Discovery
Health Medical Scheme

INTEGRATED REPORT 2025

ENTER

Discovery Health Medical Scheme registration number 1125

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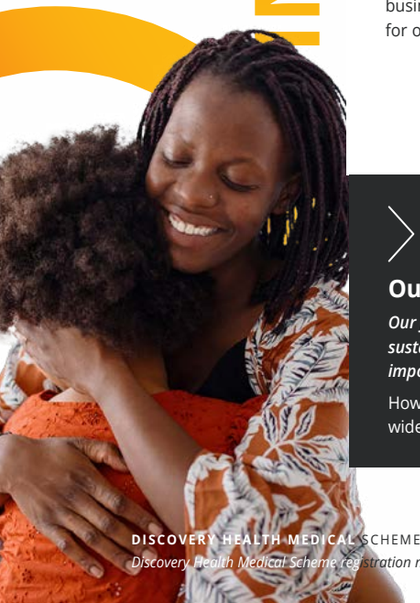

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VIEWING THIS REPORT
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* *Functionality may differ according to device and app version used.*

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SECTION 01

About DHMS

Who we are

Discovery Health Medical Scheme (DHMS or the Scheme) is a non-profit organisation which exists to care for members' health and wellness. We operate for the benefit of our members by managing a pool of funds to which all members contribute, and from which members can draw when they need to access healthcare.

Maintaining our ability to support members requires a careful balancing of limited resources in the context of above-CPI healthcare inflation and the increasing health needs of members.

Read more about how schemes operate ***pg 7***

The Scheme belongs to its members, and an independent Board of Trustees (the Trustees or the Board) – of which the majority is member elected from amongst members – oversees its activities. The Scheme is governed by the Medical Schemes Act (the Act)[1] and regulated by the Council for Medical Schemes (CMS).

DHMS is a registered open medical scheme that any member of the public can join, subject to the Scheme Rules. Covering 2 725 122 beneficiaries at 31 December 2025, DHMS is the largest open medical scheme in South Africa, with an open medical scheme market share of 57.7%[2].

The Scheme outsources its administration and managed care functions to Discovery Health (Pty) Ltd (Discovery Health) through a formal contractual arrangement. In partnering with Discovery Health and healthcare providers, we work to provide access to high-quality care and support good health outcomes for our members by integrating services and making careful, responsible use of members' pooled contributions.

In the work we do alongside other industry stakeholders, we aspire to fulfil our purpose of providing our members with quality, value-based healthcare that is affordable and equitable, now and into the future. Our approach to everything we do is rooted in our ethics and values-driven culture and our commitment to being an engaged and thoughtful corporate citizen that cares deeply for the wellbeing of our members, our industry and our society.

More about DHMS on the web
The Scheme and our key stakeholders
Scheme Rules
The Medical Schemes Act
The CMS website
Our Purpose and Vision ***pg 28***
Strategy ***pg 13***
We outsource administration and managed care to Discovery Health ***pg 100***

1. *Medical Schemes Act 131 of 1998, as amended.*
2. *Based on beneficiaries, according to the CMS Industry Report for the year ended December 2024 (https://www.medicalschemes.co.za/wp-content/CMSIndustryReport2024_4Dec.pdf). At the end of 2024 there were 16 open schemes registered with the CMS, with approximately 51.7% of the total medical schemes market and 55 restricted schemes, with approximately 48.3% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately 2.4 million beneficiaries.*

Why join DHMS?

Quality of care is key to our membership proposition

Our members are at the core of what we do, and we strive to ensure that they have access to the most safe, efficient and effective healthcare in South Africa.

Through our partnerships with Discovery Health and other healthcare providers, we enable access to quality of care initiatives and innovations, programmes, and member-centric care, which are monitored closely by the Scheme. We drive value-based healthcare, an approach based on placing importance on and reimbursing for better health outcomes for patients rather than only the volume of services delivered. Additionally, we empower our members with information that is current and relevant to their needs.

Value provided by Discovery Health ***pg 101***

WE EXIST FOR OUR MEMBERS

We provide sustainable access to the best healthcare, connecting our members and their families to an ecosystem that gives them the highest quality of care for the lowest possible cost, at every stage of their lives.

WE ARE HERE FOR YOU

Financial strength and sustainability are key factors to consider when selecting a medical scheme. Sound financial control and risk management enable the Scheme to maintain its required solvency reserve levels which ensures its ability to pay claims even when they are unexpectedly high.

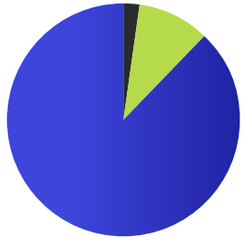
The Scheme's income is derived only from member contributions and investment returns. All contributions are pooled to fund members' claims, and surplus funds are transferred to Scheme reserves for the security and benefit of members. These reserves are invested to earn returns to bolster the Scheme's financial position.

In setting member contributions for each year, the Scheme aims to ensure sufficient contribution income to pay all claims, and to generate a modest surplus to meet regulated solvency requirements and maintain a cushion against unexpected cost increases[1]. This accords with the fundamental operating principles of a non-profit organisation that must meet the claims needs of its members as well as maintain a minimum statutory level of reserves.

A small portion of income (shown alongside) is used to fund activities that benefit our members and ensure the Scheme's sustainability. These activities include administration, managed care, financial advisers and the daily operations of the Scheme. Apart from the portion allocated to reserves and these activities, the remainder of the Scheme's income is used to fund claims.

Healthcare inflation and utilisation ***pg 91***

2025 EXPENSE BREAKDOWN



88.4%
Claims paid
(2024: 89.7%)

2.2%
Financial adviser and Scheme expenses
(2024: 2.3%)

9.9%
Administration and managed care expenses
(2024: 9.9%)

(0.4%)
(Loss)/surplus to member reserves
(2024: (1.9%))

We provide excellent cover to our members and compare well to other schemes

Average contributions for 2026 are
17.7% lower[2]
than the average of the average contributions of the next seven largest open medical schemes (2025: 12.7%).

