracts

2.5.1 Identification of insurance contracts

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

Whilst the timing, frequency, severity and type of health events are uncertain, the ultimate insurance risk covered by a medical scheme can be defined as a single risk – that of providing cover for a health event that the member may incur. The risk under the insurance contracts issued by medical schemes can be expressed as the probability that an insured event (“health event”) occurs, multiplied by the expected amount of the resulting claim. Risk transfer arrangements are dealt with in note 2.6.

2.5.2 Separating components from an insurance contract

An investment component and an insurance component are highly interrelated if, and only if:

- the entity is unable to measure one component without considering the other. Thus, if the value of one component varies according to the value of the other, an entity shall apply IFRS 17 to account for the combined investment and insurance component; or
- the policyholder is unable to benefit from one component unless the other is also present. Thus, if the lapse or maturity of one component in a contract causes the lapse or maturity of the other, the entity shall apply IFRS 17 to account for the combined investment component and insurance component

The Personal Medical Savings Account (PMSA) meets the definition of an investment component in IFRS 17 as it requires the medical scheme to repay a member in all circumstances, regardless if an insured event occurred. The investment component is not distinct and has to be accounted for in terms of IFRS 17.

The cash flows relating to the PMSA are not recorded in the statement of comprehensive income, but are considered in assessing onerous contracts.

2.5.3 Level of aggregation

The Scheme is regarded as a mutual entity for accounting purposes. The Scheme as a whole was identified as a portfolio of insurance contracts. All contracts issued by the Scheme are subject to similar risks and managed together. As the Act specifically constrains the Scheme's practical ability to set a different price or level of benefits for members with different characteristics the Scheme as a whole was also identified as the group of insurance contracts. The Scheme assesses if the group as whole is onerous or profitable. Where the following year's deficit exceeds the liability to members for future benefits – the most residual interest – the contracts written would be onerous and an onerous contract liability raised. Where the liability to members for future benefits exceeds the following year's deficit the contracts would not be determined as onerous, and no provision raised as a liability is already recognised.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

2. MATERIAL ACCOUNTING POLICIES (CONTINUED)

2.5 Insurance contracts (continued)

2.5.4 Contract boundary

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

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

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

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

IFRS 17(35) Cash flows outside the insurance contracts boundary relate to future insurance contracts and are recognised when those contracts meet the recognition criteria.

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

2.5.5 Recognition and derecognition

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

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

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

2.5.6 Premium allocation approach (PAA)

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

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

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

The Scheme measures the liability for incurred claims at the fulfilment cash flows relating to incurred claims. The future cash flows are not adjusted for the time value of money and the effect of financial risk as these cash flows are expected to be paid in one year or less from the date the claims are incurred. There is no significant financing component included in the liability for remaining coverage and thus the Scheme is not required to apply a discounted value.

2.5.7 Initial and subsequent measurement

For insurance contracts issued, on initial recognition, the Scheme measures the Liability for remaining coverage (LRC) at the amount of contributions received. 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 and increased the LRC. Debtors that paid in advance and for which no service has yet been provided are included in the LRC. Debtors in arrears and for which services and coverage have been provided but not yet paid are included in LRC.

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

- a) the LRC, including a loss component for onerous contracts where applicable; and
- b) the Liability for incurred claims (LIC), comprising the future fulfillment cash flows related to past service allocated to the group at the reporting date.

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

- a) increased for contributions received in the period; and
- b) decreased for the amounts of expected contributions received recognised as insurance revenue for the services provided in the period.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

2. MATERIAL ACCOUNTING POLICIES (CONTINUED)

2.5 Insurance contracts (continued)

2.5.7 Initial and subsequent measurement (continued)

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

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

The Scheme has chosen to account for the accounts payable related to the attributable expenses under the currently applicable accounting standard, which is IFRS 9, rather than IFRS 17. Consequently, the attributable expenses payable are disclosed as financial liabilities, specifically under the category of trade and other payables.

Refer to note 3.1 for the significant judgements and estimates used to determine the LIC and the estimates to determine the fulfilment cash flows.

Personal Medical Savings Accounts (PMSA)

PMSA balances form part of the cash flows within the contract boundary of the Scheme's medical insurance contracts. As the contracts have a coverage period of one year, all PMSA amounts relating to that coverage period are transferred from the Liability for Remaining Coverage (LRC) to the Liability for Incurred Claims (LIC) at the end of each financial year, when the underlying medical contract with the member ends.

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 liability to members for future benefits. In the rare scenario where the following year's deficit exceeds the insurance liability to members for future benefits – the contracts written would be onerous and an onerous contract liability raised. Where the liability to members for future benefits exceeds the following year's deficit the contracts would not be determined as onerous, and no provision raised as a liability is already recognised.

2.5.8 Insurance revenue

Insurance revenue for the period is the amount of expected premium receipts (excluding the PMSA) allocated to the period. The expected contribution receipts include the risk of non-payment by the member. The Scheme allocates the expected premium receipts to each period of insurance contract services on the basis of the passage of time.

2.5.9 Insurance expenses

Insurance service expenses include:

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

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

The Scheme includes the following acquisition cash flows within the insurance contract boundary that arise from selling, underwriting and starting a group of insurance contracts and that are:

- a) costs directly attributable to individual contracts and the group of contracts; and
- b) costs directly attributable to the group of insurance contracts, which are allocated on a reasonable and consistent basis.

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

2.5.10 Insurance interest income and expenses

The non-distinct investment component (PMSA) accrues interest. This is disclosed within the insurance finance expenses line item.

2.6 Risk transfer arrangements

2.6.1 Definition

Risk transfer arrangements 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. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependants.

2.6.2 Level of aggregation

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 reinsurance contracts held concluded within a calendar year (annual cohorts) into (i) groups of contracts for which there is a net gain at initial recognition, if any; (ii) contracts for which at initial recognition there is no significant possibility of a net gain arising subsequently; and (iii) 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

2. MATERIAL ACCOUNTING POLICIES (CONTINUED)

2.6 Risk transfer arrangements (continued)

2.6.3 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:

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

The Scheme does not recognise their reinsurance contract held until it has recognised at least one of the underlying insurance contracts.

2.6.4 Initial and subsequent measurement

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

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

- a) the remaining coverage; and
- b) the incurred claims, comprising the FCF related to past service allocated to the group at the reporting date.

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

- a) increased for ceding contributions paid in the period; and
- b) decreased for the amounts of ceding contributions 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 the coverage period which is one year or less. The asset for the remaining coverage for reinsurance contracts held will not be discounted and there are no significant financing components.

2.6.5 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 capitation agreements held have a duration of one year but are cancellable with a 30-day notice period by either party.

2.6.6 Net income/(expense) from reinsurance contracts held

Reinsurance income consists of the amount that depicts the value the insurer benefits from entering into a risk transfer arrangement (i.e., the value of services received from the capitation provider).

- a) reinsurance expenses; and
- b) effect of changes in risk of reinsurer non-performance.

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

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

2.7 Employee benefits

2.7.1 Defined contribution plans

A defined contribution plan is a post-employment benefit plan under which an entity pays fixed contributions into a separate entity and will have no legal or constructive obligation to pay further amounts. Obligations for contributions to defined contribution pension plans are recognised as an employee benefit expense in profit or loss when they are due. Prepaid contributions are recognised as an asset to the extent that a cash refund or a reduction in future payments is available.

2.7.2 Short-term benefits

Short-term employee benefit obligations are measured on an undiscounted basis and are expensed in profit or loss during the period in which the employee renders the related service.

A liability is recognised for the amount expected to be paid under short-term cash bonus plans if the Scheme has a present legal or constructive obligation to pay this amount as a result of past service provided by the employee and the obligation can be estimated reliably.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

2. MATERIAL ACCOUNTING POLICIES (CONTINUED)

2.7 Employee benefits (continued)

2.7.3 Other long-term benefits

There is currently a long-term deferred remuneration scheme/long-term employee benefit obligation ("LTI") in place whereby key employees who qualify are entitled to a deferred portion of each year's incentive determined based on tenure and certain performance conditions agreed to by the Board of Trustees. The amounts are payable at the end of the applicable three-year vesting period if the employees are still in the employment of the Scheme and the performance conditions have been met. The Board of Trustees will approve the final amount of the LTI to be settled in line with the terms and conditions of the Scheme's incentive policy and each participant will be allocated their amounts payable accordingly.

The liability due to eligible participants is recognised over the required service/vesting period and reflects the present value of amounts due to the participants at the end of that period. The liability is measured on the mostly likely outcome basis, with the corresponding expense recognised over the service period.

2.8 Leases

Identification of a lease

The Scheme leases property which is accounted for under IFRS 16. The contracts contains a lease as defined because it conveys the right to control the use of the identified asset for a period of time in exchange for consideration.

The Scheme as a lessee:

For contracts for which the Scheme is a lessee the initial measurement requires the recognition of a right of use asset and lease liability recognised at commencement date.

The right of use asset is initially recognised at cost which includes the initial amount of the lease liability adjusted for any lease payments made on or before commencement date plus initial direct costs incurred.

The right of use asset is subsequently depreciated on a straight line basis over the useful life which is the same basis as the lease period. Additionally the right of use asset is periodically reduced by impairments if any and adjusted for changes in the remeasurement of the lease liability.

The lease liability is initially measured at the present value of lease payments that are not paid at the commencement date discounted at the interest rate if that rate can be readily determined. If that rate cannot be readily determined, the Scheme uses the lessee's incremental borrowing rate.

Lease payments included in the measurement of the lease liability comprise fixed payments including in substance fixed payments less any incentives receivable.

The lease liability is subsequently measured by increasing the carrying amount to reflect interest on the lease liability (using the effective interest method) and by reducing the carrying amount to reflect the lease payments made.

The Scheme as a lessor:

Contracts wherein the Scheme is a lessor, are either classified as an operating lease or a finance lease based on an overall assessment to determine whether substantially all the risks and rewards are transferred or retained by the Scheme. Payments made under operating leases are recognised in profit or loss on a straight-line basis over the period of the lease.

2.9 Investment income

Investment income comprises: interest on call accounts, current accounts, bonds and money market instruments; dividend income; rental income from investment properties; net realised and unrealised fair value gains and losses on financial assets at fair value through profit or loss; changes in the fair value of investment property and gains/losses on disposal of investment properties.

2.9.1 Interest income

Interest income is recognised on a yield to maturity basis, taking account of the principal outstanding and the effective rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

2.9.2 Dividend income

Dividend income from investments is recognised when the right to receive payment is established – this is the ex-dividend date for equity securities.

2.9.3 Rental income

Assets leased to third parties are included in investment property in the statement of financial position. Lease income from operating leases is recognised in profit or loss on a straight-line basis over the lease term.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

2. MATERIAL ACCOUNTING POLICIES (CONTINUED)

2.10 Allocation of income and expenses to benefit options

The following items are directly allocated to benefit options:

- Insurance revenue;
- Claims incurred;
- Net income from risk transfer arrangements/reinsurance;
- Directly attributable expenditure;
- Accredited managed healthcare services;
- Acquisition costs; and
- Finance expenses from insurance contracts issued – PMSA

The remaining non-healthcare expenses and income are apportioned based on the average number of members per option divisible by total membership of the Scheme for the financial period.

- Other administrative expenditure;
- Investment income;
- Sundry income; and
- Asset management fees.

3. USE OF ESTIMATES AND JUDGEMENTS

Consistent with other IFRS, financial reporting under IFRS 17 is, to a larger extent, based on estimates, judgements and models rather than exact depictions. The IFRS Conceptual Framework establishes the concepts that underlie those estimates, judgements and models. Where an application of a particular standard requires judgments or provides options, it is expected that the preparers of financial information will choose among the alternatives in a way that achieves the objective of financial reporting: to provide financial information about the reporting entity that is useful to the trustees, Council for Medical Schemes (CMS) and members.

In addition to the existing requirement in IFRS to disclose critical judgements made in applying accounting policies (IAS 1(122)) and major sources of estimation uncertainties (IAS 1(125)), IFRS 17 requires the following specific disclosures with respect to contracts in the scope of the standard:

- the methods used to measure insurance contracts and the processes used for estimating inputs to those methods, including quantitative information about those inputs when practicable, and specifically approaches used to determine the risk adjustment for non-financial risk,
- any changes in the above method and process, together with an explanation of the reason for each change and the type of contracts affected.

If an entity uses a technique other than the confidence-level technique for determining the risk adjustment, it is required to disclose a translation of the result of that technique into a confidence level to allow users of financial statements to see how the entity's own assessment of its risk aversion compares to that of other entities.

3.1 Significant judgements and estimates for insurance contracts: assets and liabilities

3.1.1 Assessment as to whether the Scheme is a mutual entity

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

IFRS 3 defined a "mutual entity" as "An entity, other than an investor-owned entity, that provides dividends, lower costs or other economic benefits directly to its owners, members or participants. 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 Bonitas 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

3. USE OF ESTIMATES AND JUDGEMENTS (CONTINUED)

3.1 Significant judgements and estimates for insurance contracts: assets and liabilities (continued)

3.1.1 Assessment as to whether the Scheme is a mutual entity (continued)

Although the 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 Bonitas should be distributed to the members on liquidation if there are any and if the Scheme does not amalgamate with another scheme. Even if the assets are distributed by a regulator or by the policyholders to an independent third party e.g. another medical scheme, an administrator or a charity, the important aspect is that the choice resides with the members or the regulator acting on behalf of the members, not with an equity holder.

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

It is therefore expected that the remaining assets of the scheme will be used to pay current and future members. Based on the above, Bonitas meets the definition of a mutual entity in IFRS. Bonitas has therefore developed an accounting policy in terms of the IFRS 17 guidance for mutual entities and the educational material as issued by the IASB and the Scheme recognises any cumulative profit or losses as part of the liability to members for future benefits.

Consequently, the statement of comprehensive income reflects no total comprehensive income for the year. The movement in the liability to members for future benefits is included in the surplus or deficit for the year.

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

3.1.2 Level of aggregation

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

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 management benefit
- Risk transfer arrangements are based on conditions and not on benefit options.
- Pricing and benefit option changes are determined at a Scheme level to ensure sustainability for the Scheme overall, given inherent cross-subsidies in the medical scheme environment.
- Risk (utilisation and concentration) is managed holistically.

3.1.3 Risk adjustment – liability for incurred claims (LIC)

During the current financial year, the Scheme refined its methodology for determining the risk adjustment for non-financial risk within the Liability for Incurred Claims (LIC).

While the underlying approach to projecting claims (Chain Ladder and Adapted Bornhuetter-Ferguson) remains unchanged, the risk adjustment technique has been updated to incorporate a two-parameter Weibull distribution and Monte Carlo simulations, with the confidence level revised from 90% to 75%.

This refinement aligns with IFRS 17 principles, reflects updated actuarial practices, and better represents the Scheme's risk appetite. In terms of IAS 8, this refinement in methodology has been treated as a change in accounting estimate.

The biggest risk inherent in run-off models are the run-off assumptions applied. Any processing changes and/or delays between providers and the administrator (relative to the input assumptions) would impact on the best estimate value of fulfilment cash flows provided.

Therefore, provision for such adverse experience is made in the form of a risk adjustment (that is, where the model relies on run-off assumptions).

IFRS 17 defines the Liability for Incurred Claims as an entity's obligation to pay valid claims for insured events that have already occurred, including events that have occurred but for which claims have not been reported i.e., future cash flows related to past service. This includes a risk adjustment to reflect "the compensation that the entity requires for bearing the uncertainty about the amount and timing of the cash flows that arises from non-financial risk".

IFRS 17 requires that the Liability for Incurred Claims be calculated as an explicit, unbiased and probability-weighted estimate of future cash flows related to past service within the contract boundary.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

3. USE OF ESTIMATES AND JUDGEMENTS (CONTINUED)

3.1 Significant judgements and estimates for insurance contracts: assets and liabilities (continued)

3.1.3 Risk adjustment – liability for incurred claims (LIC) (continued)

A two-parameter Weibull distribution is fitted to the run-off factors for development period 0 (based on claims data for the period 1 January 2019 to 30 June 2025 – any later data is not deemed to be sufficiently run-off for the calculations). The run-off factors for development periods 1 onwards are modelled based on a linear relationship between the proportion of claims paid in the development period and the cumulative proportion of claims paid up to the end of the previous development period.

Monte Carlo simulations are used to generate run-off factors for each development period. The LIC is recalculated using the simulated run-off factors. The mean as well as the 75th percentile of the simulated LIC is calculated. One-sided confidence intervals for the mean of the simulated LIC are derived using the percentile method. The upper limits of the confidence intervals represent the level at which the Scheme is 75% confident that the LIC will be sufficient to cover future cash flows. The risk adjustment for non-financial risk is the difference between the upper bound of the chosen confidence interval and the probability-weighted mean of the simulated best estimate liability – incurred but not reported claims provision.

The risk adjustment reflects the Scheme's risk attitude towards the levels of conservatism considered in its liability reserving, solvency management and pricing practices. Changes in the risk adjustment for non-financial risk are not disaggregated and included in the insurance service result. Refer to note 11 for detailed disclosure.

3.1.4 Risk adjustment – risk transfer arrangements

For reinsurance contracts held, the risk adjustment for non-financial risk represents the amount of risk being transferred by the Scheme to the reinsurer.

The confidence interval level applied with regard to the determination of the risk adjustment for the risk transfer arrangements per service provider is as follows:

- Europ Assist – 75%
- Dennis – 95%
- PHA – 75%
- PPN – 90%
- Scriptpharm – 75%

Refer to note 13 for detailed disclosure.

3.1.5 Estimates of future cash flows to fulfil insurance contracts

Included in the measurement of the group of contracts are all the future cash flows within the boundary of the group of contracts.

The estimates of these future cash flows are based on probability weighted expected future cash flows. The Scheme estimates which cash flows are expected and the probability that they will occur at the measurement date. In making these expectations, the Scheme uses information about past events, current conditions and forecasts of future conditions. The Scheme's estimate of future cash flows is the mean of a range of scenarios that reflect the full range of possible outcomes. Each scenario specifies the amount, timing and probability of cash flows. The probability weighted average of the future cash flows is calculated using a deterministic scenario representing the probability weighted mean of a 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. Refer to note 11.

3.1.6 Methods used to measure the insurance contracts

Accounting practice requires that claims incurred within a certain accounting period are accounted for in that period. However, a proportion of claims incurred within a certain accounting period are usually only reported to the Scheme after the end of the accounting period and it is therefore necessary to estimate the claims that were incurred in the accounting period but only reported and paid after the end of the period. This estimate is referred to as the Incurred But Not Reported (best estimate liability – incurred but not reported) claims provision.

The methods used to estimate the best estimate liability – incurred but not reported claims provision are summarised below.

The chain-ladder method is used for calculating the best estimate liability – incurred but not reported for claims incurred up to one month prior to the date for which the Scheme has claims paid data. The run-off factors are calculated based on claims data from previous periods and vary between options and categories of service. The factors are then applied to the data for claims paid in the current period to arrive at the estimated best estimate liability – incurred but not reported claims provision. There is also a "subjective" element where the best estimate liability – incurred but not reported as calculated above is adjusted for any known factors which could influence the claims run-off patterns. For the current month the chain-ladder method is generally not used since only a relatively small percentage of claims incurred in the current month will have been paid by the end of the month and a small variation in the claims paid in that month can result in a large change in the best estimate liability – incurred but not reported estimate.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

3. USE OF ESTIMATES AND JUDGEMENTS (CONTINUED)

3.1 Significant judgements and estimates for insurance contracts: assets and liabilities (continued)

3.1.6 Methods used to measure the insurance contracts (continued)

For the current month a variation of the Bornheutter-Ferguson method is therefore generally used. Under the standard Bornheutter-Ferguson method the run-off factors are calculated as with the chain-ladder method and these run-off factors are then applied to budgeted claims (as opposed to actual claims paid as in the chain-ladder method) to determine the outstanding claims provision. The standard Bornheutter-Ferguson method yields accurate claims provisions if the actual claims experience is reasonably in-line with the budget.

With the adapted Bornheutter-Ferguson method the year-to-date experience for all months prior to the current month is calculated using the chain-ladder method. Based on this year-to-date experience, and considering seasonality, the expected claims cost is projected for the current month. The best estimate liability – incurred but not reported for the current month is then the difference between the projected claims cost for the current month and the claims incurred and settled in the current month. Using this method, the best estimate liability – incurred but not reported is therefore based on projected claims and not budgeted claims as for the standard Bornheutter-Ferguson method.