Our performance ***pg 84***

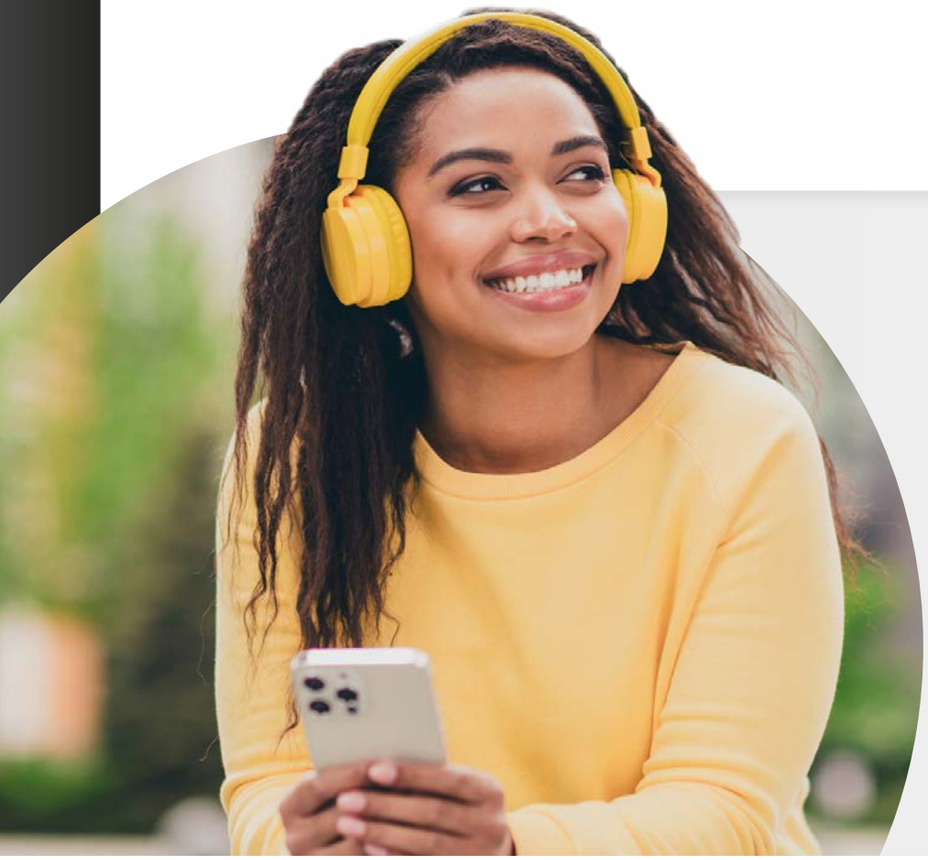
For an average risk contribution of R2 676 per month,
R75 billion
was paid out in risk claims for the period ending December 2025. This includes:

- R4 770 per beneficiary with a chronic condition for out of hospital costs (768 780 beneficiaries);
- R74 613 per admission (649 060 hospital admissions);
- R160 289 per beneficiary undergoing oncology treatment (43 993 beneficiaries).

1 *These may relate to various sources of healthcare inflation and include uncertainty about the timing and severity of burden of disease.*

2 *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes. Contribution rates on individual plans of other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*

About our report



"Our Report sets out the Scheme's efforts to work in the best interests of our members, while balancing the needs and expectations of our various stakeholders".

Our Integrated Report demonstrates the accountability of the Board of Trustees (the Board or the Trustees) of Discovery Health Medical Scheme (DHMS or the Scheme) to our members in the context of our core commitments to our members. This constitutes best practice in medical schemes governance and thought leadership in our industry.

This is our primary report to our members, the Council for Medical Schemes (CMS), and other stakeholders of DHMS. It provides a holistic assessment of our governance, business model, material matters, strategy, performance and outlook in relation to our material risks and opportunities in the South African private healthcare industry.

Our Report sets out the Scheme's efforts to work in the best interests of our members, while balancing the needs and expectations of our various stakeholders. Achieving this balance underpins the Scheme's financial, operational, and relational wellbeing. In turn, as the largest open medical scheme in the country, this supports the overall capacity and viability of the private healthcare industry and the betterment of the national healthcare system.

Board of Trustees responsibilities and approval

The Trustees are committed to providing our members with accurate and reliable information. We recognise our responsibility to assure the integrity of the Integrated Report and are confident that it covers all material matters, complies with the Scheme's responsibility to account for its operations and performance, and serves as a transparent, integrated source of information for all stakeholders.

The Trustees are satisfied that this Report complies with the requirements of the Medical Schemes Act (the Act), as amended, the Scheme Rules, International Financial Reporting Standards, and all additional financial reporting requirements of the CMS. The Trustees are also satisfied that the Scheme has adequate resources to continue with its operations into the foreseeable future. The Scheme's Financial Statements have therefore been prepared on a going concern basis.

Signed on behalf of the Trustees on 30 April 2026

MICHELLE NORTON
Chairperson

DHESAN MOODLEY
Trustee

CHARLOTTE MBEWU
Principal Officer

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Scope and boundary

This Report covers the benefit year from 01 January 2025 to 31 December 2025, also referred to as the '2025 financial year' (the year). In addition, it discusses material developments in early 2026, up to the date of approval of this Report by the Trustees.

The boundary of this Report includes an assessment of our offerings, interactions and outcomes related to key stakeholders, which underpin our ability to create, preserve and limit any erosion of value for our members. This is in line with the Scheme's regulated mandate to act in the best interests of our members, and our business model as a centre of excellence for medical schemes governance.

In line with our Vested® outsourcing model, the Scheme contracts with Discovery Health (Pty) Ltd as its administration and managed care provider.

In this Report, the terms the 'Scheme,' 'DHMS,' 'we' and 'our' refer to Discovery Health Medical Scheme. The terms 'Discovery Health' and 'our administration and managed care provider' refer to Discovery Health (Pty) Ltd. The term 'members' includes both principal members and their beneficiaries.

How Discovery Health supports the Scheme's value creation ***pg 100***

More about Vested

Process disclosures

REPORTING FRAMEWORKS

The Scheme takes guidance from the King IV™ Report on Corporate Governance for South Africa 2016 (King IV), and the SAICA[1] Medical Schemes Accounting Guide, and uses the International <IR> Framework (January 2021) (IIRF) of the Value Reporting Foundation[2] as the basis for preparing and improving its reporting. The IIRF is applied insofar as it is relevant and applicable to medical schemes in South Africa. We consider our 2025 Integrated Report to be as fully aligned to the International <IR> Framework as is possible while still meeting the requirements of our regulatory stakeholders.

The King V™ Report on Corporate Governance for South Africa 2025 (King V) was published on 31 October 2025 by the Institute of Directors in South Africa and the King Committee of South Africa. It supersedes King IV and is effective for financial years beginning on or after 01 January 2026 and as such, the Scheme will report on the basis of King V requirements in our 2026 Report.

More about King V

MATERIALITY DETERMINATION

The Trustees are responsible for determining and effectively managing the matters that materially impact the Scheme's ability to create and preserve value, or that may erode value, thus affecting the sustainability of the Scheme over time.

On at least an annual basis, the Scheme's management team engages on the material matters, strategy, risks and objectives for the year ahead and beyond, and a strategy workshop is held with the Trustees. These discussions include the broader healthcare, economic, social and political environments, as well as specific considerations of product and benefit enhancement opportunities and constraints, in concert with risks and opportunities that the Scheme and Discovery Health have identified. The positions of stakeholders are an integral part of these discussions, underpinned by a defined framework and methodology to identify stakeholder groups, assess their needs and interests, and evaluate the impact of these on the Scheme, and vice versa.

The material matters are identified from these discussions, and the Trustees consider Board and Scheme Office reports, the Scheme's risk appetite statement, risk management report, and formal and informal stakeholder interactions when subsequently considering and approving the material matters for inclusion in this Report.

AUDITOR INDEPENDENCE

Deloitte & Touche has audited the Scheme's Financial Statements (comprising the Statement of Financial Position at 31 December 2025, the Statement of Comprehensive Income, and the Statement of Cashflows) and the Notes to the Financial Statements for the financial year ended 31 December 2025. Details of fees paid to the external auditors for audit and non-audit services, where applicable, are included in the Financial Statements.

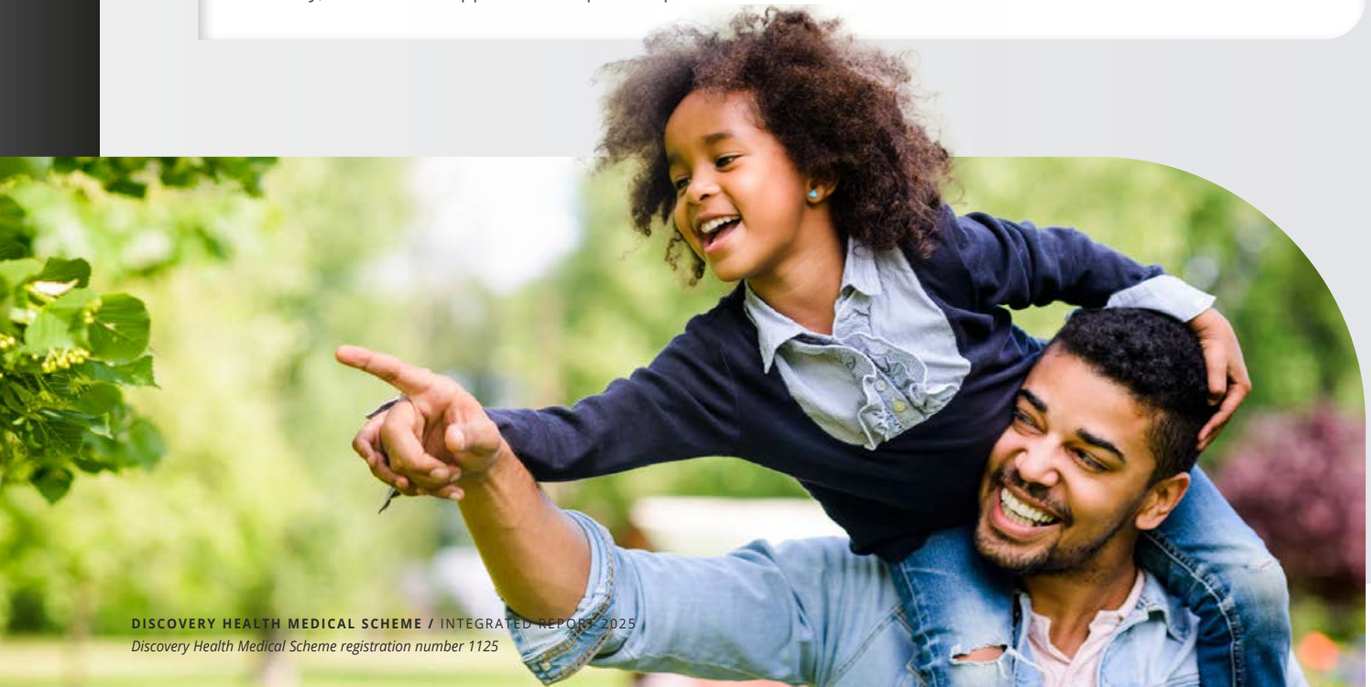
The Scheme has a formal policy governing non-audit services and the relevant fees and nature of the work must be disclosed to, and approved by, the Audit Committee. There were no non-audit services procured from the external auditors for the 2025 financial year. The Audit Committee is satisfied that the auditor is independent of the Scheme.