The following was taken into account when estimating the LIC:

- The level of homogeneity of the data;
- Changes in patterns of claims and claims processing;
- Changes in the composition of the Scheme ie. distribution of members and their beneficiaries across various options;
- Changes in benefit limits; and
- Changes in prescribed minimum benefits.

The Scheme is not required to disclose information about the development of claims for which uncertainty about the amount and timing of the claims payments is typically resolved within one year.

3.2 Determination of fair values

Investment properties, fair value through profit or loss financial instruments and derivative financial instruments are measured at fair value and include an estimation component. Fair values have been determined for measurement and/or disclosure purposes based on the methods listed below. Where applicable, further information about the assumptions made in determining fair values is disclosed in the notes specific to that asset or liability. Refer to note 6, 7 and 11 for further detailed disclosure.

3.2.1 Investment properties

An independent valuation company, having appropriate recognised professional qualifications and recent experience in the location and category of property being valued, values the Scheme's investment property portfolio annually.

Valuations reflect, when appropriate, the type of tenants actually in occupation or responsible for meeting lease commitments or likely to be in occupation after letting vacant accommodation, and the market's general perception of their creditworthiness; the allocation of maintenance and insurance responsibilities between the Scheme and the lessee; and the remaining economic life of the property.

3.2.2 Fair value through profit or loss financial assets

Financial assets classified as level 2 are valued using a discounted cash flow method, refer note 22.5.

The unlisted property holding is valued based on the fair value of the underlying property. The property is valued using the net income of the property and applying a capitalisation rate to the net income. The capitalisation rate applied is based on an assumed average commercial property yield simulating the risk characteristics of a similar investment. The majority of investments held within the portfolio are subject to various assumptions based on valuation techniques not supported by observable market data.

3.2.3 Comparative reclassification – amounts attributable to members for future benefits

In the current financial year, the Scheme changed the presentation of the item previously shown as "amounts attributable to future members" within Insurance service expenses. This item has been renamed "amounts attributable to members for future benefits" and is now presented after the insurance service result in the Statement of Comprehensive Income.

Impact on comparatives:

The comparative figures for 2024 have been reclassified to reflect this change. The reclassification had no impact on the overall result, total surplus, or total comprehensive income.

The effect of the reclassification on the prior year is as follows:

	Previously reported (2024)	Reclassified (2024)
Statement of Comprehensive Income line item		
Insurance service expenses	(22 287 304)	(22 153 413)
Insurance service result	(965 678)	(831 787)
Amounts attributable to members for future benefits		(133 891)

* The total for Insurance service expenses and insurance service result decreased by R133 891, with the same amount now presented as amounts attributable to members for future benefits after the surplus or deficit for the year before amounts attributable to members for future benefits.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

4. PROPERTY AND EQUIPMENT

Property and equipment comprise owned and leased assets that do not meet the definition of investment property.

R'000	Note	2025	2024
Property and equipment	4.1	1 754	1 725
Right of use asset	4.2	5 414	1 694
		7 168	3 419

4.1 Property and equipment

R'000	Motor vehicles	Leasehold improvements	Computer equipment	Office equipment	Fixtures and fittings	Total
Cost						
Balance at 31 December 2023	359	4 709	5 864	1 161	5 239	17 332
Additions from acquisitions	–	–	280	198	218	696
Disposals	–	–	–	–	–	–
Balance at 31 December 2024	359	4 709	6 144	1 359	5 457	18 028
Additions from acquisitions	–	357	373	–	–	730
Disposals	–	–	–	–	–	–
Balance at 31 December 2025	359	5 066	6 517	1 359	5 457	18 758
Accumulated depreciation						
Balance at 31 December 2023	359	4 417	5 596	940	4 773	16 085
Depreciation for the period	–	–	156	42	20	218
Balance at 31 December 2024	359	4 417	5 752	982	4 793	16 303
Depreciation for the period	–	389	251	40	21	701
Balance at 31 December 2025	359	4 806	6 003	1 022	4 814	17 004
Carrying amount						
Balance at 31 December 2024	–	292	392	377	664	1 725
Balance at 31 December 2025	–	312	517	283	642	1 754

4.2 Leases

Right of use of assets

The Scheme leases the building from which it operates its head office. The initial lease agreement commenced on 1 October 2022 for a period of three years, ending on 30 September 2025. The lease was renewed with effect from 1 October 2025, the renewed lease term on 31 December 2025 was determined to be 21 months (2024: 9 months), ending 30 September 2027. Depreciation charge is determined on a straight line basis over the remaining lease term. There are no impairments in the current or prior period.

The Scheme also leases additional premises, this came into effect from 01 November 2025 up to 30 September 2027. Information about the lease for which the Scheme is the lessee is presented below:

R'000	Building
Balance as 1 January 2024	3 954
Depreciation charge	(2 260)
Balance as 31 December 2024	1 694
Additions	6 135
Depreciation charge	(2 415)
Balance as 31 December 2025	5 414

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

4. PROPERTY AND EQUIPMENT (CONTINUED)

4.2 Lease (continued)

Lease liabilities

R'000	Building	Total
Maturity analysis – contractual undiscounted cash flows:		
Not later than one year	2 085	2 085
Later than one year and not later than five years	–	–
Total undiscounted lease liabilities as at 31 December 2024	2 085	2 085
Not later than one year	2 867	2 867
Later than one year and not later than five years	6 035	6 035
Total undiscounted lease liabilities as at 31 December 2025	8 902	8 902

The Scheme renewed the lease agreement effective 1 October 2025 for a two-year period ending 30 September 2027. The Scheme also leases additional premises, this came into effect from 1 November 2025 up to 30 September 2027. Included in the Statement of Financial Position is the lease liability for the remaining lease term of 1 year and 9 months as at 31 December 2025 (2024: 9 months):

	2025 R'000	2024 R'000
Current liabilities	2 957	2 405
Non-current liabilities	2 555	–
	5 512	2 405

The Scheme's interest rate per the lease contract of 11% was used to discount the cash flows to the present value of the lease liability from which the interest expense is derived. The variable costs relating to the lease were expensed in profit or loss and largely relate to the utility bill which is driven by utilisation. These expenses comprise 42% of the fixed lease payments and are excluded in the determination of the lease liability and related right of use asset.

Included in the Statement of profit or loss and other comprehensive income at 31 December 2025:

	2025 R'000	2024 R'000
Interest on lease liability	(232)	(322)
Rental costs – variable in nature	(2 338)	(2 100)
	(2 570)	(2 422)

Total cash outflow with respect to the head office lease for 31 December 2025 is as follows:

	2025 R'000	2024 R'000
Lease liability cash flows	(2 765)	(2 649)
Rental costs – variable in nature	(2 338)	(2 100)
	(5 103)	(4 749)

Details of the property and 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 ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

5. INVESTMENT PROPERTY HELD FOR SALE

	2025 R'000	2024 R'000
Balance at the beginning of the year	-	72 700
Reversal of provision for selling costs	-	2 300
Proceeds from sale of the property	-	(61 500)
Loss on sale of investment property	-	(13 500)
Net fair value less costs to sell at the end of the year	-	-
Direct operating expenses incurred in the generation of rental income applicable to investment property held for sale	-	5 194

Investment property held for sale comprised commercial properties that had been leased to third parties. The properties had been leased for various periods up to 30 September 2024. No contingent rentals were charged. Lease rental receipts amounted to R9.4 million relating to the lease of investment properties and were included in profit or loss.

The property was sold for R61.5 million in August 2024, and transfer took place on 31 October 2024. The proceeds from disposal amounted to R59.4 million after commission payable of R2.1 million. A loss on sale of investment property was recognised, representing the write down from R75 million to the selling price of R61.5 million.

6. FINANCIAL ASSETS HELD AT FAIR VALUE THROUGH PROFIT OR LOSS

	2025 R'000	2024 R'000
Balance at the beginning of the year	10 688 215	10 133 968
Additions/reinvestments	2 282 731	2 414 357
Withdrawals	(2 515 743)	(2 733 252)
Interest income reinvested	259 043	230 954
Dividend income reinvested	1 135	215
Asset management fees capitalised to investments	(100)	(310)
Net fair value gains on fair value assets through profit or loss (note 16)	1 827 167	642 283
Balance at the end of the year	12 542 448	10 688 215
Non-current	6 262 992	5 932 586
Current	6 279 456	4 755 629
	12 542 448	10 688 215
Comprises:		
Listed equities	5 640 668	4 105 840
Bonds	4 611 433	3 825 090
Money market instruments	2 290 347	2 757 285
	12 542 448	10 688 215

7. TRADE AND OTHER RECEIVABLES

	2025 R'000	2024 R'000
Trade and other receivables comprise:		
Prepaid expenses	6 193	6 093
Amounts owing to related parties	-	1 061
Other receivables	5 288	5 182
Interest receivables	75	117
Rent receivables	821	821
Rent deposit	1 210	1 210
Sundry debtors	3 182	3 034
Total trade and other receivables	11 481	12 336

The carrying amounts of receivables approximate their fair values, due to the short-term maturities of these assets.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

8. CASH AND CASH EQUIVALENTS

	2025 R'000	2024 R'000
Cash and cash equivalents included in current assets:		
Cash with investment managers	366 983	414 711
Call accounts with investment managers	148 422	187 251
Current accounts with banks	451 061	246 753
	966 466	848 715

The carrying amount of the cash and cash equivalents approximates the fair values due to the short-term nature of the investments. The weighted average effective interest rate was 8.9% (prior year: 8.1%) on call account balances.

9. LONG-TERM EMPLOYEE BENEFIT OBLIGATION

Eligible executives and staff qualify for a long-term incentive that runs over a fixed three-year cycle. The vesting criteria is dependent upon both service and performance elements. The three-year cycle/vesting period runs from January 2024 to December 2026.

	2025 R'000	2024 R'000
Unvested long-term employee benefit obligation	6 443	2 927
Balance at the end of the year	6 443	2 927

The liability is recognised over the required service/vesting period and reflects the present value of amounts due to the participants on a most likely outcome basis at the end of the three-year cycle.

	2025 R'000	2024 R'000
Non-current portion	6 443	2 927
	6 443	2 927

10. LIABILITY TO MEMBERS FOR FUTURE BENEFITS

	2025 R'000	2024 R'000
Balance at the beginning of the year	9 029 093	8 895 202
Amounts attributable to members for future benefits	1 795 475	133 891
Balance at the end of the year	10 824 568	9 029 093

The Scheme is and was not projecting any onerous contract liability to be incurred for the following financial year and therefore the balance as at 31 December 2025 and 31 December 2024 is/was considered a non-current liability. The liability to members for future benefits has been classified on the basis that administration costs are covered by future contributions and there is no view for the Scheme to be liquidated in the foreseeable future.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

11. INSURANCE CONTRACT LIABILITIES

The Scheme as a whole is identified as a portfolio. All the contracts issued by the Scheme are subject to similar risks and are managed together. The breakdown at a portfolio level of the Liability for remaining coverage and Liability for incurred claims is set out below:

Reconciliation of Liability for remaining coverage and Liability for incurred claims

	Liability for remaining coverage (LRC)		Liability for incurred claims (LIC)		
	Excluding loss component R'000	Loss component R'000	Best Estimate Liability R'000	Risk Adjustment R'000	Total for 2025 R'000
Opening insurance contract assets	-	-	-	-	-
Opening insurance contract liabilities	(278 603)	-	2 711 313	150 500	2 583 210
Net insurance contract liabilities as at 1 January 2025	(278 603)	-	2 711 313	150 500	2 583 210
<i>Changes in the statement of comprehensive income</i>					
Insurance revenue from contracts measured under the PAA (note 15)	(22 568 292)	-			(22 568 292)
Insurance services expense	-	-	23 463 034	(58 754)	23 404 280
Incurred claims and other insurance service expenses (note 15)	-		23 528 744	91 746	23 620 490
Changes that relate to past service – adjustments to the LIC (note 15)	-	-	(65 710)	(150 500)	(216 210)
Losses on onerous contracts and reversal of those losses	-	-	-	-	-
Insurance service result	(22 568 292)	-	23 463 034	(58 754)	835 988
Finance expense from insurance contracts issued (note 11.4)	-	-	84 732	-	84 732
Total changes in the statement of comprehensive income	(22 568 292)	-	23 547 766	(58 754)	920 720
Investment components*	(1 297 632)	-	1 297 632	-	-
<i>Cash flows</i>					
Contributions received**	23 851 412	-	-	-	23 851 412
Claims and other directly attributable expenses paid***			(24 163 145)		(24 163 145)
Insurance acquisition cash flows paid			(427 953)		(427 953)
Total cash flow	23 851 412	-	(24 591 097)	-	(739 685)
Net insurance contract liabilities as at 31 December 2025					
Closing insurance contract liabilities	(293 114)	-	2 965 614	91 746	2 764 246
Net insurance contract liabilities as at 31 December 2025	(293 114)	-	2 965 614	91 746	2 764 246
*Savings contributions received					23 851 412
**Contributions received					22 553 780
Risk contributions					1 297 632
PMSA contributions					
***Claims and other directly attributable expenses paid					(24 163 145)
Risk claims					(19 231 818)
PMSA claims					(1 060 396)
Expenses					(1 307 978)
PMSA refunds					(83 334)
Claim recoveries ¹					(2 479 618)

¹ Claims recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

11. INSURANCE CONTRACT LIABILITIES (CONTINUED)

Reconciliation of Liability for remaining coverage and Liability for incurred claims (continued)

	Liability for remaining coverage (LRC)		Liability for incurred claims (LIC)		
	Excluding loss component R'000	Loss component R'000	Best Estimate Liability R'000	Risk Adjustment R'000	Total for 2024 R'000
Opening insurance contract assets					
Opening insurance contract liabilities	(242 174)	–	2 223 312	145 351	2 126 489
Net insurance contract liabilities as at 1 January 2024	(242 174)		2 223 312	145 351	2 126 489
Opening insurance contract liabilities					
Insurance revenue					
Changes in the statement of comprehensive income					
Insurance revenue from contracts measured under the PAA (note 15)	(20 888 306)	–			(20 888 306)
Insurance services expense	–	–	22 282 155	5 149	22 287 304
Incurred claims and other insurance service expenses (note 15)			22 310 200	150 500	22 460 700
Changes that relate to past service – adjustments to the LIC (note 15)	–	–	(28 045)	(145 351)	(173 396)
Losses on onerous contracts and reversal of those losses	–	–	–	–	–
Insurance service result	(20 888 306)	–	22 282 155	5 149	1 398 998
Finance expense from insurance contracts issued (note 11.4)	–	–	84 852	–	84 852
Total changes in the statement of comprehensive income	(20 888 306)	–	22 367 007	5 149	1 483 850
Investment components*	(1 115 177)	–	1 115 177	–	–
<i>Cash flows</i>					
Contributions received**	21 967 054	–	–	–	21 967 054
Claims and other directly attributable expenses paid***	–	–	(22 573 777)	–	(22 573 777)
Insurance acquisition cash flows paid	–	–	(420 406)	–	(420 406)
Total cash flow	21 967 054	–	(22 994 183)	–	(1 027 129)
Net insurance contract liabilities as at 31 December 2024	(278 603)	–	2 711 313	150 500	2 583 210
Closing insurance contract assets	–	–	–	–	–
Closing insurance contract liabilities	(278 603)	–	2 711 313	150 500	2 583 210
Net insurance contract liabilities as at 31 December 2024	(278 603)	–	2 711 313	150 500	2 583 210
*Savings contributions received					
**Contributions received					21 967 054
Risk contributions					20 851 877
PMSA contributions					1 115 177
***Claims and other directly attributable expenses paid					(22 573 777)
Risk claims					(17 819 484)
PMSA claims					(927 066)
Expenses					(1 341 314)
Expenses					–
PMSA refunds					(76 784)
Claim recoveries ¹					(2 409 129)

¹ Claims recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

11. INSURANCE CONTRACT LIABILITIES (CONTINUED)

11.1 Reconciliation of Liability for remaining coverage and Liability for incurred claims

The breakdown of the net insurance contract liabilities is set out below:

	Liability for remaining coverage (LRC) R'000	Liability for incurred claim (LIC) R'000	Total 2025 R'000
Contributions outstanding*	(695 941)	–	(695 941)
Recoveries due from members for co-payments*	–	(2 038)	(2 038)
Service provider receivables*	–	(11 744)	(11 744)
Savings plan account advances*	–	(1 686)	(1 686)
Contributions received in advance	371 288	–	371 288
Credit balances due to members – overpayments	31 539	–	31 539
Reported claims not yet paid	–	254 647	254 647
Personal medical savings accounts liability (note 11.4)	–	1 583 531	1 583 531
Best estimate liability – incurred but not reported	–	1 142 903	1 142 903
Risk adjustment	–	91 746	91 746
Total net insurance contract liabilities as at 31 December 2025	(293 114)	3 057 360	2 764 246

	Liability for remaining coverage (LRC) R'000	Liability for incurred claim (LIC) R'000	Total 2024 R'000
Contributions outstanding*	(658 034)	–	(658 034)
Recoveries due from members for co-payments*	–	(1 344)	(1 344)
Service provider receivables*	–	(6 038)	(6 038)
Savings plan account advances*	–	(831)	(831)
Contributions received in advance	366 461	–	366 461
Credit balances due to members – overpayments	12 971	–	12 971
Reported claims not yet paid	–	253 977	253 977
Personal medical savings accounts liability (note 11.4)	–	1 363 188	1 363 188
Best estimate liability – incurred but not reported	–	1 102 360	1 102 360
Risk adjustment	–	150 500	150 500
Total net insurance contract liabilities as at 31 December 2024	(278 602)	2 861 812	2 583 210

* Insurance contract assets amounted to R711 409 (2024: R666 247).

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

11. INSURANCE CONTRACT LIABILITIES (CONTINUED)

11.2 Liability for remaining coverage (LRC)

During the reporting period, the LRC was reduced by the amount of insurance revenue recognised for the services provided in the period. The composition of insurance revenue is disclosed in the analysis of insurance revenue provided in note 15. 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 and increased the LRC. Debtors that paid in advance and for which no service has yet been provided are included in the LRC. Debtors in arrears and for which services and coverage have been provided but not yet paid are included in LRC.

11.3 Liability for incurred claims (LIC)

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

- a. best estimate of cash flows and
 - b. risk adjustment.
- (i) Members must submit all claims for payment within four months of seeking medical treatment. However, some claims do take significantly longer than four months to settle (i.e., to “run-off”).

The run-off factors are calculated based on claims data from previous periods and vary between options and categories of service.

The best estimate of cash flow provision is based on information available as at the measurement date, which includes amounts already settled (processed) as at the measurement date, the run-off input assumptions outlined above, as well as any other available estimates (for example, budgeted claims or independently estimated hospital amounts from pre-authorisation case estimate models).

Risk adjustment:

The biggest risk inherent in run-off models are the run-off assumptions applied. Any processing changes and/or delays between providers and the administrator (relative to the input assumptions) would impact on the best estimate value of fulfilment cash flows provided.

Therefore, provision for such adverse experience is made in the form of a risk adjustment (that is, where the model relies on run-off assumptions).

The risk adjustment is determined using the two-parameter Weibull distribution and incurred but not yet reported (IBNR) is recalculated from simulated run-off factors generated using Monte Carlo simulations.

Monte Carlo simulations are used to generate run-off factors for each development period. IBNR is calculated from simulated run-off factors. The risk adjustment, relative to this level, was assessed to be greater than or equal to 75.0%.

The risk adjustment reflects the Scheme's risk attitude towards the levels of conservatism considered in its liability reserving, solvency management and pricing practices.