1. *South African Institute of Chartered Accountants.*
2. *Formerly the International Integrated Reporting Council.*

REPORT PREPARATION AND APPROVAL

Under the direction and oversight of an experienced and expert executive, the Scheme executive team prepares the Integrated Report.

- The Head: Special Projects and Stakeholder Relations is responsible for gathering, vetting, drafting and co-ordinating reviews and approval of qualitative and quantitative information submitted by relevant content owners.
- Support, in the form of content provision and verification, is provided by specialist internal and Discovery Health functions such as governance, regulatory, legal, clinical, financial, actuarial, risk management, and strategy development and implementation.
- Subject matter experts contribute to data validation, interpretation and contextualisation to ensure that the data relating to the Scheme's initiatives is accurately presented in the Integrated Report.
- The responsible executive has unfettered access to the Chairperson of the Board, the Principal Officer, Scheme Executives and Independent Committee Members, who provide input during report preparation, and review and approve relevant sections before these are submitted to the Board for review.
- Following a detailed review by the Audit and Stakeholder Relations and Ethics Committees, the Audit Committee recommends the Integrated Report to the Trustees for approval.
- The Scheme's external auditors provide independent assurance of the Financial Statements.
- Finally, the Trustees approve the report for publication and submission to the CMS.



COMBINED ASSURANCE

The Scheme applies a combined assurance model, a risk-based methodology to obtain assurance over key controls across the Scheme's key activities. The internal reporting arising from the assurance process provides insight and data that are applied in preparing the Integrated Report.

The model is based on a three lines of defence framework. The first line consists of functions that own and manage risks; the second line consists of functions that provide oversight or specialise in risk management and compliance; and the third line consists of functions that provide independent assurance.

FIRST LINE

The Scheme Executives provide the Trustees with assurance that internal control and risk management processes are embedded in and integrated into the day-to-day operations of the Scheme, and monitored on an ongoing basis.

SECOND LINE

The outsourced Group Risk Management, Forensics and Compliance functions provide oversight and assess the adequacy and effectiveness of the Scheme's internal control environment and risk management processes.

THIRD LINE

The executives and the Trustees obtain independent assurance on the Scheme's financial performance and internal control environment from the Internal Audit function, the appointed external auditor, appointed independent actuary and other independent assurance providers.

SECTION 03

Our value story

Our operating context

What schemes are and how they work

South African medical schemes operate according to social solidarity principles and are non-profit entities.

We operate in a multifaceted environment shaped by our regulatory framework, multiple local and international supply chains, a wide variety of healthcare provider types, and the effects of high healthcare inflation. At its centre are the needs of our members, whom we serve and whose healthcare needs are often critical and complex, and influenced by their social, financial and other circumstances.

Anyone can join a medical scheme, as schemes must accept all prospective members under the principles of social solidarity. These include community risk rating which ensures standardised pricing with no differentiation based on, for example, the status of an individual's health or age. Schemes must charge all members on a specific benefit plan the same contribution rate. Members can choose between benefit plans based on benefits and benefit limits, albeit that Prescribed Minimum Benefits (PMBs) apply equally across all benefit plans. Members' funds[1] are pooled to provide healthcare funding in an equitable manner, thereby providing our members access to healthcare services.

1. *Now referred to as insurance contract liabilities in the Financial Statements.*

Scheme income and pricing

Medical schemes must continually balance affordability, sustainability and the availability of benefits. Members face real affordability pressures, while schemes must ensure that they maintain the financial stability to meet members' current and future healthcare needs.

Schemes derive their income solely from member contributions and from investment returns earned on member funds. Contributions are priced to match the expected claims for the forthcoming year, taking into account healthcare inflation (including tariff increases and the effects of supply and demand, as reflected in expected utilisation of healthcare services), the demographic profile of the membership base, and the scheme's operational expenses.

Medical schemes are exempt from levying VAT on member contributions and are therefore unable to recover VAT incurred on behalf of their members. However, most expenses incurred by medical schemes, including medical claims paid on behalf of members, include VAT. As a result, changes to the statutory VAT rate have a direct effect on contribution increases.

Medical schemes are required to maintain sufficient reserves, in the form of a regulated solvency ratio of at least 25% of gross annual member contributions. This requirement helps ensure that schemes are able to withstand periods of economic pressure and unexpected claims; accommodate variations in utilisation and increases in treatment costs; optimise benefits according to appropriateness, cost and the health needs of members; and treat all members equitably.

Because the demographic characteristics of membership – such as the proportion of members with chronic conditions – differs between schemes, each scheme faces distinct pricing considerations and constraints.

Contribution pricing therefore reflects the need to balance utilisation, scheme sustainability and member affordability, while also responding to evolving healthcare needs.

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Barriers to lower contribution rates

As membership of medical schemes is voluntary, medical schemes are vulnerable to anti-selection, where members may choose to join and leave schemes at different times in their lives based on their healthcare needs. This affects the ability of schemes to keep contributions lower. It is estimated[1] that if mandatory membership for economically active citizens was implemented (as was proposed as a key requirement when the Act came into law), this would lower contribution rates for all scheme members by approximately 20%.

Economic dynamics in the healthcare sector differ from those in most other industries, where prices are typically shaped by direct interactions between supply and demand. In healthcare funding, members pay contributions to medical schemes to insure their healthcare needs, and the scheme then pays for healthcare services on their behalf when these are required. This means that members are distanced from the pricing of healthcare services as schemes fund these on their behalf. This weakens the natural market mechanisms that would otherwise regulate pricing in healthcare. In a private healthcare environment where most pricing is unregulated (with the exception of medicines pricing), the role of medical schemes in negotiating prices on behalf of their members is therefore important in helping to mitigate healthcare inflation.

Also to mitigate healthcare inflation, schemes implement interventions to achieve better access and pricing for members, for example, through the creation of designated service provider (DSP) networks, which achieve lower prices based on the volume of members making use of the DSP network. A co-payment may be imposed for utilising non-DSP healthcare providers, as the lower pricing is dependent on sufficient numbers of members making use of the DSP network.

Better health outcomes, as well as lower prices, can be achieved by negotiating agreements for the treatment of populations of members, for example in caring for members with specific diseases. Providers engaged in this type of work monitor their patients' adherence to medicine and testing requirements, thereby preventing their disease from worsening and keeping claims lower.

More about our healthcare programmes ***pg 43***

Medicine prices are regulated by the National Department of Health. Medicine prices and price inflation are of concern to schemes as, together with an increasing demand for new and high-cost medicines, they contribute to healthcare inflation. Healthcare inflation is expected to be significantly higher than ordinary inflation every year due to increasing utilisation, driven by the expansion of available healthcare services and changing demographic profiles, as well as tariff increases.

In 2025, Discovery Health Medical Scheme (DHMS or the Scheme) paid R14.66 billion for medicine claims, including approximately R3.73 billion for chronic conditions (including HIV) and R1.89 billion for oncology. High-cost novelty[2] medicines, as defined by Discovery Health, accounted for 42% of the medicine risk spend in 2025. Expenditure on high-cost novelty medicines is expected to grow by 54% by 2030. Only 5% of medicine risk claimants account for 62% of the medicine risk spend in 2025 – driven largely by high-cost novelty medicines.

More about healthcare inflation ***pg 91***

More about medicine pricing ***pg 83***

1. *It has been estimated that prices in a voluntary environment are some 17%–23% more expensive than they could be under mandatory cover (McLeod & Grobler, 2009). Similarly, it is estimated that open scheme contributions could be lower by 23% in an environment without anti-selection (Childs, 2012). Source: Anti-selection in voluntary health insurance markets: A focus on medical schemes in South Africa by R. Harris and S. Besesar, published in the South African Actuarial Journal in 2021.*
2. *Novelty medicines are new in terms of their scientific mechanism or technology, and are often high-cost in that they are substantially more expensive than typical treatments for the same condition. For DHMS, high-cost novelty medicines are defined as having a minimum cost per claim of R3500 and more, or R1 million per molecule per year. They are predominantly patent protected and / or specialised in design or clinical action e.g. biologics and biosimilars.*
3. *The Scheme's Nomination Committee provides an additional layer of oversight in approving the vetting of nominees and candidates eligible for election.*
4. *Total healthcare benefits paid refers to the sum of the benefits paid from both the risk pools of medical schemes and the savings accounts of members.*
5. *Source for industry information: the CMS Industry Report 2024–2025. Data includes both open and restricted schemes but does not include data for 2025. Source: https://www.medicalschemes.co.za/wp-content/CMSIndustryReport2024_4Dec.pdf.*

Medical scheme governance and regulation

Section 7 of the Medical Schemes Act (the Act) describes the responsibilities of the Council for Medical Schemes (CMS), which include:

- Protecting the interests of beneficiaries at all times;
- Establishing that medical schemes are financially sound, with a sufficient number of contributing members;
- Checking and confirming that medical schemes do not unfairly discriminate against any person on arbitrary grounds;
- Investigating complaints in relation to the affairs of medical schemes;
- Conducting routine monitoring, and regular and specific inspections on schemes regarding appropriate governance and adherence to the Act and Regulations; and
- Making recommendations to the Minister of Health on matters relating to medical schemes such as Low-Cost Benefit Options (LCBOs), criteria for the measurement of quality, and outcomes of the relevant health services provided by medical schemes.

The CMS regularly publishes circulars to guide medical schemes on interpreting and implementing the Act, and also conducts research into various aspects of the industry. It approves the benefit plans and rules of each scheme, with the latter being binding on the scheme, its members, officers and any person who claims any benefit. The CMS also requires that elected and appointed Trustees as well as the Principal Officer submit a CMS-developed vetting questionnaire[3]. The CMS offers medical scheme governance training and information sessions to trustees and financial advisers.

The CMS accredits medical scheme administration and managed care providers, as well as the financial advisers who advise current and potential members on private healthcare cover. The Minister of Health annually prescribes the fees paid by medical schemes to financial advisers.

Schemes are governed by independent boards of trustees responsible for overseeing the business thereof. The Act requires that at least half of the trustees must be elected by scheme members from amongst scheme members.

More about how we are governed ***pg 50***

The industry landscape

At the end of 2024, there were 71 medical schemes registered with the CMS, consisting of 16 open schemes and 55 restricted schemes, covering over 9 169 000 beneficiaries (2023: 9 127 000). These schemes paid out approximately R259 billion in total healthcare benefits[4] in 2024 (2023: R239 billion). The average age of total registered scheme members in 2024 increased by 0.2 years to 34.2 from 34.0 in 2023, and the proportion of pensioners increased to 9.8% from 9.4%[5].

More about why these metrics are important ***pg 85***

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The outlook for medical schemes

The rising prevalence of chronic disease remains a worldwide healthcare concern. Mental health conditions are a significant contributor to healthcare utilisation and expenditure and are closely linked to other chronic conditions through shared risk factors and co-morbidities. Cancer, cardio-metabolic conditions[1] and kidney disease also contribute to an escalating burden of disease in scheme populations. The effect of these diseases on schemes is amplified by an aging scheme membership and relatively slow membership growth, particularly in younger lives, placing increasing pressure on risk pools. As medical schemes rely on cross-subsidisation, where younger and healthier members subsidise those with greater healthcare needs, shifts in membership age profiles can contribute to rising healthcare costs and contribution increases over time. For DHMS, claims increase by 2.8% for every year's increase in the Scheme's average age, directly impacting required contribution increases.

In South Africa, many people remain unable to access medical scheme membership due to affordability constraints. To fund their healthcare needs, individuals must either pay out-of-pocket for private healthcare or access care in the public sector according to their financial means[2]. Although the domestic economic outlook showed modest improvement during 2025, unemployment remains high – particularly among younger age groups – and household incomes remain constrained. These pressures continue to affect the ability of current and prospective members to afford scheme membership, a challenge of which the industry is acutely aware and actively seeks to mitigate. The CMS plays an important role in supporting the sustainability of schemes through the optimisation of the regulatory environment and the continued development of policy frameworks for the industry.