Claims sensitivity:

Refer Note 21.4 for the claims sensitivity analysis.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

11. INSURANCE CONTRACT LIABILITIES (CONTINUED)

11.4 Reconciliation of members' PMSA balance

The PMSA is a non-distinct investment component with the balances included in either insurance contract assets or liabilities in the statement of financial position. The Members' PMSA Reconciliation in line with Regulation 10 of the Act:

	2025 R'000	2024 R'000
Balance of Personal medical savings account liability at 1 January	1 363 188	1 180 666
Less: Personal medical savings plan advances	(1 529)	(1 339)
Balance of Personal medical savings account liability at 1 January	1 361 659	1 179 327
Add: Savings account contributions received (note 15)	1 297 632	1 115 177
Savings plan liabilities transferred to the Scheme from other schemes in terms of Regulation 10 (4)	2 565	2 232
Reinstatement of members savings	13 767	–
Net interest paid on savings plan account	84 732	84 852
Interest paid	106 498	103 571
Investment fees	(1 913)	(1 648)
Recovery of personal medical savings account investment and administrative expense (note 17)	(19 853)	(17 071)
Less: Claims paid on behalf of members	(1 060 396)	(927 066)
Refunds on death or resignation in terms of Regulation 10 (5)	(83 334)	(76 784)
Personal medical savings plan advances	2 957	1 529
Unclaimed Personal medical savings account liability written off to Scheme funds (note 17)	(36 050)	(16 079)
Balances due to members on Personal medical savings accounts held at 31 December	1 583 531	1 363 188

The BonSave, BonClassic, BonComprehensive, BonComplete and BonFit Select benefit options allow members the facility to pay a percentage of their gross contributions into a savings account, to assist members in managing their healthcare costs to their own requirements. The percentage per option varies from 14.1% on BonClassic, 15.0% on BonFit Select, 15.0% on BonComplete, 25.0% on BonSave, and 18.9% on BonComprehensive. Savings are capped at a maximum of 25.0% of the gross contributions.

The personal medical savings account (PMSA) contains a demand feature in terms of Regulation 10 of the Act that any credit balance on a member's PMSA must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option, and then enrolls in another benefit option or medical scheme without a PMSA, or does not enrol in another medical scheme.

The following Scheme Rules were adopted from 1 January 2020:

- Interest would still be paid to members on PMSA monies at the rate achieved by the Scheme's cash portfolio net of administration costs. An effective 0.125% return achieved for a particular month (1.5% annual) is deducted for investment expenses from the return allocated to the PMSA, relating to administration costs associated with managing the members' PMSA.
- Interest would be applied to members' accumulated fund balances. Net interest is not allocated to current savings balances. The effective interest rate earned was 8.0% (2024: 9.0%) and 6.5% (2024: 7.5%) was allocated to the PMSA balances.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

12. IAS 8 CHANGE IN ACCOUNTING ESTIMATE

12.1 Nature of change

During the financial year ended 31 December 2025, the Scheme refined its actuarial methodology for measuring the Liability for Incurred Claims (LIC) under IFRS 17. The refinement relates to the technique and confidence level applied in determining the risk adjustment for non-financial risk. It reflects new developments in actuarial practice and enhances alignment with the Scheme's risk objectives following the appointment of new external actuaries and related governance discussions.

Previously, the LIC relied on the Chain Ladder and Adapted Bornhuetter Ferguson methods, with a 15% slower run off sensitivity and a 90% confidence level for the risk adjustment. Under the revised approach, the Scheme continues using these projection methods but now calculates the risk adjustment using a Weibull distribution and Monte Carlo simulations for best estimate liability – incurred but not reported claims. The confidence level has also been revised to 75%, providing a more appropriate reflection of the Scheme's risk appetite and diversification benefits.

12.2 Previous methodology

- Claims projection: The Chain Ladder and Adapted Bornhuetter-Ferguson methods were used to project cash flows.
- Risk adjustment: Deterministic sensitivity (15% slower run-off) at 90% confidence level

12.3 Revised methodology

- Claims projection: the Scheme continues to apply the Chain Ladder and Adapted Bornhuetter-Ferguson methods for projecting claim cash flows
- Risk adjustment:
 - a) Determined using a two-parameter Weibull distribution for development period 0.
 - b) Best estimate liability – incurred but not reported claims recalculated based on simulated run-off factors generated through Monte Carlo simulations.
 - c) Confidence level revised to 75%, reflecting the Scheme's risk appetite and diversification benefits.

12.4 Reason for change

- Alignment with IFRS 17 principles and industry best practice.
- Enhancing robustness and reliability of LIC measurement.
- Responding to governance concerns and improve risk alignment.

12.5 Compliance

- The revised methodology remains fully compliant with IFRS 17, which requires the LIC to be measured as the present value of fulfilment cash flows, together with an explicit risk adjustment for non-financial risk.
- IFRS 17 does not prescribe a single estimation technique for the risk adjustment but requires disclosure of the technique used and the confidence level corresponding to the results of that technique.

The change has been assessed as a change in accounting estimate under IAS 8 (paragraph 34-36), as it reflects the use of updated actuarial techniques and assumptions within the existing IFRS 17 measurement framework, rather than a change in accounting policy or prior period error.

12.6 Impact on financial statements

The impact of the change was as follows:

Effect on closing LIC balance : (decrease)	(17 105)
Effect on profit or (loss) for the period	17 105

At the date of the change in estimate (June 2025), the recalculation of the LIC under the revised methodology resulted in a difference of R17 million compared with the previous methodology. The Scheme considers that the revised methodology provides a more robust measure of insurance liabilities and enhances the relevance and reliability of reported results.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

13. REINSURANCE CONTRACTS

	Asset for remaining coverage (ARC)		Asset for incurred claims (AIC)		Total for 2025 R'000
	Excluding loss component R'000	Loss component R'000	Best Estimate Liability R'000	Risk Adjustment R'000	
2025					
Opening reinsurance contract assets as at 1 January 2025	38 006	–	53 166	4 212	95 384
Changes in the statement of comprehensive income:					
Allocation of RTA premiums paid* (note 15.6)	(2 045 231)	–			(2 045 231)
Amounts recoverable from reinsurers (note 15.6)			2 498 426	631	2 499 057
Recoveries for incurred claims	–		2 551 592	4 843	2 556 435
Changes that relate to past service – adjustments to incurred claims			(53 166)	(4 212)	(57 378)
Total changes in the statement of comprehensive income	(2 045 231)	–	2 498 426	631	453 826
<i>Cash flows</i>					
Premiums paid	2 042 946		–		2 042 946
Recoveries from reinsurance**			(2 479 618)	–	(2 479 618)
Total cash flow	2 042 946	–	(2 479 618)	–	(436 672)
Closing reinsurance contract assets as at 31 December 2025	35 721	–	71 974	4 843	112 538

* FY2025 includes a refund owing of capitation fees totalling R36 million, comprising of R35.2 million due by Scriptpharm Risk Management Proprietary Limited and R0.5 million due by Preferred Provider Negotiators Proprietary Limited.

** Recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction

	Asset for remaining coverage (ARC)		Asset for incurred claims (AIC)		Total for 2024 R'000
	Excluding loss component R'000	Loss component R'000	Best Estimate Liability R'000	Risk Adjustment R'000	
2024					
Opening reinsurance contract assets as at 1 January 2024	4 698	–	77 051	4 449	86 198
Changes in the statement of comprehensive income:					
Allocation of RTA premiums paid* (note 15.6)	(1 951 687)				(1 951 687)
Amounts recoverable from reinsurers (note 15.6)			2 385 244	(237)	2 385 007
Recoveries for incurred claims	–		2 462 295	4 212	2 466 507
Changes that relate to past service – adjustments to incurred claims			(77 051)	(4 449)	(81 500)
Total changes in the statement of comprehensive income	(1 951 687)	–	2 385 244	(237)	433 320
<i>Cash flows</i>					
Premiums paid	1 984 995				1 984 995
Recoveries from reinsurance**			(2 409 129)	–	(2 409 129)
Total cash flow	1 984 995	–	(2 409 129)	–	(424 134)
Closing reinsurance contract assets as at 31 December 2024	38 006	–	53 166	4 212	95 384

* FY2024 includes a refund owing of capitation fees totalling R38 million, comprising of R10 million due by Scriptpharm Risk Management Proprietary Limited and R28 million due by Preferred Provider Negotiators Proprietary Limited.

** Recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

14. TRADE AND OTHER PAYABLES

	2025 R'000	2024 R'000
Accrual of external audit fees	2 980	2 925
Accrual of internal audit fees	1 786	1 721
Amounts owing to administrator	2 590	2 344
Amounts owing to related parties (including marketing costs)	5 559	4 549
Broker fees payable	1 191	–
Accrual for advertising and marketing expenses (excluding related entity)	6 889	4 935
Sundry payables	18 337	13 960
Total trade and other payables	39 332	30 434

The carrying amount of trade and other payables approximate their fair values due to the short-term maturities of these liabilities.

15. INSURANCE REVENUE AND EXPENSE

	2025 R'000	2024 R'000
Gross contributions from contracts	23 865 924	22 003 483
Savings contributions from contracts (note 11)	(1 297 632)	(1 115 177)
Total insurance revenue*	22 568 292	20 888 306
Insurance service expenses		
Claims incurred (note 15.1)	21 281 318	20 091 944
Third party recoveries (note 15.7)	(67 798)	(58 387)
Changes that relate to past service – adjustment to the LIC (note 15.2)	(216 210)	(173 396)
Insurance acquisition cash flows amortisation (note 15.3)	429 145	420 406
Accredited managed healthcare services (note 15.4)	702 008	664 000
Directly attributable expenditure (note 15.5)	1 275 817	1 208 846
Total insurance service expenses	23 404 280	22 153 413
Net income from risk transfer arrangements/reinsurance (note 15.6)	453 826	433 320
Total insurance service result	(382 162)	(831 787)
15.1 Claims incurred		
Incurred claims	21 281 318	20 091 944
Total claims incurred	21 281 318	20 091 944
15.2 Changes that relate to past service – adjustment to the LIC		
Changes that relate to past service – adjustment to the LIC	(216 210)	(173 396)
Total changes that relate to past service – adjustment to the LIC	(216 210)	(173 396)
15.3 Insurance acquisition cash flows		
Broker fees	429 145	420 406
Total insurance acquisition cash flows	429 145	420 406
15.4 Accredited managed healthcare services (no transfer of risk)		
Hospital benefit management	238 137	227 466
Medicine benefit management	116 572	111 335
Disease management	145 643	130 152
HIV/AIDS management	64 874	62 223
Provider network management	112 657	109 266
Dental risk management	24 125	23 558
Total accredited managed healthcare services (no transfer of risk)	702 008	664 000

* Total insurance revenue represents the amount of expected premium receipts (excluding investment component) allocated for the period under the premium allocation approach and includes changes in the expected recoverability of contributions of R7.4 million (2024: R2.5 million).

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

15. INSURANCE REVENUE AND EXPENSE (CONTINUED)

	2025 R'000	2024 R'000
15.5 Directly attributable expenditure		
15.5.1 Accredited administration service	1 033 075	1 010 512
Member record management	143 081	140 639
Contribution management	57 567	54 549
Claims management	253 381	240 134
Financial management	46 050	43 634
Information management and data control	161 109	152 687
Broker remuneration management	115 105	109 060
Customer services	256 781	269 809
15.5.2 Other administration expenditure	242 742	198 334
Marketing costs	191 243	148 831
Benefit management services	38 030	35 534
RAF administration expense	230	2 344
Wellness expenses	8 930	9 132
Actuarial services	4 309	2 493
Total directly attributable expenditure	1 275 817	1 208 846
15.6 Net income from risk transfer arrangements/reinsurance contracts held		
An allocation of premiums paid	2 045 231	1 951 687
Dental Information Systems Proprietary Limited	350 130	338 785
Scriptpharm Risk Management Proprietary Limited*	777 781	811 330
Preferred Provider Negotiators Proprietary Limited*	242 866	249 768
AZOZA – previously Europ Assistance Worldwide Services (South Africa) Proprietary Limited – EMS**	173 104	159 529
AZOZA – previously Europ Assistance Worldwide Services (South Africa) Proprietary Limited – Travel**	19 031	14 866
Private Health Administrators Proprietary Limited	482 319	377 409
Amounts recovered from risk transfer arrangement/reinsurance	(2 499 057)	(2 385 007)
Claims recoveries	(2 499 057)	(2 385 007)
Total net income from risk transfer arrangements/reinsurance contracts held	(453 826)	(433 320)

* FY2025 includes a refund owing of capitation fees totalling R36 million, comprising of R35.2 million due by Scriptpharm Risk Management Proprietary Limited and R0.5 million due by Preferred Provider Negotiators Proprietary Limited (FY2024 includes a refund owing of capitation fees totalling R38 million, comprising of R10 million due by Scriptpharm Risk Management Proprietary Limited and R28 million due by Preferred Provider Negotiators Proprietary Limited.)

** During the 2025 financial year, Europ Assistance Worldwide Services (South Africa) Proprietary Limited changed its name to AZOZA Proprietary Limited.

The net (income)/loss of the risk transfer arrangements/reinsurance contracts for the current financial year per third party service provider is as follows:

	2025 R'000	2024 R'000
Dental Information Systems Proprietary Limited	(115 058)	(128 668)
Scriptpharm Risk Management Proprietary Limited	(182 605)	(159 121)
Preferred Provider Negotiators Proprietary Limited	(72 180)	(43 259)
AZOZA – previously Europ Assistance Worldwide Services (South Africa) Proprietary Limited – EMS	(38 372)	(45 368)
AZOZA – previously Europ Assistance Worldwide Services (South Africa) Proprietary Limited – Travel	9 162	6 399
Private Health Administrators Proprietary Limited	(54 773)	(63 303)
Total net income from risk transfer arrangements/reinsurance contracts held	(453 826)	(433 320)

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

15. INSURANCE REVENUE AND EXPENSE (CONTINUED)

15.6 Net income from risk transfer arrangements/reinsurance contracts held (continued)

Risk transfer arrangements are entered into in respect of the provision of medical services that are outsourced to third parties by the Scheme. These services comprise:

- Dental benefits provided by Dental Information Systems Proprietary Limited;
- Chronic medicine benefits provided by Scriptpharm Risk Management Proprietary Limited;
- Optical benefit management provided by Preferred Provider Negotiators Proprietary Limited;
- Ambulance and emergency services provided by AZOZA Proprietary Limited;
- International travel benefits provided by AZOZA Proprietary; and
- Non-hospital events for BonCap provided by Private Health Administrators Proprietary Limited.

The service providers noted above have a national footprint across South Africa, providing access to all members.

Refer to note 21 to the financial statements for nature, terms and conditions of the risk transfer arrangements.

Dental Information Systems Proprietary Limited ("DENIS")

The Scheme has appointed DENIS to attend to all aspects of dental claim administration, including payments of all claims and to provide the SMILE programme. The Scheme pays DENIS a fixed fee on a monthly basis for members on the Standard, BonSave, BonComplete, BonFit and BonClassic options.

Scriptpharm Risk Management Proprietary Limited ("Scriptpharm")

The Scheme has entered into a risk transfer arrangement with Scriptpharm to provide chronic medicine benefits for the members. The Scheme pays Scriptpharm a monthly fixed fee per beneficiary on all of the options.

Preferred Provider Negotiators Proprietary Limited ("PPN")

The Scheme has entered into a risk transfer arrangement with PPN for optometrical services and pays a monthly fee per member per month on the Standard, Primary, BonClassic and BonCap options. Included in the contract is an arrangement whereby if a defined surplus, comprised of premiums less claims paid less expenses, is reported at the end of the benefit or contract cycle then 100% of the defined surplus, up to a maximum of 6% of the total of the premiums paid, is due to PPN and remainder to the Scheme.

AZOZA Proprietary Limited ("AZOZA")

The Scheme has entered into a risk transfer arrangement with AZOZA (previously Europ Assistance Worldwide Services (South Africa) Proprietary Limited – EMS) to render emergency medical services whereby they will maintain a twenty-four (24) hour a day professionally staffed contact centre to provide general medical advice, appropriate rapid response vehicle services with the necessary life saving support equipment and care as well as medical transportation to the most appropriate medical facility for providing adequate care for all members of the Scheme.

AZOZA Proprietary Limited ("AZOZA")

The Scheme has entered into a risk transfer arrangement with AZOZA (previously Europ Assistance Worldwide Services (South Africa) Proprietary Limited – Travel) for the provision of international travel benefits for members who travel overseas for a period of not more than 90 days at a fixed fee per member per month. This contract applies to all members of the Scheme except for those on the BonCap option.

Private Health Administrators Proprietary Limited ("PHA")

The Scheme has entered into a risk transfer arrangement with PHA to provide non-hospital benefits to members belonging to the BonCap option. The Scheme pays PHA a monthly fixed fee per beneficiary on the BonCap option.

15.7 Third party claim recoveries

Third party claim recoveries of R67.8 million (2024: R58.4 million) are included in insurance services expenses as part of net claims incurred. Included in this are third party recoveries for motor vehicle accident ("MVA") and injury on duty ("IOD") claims of R0.85 million (2024: R1.4 million). The timing and consideration of MVA or Road Accident Fund ("RAF") recoveries is uncertain. These claims are currently being administered by Gildenhuis Malatji Attorneys and Karl Els Attorneys. The claims recoveries in the current year include R41.5 million (2024: R34.5 million), net of recovery fees, in relation to forensic recoveries pertaining to the fraud, waste and abuse services provided by the Administrator, R0 million (2024: R0.2 million) in relation to clawbacks from the diabetes programme and R25.5 million (2024: R22.2 million) in recoveries from Mediclinic, Netcare and Life Healthcare related to settlement discounts.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

16. INVESTMENT INCOME

	2025 R'000	2024 R'000
16.1 Investment income – Scheme		
Cash and cash equivalents interest income	10 860	19 942
Financial assets held at fair value through profit or loss	772 443	714 103
Interest income	552 981	521 185
Dividend income	219 462	192 918
Net fair value gains on financial assets held at fair value through profit or loss	1 827 167	642 283
Rentals received	–	9 368
Contractual rental	–	9 368
Straight-lining of lease accrual	–	–
Total investment income – Scheme	2 610 470	1 385 696

17. SUNDRY INCOME

	2025 R'000	2024 R'000
Sundry income	56 590	44 020
Unclaimed personal medical savings account write backs (note 11.4)	36 050	16 079
Recovery of personal medical savings account investment and administration expense (note 11.4)	19 853	17 071
Service Level Agreement penalty recoveries from Administrator	101	9 655
Other income	585	1 215
Total sundry income	56 590	44 020

Claim recoveries from Healthcare practitioners are offset against claims paid. Forensic recoveries comprise financial recoveries from members and healthcare providers arising from irregularities due to fraud and abuse as these members and healthcare providers were thoroughly investigated and either legally prosecuted by the Scheme, or have signed an acknowledgement of debt, thereby committing to pay back the Scheme the amounts claimed erroneously. See note 15.7 third party claims recoveries which include recoveries as a result of fraud, waste and abuse services provided by the Administrator.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

18. ADMINISTRATIVE EXPENSES

	2025 R'000	2024 R'000
Other administration services provided by Accredited Administrator (note 18.1)	122 957	116 647
Actuarial services	5 266	3 046
Annual general meeting costs	1 191	1 356
Audit remuneration – external	4 258	6 694
Audit fees (note 18.2)	4 258	3 657
Fees for non-audit services	–	2 761
Prior year under provision	–	276
Audit remuneration – internal	4 404	4 691
Audit fees	4 200	4 569
Prior year under provision	204	122
Bank charges	4 390	4 095
Communication expense	174	219
Consulting fees	9 709	7 236
Council for Medical Schemes levies	18 110	16 805
Committee fees – independent members	1 973	1 646
Audit and risk committee fees	1 025	714
Investment committee fees	254	222
Managed care committee fees	334	302
Remuneration committee fees	360	408
Computer maintenance	9 591	5 650
Depreciation	3 116	2 478
Fidelity, professional indemnity and other insurance premiums	1 278	1 579
Hire of equipment	148	148
Human resourcing and payroll management fees	508	154
Legal fees and inspection costs	8 808	2 685
Marketing and advertising expenses	107 944	82 409
Meeting venue and catering costs	352	198
Office expenses	380	355
Postage and courier service	15	47
Principal Officer short-term employee benefits	9 271	9 369
Principal Officer remuneration	5 958	5 391
Performance incentive	1 739	2 215
Unvested long term employee benefit	1 320	1 246
Defined contribution benefits	54	318
Other disbursements	200	199
Printing and stationery	156	768
Professional services	1 180	1 133
Rental costs	2 338	2 100
Repairs and maintenance	9	4
Staff short-term employee benefits	33 130	31 653
Staff remuneration	23 068	22 073
Performance incentive	5 336	5 143
Unvested long term employee benefit	2 195	1 681
Defined contribution benefits	1 217	1 318
Other disbursements	1 314	1 438
Subscription fees	3 915	3 658
Sundry expenses	326	402
Travel, accommodation and conferences	933	813
Trustee elections	–	8 352
Trustees' remuneration and other disbursements (note 18.3)	8 626	8 111
Trustees' remuneration	7 806	7 460
Other disbursements	820	651
Total administrative expenses	364 456	324 501

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

18. ADMINISTRATIVE EXPENSES (CONTINUED)

	2025 R'000	2024 R'000
18.1 Other administration services provided by Accredited Administrator		
Internal audit services	34 733	32 914
Forensic investigations and recoveries	42 602	40 521
Governance and compliance services rendered	45 622	43 212
Total other administration services provided by Accredited Administrator	122 957	116 647
18.2 Audit fees breakdown*		
Financial statement audit	3 803	3 228
Regulatory related services:	371	350
Compliance with the Medical Schemes Act	126	119
Annual Statutory Return	245	231
Other assurance and related services:		
SALGA agreed-upon procedures	84	79
Total audit fees	4 258	3 657

* The audit fees breakdown note has been included in the current year, with the comparatives re-presented, to align with the disclosure requirements of the IESBA Code.