DRIVING OPTIMAL PERFORMANCE IN HEALTHCARE FUNDING AND PROVISION

Key performance drivers for medical schemes include containing healthcare cost increases while enabling members to maintain their health and improving member health outcomes. This requires balancing the use of new and existing technologies' evidence-based approaches, ensuring schemes meet the healthcare needs of their members through expanded screening and preventative programmes, and the implementation of value-based care, including in areas such as disease prevention and management initiatives.

Reducing fragmentation in care and improving co-ordination between healthcare providers remain important priorities for the industry. In addition, schemes continue to implement robust measures to address fraud, waste, abuse and errors in accordance with their fiduciary duties to protect their members' interests, and the industry is working closely with the CMS to formalise consistent and structured practices, while ensuring that schemes are still able to adequately protect member funds. There is also a strong focus across the healthcare system on measuring and improving the quality of care through better understanding of clinical processes and outcomes. These efforts provide opportunities to support healthcare providers in delivering better health outcomes for members.

Schemes must also remain responsive to evolving healthcare needs as well as rapid changes in technology and societal factors. Advances in artificial intelligence and digital health tools are increasingly shaping healthcare delivery models globally. These technologies have applications across diagnosis, clinical decision support, administration, information, and care access and research. Within medical schemes, they offer opportunities to enhance member support and healthcare journeys through improved personalisation, accessibility and convenience. At the same time, their use requires careful governance and oversight to address ethical considerations, including equity, privacy, transparency, potential bias and accountability. It is also important to retain access to human interaction for members, particularly given the highly personal and often emotive nature of healthcare and the need for accurate servicing and information.

1. *A group of metabolic abnormalities and cardiovascular risk factors that increase the risk of heart disease, stroke, and type 2 diabetes.*
2. *The National Department of Health makes use of a means test used to determine who is eligible for free or discounted fees at public facilities. The poorest households are entitled to free healthcare, those on modest incomes are charged subsidised rates and those that earn more than the upper threshold of the means test must pay in full.*

CHALLENGES TO ACCESSIBLE HEALTHCARE FOR ALL

In 2025 and early 2026, the medical schemes industry continued to face a complex and evolving legislative environment with the potential to significantly affect healthcare funding in South Africa.

The National Health Insurance (NHI) Act, signed into law in May 2024, remains subject to multiple legal challenges brought by a range of stakeholders, including healthcare industry bodies, professional associations and civil society organisations. These challenges relate to both the constitutionality of aspects of the NHI Act and the legislative process followed prior to its enactment. Court proceedings are ongoing and implementation of substantive provisions of the NHI Act has been delayed pending the outcome of these matters. Stakeholder concerns include the unaffordability of NHI, as well as the risks to healthcare access for current medical scheme members if the prohibition on medical scheme coverage for NHI-funded services were implemented without a functioning alternative system.

A number of stakeholders have proposed alternative approaches to universal health coverage that retain a role for both public funding and private medical schemes, reflecting international experience with multi-payer health systems. These discussions are likely to continue as the legislative and judicial processes unfold and as policymakers seek to balance the goals of improved equity, access, sustainability and quality of care across the health system.

Medical schemes continue to advocate for the introduction of primary healthcare products (also known as Low-Cost Benefit Options) within schemes as they hold the potential to expand access to many thousands of currently uncovered South Africans, who would be able to access tax credits through scheme membership, and can help reduce the burden on the public sector while the NHI is established. The CMS has a critical role to play in facilitating the introduction of these products, as well as proceeding with the PMB review to bring the PMBs into alignment with current healthcare needs and affordability constraints.

Industry discussion continues on the Minister of Trade, Industry and Competition's draft regulations to establish a new tariff determination framework for private healthcare practitioners. If implemented in a comprehensive manner, this initiative could decrease some costs for schemes, and therefore support lower contribution increases for their members.

Strengthening healthcare for our members and improving the broader South African healthcare system requires meaningful collaboration between the industry, government, business, labour and civil society. Such partnership is critical to sustaining the healthcare system and enabling equitable access to care for all South Africans.

Our strategic themes ***pg 13***

Regulatory and industry matters dealt with in 2025 ***pg 78***

Our material matters

Our material matters are derived by assessing emerging and sustained events, risks and opportunities in our operating context, and the needs and concerns of our members and other stakeholders.

Working for and with our members

Affordability and scheme sustainability

Health system reform and regulatory uncertainty

Ethical stewardship, governance, operational resilience and stakeholder partnerships

Working for and with our members

Medical schemes in South Africa provide substantial value to members, particularly in protecting against unpredictable and catastrophic healthcare costs in addition to supporting wellness and improved health outcomes. This value is often underestimated due to misconceptions that schemes are profit-driven, are reluctant to pay claims, or constrain benefits for financial gain. A perceptual shift towards recognising the collective and non-profit nature of scheme funding, and the role of mutual support across members and life stages, would strengthen social solidarity and enable schemes to better sustain access to healthcare. Such a shift, pursued through appropriate industry communications, would dovetail with system reforms and better align public and private healthcare philosophies.

Increasing member activism, through various social media and advocacy groups, challenges schemes and other industry participants to reflect on the value provided by the healthcare funding system to members and how it is perceived, while offering opportunities to increase understanding and co-creation of an improved system. Members expect more personalised support in a navigable healthcare system; digital convenience balanced with human support; clear, reliable benefit communication; and co-ordinated and understandable care and funding journeys.