18.3 Trustees' remuneration and considerations

2025

R	Fees for meeting attendance ¹	Fees for holding of office ²	Fees for other meeting attendance ³	Total remuneration	Accommodation, travel and meals	Training and annual subscription fees	Total
Mr O Komane	534 312	430 036	846 412	1 810 760	39 555	20 606	1 870 921
Mr J Bagg	348 000	275 512	178 149	801 661	34 208	9 866	845 735
Mr MG Netshisaulu	374 838	275 512	281 826	932 176	41 165	23 291	996 631
Mr R Cowlin	302 124	275 512	551 454	1 129 090	251 736	19 821	1 400 647
Mr JR Venter	267 631	275 512	259 998	803 141	170 827	9 866	983 834
Mr P Ribbens	246 400	275 512	187 875	709 787	56 070	9 866	775 723
Ms RT Monene	249 498	275 512	302 292	827 302	49 722	20 606	897 629
Mr A Edwards	271 029	275 512	245 320	791 861	52 725	9 866	854 452
	2 593 832	2 358 620	2 853 326	7 805 778	696 009	123 784	8 625 572

¹ Fees for meeting attendance refers to remuneration payable to Trustees for attending meetings of Board of Trustees.

² Fees for holding office refers to remuneration payable to individuals to act in their capacity as Trustee, including carrying out their fiduciary duty.

³ Fees for other meeting attendance refers to remuneration payable to Trustees for attendance of other meetings at which their attendance is required to act in the interest of the Scheme.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

18. ADMINISTRATIVE EXPENSES (CONTINUED)

18.3 Trustees' remuneration and considerations (continued)

2024

R	Fees for meeting attendance ¹	Fees for holding of office ²	Fees for other meeting attendance ³	Total remuneration	Accommodation, travel and meals	Training and annual subscription fees	Total
Mr O Komane	669 850	412 020	567 631	1 649 501	52 362	23 940	1 725 803
Mr J Bagg	297 899	263 972	188 274	750 145	31 676	8 572	790 393
Mr MG Netshisaulu	412 872	263 972	35 321	712 165	31 297	36 290	779 752
Mr R Cowlin	374 638	263 972	410 431	1 049 041	114 705	8 572	1 172 317
Mr JD Ngwane	105 959	129 738	32 796	268 493	25 516	35 853	329 861
Mr JR Venter	324 173	254 904	30 276	609 353	68 566	8 572	686 491
Mr P Ribbens	272 670	254 904	71 694	599 268	47 702	8 572	655 542
Ms V Rikhotso*	226 841	241 225	260 488	728 554	37 574	8 572	774 699
Ms RT Monene	230 990	263 972	63 988	558 950	28 312	37 140	624 403
Mr A Edwards	186 366	199 103	87 356	472 825	23 212	2 265	498 303
Mr PS Sotshangane**	30 274	31 388	–	61 662	8 238	3 760	73 661
	3 132 532	2 579 171	1 748 255	7 459 957	469 161	182 106	8 111 224

* Ms V Rikhotso was appointed as CFO effective 1 February 2025.

** Mr PS Sotshangane's term ended due to his untimely passing on 19 August 2024.

¹ Fees for meeting attendance refers to remuneration payable to Trustees for attending meetings of Board of Trustees.

² Fees for holding office refers to remuneration payable to individuals to act in their capacity as Trustee, including carrying out their fiduciary duty.

³ Fees for other meeting attendance refers to remuneration payable to Trustees for attendance of other meetings at which their attendance is required to act in the interest of the Scheme.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

19. SURPLUS/(DEFICIT) PER BENEFIT OPTION

For management purposes the traditional Scheme is organised into the following twelve benefit options: Standard, BonSave, Primary, BonCap, BonFit Select, BonClassic, BonComprehensive, BonEssential, BonComplete, Hospital Standard, BonStart and BonStart Plus. The features of the benefit options are disclosed in the Annual Report.

R'000	Standard	BonSave	Primary	BonCap	BonFit Select
2025					
Insurance revenue	8 898 779	2 367 938	5 732 177	1 338 541	1 067 952
Insurance service expense	(9 324 607)	(2 295 912)	(5 814 509)	(1 661 871)	(1 039 069)
<i>Net claims incurred</i>	(8 659 407)	(1 979 336)	(5 116 798)	(1 437 543)	(855 339)
Claims incurred	(8 776 311)	(1 994 632)	(5 185 817)	(1 460 178)	(876 214)
Third party recoveries	16 876	8 292	17 775	9 669	5 088
Changes that relate to past service – adjustments to the LIC	100 028	7 004	51 244	12 965	15 786
Insurance acquisition costs	(114 826)	(61 891)	(128 319)	(37 520)	(32 505)
Accredited managed healthcare services (no risk transfer)	(191 081)	(81 013)	(201 071)	(84 771)	(47 446)
Directly attributable expenditure	(359 293)	(173 673)	(368 321)	(102 037)	(103 780)
Accredited Administration service	(298 861)	(143 987)	(304 466)	(67 324)	(85 757)
Other administration expenditure	(60 431)	(29 686)	(63 855)	(34 713)	(18 023)
Net income from risk transfer arrangements/reinsurance	258 739	31 516	80 752	58 344	(224)
An allocation of premiums paid	(842 634)	(124 780)	(272 588)	(531 004)	(46 280)
Amounts recovered from risk transfer arrangement/reinsurance	1 101 373	156 295	353 339	589 348	46 057
Insurance service result	(167 088)	103 541	(1 579)	(264 987)	28 659
Other income	639 293	358 181	673 904	367 327	202 283
Investment income – Scheme	625 253	351 236	659 111	359 277	197 982
Loss on sale of investment property	14 040	6 947	14 793	8 051	4 302
Sundry income	–	–	–	–	–
Net insurance finance expenses	–	(41 044)	–	–	(4 698)
Finance expenses from insurance contracts issued – PMSA	–	(41 044)	–	–	(4 698)
Other expenditure	(100 747)	(49 546)	(106 096)	(57 712)	(30 349)
Administration fees and other operating expenses	(90 731)	(44 607)	(95 554)	(51 985)	(27 330)
Interest expense	(57)	(29)	(60)	(33)	(18)
Asset management fees	(9 958)	(4 910)	(10 481)	(5 694)	(3 001)
Surplus or Deficit for the year before amounts attributable to members for future benefits	371 458	371 133	566 229	44 628	195 896
Amounts attributable to members	(371 458)	(371 133)	(566 229)	(44 628)	(195 896)
Surplus or Deficit for the year	–	–	–	–	–
Average number of members (n)	89 798	43 978	94 525	51 383	26 730
Average number of beneficiaries (n)	187 447	102 707	216 918	74 852	59 550
Average beneficiary age	41.7	32.6	32.6	36.9	29.7
Pensioner ratio	31.8%	10.9%	11.0%	16.4%	5.7%

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FOR THE YEAR ENDED 31 DECEMBER 2025

BonClassic	BonComprehensive	BonEssential	BonComplete	Hospital Standard	BonStart	BonStart Plus	Scheme Total
694 832 (706 927)	509 022 (563 394)	651 543 (704 389)	583 488 (598 253)	207 947 (230 592)	254 787 (231 657)	261 286 (233 099)	22 568 292 (23 404 280)
(660 894)	(536 661)	(614 117)	(549 372)	(207 573)	(181 554)	(198 718)	(20 997 310)
(672 673) 1 210	(551 087) 616	(616 332) 2 559	(559 907) 1 205	(204 663) 621	(181 410) 2 381	(202 094) 1 504	(21 281 318) 67 798
10 569	13 810	(344)	9 330	(3 531)	(2 525)	1 874	216 210
(5 984)	(3 884)	(15 993)	(8 672)	(3 882)	(8 001)	(7 670)	(429 145)
(14 159) (25 890)	(9 641) (13 208)	(22 636) (51 643)	(14 391) (25 818)	(5 812) (13 326)	(18 298) (23 805)	(11 690) (15 022)	(702 008) (1 275 817)
(21 535) (4 355)	(10 977) (2 232)	(42 497) (9 146)	(21 478) (4 339)	(11 089) (2 237)	(15 397) (8 407)	(9 706) (5 316)	(1 033 075) (242 742)
19 429 (68 701)	1 241 (48 317)	2 462 (27 051)	3 589 (56 191)	3 229 (9 829)	(3 690) (10 376)	(1 560) (7 480)	453 826 (2 045 231)
88 130	49 557	29 513	59 780	13 059	6 686	5 920	2 499 057
7 334 63 374	(53 133) 33 488	(50 382) 97 576	(11 176) 56 752	(19 416) 23 449	19 439 92 895	26 627 58 536	(382 163) 2 667 062
62 369	32 976	95 439	55 751	22 934	90 878	57 264	2 610 470
1 006 (17 606)	512 (10 183)	2 137 –	1 001 (11 201)	515 –	2 016 –	1 273 –	56 592 (84 732)
(17 606)	(10 183)	–	(11 201)	–	–	–	(84 732)
(7 225)	(3 678)	(15 271)	(7 196)	(3 709)	(14 199)	(8 965)	(404 691)
(6 508) (4) (714)	(3 312) (2) (364)	(13 753) (9) (1 509)	(6 481) (4) (711)	(3 340) (2) (366)	(12 783) (9) (1 407)	(8 072) (5) (888)	(364 456) (232) (40 003)
45 876 (45 876)	(33 505) 33 505	31 923 (31 923)	27 179 (27 179)	325 (325)	98 136 (98 136)	76 201 (76 201)	1 795 477 (1 795 477)
–	–	–	–	–	–	–	–
6 446 10 780 57.2 61.2%	3 280 5 311 58.7 61.2%	13 566 30 480 38.3 20.8%	6 422 12 053 48.7 40.2%	3 311 5 872 52.4 45.8%	12 471 13 991 37.1 5.4%	7 887 14 270 27.8 2.7%	359 796 734 230 36.2 11.8%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

19. SURPLUS/(DEFICIT) PER BENEFIT OPTION (CONTINUED)

R'000	Standard	BonSave	Primary	BonCap	BonFit Select
Year ended 31 December 2024					
Insurance revenue	8 591 633	2 029 908	5 348 235	1 340 938	671 608
Insurance service expense	(9 019 561)	(1 931 176)	(5 836 503)	(1 645 463)	(677 303)
<i>Net claims incurred</i>	(8 340 520)	(1 644 437)	(5 147 227)	(1 425 798)	(556 182)
Claims incurred	(8 466 974)	(1 671 810)	(5 169 625)	(1 444 286)	(553 895)
Third party recoveries	15 601	6 723	16 023	8 828	3 043
Changes that relate to past service – adjustments to the LIC	110 854	20 650	6 374	9 659	(5 330)
Insurance acquisition cash flows	(118 435)	(57 083)	(127 878)	(41 713)	(21 846)
Accredited managed healthcare services (no risk transfer)	(195 875)	(73 614)	(199 226)	(79 289)	(30 701)
Losses on onerous contracts and reversal of those losses	–	–	–	–	–
Directly attributable expenditure	(364 732)	(156 041)	(362 171)	(98 662)	(68 574)
Accredited Administration service	(311 600)	(133 188)	(307 849)	(68 772)	(58 194)
Other administration expenditure	(53 132)	(22 854)	(54 322)	(29 890)	(10 380)
Net income from risk transfer arrangements/reinsurance	248 886	25 062	53 627	76 937	(2 714)
An allocation of premiums paid	(838 592)	(113 808)	(278 629)	(468 446)	(32 292)
Amounts recovered from risk transfer arrangement/reinsurance	1 087 478	138 870	332 255	545 383	29 577
Insurance service result	(179 042)	123 794	(434 641)	(227 588)	(8 409)
Other income	352 747	192 096	364 445	201 208	75 964
Investment income – Scheme	344 671	188 550	356 019	196 577	74 394
Sundry income	11 728	5 076	12 057	6 644	2 331
Loss on sale of investment property	(3 652)	(1 529)	(3 631)	(2 014)	(761)
Net insurance finance expenses	–	(38 981)	–	–	(4 035)
Finance expenses from insurance contracts issued – PMSA	–	(38 981)	–	–	(4 035)
Other expenditure	(97 232)	(42 085)	(100 028)	(56 024)	(19 168)
Administration fees and other operative expenses	(86 375)	(37 316)	(88 699)	(49 779)	(16 986)
Interest expense	(86)	(37)	(88)	(49)	(17)
Asset management fees	(9 504)	(4 113)	(9 771)	(5 386)	(1 887)
Operating expenses on investment	(1 266)	(618)	(1 471)	(811)	(279)
Surplus or Deficit for the year before amounts attributable to members for future benefits	76 474	234 824	(170 225)	(82 406)	44 351
Amounts attributable to members for future benefits	(76 474)	(234 824)	170 225	82 406	(44 351)
Surplus or Deficit for the year	–	–	–	–	–
Average number of members (n)	95 359	41 155	97 818	53 857	18 616
Average number of beneficiaries (n)	200 202	95 330	224 519	78 367	41 452
Average beneficiary age	42.1	32.5	32.5	36.1	29.1
Pensioner ratio	31%	7%	6%	9%	4%

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FOR THE YEAR ENDED 31 DECEMBER 2025

BonClassic	BonComprehensive	BonEssential	BonComplete	Hospital Standard	BonStart	BonStart Plus	Scheme Total
695 243 (662 436)	500 819 (628 514)	583 185 (621 197)	582 525 (618 381)	212 708 (216 715)	170 566 (142 499)	160 938 (153 666)	20 888 306 (22 153 413)
(614 635)	(601 330)	(535 281)	(565 518)	(191 044)	(107 022)	(131 165)	(19 860 161)
(627 161) 1 156	(607 743) 603	(542 613) 2 199	(570 374) 1 182	(197 376) 603	(107 112) 1 526	(132 976) 900	(20 091 944) 58 387
11 370 (6 469)	5 810 (4 666)	5 132 (15 853)	3 674 (10 757)	5 729 (5 185)	(1 436) (5 568)	910 (4 953)	173 396 (420 406)
(14 238)	(8 397)	(21 257)	(14 417)	(6 340)	(12 991)	(7 655)	(664 000)
– (27 094) (23 171) (3 923)	– (14 121) (12 076) (2 045)	– (48 805) (41 333) (7 472)	– (27 689) (23 686) (4 003)	– (14 146) (12 100) (2 046)	– (16 918) (11 719) (5 199)	– (9 893) (6 824) (3 068)	– (1 208 846) (1 010 512) (198 334)
19 142 (69 430)	1 744 (52 049)	3 402 (23 855)	10 591 (52 643)	1 024 (9 945)	(3 139) (7 167)	(1 241) (4 831)	433 320 (1 951 687)
88 572	53 793	27 257	63 234	10 969	4 028	3 590	2 385 007
51 949 44 906	(125 951) 24 450	(34 610) 50 276	(25 265) 38 797	(2 983) 13 608	24 928 36 044	6 031 21 676	(831 787) 1 416 216
44 294 868 (257)	24 131 453 (134)	49 120 1 662 (506)	38 171 886 (260)	13 288 453 (133)	35 267 1 168 (391)	21 214 693 (231)	1 385 696 44 020 (13 500)
(18 812)	(10 826)	–	(12 198)	–	–	–	(84 852)
(18 812)	(10 826)	–	(12 198)	–	–	–	(84 852)
(7 218)	(3 764)	(13 761)	(7 365)	(3 764)	(9 601)	(5 675)	(365 686)
(6 401) (6) (704) (106)	(3 338) (3) (367) (55)	(12 201) (12) (1 346) (202)	(6 532) (7) (718) (109)	(3 339) (3) (367) (55)	(8 506) (8) (947) (140)	(5 028) (5) (559) (83)	(324 501) (322) (35 669) (5 194)
70 825 (70 825)	(116 090) 116 090	1 905 (1 905)	(6 032) 6 032	6 861 (6 861)	51 371 (51 371)	22 032 (22 032)	133 891 (133 891)
–	–	–	–	–	–	–	–
7 070 11 939 56.0 44%	3 686 6 030 57.7 27%	13 445 30 024 37.4 13%	7 217 13 598 47.6 27%	3 688 6 597 51.2 33%	9 309 10 310 35.2 4%	5 493 9 577 27.3 2%	356 713 727 946 35.9 11%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

20. CASH FLOW NOTES

20.1 Returns on financial assets at fair value through profit or loss

The bulk of investment income on investments is held as cash and cash equivalents and not reinvested by the fund managers into financial instruments.

	2025 R'000	2024 R'000
20.1.1 Interest received		
Finance income (note 16)	552 981	521 185
Interest capitalised in investments	(259 043)	(230 954)
	293 938	290 231
20.1.2 Dividends received		
Dividend income (note 16)	219 462	192 918
Dividend capitalised in investments	(1 135)	(215)
	218 327	192 703
20.1.3 Asset management fees		
Asset management fees per statement of comprehensive income	(40 003)	(35 669)
Fees capitalised in investments	100	310
	(39 903)	(35 359)
20.1.4 Rentals received		
Rentals received (note 16)	–	9 368
Increase in rent receivables	–	(44)
	–	9 324
20.1.5 Cash paid to providers and members		
Cash paid to providers and members – claims (risk and PMSA) (note 11)	20 292 214	18 746 550
Cash paid to providers – premiums paid (note 13)	2 042 946	1 984 995
Cash paid to providers – acquisition costs (note 11)	427 953	420 406
	22 763 113	21 151 951
20.1.6 Cash paid to providers and employees – non healthcare expenditure		
Cash paid to providers and employees – directly attributable expenses (note 11)	1 307 978	1 341 314
Cash paid to providers and employees – other operating expenses	317 000	230 031
	1 624 978	1 571 345

21. INSURANCE RISK MANAGEMENT

21.1 Risk management objectives, policies and strategies to mitigate insurance risk

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. This risk relates 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 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. Certain risks are mitigated by entering into risk transfer arrangements.

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

This variation could be due to adverse experience for example an unexpected pandemic, unanticipated demographic movements e.g. a substantial number of young members leaving the Scheme, changes in the health profile of the membership, unexpected price increases and the cost of new technologies or drugs.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

21. INSURANCE RISK MANAGEMENT (CONTINUED)

21.1 Risk management objectives, policies and strategies to mitigate insurance risk (continued)

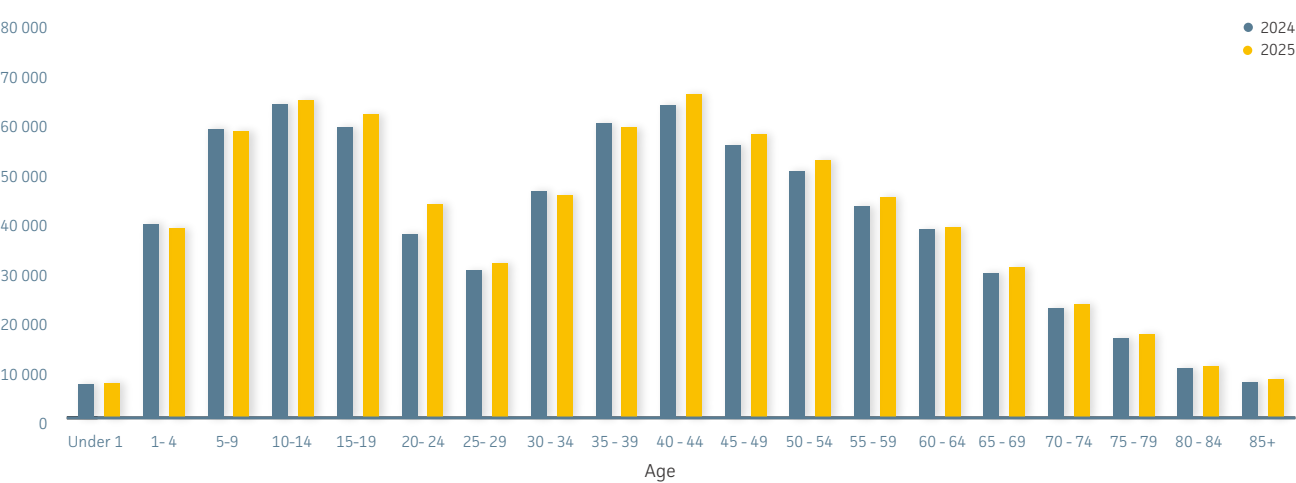
A major risk affecting the future sustainability of the Scheme is the possibility of deterioration in the risk profile of members. Schemes with a better member risk profile can offer the same benefits at a lower contribution rate than other schemes, as their members will be claiming less.

If a scheme charges higher contribution rates than the market, it is at risk of losing members and not replacing them. It is typically easier for younger, healthier members to move to another scheme. Should this happen, the member risk profile would deteriorate, resulting in even higher contribution rates being required.

One of the Scheme’s key objectives, therefore, is to keep contribution rates as competitive and affordable as possible given the increases in claims costs. It is important that the Scheme maintains or improves its member risk profile, by attracting lower risk members and retaining healthy members in the Scheme.

The chart below provides an overview of the Scheme’s beneficiaries demographic profile:

BENEFICIARY DEMOGRAPHIC PROFILE



The Scheme’s strategy seeks diversity to ensure a balanced portfolio approach. This approach is based on having a large portfolio of similar risks over a number of years, which is believed to reduce the variability of the outcome.

The strategy is set out in the annual pricing and benefit plan, and specifies the benefits to be provided by each option, the expected number of members per option and their expected demographic profile.

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

It is important to note that the Scheme’s insurance risk management strategy focuses primarily on the management of systematic risk factors, which are risks within the control of the Scheme. Conversely, limited focus is placed on the management of non-systematic risk factors as these factors are uncontrollable in nature and are inherent to the medical industry as a whole.

The Scheme has noted the steady migration of insurance risk pertaining to Prescribed Minimum Benefits (“PMBs”), from systematic to non-systematic risk over the past five years. This is mainly attributable to change in legislation associated with PMBs, which requires the Scheme to pay for PMBs at full invoice price and no longer at set benefit limits and sub-limits.

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21. INSURANCE RISK MANAGEMENT (CONTINUED)

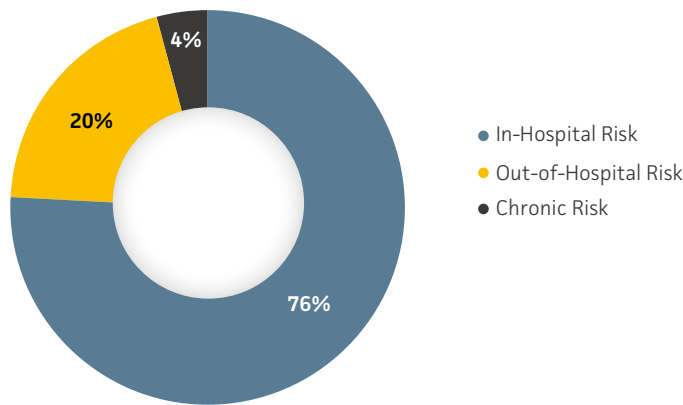
21.2 Concentrations of insurance risk

The Scheme’s concentrations of insurance risk can be split into the following three benefit categories:

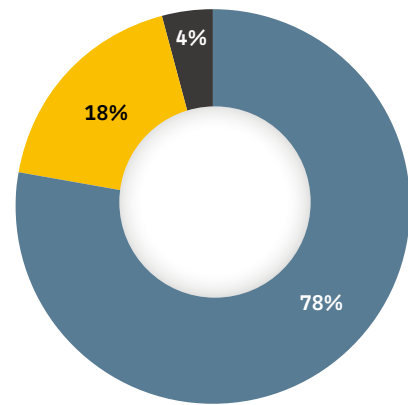
- **Out-of-hospital benefits**
The out-of-hospital benefits include both the PMSA and an insurance risk element, dependent on the elected benefit option. These benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed acute medicines.
- **In-hospital benefits**
The hospital benefit covers medical expenses incurred due to admission to hospital.
- **Chronic illness benefit**
The Chronic Illness Benefit (CIB) covers approved medication for listed conditions, including the 27 PMB chronic conditions.

The following charts summarise the concentrations of insurance risk in relation to the type of risk covered/benefits provided:

CONCENTRATION OF INSURANCE RISK: 2024



CONCENTRATION OF INSURANCE RISK: 2025

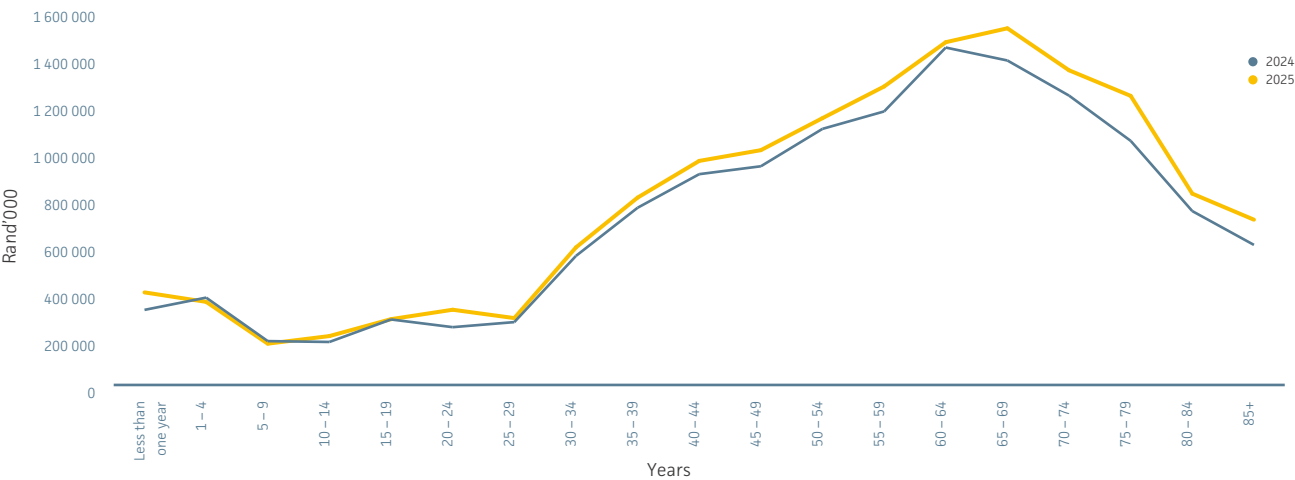


The following graphs summarise the concentrations of insurance risk, with reference to the carrying amount of the insurance claims incurred (before risk transfer arrangements), by age category in years of the Scheme and in relation to the benefit category.

The health status of the membership is a primary determinant of demand for health services which subsequently affects total cost of care. Therefore mitigation strategies are focused on positively influencing the utilisation and price of such services, to ensure overall system-wide cost-containment of quality care. These strategies for each benefit category are also summarised below.

21.2.1 In-hospital risk

CONCENTRATION OF INSURANCE RISK: IN-HOSPITAL RISK



Hospital and major medical expenses make up a significant part of overall expenditure and require close management. Therefore, there is a strong focus on ensuring appropriate treatment during the hospital stay (including level of care and length of stay), as well as post-discharge, which improves patient outcomes and reduces the likelihood of readmission for high risk admissions.

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21. INSURANCE RISK MANAGEMENT (CONTINUED)

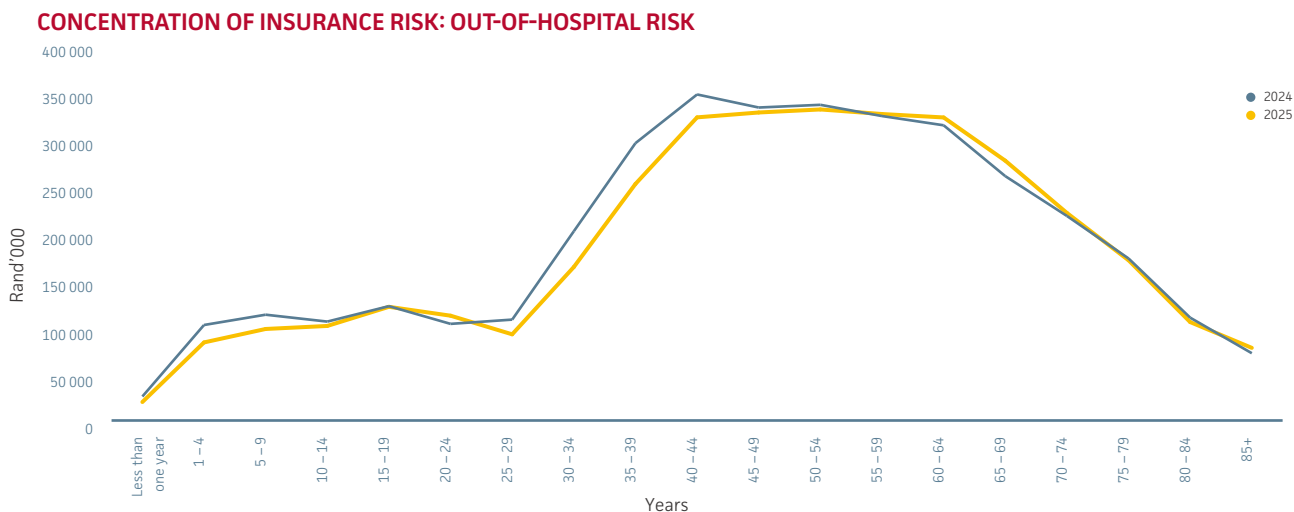
21.2 Concentrations of insurance risk (continued)

21.2.1 In-hospital risk (continued)

Initiatives used by the Scheme include:

- Hospital Benefit Management Programme – focusing on patient care co-ordination, from pre-admission to six weeks post- discharge, in order to ensure best and appropriate care.
- Reviewing and updating of clinical funding protocols as well as criteria for recognising specific healthcare professionals as being able to perform certain procedures.
- Health technology assessments (HTA) on existing and new technologies entering the market, within a framework of clinical validity and economic appropriateness of the healthcare intervention, based on a systematic review of the evidence base and costing considerations.
- Specialised case management – providing a dedicated focus on psychiatric cases, neonates, high cost cases and cases involving alternatives to hospitalisation (e.g. step down facilities).
- “Call-me-back” functionality to promote treating Doctor and/or Medical Advisor engagement in answering questions and offering choice in terms of funding alternatives.
- Monitoring compliance to care pathways to reduce the risk of readmission. This involves a follow-up process where, in the case of non-compliance, support is provided to assist the beneficiary to return to the care pathway.
- Innovative reimbursement models with hospitals/hospital groups to ensure the most appropriate level of risk is transferred through reimbursement such as;
- Efficiency gain share
- Claims increase protection
- Rewarding providers for efficiency and quality care
- Entering into risk-based contracting with specialists where specific risks within the member population can be addressed e.g. arthroplasty (global fee).
- Contracting of a specialist network at agreed reimbursement rates.
- Clinical audit and re-pricing of claims to ensure that claims are paid against the contracted hospital rates and the pre- authorised level of care.
- Promoting alternatives to hospitalisation such as step-down facilities, Hospital-at-home and Home-Based Nursing to ensure that the right patient receives the right care at the right time.

21.2.2 Out-of-hospital risk



Managing claims expenditure is not only about negotiating lower rates but also about curtailing preventable hospital utilisation and cost. Initiatives focused on coordinating care for segments of the population who are likely to present for medical care, with associated high claim costs, have been implemented. Such initiatives include:

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

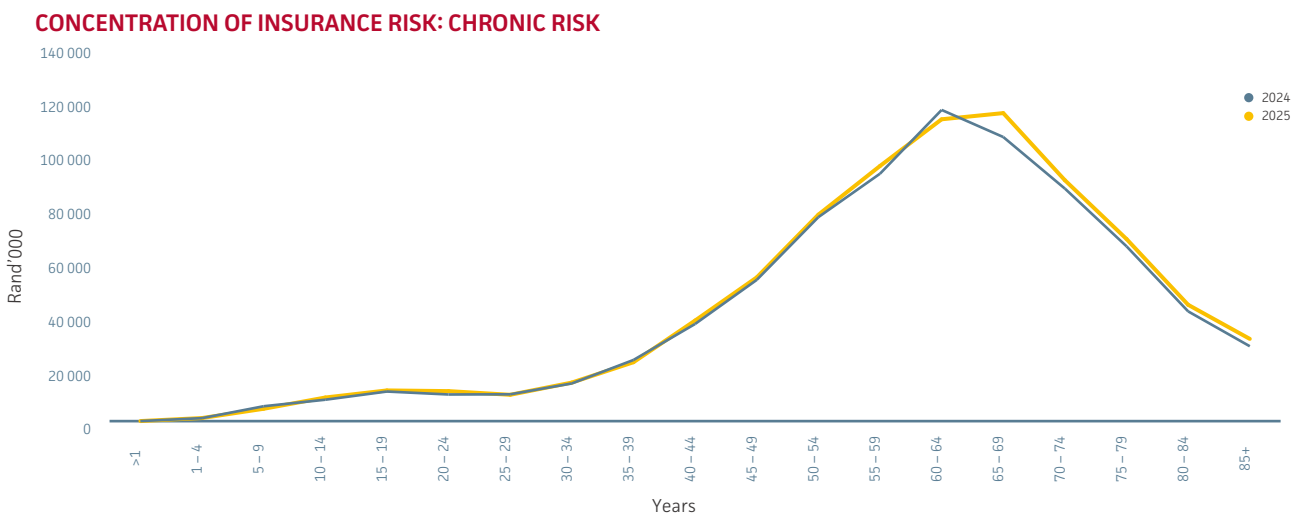
21. INSURANCE RISK MANAGEMENT (CONTINUED)

21.2 Concentrations of insurance risk (continued)

21.2.2 Out-of-hospital risk (continued)

- Active Disease Risk Management Programme – An integrated care coordination programme enabling high and emerging risk beneficiaries to improve their health and quality of life by empowering the beneficiary through information sharing and counselling, to take responsibility for his or her own health and wellness.
- Back Rehabilitation Programme – An evidence-based physiotherapy and active rehabilitation programme that concentrates primarily on back and neck ailments, thus reducing the need for surgical intervention.
- High Risk Maternity Case Management – Pregnant mothers with potentially high risk pregnancies are supported and additional benefits are provided where this is deemed necessary to reduce the risk of high-cost hospitalisation and premature deliveries.
- Oncology Disease Management – Complex or unusual patient-specific requirements are managed on a case-by-case basis ensuring that beneficiaries access funding for appropriate and cost-effective oncology therapy before, during and after active treatment.
- Palliative care for oncology – Most terminally ill patients indicate a wish to spend their remaining days at home, but in the South African private healthcare sector they are much more likely to remain in an intensive care or high care unit, frequently receiving aggressive, invasive and non-beneficial care. Under the palliative care programme, oncology patients are supported by a multidisciplinary team to ensure that they receive the most appropriate care in the most appropriate setting.
- Pathology Programme – Application of clinical protocols and utilisation rules to prevent wasteful utilisation of pathology benefits.
- Contracting of a general practitioner (GP) network at agreed reimbursement rates.

21.2.3 Chronic Illness Risk



Chronic risk may, if not managed appropriately, have a significant impact on both out-of-hospital and in-hospital risks. Initiatives in this regard include:

- Diabetes Management Programme - The programme is made up of a combination of care co-ordination including risk stratification, adherence and pathology management and health coaching. The programme also includes family practitioner up- skilling and payment for prolonged consultations for diabetic patients through enhanced care plans. There is also an arrangement for acute diabetic hospitalisations where the diabetic beneficiaries are registered on the chronic programme.
- A chronic medicine pre-authorisation process which ensures access to appropriate treatment and the management of the chronic medicine benefit through a formal drug utilisation review.
- Generic reference pricing and formularies incentivise cost-effectiveness.
- Medicine exclusions eliminate products with no clinical benefit or which may be harmful.
- Real-time drug utilisation evaluation to alert against potential contraindications and drug interactions as well as excessive utilisation.
- Processing of claims in real-time against all Scheme Rules and benefit limits.
- Sophisticated analytical capabilities to identify medicine trends and potential fraud.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

21. INSURANCE RISK MANAGEMENT (CONTINUED)

21.3 Risk transfer arrangements

The Scheme makes use of risk transfer arrangements as an alternative insurance risk management strategy to mitigate specified risks associated with the provision of certain in-hospital and out-of-hospital benefits. Currently risk transfer arrangements approximate 9.1% (2024: 8.8%) of the Scheme's Insurance service expenditure.

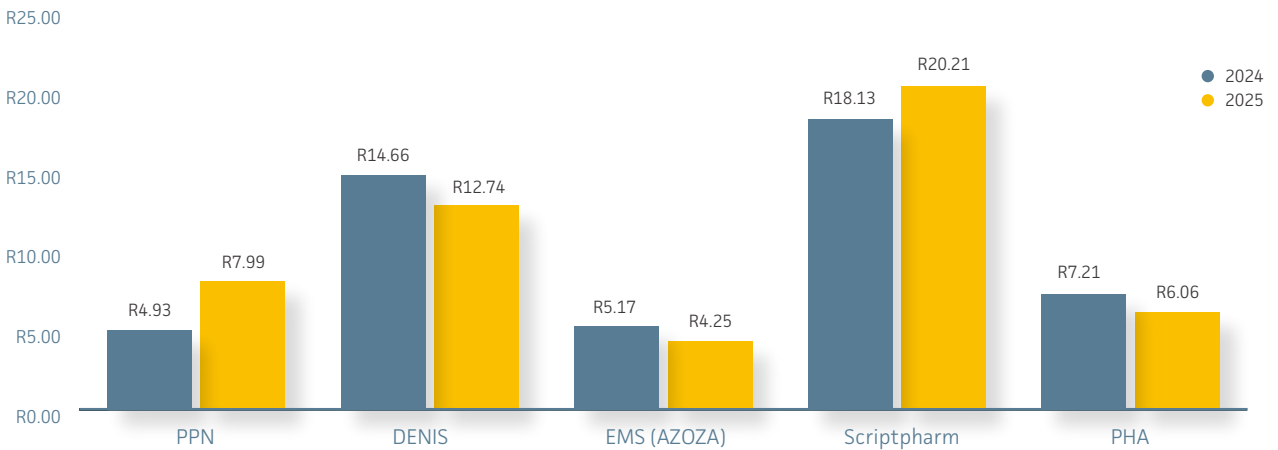
The Scheme entered into capitation agreements directly with DENIS, Scriptpharm, PPN, PHA and AZOZA. The capitation agreements involve a transfer of risk however the Scheme remains ultimately liable to its members with respect to ceded risks if any supplier fails to meet the obligations it assumes.

These risk transfer arrangements spread the insurance risk and minimise the effect of losses. The amount of each risk retained depends on the Scheme's evaluation of the specific risk, subject in certain circumstances, to maximum limits on the basis of characteristics of coverage. According to the terms of the capitation agreements, the suppliers provide certain minimum benefits to all Scheme members, as and when required by the members.

When selecting a supplier, the Scheme considers its relative security and ability to deliver the relevant service. Management renegotiates the agreed fees and benefits of the capitation agreements annually.

The graph below outlines the net income (i.e., capitation premiums less cost recoveries) incurred per beneficiary relevant to services provided in accordance with the capitation agreements.

AVERAGE NET INCOME PER AVERAGE BENEFICIARY PER MONTH



21.3.1 Dental Information Systems Proprietary Limited (“DENIS”)

The Scheme contracts DENIS to manage all aspects of dental claims administration, including the payment of all approved claims from service providers. Services rendered by DENIS are limited to all aspects of dental benefits including related hospitals, clinic and anaesthetist cost and any claim administration related to such dental and related services excluding services, benefits and claims classified under PMB as defined by the Medical Scheme Act, or amendments of the Act applicable to PMBs. DENIS also provides the Scheme with monthly financial reports reflecting all transactions related to fees paid by the Scheme and services rendered by DENIS.