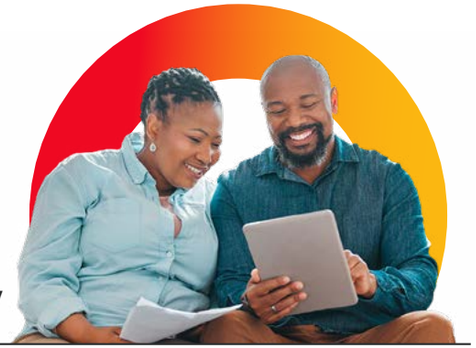
It remains essential that DHMS membership provides access to appropriate, cost-effective and quality healthcare that generates good health outcomes for our members. This is increasingly difficult in an environment characterised by affordability challenges, persistent healthcare inflation, information asymmetry in healthcare decision-making, and increasing complexity of treatment pathways – exacerbated by the introduction of new technologies.

The burden of chronic disease continues to shape member needs and scheme claims, with particular pressure from cardio-metabolic disease, mental health conditions and cancer, alongside expanding pharmaceutical and medical device innovation.

In response, DHMS' focus remains on enabling high-quality, member-centred healthcare journeys at every life stage, supporting disease prevention and early detection, improving care co-ordination, and using data responsibly to support members and clinicians to make informed choices. This includes working with healthcare professionals to improve clinical appropriateness and outcomes, strengthening member education, and maintaining service reliability, ensuring that members can trust the Scheme in moments of need.

Drivers of value include co-ordinated prevention and care, improved health outcomes, trusted and transparent member engagement, perceptual shifts on social solidarity, and responsible use of data to support informed clinical and funding decisions.

Constraints include affordability, system complexity, fragmented care and funding journeys, information asymmetry, and rising costs associated with increasingly complex treatments.



Affordability and scheme sustainability

Medical schemes must continually balance affordability, sustainability and the provision of benefits in a context where household budgets are constrained and healthcare cost growth remains higher than CPI.

Affordability pressures increase the risk of anti-selection and muted membership growth, weakening cross-subsidisation within risk pools. This is exacerbated when members seek more affordable 'substitute' health insurance products outside medical schemes, or downgrade cover and reduce their use of early and preventative care, increasing the likelihood of higher-cost interventions later. Membership retention and risk pooling stability can also be impacted by NHI policy implementation, increasing affordability pressures. The sustainability challenge is not only financial, but also relational and social: medical schemes must sustain members' trust that pooled funds are stewarded prudently and that benefit design remains fair and clinically sound.

The geopolitical and economic context continues to influence healthcare inflation as well as employment and local economic recovery.

In response, DHMS must continue to price prudently and transparently, manage solvency responsibly, and actively mitigate healthcare inflation through innovative benefit design, provider contracting and ongoing utilisation management that preserves access and outcomes. In practice this means ongoing emphasis on value-based interventions with a focus on appropriateness, and benefit design choices that attract new young and healthy members[1] to support the risk pool, promote wellbeing and improved disease management, and protect members from catastrophic costs while retaining affordability as far as possible.

Drivers of value include disciplined pricing, strong risk management and effective inflation mitigation.

Constraints include weak economic growth, affordability strain, the implementation of damaging government policy, and persistent healthcare inflation.

1. *Growth in the number of young and healthy members improves risk pooling through cross-subsidisation principles and increases the overall health and sustainability of a scheme.*

Health system reform and regulatory uncertainty

The health policy environment remains a primary determinant of industry sustainability. The NHI Act continues to be contested through multiple legal challenges on constitutional and procedural grounds, reinforcing uncertainty for households, employers, healthcare professionals and funders about the future configuration of public and private healthcare. This uncertainty has practical consequences: delayed investment decisions, polarised stakeholder positions, and ongoing risk of reforms being implemented without sufficient operational readiness or funding realism, and without taking into account the damaging effects on schemes and their members. A critical skills shortage of key healthcare workers is also exacerbated.

Alongside NHI uncertainty, the Low-Cost Benefit Option (LCBO) debate remains unresolved, with schemes blocked from extending access in this area while insurers continue to be exempted from Medical Schemes Act requirements. The regulatory environment also continues to grapple with structural issues in private-sector pricing, including attempts to progress tariff-determination mechanisms through competition-law instruments and proposed negotiation structures.

Ongoing regulatory reform gaps include the Prescribed Minimum Benefits, which need to be better aligned to changing healthcare needs and affordability constraints; supply-side regulation; mandatory membership for employed population; the implementation of a risk-equalisation mechanism; risk-based solvency; and other financial reforms that would enable schemes to better-manage their financial position. Schemes also continue to be impacted by the Road Accident Fund's inability or refusal to refund road accident claims, and other participants in the healthcare industry are no longer able to provide services to patients as a result of the RAF's financial position. Possible changes to regulations emanating from the final report of the Section 59 Investigation Panel into fraud, waste and abuse, together with related misinformation, may also negatively impact the sustainability of medical schemes.

For DHMS, this material matter is about protecting members' interests in a changing policy environment while supporting the national objective of universal health coverage. It requires considered stakeholder engagement; evidence-based submissions; ongoing readiness for regulatory changes affecting benefits, governance, pricing and contracting; and clear communication to members amid misinformation and heightened public debate.

Drivers of value include stable, enabling regulation, and constructive multi-stakeholder collaboration.

Constraints include constrained healthcare system capacity, poor policy, litigation-driven uncertainty and incomplete implementation of reforms.

Ethical stewardship, governance, operational resilience and stakeholder partnerships

Ethical business and best practice governance remain prerequisites for protecting members' funds and for maintaining the Scheme's regulatory and social licence to operate. This includes active management of fraud, waste, abuse and errors across the healthcare funding chain, and ensuring that controls and investigations are effective, fair and trusted by stakeholders.

The environment is further complicated by heightened levels of stakeholder misinformation, scepticism and activism, rapid information spread, and pressure on institutions. Partnerships with healthcare providers, regulators, employer groups and broader civil society remain essential to system improvement and development, but they must be structured to manage conflicts of interest, promote transparency, and protect members' interests.