The Scheme pays DENIS a monthly fixed fee, in advance for beneficiaries on Standard, BonSave, BonClassic, BonComplete and BonFit options.

The current contract took effect from 1 January 2023 for a period of three years ending December 2025. The contract been renewed for a further 12 months to 31 December 2026. Fees and benefits have been agreed for the 2026 benefit year.

21.3.2 Scriptpharm Risk Management Proprietary Limited (“Scriptpharm”)

The Scheme contracted Scriptpharm as an accredited managed care organisation, to provide chronic medicine benefits to beneficiaries of the Scheme on a capitated basis. Scriptpharm creates and provides the Scheme with a Network of Providers which shall ensure the delivery of chronic medicines to the beneficiaries of the Scheme. Scriptpharm pays all valid medicine claims which shall be submitted to Scriptpharm by any pharmacy that is a Designated Service Provider and any General Practitioner or Specialist. Scriptpharm will provide the Scheme with all information, data and reports as required.

The Scheme pays Scriptpharm a monthly fixed fee per beneficiary on BonComprehensive, BonClassic, Standard, Standard Select, BonComplete, BonSave, Primary, Primary Select, BonFit, Hospital Standard BonEssential, BonEssential Select, BonCap, BonStart and BonStart Plus options.

The contract commenced on 1 February 2020 and was renewed on 1 January 2022, extending its term to 31 December 2023. Subsequently, the contract was renewed for an additional 12 months to 31 December 2024, followed by further extensions of 12 months to 31 December 2025 and 6 months to 30 June 2026. Fees for the 2026 financial year have been agreed.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

21. INSURANCE RISK MANAGEMENT (CONTINUED)

21.3 Risk transfer arrangements (continued)

21.3.3 Preferred Providers Negotiators Proprietary Limited ("PPN")

The Scheme has contracted PPN for optometrical services and pays a monthly fixed fee per member per month on the Standard, Standard Select, Primary, Primary Select, BonClassic and BonCap options. Included in the contract is an arrangement whereby if a defined surplus, comprised of premiums less claims paid less expenses, is reported at the end of the benefit or contract cycle then 100% of the defined surplus, up to a maximum of 6% of the total of the premiums paid, is due to the PPN and the remainder to the Scheme.

The contract of 1 January 2019 to 31 December 2022 was renewed, following a request for proposal (RFP) process, on 1 January 2023 and remained in force until 31 December 2024. This contract has been renewed for a 24 month period until 31 December 2026. Fees and benefits have been agreed for the 2026 financial year.

21.3.4 AZOZA Proprietary Limited ("AZOZA") (previously Europ Assistance Worldwide Services (South Africa) Proprietary Limited – EMS and Travel divisions)

Travel benefit

The Scheme has entered into a risk transfer arrangement with AZOZA for the provision of international travel benefits for members who travel overseas for a period of not more than 90 days. This contract applies to all members of the Scheme except for those on the BonCap Option.

The contract commenced on 1 July 2022 and remained in force until 31 December 2024. The contract was renewed and extended for a 12 month period up until 31 December 2025. Fees and benefits were agreed upon for 2026.

Emergency medical services

From 1 May 2022 the Scheme entered into a risk transfer arrangement with AZOZA (previously called EASA) for the provision of emergency medical services to provide emergency response, assistance and transportation to the members of the Scheme.

The contract commenced on 1 July 2022 and remained in force until 31 December 2024. The contract was renewed and extended for a 12 month period up until 31 December 2025. Fees and benefits were agreed upon for 2026.

21.3.5 Private Health Administrators Proprietary Limited ("PHA")

The Scheme has entered into a risk transfer arrangement with PHA for the provision of non-hospital benefit services for the BonCap option and the provision of chronic medicine for the BonCap option.

The contract for the provision of non-hospital benefit services commenced on 1 January 2023 with an original term of 36 months. A new contract was negotiated effective 1 January 2024 for a period of 24 months and has been renewed for another 24 months.

The contract for the provision of chronic medicine commenced on 1 January 2025 for a period of 12 months, with an automatic annual renewal of 12 months, subject to both parties agreeing in writing on the new fee payable for each renewal period.

21.4 Sensitivity disclosure

21.4.1 Claims sensitivity analysis

The table below outlines the sensitivity of claims and solvency to the major insurance risks, i.e., tariff inflation, ageing and utilisation being higher than expected. Each change in the criteria is quantified in the form of an expected claims and solvency impact on the Trustee-approved 2026 Budget.

Claims category	Change in variable	Estimated impact on expected 2026 claims R'000	Estimated impact on expected 2026 solvency %
Inflation assumptions <i>Represents the increase in the price of service units rendered</i>			
In-hospital claims (ward/theatre/consumables)	Tariff inflation 1% higher	59 809	-0.23%
Ageing assumptions <i>Represents the expected claims increase due to members getting older on average</i>			
In-hospital claims (ward/theatre/consumables)	Average member age 0.5 years higher	227 206	-0.88%
Acute Medicine claims	Average member age 0.5 years higher	17 928	-0.07%
Utilisation assumptions <i>Represents expected claims increases over and above what is explained by inflation, ageing and benefit changes</i>			
In-hospital claims (ward/theatre/consumables)	Utilisation rate 1% higher	85 442	-0.33%
Specialist costs	Utilisation rate 1% higher	26 888	-0.10%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

21. INSURANCE RISK MANAGEMENT (CONTINUED)

21.4 Sensitivity disclosure (continued)

21.4.2 Risk adjustment sensitivity

The following table provides a sensitivity on the insurance contract liabilities. The table provides the sensitivity before and after the impact of the Scheme being a mutual entity. As the Scheme is a mutual entity, the impact of any changes in the insurance liability to current members would impact the liability 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		
	LIC as at 31 December	Impact on LIC	Impact on SOCI	LIC as at 31 December	Impact on LIC	Impact on SOCI
Insurance contract liabilities						
Net insurance contract liabilities	2 764 246			2 583 210	–	–
Unpaid claims and expenses – 5% increase		138 212	(138 212)		129 161	(129 161)
Insurance service expense	(23 404 280)			(22 153 413)	–	–
Insurance service expenses – 5% increase	–		(1 170 214)		–	(1 107 671)

Sensitivity description	Method	Change in variable	Effect of change in risk adjustment and Risk mitigation by RTA		Comment
			2025 R'000	2024 R'000	
Change in confidence intervals (due to higher confidence intervals)	Monte Carlo Simulations based on a two parameter Weibull distribution for development period 0, linear distribution for later run-off periods (with a confidence interval of 75% as reported)	8%	91 746	79 606	Also adopted as Risk Adjustment Value
	Monte Carlo Simulations based on a two parameter Weibull distribution for development period 0, linear distribution for later run-off periods (with a confidence interval of 80%)	11%	118 492	107 859	
	Monte Carlo Simulations based on a two parameter Weibull distribution for development period 0, linear distribution for later run-off periods (with a confidence interval of 85%)	15%	157 728	142 423	
	Monte Carlo Simulations based on a two parameter Weibull distribution for development period 0, linear distribution for later run-off periods process month (with a confidence interval of 90%)	20%	212 113	190 392	
	Monte Carlo Simulations based on a two parameter Weibull distribution for development period 0, linear distribution for later run-off periods (with a confidence interval of 95%)	29%	301 109	270 258	
Hospital & Specialist Utilisation (higher)	Monte Carlo Simulations based on a two parameter Weibull distribution for development period 0, linear distribution for later run-off periods – December service month	5%	29 211	32 021	
Chronic Utilisation (higher)	Deterministic – December service month	2%	–	–	Capitation Arrangement (Risk Transfer Arrangement), therefore no change to LIC (demonstrates impact of RTA on LIC)

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

The analysis is based on a change in an assumption while holding all the other assumptions constant. In practice, this is unlikely to occur, and changes in some of the assumptions may be correlated. The Scheme has updated its projection approach. While it continues to use the same projection techniques, the risk adjustment is now calculated using a Weibull distribution together with Monte Carlo simulations to determine the best estimate liability for incurred but not reported claims. In addition, the confidence level applied in the calculation has been reduced from 90% to 75%, providing a more appropriate reflection of the Scheme's risk appetite and diversification benefits. Refer to note 12 for details on the change of methods used.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

22. FINANCIAL RISK MANAGEMENT

22.1 Financial risk management principles

The Scheme’s activities expose it to the following financial risks:

- Credit risk;
- Liquidity risk; and
- Market risk from equity market prices (price risk) and interest rate 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.

Financial risk management and investment decisions are made under the guidance and policies approved by the Board of Trustees, together with the Scheme’s Executive Management, who have overall responsibility for the establishment and oversight of the Scheme’s financial and non-financial risk management framework.

The Investment Committee is responsible for assisting the Board to manage the investment portfolio in accordance with the agreed policies of the Scheme and ensure compliance with the regulations of the Act. Refer to page 81 of the Annual Report for further details on the Scheme’s investment strategy.

22.2 Credit risk

Credit risk is the risk that the Scheme will suffer a financial loss if a customer (insurance or trade receivable) or other counterparty to a financial instrument fails to meet their current obligations to the Scheme. Credit risk arises principally from the Scheme’s investment securities (excluding the equity instruments), cash and cash equivalents and insurance, trade and other receivables.

22.2.1 Exposure to credit risk

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

	2025 R’000	2024 R’000
Investments (current and non-current)	6 901 780	6 582 375
Trade and other receivables (excluding prepayments)	5 288	6 243
Reinsurance contracts assets	112 538	95 384
Insurance contract assets	711 409	666 247
Cash and cash equivalents	966 466	848 715
	8 697 481	8 198 964

22.2.2 Investments

No expected credit loss (ECL) has been recognised on the Scheme’s investments, including cash and cash equivalents, as the impact is assessed to be negligible. These instruments are held with highly-rated South African banks and are considered to have low credit risk at the reporting date. In accordance with IFRS 9, any resulting ECL would be immaterial. The credit risk is further mitigated through limits on exposure and by restricting investments to high-quality instruments, thereby reducing the potential impact of any default on the overall portfolio.

Domestic fixed-income and cash investments

An important element of credit risk management is the establishment of exposure limits on single counterparties and groups of connected counterparties. Limits should also be established for industries or economic sectors, geographic regions, etc. Risk ratings are an important tool in monitoring and controlling credit risk. In order to facilitate early identification of changes in risk profiles, the Scheme’s risk rating system should be responsive to indicators of potential or actual deterioration in credit risk. The credit limits set out below shall apply to all debt securities:

Per Issuer Limit:	
Credit category (Fitch/S&P or equivalent)	Per issuer limit as % of total bond and cash allocation
RSA bonds	Up to 100%
AAA (including sovereign & Government-guaranteed bonds)	Not more than 25%
Below AAA but not lower than AA-	Not more than 20%
Below AA- but not lower than A	Not more than 15%
Below A but not lower than BBB	Not more than 10%
Below BBB	Not more than 5%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.2 Credit risk (continued)

22.2.2 Investments (continued)

In addition to the per issuer limits, a minimum of ninety percent of the debt securities held by the fund must be investment grade (AAA to BBB- or equivalent) credit rating).

The table below presents the gross credit risk exposure of the Scheme's investments, based on available credit ratings or, where applicable, the asset manager's rating, using the Fitch national scale framework:

Long-term rating	December 2025		December 2024	
	Gross carrying amount R'000	% per rating band	Gross carrying amount R'000	% per rating band
AAA	3 337 767	25%	2 903 230	39%
AA+ to AA-	4 182 664	31%	4 200 752	57%
A+ to A-	209 303	2%	177 060	2%
BBB+ to BBB-	39 867	0%	54 840	1%
Not rated	98 645	1%	95 208	1%
Total gross credit risk exposure of bonds and cash allocation	7 868 246		7 431 090	

Gross Credit Risk Exposure: Top Five Institutions (Fitch National Scale Ratings) at the reporting date:

2025

Issuer	Long-term rating		2025 R'000	Per issuer %
	AAA R'000	AA+ to AA- R'000		
Republic of South Africa	2 870 193	–	2 870 193	36.5%
Nedbank Limited*	–	1 610 578	1 610 578	20.5%
The Standard Bank of South Africa Limited	–	816 538	816 538	10.4%
Absa Bank Limited	–	731 496	731 496	9.3%
FirstRand Limited	–	118 095	118 095	1.5%
Total Top 5 institutions credit risk exposure			6 146 900	78.1%

* Nedbank Limited's percentage allocation as at 31 December 2025 exceeded the 20% threshold prescribed in the Scheme's investment policy. This was due to cash deposits of R261 million received from employer groups on the last day of the financial year. The excess exposure was temporary in nature and the funds were subsequently reinvested in accordance with the Scheme's cash and investment policies.

2024*

Issuer	Long-term rating		2024 R'000	Per issuer %
	AAA R'000	AA+ to AA- R'000		
Republic of South Africa	2 391 420	–	2 391 420	32.2%
Nedbank Limited	–	797 510	797 510	10.7%
The Standard Bank of South Africa Limited	–	777 161	777 161	10.5%
Absa Bank Limited	–	742 611	742 611	10.0%
FirstRand Limited	–	681 090	681 090	9.2%
Total Top 5 institutions credit risk exposure			5 389 792	72.5%

* The prior year note disclosure has been represented in order to report on credit risk exposure by institution to enhance the presentation to the users of the financial statements.

Derivatives

Derivative instruments are used for the purposes of hedging or protecting the Scheme's investment portfolio, rebalancing or facilitating cash flows in order to enhance the Scheme's investment returns. The mark-to-market value of investments is limited to 2.5% of the investment portfolio.

There were no open positions on derivatives at year end 31 December 2025 or 31 December 2024. The Scheme did not trade any derivatives during the 2024 or 2025 financial period.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.2 Credit risk (continued)

22.2.3 Insurance contracts, trade and other receivables

The Scheme's exposure to credit risk is influenced by the individual characteristics of each member. The demographics of the Scheme's membership base, including the default risk of the industry in which the member operates, has less of an influence on credit risk. The Scheme's revenue streams are evenly spread thereby reducing credit risk exposure.

The majority of the Scheme's members have been loyal to the Scheme for many years, resulting in infrequent losses occurring. Credit risk is actively managed by suspending members accounts on non-receipt of contributions.

Age analysis of insurance contracts and trade and other receivables:

	Not past due	Past due 1 – 30 days	Past due 61 – 90 days	Past due more than 90 days	Total
2025					
Financial assets					
Trade and other receivables (excluding prepayments)	2 369	–	–	2 919	5 288
Reinsurance assets					
Reinsurance contract assets	112 538	–	–	–	112 538
Insurance assets					
Insurance contract assets	668 570	27 701	9 489	5 649	711 409
	783 477	27 701	9 489	8 568	829 235

	Not past due	Past due 1 – 30 days	Past due 61 – 90 days	Past due more than 90 days	Total
2024					
Financial assets					
Trade and other receivables (excluding prepayments)	3 338	–	–	2 905	6 243
Reinsurance assets					
Reinsurance contract assets	95 384	–	–	–	95 384
Insurance assets					
Insurance contract assets	642 390	18 627	4 860	370	666 247
	741 112	18 627	4 860	3 275	767 874

With respect to the financial and insurance assets that are neither impaired nor past due, there are no indications as of the reporting date that the debtors will not meet their payment obligations based on the nature of the counterparty, the historical information about the counterparty default rates and other information used to assess credit quality. With respect to past due financial and insurance assets, these balances are disclosed net of the related impairment after taking into account default risk using the ECL (expected credit loss) impairment model, where material.

22.2.4 Cash and cash equivalents

Cash transactions are limited to high credit quality financial institutions. The Scheme has a policy of limiting the amount of credit exposure to any one financial institution and only uses the reputable banks.

22.2.5 Concentrations of credit risk

The Scheme is exposed to credit risk through its investments, cash and cash equivalents, and trade and other receivables. Concentration risk is managed by limiting exposure to individual counterparties and investing only with institutions that meet the Scheme's credit quality requirements, thereby reducing the impact of any single default. An impairment allowance is maintained for trade and other receivables, based on the Scheme's policy and historical payment experience.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.3 Liquidity risk

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

The Scheme manages its cash flows on a daily basis to ensure sufficient liquidity to cover daily requirements of which the rental costs constitute a non-significant portion of cash flow requirements on a monthly basis.

Furthermore, the Scheme has appointed asset managers to manage its liquidity requirements in the short, medium and long-term.

The Scheme aims to hold approximately 25% of its total investment assets to be invested in cash which provides a high degree of liquidity on investments. Additionally, the other equity asset managers are keeping cash in their portfolios at no more than 5% of total investments.

As part of the Scheme's liquidity risk management on market linked investments, the following categories are specifically excluded from the investment portfolio unless the Board of Trustees provides prior written approval for these investments:

- Private equity funding including venture capital and direct property investments;
- Physical commodities or physical commodity contracts; and
- Unregistered and/or restricted instruments which are unlisted and/or not freely traded.

The contractual maturities of the financial and insurance liabilities at reporting date are tabled below. The insurance and financial assets at fair value have been included to match against the financial liabilities. All financial assets and liabilities have been considered in the analysis. The time bands within 3 months, and up to 12 months, and over 1 year were included as claims are generally settled in a short period, approximately 95% in the first 3 months after the claim was incurred and the remainder are expected to be settled within 1 year and there are no estimated cash flows other than the long-term employee obligation greater than 1 year. The amounts are gross and undiscounted and in the case of financial assets held at fair value through profit or loss, exclude future accrued interest.

	Within 3 months	3 to 12 months	Over 1 year	Total
2025				
Liabilities				
Trade and other payables (note 14)	(39 332)	–	–	(39 332)
Liability for remaining coverage (note 11)	(402 826)	–	–	(402 826)
Liability for incurred claims (note 11)	(1 464 299)	(1 608 529)	–	(3 072 828)
Insurance contract assets (note 11)	705 760	5 649		711 409
Lease liability (note 4.2)	(834)	(2 551)	(2 651)	(6 036)
Long-term employee benefit obligation (note 9)	–		(6 443)	(6 443)
Total liabilities (excluding liability to members for future benefits)	(1 201 531)	(1 605 431)	(9 094)	(2 816 056)
Cash and cash equivalents (note 8)	966 466	–	–	966 466
Financial assets held at fair value through profit or loss (note 6)	5 674 528	604 928	6 262 992	12 542 448
Reinsurance contract assets (note 13)*	76 817	35 721		112 538
Trade and other receivables (note 7)	8 216	3 267		11 481
Available cash and investments	6 726 027	643 916	6 262 992	13 632 933
Liquidity surplus/(gap)	5 524 496	(961 515)	6 253 898	10 816 877

* Reinsurance contract assets include a non-cash flow transaction for provision for claims recoveries of R77 million (2024: R57 million) and a risk sharing cash flow transaction of R36 million (2024: R38 million).

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.3 Liquidity risk (continued)

	Within 3 months	3 to 12 months	Over 1 year	Total
2024**				
Financial liabilities				
Trade and other payables (note 14)	(30 434)	–	–	(30 434)
Liability for remaining coverage (note 11)	(379 432)			(379 432)
Liability for incurred claims (note 11)	(1 462 547)	(1 407 477)	–	(2 870 024)
Insurance contract assets (note 11)	665 876	371	–	666 247
Lease liability (note 4.2)	(650)	(1 755)	–	(2 405)
Long-term employee benefit obligation (note 9)			(2 927)	(2 927)
Total liabilities (excluding liability to members for future benefits)	(1 207 188)	(1 408 861)	(2 927)	(2 618 976)
Cash and cash equivalents (note 8)	848 715	–	–	848 715
Financial assets held at fair value through profit or loss (note 6)	4 178 194	577 436	5 932 586	10 688 216
Reinsurance contract assets (note 13)*	57 378	38 006		95 384
Trade and other receivables (note 7)	12 336			12 336
Available cash and investments	5 096 623	577 436	5 932 586	11 644 651
Liquidity surplus/(gap)	3 889 435	(831 425)	5 929 659	9 025 675

* Reinsurance contract assets include a non-cash flow transaction for provision for claims recoveries of R77 million (2024: R57 million) and a risk sharing cash flow transaction of R36 million (2024: R38 million).

** The prior year note disclosure has been represented to include "Reinsurance contract assets" cash flow and non-cash flow transactions to provide more useful information.

The liability to members for future benefits is considered greater than five years as this is only payable on liquidation. The balance for 2025 is R10.8 billion (2024: 9.0 billion).

Liquidity analysis assumptions:

- The carrying amount of the financial liabilities equals the undiscounted contractual value of these instruments due to the short period to maturity.
- PMSA balances are included in Liability for incurred claims and payable on demand when a member exits the Scheme.

22.4 Market risk

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

22.4.1 Currency risk

Currency risk is the risk that the value of a financial instrument will fluctuate in Rands due to changes in foreign exchange rates.

The Scheme had no material exposure to currency risk during the year or the prior year under review as no material foreign currency-denominated investments were held.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.4 Market risk (continued)

22.4.2 Interest rate risk

The Scheme is exposed to interest rate risk on its money market investments, bonds and cash and cash equivalents. The money market investments, bonds and cash and cash equivalents are managed on a net returns basis by the Scheme's asset managers. The balance of fixed and variable instruments being held in these portfolios is adjusted in response to movements in market interest rates to maintain an acceptable level of risk as well as returns. The net returns are benchmarked against the SteFi Composite index.

The carrying amounts of fixed-rate instruments in these portfolios approximate their fair values due to the short period to maturity, and no fair value adjustments are processed to the statement of profit or loss in respect of these instruments. Variable-rate instruments are not linked to one specific market interest rate. The reported returns on these investments will vary in response to movements in market rates.

The Scheme does not discount insurance, trade and other receivables and payables as they are all settled or fall due within one year.

	2025 R'000	2024 R'000
Interest-bearing instruments		
<i>Financial assets</i>	7 868 246	7 431 090
Investments – interest-bearing assets (note 6)	6 901 780	6 582 375
Cash and cash equivalents (note 8)	966 466	848 715
<i>Insurance contract liabilities</i>		
Personal medical savings account liability (note 11.4)	(1 583 531)	(1 363 188)
Interest rate sensitivity analysis	6 284 715	6 067 902

Interest rate sensitivity analysis

At the end of December 2025, the Scheme earned interest income of R564m (2024: R541m) from its investments in bonds, cash and cash equivalents and money market instruments.

The following tables illustrates the impact of negative and positive market fluctuations to the overall Scheme as a result of the current interest rate exposure. The sensitivity analysis is based on the modified duration of each of the Scheme's fixed income portfolios. The modified duration of each portfolio was obtained from the applicable Investment Manager (modified duration is a measure of the sensitivity of the value of an investment to a change in interest rates. As an example, the value of a portfolio with a modified duration of 5 will increase by 5% when interest rates decrease by 5% and vice versa):

(R'000)

Decrease in interest rate	-2.5%	-2.0%	-1.5%	-1.0%	-0.5%	-0.25%	0.0%
2025							
Scheme impact (surplus) (R'000)	715 773	572 618	429 464	286 309	143 155	71 577	–
Solvency impact	3.00%	2.40%	1.80%	1.20%	0.60%	0.30%	–
2024							
Scheme impact (surplus) (R'000)	604 141	483 313	362 485	241 656	120 828	60 414	–
Solvency impact	2.75%	2.2%	1.65%	1.10%	0.55%	0.27%	–

(R'000)

Increase in interest rate	0.0%	0.25%	0.5%	1.0%	1.5%	2.0%	2.5%
2025							
Scheme impact (surplus) (R'000)	–	(71 577)	(143 155)	(286 309)	(429 464)	(572 618)	(715 773)
Solvency impact	–	-0.30%	-0.60%	-1.20%	-1.80%	-2.40%	-3.00%
2024							
Scheme impact (surplus) (R'000)	–	(60 414)	(120 828)	(241 656)	(362 485)	(483 313)	(604 141)
Solvency impact	–	-0.27%	-0.55%	-1.10%	-1.65%	-2.2%	-2.75%

Solvency figures are calculated on the assumption that all cumulative unrealised fair value reserves have been realised.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.4 Market risk (continued)

22.4.2 Interest rate risk (continued)

The impact of interest rate changes on the Scheme's money market deposits is as follows:

(R'000)

Increase in interest rate	2.5%	2.0%	1.5%	1.0%	0.5%	0.25%	0.0%
2025							
Scheme impact (surplus) (R'000)	81 420	65 136	48 852	32 568	16 284	8 142	–
Solvency impact	0.34%	0.27%	0.20%	0.14%	0.07%	0.03%	–
2024							
Scheme impact (surplus) (R'000)	90 150	72 120	54 090	36 060	18 030	9 015	–
Solvency impact	0.41%	0.33%	0.25%	0.16%	0.08%	0.04%	–

(R'000)

Decrease in interest rate	-0.0%	-0.25%	-0.5%	-1.0%	-1.5%	-2.0%	-2.5%
2025							
Scheme impact (surplus) (R'000)	–	(8 142)	(16 284)	(32 568)	(48 852)	(65 136)	(81 420)
Solvency impact	–	-0.03%	-0.07%	-0.14%	-0.20%	-0.27%	-0.34%
2024							
Scheme impact (surplus) (R'000)	–	(9 015)	(18 030)	(36 060)	(54 090)	(72 120)	(90 150)
Solvency impact	–	-0.04%	-0.08%	-0.16%	-0.25%	-0.33%	-0.41%

Interest credited on members' personal medical savings accounts is administered in accordance with Scheme rules and is not contractually linked to market interest rates; accordingly, it has not been included in the interest rate sensitivity analysis.

22.4.3 Market price risk

Market price risk arises from fair value through profit or loss of equity securities held for partially meeting the Scheme's financial obligations. The Scheme's assets are managed by various asset managers on behalf of the Scheme. All buy and sell decisions are measured in terms of the investment mandate of the Scheme.

The following guidelines provide the current limits on each instrument:

Domestic equity investments

- Domestic equity investments shall be restricted to securities that are actively traded on the Johannesburg Stock Exchange (JSE) and readily marketable.
- Not more than 7.5% of the Investment Portfolio of the Scheme may be invested in the share instrument of any one company with market capitalisation of more than R50 billion.
- Not more than 5% of the Investment Portfolio of the Scheme may be invested in the share instrument of any one company with market capitalisation of between R5 billion and R50 billion.
- Not more than 2.5% of the Investment Portfolio of the Scheme may be invested in a share instrument of a company with market capitalisation less than R5 billion at any point in time.
- In cases of investments into a pooled fund, the Scheme may invest in accordance with Regulation 30 requirements, in which case the Scheme may waive strict adherence to the guidelines above.

Domestic fixed-income and cash investments

The credit limits set out below shall apply to all debt securities:

Per Issuer Limit:	
Credit category (Fitch/S&P or equivalent)	Per Issuer limit as % of total bond and cash allocation
RSA bonds	Up to 100%
AAA (including sovereign & Government-guaranteed bonds)	Not more than 25%
Below AAA but not lower than AA-	Not more than 20%
Below AA- but not lower than A	Not more than 15%
Below A but not lower than BBB	Not more than 10%
Below BBB	Not more than 5%

In addition to the per issuer limits, a minimum of ninety percent of the debt securities held by the fund must be investment grade (AAA to BBB- or equivalent) credit rating.

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FOR THE YEAR ENDED 31 DECEMBER 2025

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.4 Market risk (continued)

22.4.3 Market price risk (continued)

Derivatives

- The Scheme is permitted to invest into derivative structures as per Annexure B of the Medical Schemes Act. Annexure B of Regulation 30 Section 7 a(ii) allows for an allocation of no more than 2.5% of Scheme's assets towards any other local assets not referred to in Annexure B and derivative instruments are not referred to anywhere in Annexure B. Therefore, this provision qualifies derivatives as "other" among other assets not referred to in Annexure B.
- The Regulation 30 limitation would therefore permit the Scheme to invest in derivative instruments not exceeding 2.5% of the Scheme's assets. For clarity, the 2.5% would relate to the value of the derivative asset/liability recognised and not the value of the underlying assets held by the Scheme.

The Scheme strives to minimise market risk as follows:

- The Scheme has established an investment strategy and in line with this strategy, the Scheme diversifies its investment portfolio by investing in domestic equities, domestic bonds, domestic listed and fixed property and domestic cash to achieve a balanced investment portfolio.
- Investments are limited to the types of securities listed in the Investment Policy Statement. Furthermore, the following categories of securities are excluded and may only be considered with written approval from the Board of Trustees:
 - a) Private equity funding including venture capital and direct property investments;
 - b) Physical commodities or physical commodity contracts; and
 - c) Unregistered and/or restricted instruments which are unlisted and/or not freely traded.
- Diversifying the management of the Scheme's investment portfolio to specific specialised mandates thus mitigating the risk through diversification. The Scheme, in addition to this, has one asset manager responsible for managing the Scheme's cash.
- Structuring the investment portfolio in order to ensure that sufficient cash and cash-like securities are available to meet cash requirements for ongoing cash flow needs, thereby avoiding the need to sell securities on the open market during periods of market volatility.

Sensitivity analysis

The analysis presented below assumes all other factors remain constant and is performed on the same basis for 2025 and 2024. The sensitivity ranges applied have been reassessed to ensure alignment with IFRS 7 paragraphs 40 - 41, which require the use of reasonably possible changes in market variables at reporting date. The revised assumptions reflect observable market volatility and are consistent with sensitivity ranges applied by comparable open medical schemes.

Listed equities

At the end of December 2025, the Scheme had 45.0% (2024: 38.4%) of its investment portfolio (excluding cash and cash equivalents) invested in equity listed instruments. The following tables illustrates the impact of negative and positive market returns to the overall Scheme as a result of the current equity exposure:

(R'000)

Decrease	-20%	-15%	-10%	-5%	-2%	0%
2025						
Scheme impact (surplus) (R'000)	(1 128 134)	(846 100)	(564 067)	(282 033)	(112 813)	–
Solvency impact	-4.73%	-3.55%	-2.36%	-1.18%	-0.47%	–
2024						
Scheme impact (surplus) (R'000)	(821 168)	(615 876)	(410 584)	(205 292)	(82 117)	–
Solvency impact	-3.73%	-2.80%	-2.24%	-1.12%	-0.45%	–

(R'000)

Increase	0%	2%	5%	10%	15%	20%
2025						
Scheme impact (surplus) (R'000)	–	112 813	282 033	564 067	846 100	1 128 134
Solvency impact	–	0.47%	1.18%	2.36%	3.55%	4.73%
2024						
Scheme impact (surplus) (R'000)	–	82 117	205 292	410 584	615 876	821 168
Solvency impact	–	0.45%	1.12%	2.24%	2.80%	3.73%

Solvency figures are calculated on the assumption that all cumulative unrealised fair value reserves have been realised.

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22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.5 Fair value

For financial assets held at fair value, disclosure is required of the fair value hierarchy which reflects the significance of the inputs used to make the measurements. Fair value disclosures are based on the level within which an instrument falls in the fair value hierarchy. The inputs are categorised into three levels, with the highest priority given to unadjusted quoted prices in active markets for identical assets or liabilities and the lowest priority given to unobservable inputs.

The three fair value hierarchy levels are:

- Level 1 inputs are unadjusted quoted prices in active markets for identical assets or liabilities;
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are either directly or indirectly (that is, derived from prices) observable for the asset or liability;
- Level 3 inputs for the asset or liability that are not based on observable market data (that is, unobservable inputs).

The following table presents the Scheme's assets held at fair value:

	Level 1	Level 2	Level 3	Total
31 December 2025				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	5 640 668	–	–	5 640 668
Bonds	4 611 433	–	–	4 611 433
Money market instruments	–	2 290 347	–	2 290 347
Total assets	10 252 102	2 290 347	–	12 542 448

	Level 1	Level 2	Level 3	Total
31 December 2024				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	4 105 840	–	–	4 105 840
Bonds	3 825 090	–	–	3 825 090
Money market instruments	–	2 757 285	–	2 757 285
Total assets	7 930 930	2 757 285	–	10 688 215

There were no changes in levels noted in the current year.

Financial assets held at fair value through profit or loss held by the Scheme categorised as Level 1 were invested in listed preference shares, equities, bonds and priced with reference to published price quotations (unadjusted) in an active market.

Financial assets held at fair value through profit or loss held by the Scheme categorised as Level 2:

- unlisted money market instruments, and valued using discounted cash flows based on applicable interest rates.

Unconsolidated investment structures

The asset managers invest the Scheme's monies in reputable funds which target returns to 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.5 Fair value (continued)

The Scheme has investments in pooled investment products and collective investment schemes (the funds) as listed in the table below. The exposure the Scheme has to these funds is listed in the table below in terms of Regulation 30 of the Act. The Scheme's maximum exposure to loss from its interests in the fund is limited to the total fair value of its investments as detailed below:

	at 31 December 2025		at 31 December 2024	
	Fair value R'000	% exposure in terms of Regulation 30	Fair value R'000	% exposure in terms of Regulation 30
Nedgroup Structured Life Taquanta EIF	673 423	5%	612 821	6%
Nedgroup Investments Corporate Money Market Fund Class C4	246 144	2%	286 279	3%
Nedgroup Investments Money Market Fund Class C4	326 602	3%	211 125	2%
Nedgroup Investments Core Income Fund Class C4	252	0%	118 021	1%
	1 246 422	10%	1 228 246	12%

22.6 Capital management

The Board of Trustees' policy is to maintain a strong capital base so as to maintain investor, creditor and market confidence and to sustain future growth of the business. RisCura Solutions (Pty) Ltd provides consulting on the Scheme's portfolio of investments and cash and cash equivalents to achieve this objective.

The Board of Trustees monitors the solvency ratio of the Scheme. The Scheme is required to maintain a minimum level of accumulated funds in terms of Regulation 29 of the Act. Accumulated funds (as per Regulation 29 of the Act) expressed as a percentage of gross annual contributions for the accounting period under review may not be less than 25.0%. "Accumulated funds" is defined as the net asset value of the Scheme, excluding funds set aside for specific purposes and unrealised non-distributable reserves. In addition to meeting the regulatory solvency requirement, the Scheme applies internal capital management practices to ensure adequate funding beyond statutory rules. These include maintaining internal solvency targets above the minimum, performing regular stress testing, and holding sufficient liquidity buffers to withstand adverse claims and market conditions. Through these measures, the Scheme ensures it remains appropriately capitalised and financially sustainable.

	2025 R'000	2024 R'000
Liability to members for future benefits	10 824 568	9 029 093
Adjusted for:		
Regulation 29 exclusion of unrealised gains on remeasurement of investments and investment property to fair value*	(2 003 115)	(543 800)
Accumulated funds per Regulation 29	8 821 453	8 485 293
Gross contributions (note 15)	23 865 924	22 003 483
Solvency ratio (%)	36.96%	38.56%
* Cumulative net (losses)/gains on remeasurement to fair value of investments and investment property are calculated as follows:		
At beginning of year	543 800	403 544
Movement in unrealised gains on remeasurement to fair value of investments included in accumulated funds (as per Regulation 29 of the Act)	1 459 315	140 256
At end of year	2 003 115	543 800
At beginning of year	–	17 774
Movement in unrealised losses on remeasurement to fair value of investment property included in accumulated funds (as per Regulation 29 of the Act)	–	(17 774)
At end of year	–	–
Cumulative net gains on remeasurement of investments and investment property at the end of the year	2 003 115	543 800

Cumulative net unrealised gains on remeasurement to fair value of investments and investment properties are excluded from the solvency calculation according to Regulation 29.

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23. COMMITMENTS

Lessee operating lease commitments

The future aggregate minimum lease payments under non-cancellable operating leases are as follows:

	2025 R'000	2024 R'000
Not later than one year	3 385	2 405
Later than one year and not later than five years	2 651	–
	6 036	2 405

24. RELATED PARTY TRANSACTIONS

24.1 Related party relationships

24.1.1 Key management personnel and their close family members

Key management personnel are those who have authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the Chairman of the Board, the Board of Trustees, the Principal Officer, the Chief Financial Officer, the Clinical Executive and the Chief Operations Officer.

Close family members include direct family members of the Chairman of the Board, the Board of Trustees, the Principal Officer, the Chief Financial Officer, the Clinical Executive and the Chief Operations Officer.

24.1.2 Key service providers

Medscheme Holdings Proprietary Limited, is a key service provider for the Scheme as it has a significant role in the administering of Scheme's financial, actuarial and operating activities. The actuarial agreement terminated on 31 July 2025.

Medscheme Holdings Proprietary Limited is also the accredited managed care service provider.

Afrocentric Distribution Services Proprietary Limited, is a key service provider as it handled the Scheme's advertising and marketing activities in the prior year. It was a fellow subsidiary of the Scheme's administrator. The marketing agreement terminated on 31 August 2024.

Aids for Aids Management Proprietary Limited, is a key service provider for the Scheme as it participates in providing managed care services to the Scheme's members. It is a fellow subsidiary of the Scheme's administrator.

Pharmacy Direct Proprietary Limited, is a key service provider as it handles the Scheme's dispensing and delivery of chronic medication. It is a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of the Scheme's administrator.

Dental Information Systems Proprietary Limited, is a key service provider as it handles the Scheme's dental claims management. It is a fellow subsidiary of the Scheme's administrator.

Scriptpharm Risk Management Proprietary Limited, is a key service provider as it handles the Scheme's chronic risk management. It is a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of the Scheme's administrator.

Private Health Administrators (PHA) Proprietary Limited, is a key service provider as it handles the Scheme's benefit option, BonCap claims. This also includes associated administration and managed care services relating to the BonCap option. It is an associate of ACT Healthcare Assets Proprietary Limited, the holding company of the Scheme's administrator.

Tendahealth Proprietary Limited, is a service provider that provides the Scheme's members with brokerage services. It is a subsidiary of Afrocentric Distribution Services, a fellow subsidiary of the Scheme's administrator. The brokerage agreement terminated on 31 October 2025.

Agile Alternative Business Solutions Proprietary Limited, is a key service provider that provides the Scheme's marketing, communication, onboarding, underwriting, product development, digital platforms, technical actuarial marketing and related activities.

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FOR THE YEAR ENDED 31 DECEMBER 2025

24. RELATED PARTY TRANSACTIONS (CONTINUED)

24.2 Transactions with related parties

All transactions with related parties are at arm's-length.

	2025 R'000	2024 R'000
24.2.1 Parties with significant influence over the Scheme		
Medscheme Holdings Proprietary Limited – Scheme administrator		
Statement of comprehensive income		
<i>Administration fees paid</i>		
Medscheme Holdings Proprietary Limited administers the Scheme in terms of the administration agreement, which prescribes that all administration activities be carried out in accordance with the Scheme Rules and under the guidance of the Board of Trustees.	1 071 148	1 040 775
<i>Service Level Agreement penalty recoveries from Administrator</i>		
As part of the administration agreement, the Scheme is entitled to recoveries due to service failures if services as per the agreements are not satisfied.	(101)	(9 655)
<i>Third party recoveries</i>		
As part of the administration agreement, the Administrator was entitled to 25% on fraud, waste and abuse recoveries.	13 825	11 553
Statement of financial position		
<i>Balances payable to related party</i>		
The balances payable bear no interest, are unsecured and are due within 30 days.	(2 590)	(2 344)
Medscheme Holdings Proprietary Limited – Managed care provider		
Statement of comprehensive income		
<i>Managed care fees (including wellness)</i>		
The managed care agreement between Medscheme Holdings (Pty) Ltd and the Scheme stipulates that Medscheme Holdings (Pty) Ltd renders managed healthcare services to the Scheme in terms of the rules of the Scheme and in accordance with the instructions given by the Board of Trustees.	508 330	487 289
Statement of financial position		
<i>Balances payable (to)/by related party</i>		
The balances (payable)/owed bear no interest, are unsecured and are owed upon presentation of an approved invoice (managed care).	–	–
Medscheme Holdings Proprietary Limited – Actuarial service provider		
Statement of comprehensive income		
<i>Actuarial consulting fees</i>		
The actuarial consulting agreement between Medscheme Holdings (Pty) Ltd and the Scheme stipulates that Medscheme Holdings (Pty) Ltd renders actuarial consulting services and technical marketing services to the Scheme in accordance with the instructions given by the Board of Trustees. This agreement terminated on 31 July 2025.	905	2 553
Statement of financial position		
<i>Balances owed to related party</i>		
The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice.	–	–

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24. RELATED PARTY TRANSACTIONS (CONTINUED)

24.2 Transactions with related parties (continued)

	2025 R'000	2024 R'000
24.2.1 Parties with significant influence over the Scheme (continued)		
Afrocentric Distribution Services Proprietary Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
The contract terminated on 31 August 2024		
Statement of comprehensive income		
<i>Sales and marketing fees</i>	–	91 512
Statement of financial position		
<i>Balances payable to related party</i>		
The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice.	–	–
Aid for Aids Management Propriety Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
<i>Managed care fees</i>		
The managed care agreement between Aid for Aids Management Proprietary Limited and the Scheme stipulates that Aid for Aids Management Proprietary Limited renders management services to the Scheme in terms of the rules of the Scheme and in accordance with the instructions given by the Board of Trustees.	56 910	54 335
Statement of financial position		
<i>Balances payable to related party</i>		
The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice.	(4 809)	(4 549)
Pharmacy Direct Proprietary Limited (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
<i>Claims paid during the year</i>	239 525	313 723
Statement of financial position		
<i>Balances payable to related party</i>		
The balances payable bears no interest, is unsecured and are due within 30 days.	(984)	–
Scriptpharm Risk Management (Pty) Ltd (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
<i>An allocation of premiums paid</i>		
The capitated risk management agreement between the Scheme and Scriptpharm Risk Management (Pty) Ltd, as an accredited managed care organisation, stipulates that Scriptpharm Risk Management (Pty) Ltd renders chronic medicine benefits to beneficiaries of the Scheme on a capitated basis.	813 734	821 525
<i>Refund of capitation fees</i>	(35 230)	(10 195)
Statement of financial position		
<i>Balances owing by related party</i>		
The balances owing bears no interest, is unsecured and are due within 30 days.	35 230	10 195
Dental Information Systems Proprietary Limited		
<i>An allocation of premiums paid</i>		
The capitated risk agreement between Dental Information Systems Holdings Proprietary Limited and the Scheme stipulates that Dental Information Systems Holdings Proprietary Limited renders dental risk management to the members of the Scheme.		
Capitation fees payable (including fees for wellness and administration costs)	363 511	351 177

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24. RELATED PARTY TRANSACTIONS (CONTINUED)

24.2 Transactions with related parties (continued)

	2025 R'000	2024 R'000
24.2.1 Parties with significant influence over the Scheme (continued)		
Dental Information Systems Proprietary Limited (continued)		
<i>Managed care services</i>		
The managed care agreement between Dental Information Systems Holdings Proprietary Limited and the Scheme stipulates that Dental Information Systems Holdings Proprietary Limited renders managed care services for Primary and Primary Select options of the Scheme.		
Dental risk management	24 125	23 559
Statement of financial position		
<i>Balances payable to related party</i>		
The balances payable bears no interest, is unsecured and are due within 30 days.	–	–
Private Health Administrators (Pty) Ltd (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
<i>Administration fees paid</i>		
The administration agreement between Private Health Administrators (Pty) Ltd and the Scheme stipulates that Private Health Administrators (Pty) Ltd administers BonCap option in terms of the rules of the Scheme and in accordance with the instructions given by the Board of Trustees.	84 884	86 383
<i>Managed care fees (including wellness)</i>		
The managed care agreement between Private Health Administrators (Pty) Ltd and the Scheme stipulates that Private Health Administrators (Pty) Ltd renders managed healthcare services for the BonCap option in terms of the rules of the Scheme and in accordance with the instructions given by the Board of Trustees.	83 338	89 253
<i>An allocation of premiums paid</i>		
The capitated risk management agreement between the Scheme and Private Health Administrators (Pty) Ltd, as an accredited managed care organisation, stipulates that Private Health Administrators (Pty) Ltd renders all associated non-hospital benefits to beneficiaries of the BonCap option of the Scheme on a capitated basis.	482 319	377 409
Statement of financial position		
<i>Balances payable (to)/by related party</i>		
The balances (payable)/owing bears no interest, is unsecured and are due within 30 days.	(654)	1 061
HearConnect (Pty) Ltd		
Statement of comprehensive income		
The audiology benefit management agreement between HearConnect (Pty) Ltd and the Scheme stipulates that HearConnect (Pty) Ltd is responsible for the administration and management of audiology benefits across all options, in accordance with the Scheme rules and under the guidance of the Board of Trustees.	14 689	–
Statement of financial position		
The balances payable bears no interest, are unsecured and is due within 30 days.	–	–
Tendahealth (Pty) Ltd (a subsidiary of Afrocentric Distribution Services (Pty) Ltd, a fellow subsidiary of Medscheme Holdings (Pty) Ltd)		
The brokerage agreement terminated on 31 October 2025.		
Statement of comprehensive income		
<i>Insurance acquisition cash flows/broker fees.</i>	22 865	29 659
Statement of financial position		
<i>Balances payable to related party</i>		
The balances payable bears no interest, is unsecured and are due within 30 days.	–	–
Agile Alternative Business Solutions Proprietary Limited		
Effective 1 September 2024 the Scheme entered into an agreement with Agile Alternative Business Solutions Proprietary Limited to provide the Scheme's marketing and related activities.		
Statement of comprehensive income		
<i>Sales and marketing fees</i>	204 663	57 257
<i>Wellness and actuarial fees</i>	14 315	3 057
<i>Digital computer maintenance fees</i>	2 330	–
Statement of financial position		
<i>Balances payable to related party</i>		
The balances payable bears no interest, is unsecured and are due within 30 days.	(97)	–

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24. RELATED PARTY TRANSACTIONS (CONTINUED)

24.2 Transactions with related parties (continued)

	2025 R'000	2024 R'000
24.2.2 Key management personnel and their close family members		
Key management compensation		
Trustees' remuneration and other disbursements (note 18)	8 626	8 111
Principal Officer's remuneration and other disbursements (note 18)	9 271	9 369
Executive remuneration and other disbursements	12 777	8 497
	30 674	25 977
Statement of comprehensive income		
<i>Contributions received</i>		
This constitutes the contributions paid by the Executive Management and Trustees as members of the Scheme, in their individual capacity. All contributions were at the same terms as applicable to third parties.	1 109	1 103
<i>Claims paid</i>		
This constitutes amounts claimed by the Executive Management and Trustees, 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 third parties.	425	820
<i>Trustees savings balances</i>		
This constitutes savings balances held by the Scheme on behalf of the trustees.	–	–

25. CONTINGENCIES

The Scheme has a contingent asset arising from its statutory right of recovery of medical costs from the Road Accident Fund ("RAF") in respect of members who have been, or may have been, involved in motor vehicle accidents. These recoveries relate to healthcare expenditure already incurred by the Scheme for which claims may be lodged against the RAF in line with the Road Accident Fund Act 56 of 1996.

At reporting date, the gross value of submitted and potential RAF medical cost recoveries amounted to R795 million (2024: R670 million). This amount represents claims submitted, claims in progress and claims in an await payment status, where the underlying accident and treatment have occurred.

The realisation of these recoveries is dependent on a number of uncertain future events that are not wholly within the control of the Scheme, including the acceptance of claims by the RAF, the outcome of legal and administrative processes, the timing of settlements, and the ongoing court cases, operational and funding constraints experienced by the RAF. As a result, both the timing and the amount of cash inflows remain uncertain. Additionally this treatment is in line with the SAICA Medical Schemes Accounting Guide for 2025.

Accordingly, while the Scheme considers it probable that a portion of these amounts will ultimately be recovered, the inflow of economic benefits is not considered to be virtually certain at reporting date. No asset has therefore been recognised in the statement of financial position in respect of these recoveries.

The Scheme continues to actively pursue these claims through internal processes and external legal mechanisms. The disclosure of this contingent asset has been made in accordance with IAS 37 paragraphs 89 to 91, and no further information has been disclosed where such disclosure could prejudice the Scheme's position in ongoing recovery processes.

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26. NON-COMPLIANCE WITH THE ACT

The following areas of non-compliance with the Medical Schemes Act were identified during the course of the financial year:

26.1 Contravention of Section 33(2) of the Act

26.1.1 Nature and cause

In terms of Section 33(2) of the Act, the Registrar may withdraw the approval of such benefit options which, in his opinion, are not financially sound. For the year ended 31 December 2025 the Scheme reported the following loss making options as defined by the Council of Medical Schemes on seven (2024: eight) of its benefit options:

	2025 R'000	2024 R'000
Standard	(167 088)	(179 042)
Primary	(1 580)	(434 641)
BonCap	(264 986)	(227 588)
Bonfit	–	(8 409)
BonComprehensive	(53 132)	(125 951)
BonEssential	(50 383)	(34 610)
BonComplete	(11 176)	(25 265)
Hospital Standard	(19 416)	(2 983)

Options that are considered loss making by the Council of Medical Schemes are benefit options that report an insurance service result deficit after excluding amounts attributable to members for future benefits.

26.1.2 Possible impact

Loss-making benefit options erode the solvency margin of the Scheme. However, due to historical member reserves coupled with an efficient return on investments, the Scheme is able to absorb these losses.

26.1.3 Corrective course of action

The Scheme continues to monitor the performance of the eight benefit options listed above on a monthly basis. The Scheme has adopted a long-term strategy to correct the loss-making options into the future. The Scheme has also appointed a task team to drive initiatives which will reduce both healthcare and non-healthcare costs over the medium term and improve health outcomes. These measures should have a positive impact across all options. For 2026, the Scheme has budgeted for eight loss-making options, consistent with the options that incurred losses as detailed in Note 26.1.1.

26.2 Contravention of Section 26(7) of the Act

26.2.1 Nature and cause

Section 26(7) of the Act, requires that all subscriptions and contributions be paid directly to a medical scheme not later than three days after payment thereof becomes due. The Scheme has aged debtors of up to 120 days for both group and direct paying members and is thus in breach of the three day rule.

26.2.2 Possible impact

There is a risk of non-compliance with Section 26(7) of the Act. Significant debt with members could affect the liquidity of the Scheme and its ability to service members and potential non recoverability of such debtors.

26.2.3 Corrective course of action

It is not possible to receive all contributions within three days of becoming due, as there may be economic circumstances whereby contributions cannot be paid as per Section 26(7).

In such instances members are notified of the breach. In addition, the Scheme has mitigating controls in place to address the non-payment of contributions, which include the enforcement of the Scheme's Credit Control Policy. Other interventions include direct management engagement with affected groups to resolve such concerns.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

26. NON-COMPLIANCE WITH THE ACT (CONTINUED)

26.3 Exemption of Section 35(8) of the Act

26.3.1 Nature and cause

Section 35(8) of the Act prohibits a medical scheme from investing any of its assets in the business of or granting loans to; (a) an employer group who participates in the medical scheme or any administrator or any arrangement associated with the medical scheme; (b) any other medical scheme; (c) any administrator; and (d) any person associated with any of the above.

26.3.2 Possible impact

The Scheme has invested with various entities associated with its administrator and the Scheme's employer groups during the financial year.

26.3.3 Corrective course of action

The Scheme obtained an exemption in terms of Section 35(8) of the Act from the Council for Medical Schemes in respect of the non-compliance noted.

26.4 Contravention of Section 59 (2) of the Act

26.4.1 Nature and cause

Section 59(2) of the Act states that: "A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme".

Exceptions were noted during the year where claims were delayed when providers exceeded their monthly limit or where members/providers had no banking details on record. Providers are screened first by the forensic team prior to the limit being lifted, resulting in the claims being paid after the 30 days.

Further exceptions were noted where claim payments were delayed due to system related backlogs, including claims held in validation status and claims not progressing through the pricing engine.

26.4.2 Possible impact

Providers and/or members not settled timeously should be communicated with appropriately to avoid non-compliance.

26.4.3 Corrective course of action

Provider limits are lifted before the next weekly payment run where no fraud risk is identified, and communication is issued within the 30 day period when required. System issues were resolved through the manual release of affected claims, which were paid in the subsequent payment run. Parameter settings were enhanced to detect such anomalies earlier in the automation process and to release claims accordingly. Ongoing monitoring of exception reports is maintained to identify issues proactively and implement corrective actions. In addition, a communication process and strategy is in place to inform providers and members of any claim payment delays beyond 30 days to mitigate non-compliance risk.

26.5 Contravention with Regulation 30 read in conjunction with Annexure B (Item 4(b)) of the Regulations to the Medical Schemes Act, 131 of 1998 – Investments Outside the Republic

26.5.1 Nature and cause

During the financial year ended 31 December 2025, the Scheme held a portion of its investment portfolio classified as "Territories outside the Republic".

In terms of Regulation 30 of the Regulations to the Medical Schemes Act, read together with Annexure B (Item 4(b)), medical schemes are required to maintain 0% exposure to investments outside the Republic. At year end, the Scheme's temporary exposure to this category amounted to approximately 0.0004% (R58k) of the total investment portfolio.

The non compliance arose from the look-through classification of an underlying investment exposure and was not the result of a deliberate investment strategy to invest outside the Republic.

26.5.2 Possible impact

The exposure represented an immaterial portion of the Scheme's total investment portfolio and did not have a material adverse impact on the Scheme's solvency position, liquidity, or its ability to meet obligations to members. Notwithstanding the immaterial quantum, the exposure constitutes a technical non compliance with the investment limits prescribed in terms of the Medical Schemes Act and its Regulations.

26.5.3 Corrective course of action

Management has reviewed the underlying investment exposure and will ensure strengthened oversight over Regulation 30 and Annexure B classifications, including enhanced monitoring of look through investment exposures.

Investment governance and reporting processes will be reinforced to ensure ongoing compliance with the Medical Schemes Act and related Regulations, and compliance will continue to be monitored on an ongoing basis.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2025

27. EVENTS AFTER THE REPORTING DATE

27.1 Liability for incurred claims

The outstanding claims provision is expected to have a run-off period of four months after the date of the statement of financial position date, thereafter the stale claims mandate will apply which will assess each claim on merit. However, changes past reporting period would be adjusted in a subsequent period for past services.

27.2 Other events after Statement of Financial position date

The Trustees have considered events occurring between the reporting date and the date of authorisation of the annual financial statements for issue.

During the 2025 financial year, the Scheme initiated competitive Request for Proposal (“RFP”) processes in respect of its administration and managed care service arrangements.

Following the completion of the RFP evaluation processes, the Trustees approved the appointment of Momentum Health (Pty) Ltd as the Scheme’s administrator and Private Health Administrators (Pty) Ltd as the Scheme’s managed care service provider on 10 December 2025.

As at 31 December 2025, no new contractual arrangements had been concluded. Although the Board had approved the appointment of administrator and managed care service providers on 10 December 2025, the related contracts were only signed on 28 January 2026. Accordingly, as at the reporting date, the Scheme remained contractually committed to its existing administrator and managed care service provider under the agreements then in force.

The new administration and managed care arrangements, which were signed on 28 January 2026, will become effective on 1 June 2026. The contracts have a term of five years, with an option to renew for a further two years.

The conclusion of these appointments after the reporting period will give rise to new contractual relationships and do not provide evidence of conditions that existed at the reporting date. Accordingly, these events have been classified as non-adjusting events after the reporting period in accordance with IAS 10 – Events after the Reporting Period. No amounts recognised in the annual financial statements have been adjusted as a result of these events.

Given the strategic importance of the administration and managed care arrangements, the Trustees consider disclosure of these events to be relevant to users of the annual financial statements.

OTHER INFORMATION

OUR CONTACT DETAILS

Medical Emergency Services: Bonitas SOS

call 0860 555 505

Pharmacy Direct Registration

call 0860 027 800

email care@pharmacydirect.co.za

or visit www.pharmacydirect.co.za

HIV/AIDS Programme

call 0860 100 646

please call me 083 410 9078

email afa@afadm.co.za

or visit www.afa.co.za

Optical Benefits (PPN)

call 041 065 0650

email bonitas@ppn.co.za

or visit www.ppn.co.za

International Travel Benefit

call 087 135 4795 / +27 (10) 211 4958

or email bonitas-assist@linkham.com

Hip and Knee Programme (JointCare)

call 011 568 3334

or visit www.joint-care.co.za

Mental Health Programme

call 0860 106 155

or email mentalhealth@bonitas.co.za

Hip and Knee Programme (ICPS)

call 011 327 2599

or visit www.icpservices.co.za

Diabetes Programme

call 0860 002 108

or email diabeticcare@bonitas.co.za

Dental Programme (DENIS)

call 0860 336 346

or email denis@bonitas.co.za

Oncology Management Programme (Cancer)

call 0860 100 572

or email oncology@bonitas.co.za

Back and Neck Programme (DBC)

call 0860 105 104

or visit www.dbcsa.co.za

Babyline and Baby Bags

call 0860 999 121

BonCap (all services)

call 0861 239 333

or email BonCap@bonitas.co.za

for HIV email BonCapCares@bonitas.co.za

Palliative Care Programme

email info@alignd.co.za



Phone 0860 002 108



Message 060 070 2491



www.facebook.com/BonitasMedical



www.instagram.com/bonitasmedicalaid



x.com/bonitasmedical



www.bonitas.co.za

ABBREVIATIONS AND DEFINITIONS

Abbreviation	Definition
AfA	Aid for Aids
AGM	Annual general meeting
AI	Artificial intelligence
AIDS	Acquired immunodeficiency syndrome
AQIs	Audit Quality Indicators
B-BBEE	Broad-Based Black Economic Empowerment
BPO	Business Process Outsourcing
BHF	Board of Healthcare Funders
Board	Board of Trustees
Bonitas	Bonitas Medical Fund
CFO	Chief Financial Officer
CMS	Council for Medical Schemes
COBIT	Control Objectives for Information and Related Technology
COFI	Conduct of Financial Institutions
COO	Chief Operations Officer
COSO	Committee of Sponsoring Organizations
COVID-19	Coronavirus disease
CPI	Consumer Price Index
CT	Computed tomography
DBC	Documentation Based Care
Deloitte	Deloitte & Touche
DENIS	Dental Information Systems Proprietary Limited
DPM	Direct-paying member

EDO	Efficiency discounted option
ESG	Environmental, social and governance
Europ Assistance	Europ Assistance Worldwide (South Africa) Services Proprietary Limited now AZOZA)
FY	Financial year
FWA	Fraud, waste and abuse
GP	General practitioner
GRC	Governance, Risk and Compliance
HASA	Hospital Association of South Africa
HFMU	Healthcare Forensic Management Unit
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HPV	Human Papillomavirus
I&T	Information and technology
IBNR	Incurred but not reported
ICPS	Improved Clinical Pathway Services
IFRS	International Financial Reporting Standards
IR	Integrated Reporting
ISMS	International Standard for Information Security Management Systems
ITIL	IT Infrastructure Library
King IV™	King IV Report on Corporate Governance™ for South Africa, 2016
LCBO	Low-cost benefit option
LTI	Long-term incentive
MANCO	Management Committee
Medscheme	Medscheme Holdings Proprietary Limited

ABBREVIATIONS AND DEFINITIONS

Abbreviation	Definition
MSA	Medical Schemes Act, No 131 of 1998, as amended
NCD	Non-communicable disease
NHI	National Health Insurance
NMAS	Nedgroup Medical Aid Scheme
NPA	National Prosecuting Authority
NPS	Net promoter score
OPSCO	Operations Committee
PET	Positron emission tomography
PMB	Prescribed minimum benefit
PMBOK	Project Management Body of Knowledge
pmpm	per member per month
PMSA	Personal Medical Savings Account
PHA	Private Health Administrators
POPIA	Protection of Personal Information Act, No 24 of 2013
PPN	Preferred Providers Negotiators Proprietary Limited
PwC	PricewaterhouseCoopers

RAF	Road Accident Fund
the report	2025 Integrated Report
RFP	Request for Proposal
RisCura Solutions	RisCura Solutions Proprietary Limited
SAMA	South African Medical Association
SAPS	South African Police Service
SACSSP	South African Council for Social Service Professions
Scriptpharm	Scriptpharm Risk Management Proprietary Limited
SDG	Sustainable Development Goal
SGM	Special general meeting
SIU	Special Investigating Unit
SLA	Service level agreement
SMS	Short messaging service
STI	Short-term incentive
UNICEF	United Nations Children's Fund
the year	Financial year ended 31 December 2025



Bonitas
Medical Aid for South Africa

 **Bonitas WhatsApp 060 070 2491**
BonCap & BonCore WhatsApp
060 042 9254

 bonitas.co.za/member

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