Healthcare funding and delivery are increasingly digitally and AI mediated, making operational resilience, risk management, data accuracy and integrity and governance material to member experience and trust. This includes recognising the importance of service reliability, cyber security and resilience, data quality and privacy protection, and the ability to detect and correct errors quickly and fairly when they occur.

This material matter is sharpened by public scrutiny when operational issues affect large numbers of members, or when individual members are significantly affected. Events of this nature become material because they directly influence member trust and perceptions of stewardship, and increase the risk of dissatisfaction and complaints.

In response, our emphasis remains on ethical leadership, robust oversight, fair and consistent application of regulations, agility in responding to stakeholders, and partnerships that improve healthcare access, affordability and outcomes. Where governance failures occur anywhere in the ecosystem (public or private), members ultimately bear the cost through reduced access to healthcare, higher contributions and eroded trust. Preventative controls are key, as are transparent and constructive engagement and collaboration with members.

Drivers of value include high-trust partnerships, credible governance, resilient operations, trusted services and effective controls.

Constraints include system-wide corruption risks, system complexity, escalating cyber risk, heightened reputational sensitivity, and adversarial stakeholder dynamics.

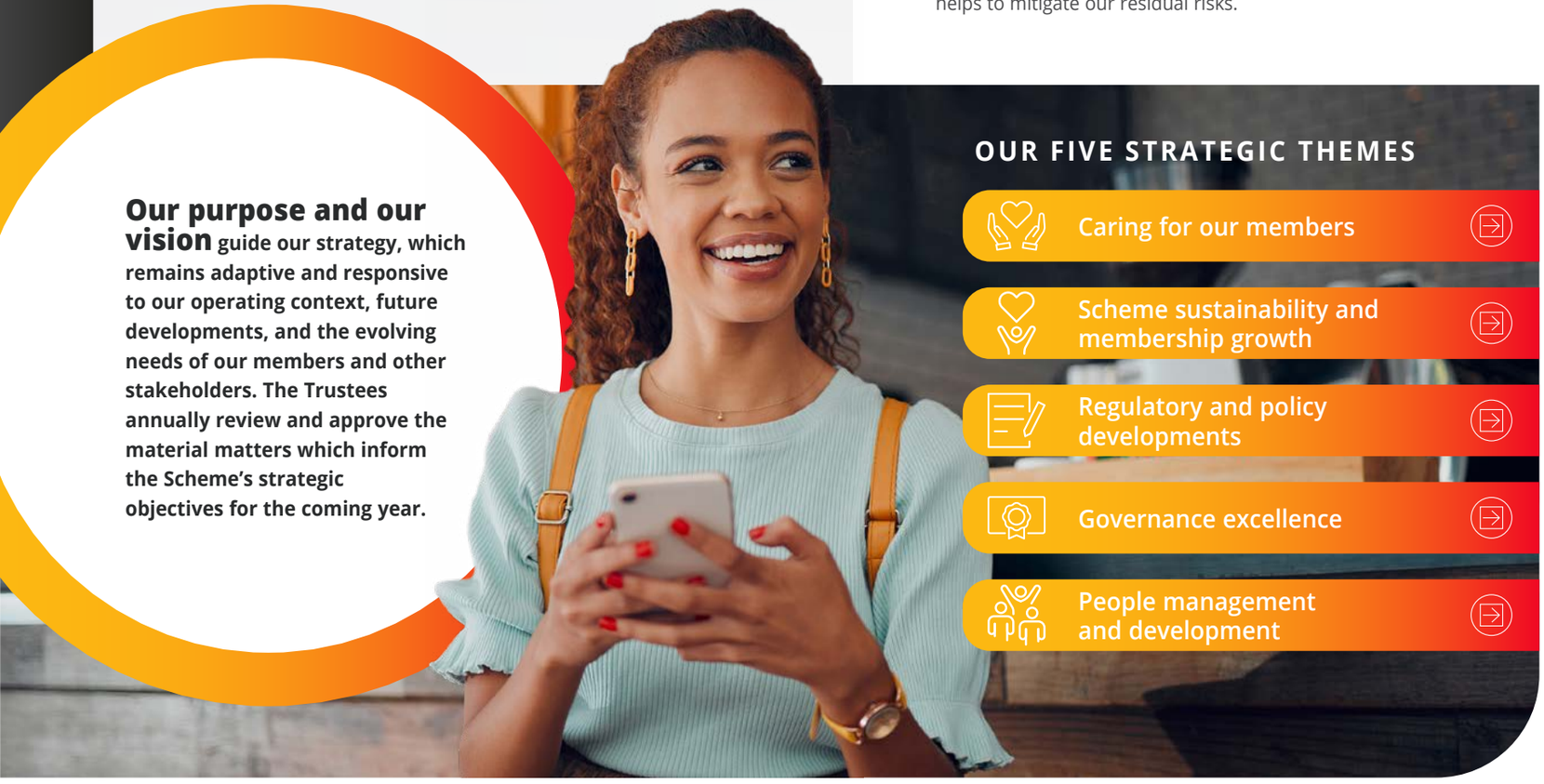
"Healthcare funding and delivery are increasingly digitally and AI mediated, making operational resilience, risk management, data accuracy and integrity and governance material to member experience and trust. This includes recognising the importance of service reliability, cyber security and resilience, data quality and privacy protection, and the ability to detect and correct errors quickly and fairly when they occur."

Our strategic themes

Our holistic view of value for members encompasses health, wellness needs, ability to access quality healthcare and its efficient funding, and the appropriateness of healthcare services, balanced with the sustainability of the Scheme.

We continually review internal and external factors to identify, mitigate and manage our residual risks, seeking opportunities to optimise value outcomes for our members while ensuring the long-term sustainability of the Scheme. Our strategic themes respond to our material matters with due consideration of broader healthcare trends, while achieving related objectives helps to mitigate our residual risks.

Our purpose and our vision guide our strategy, which remains adaptive and responsive to our operating context, future developments, and the evolving needs of our members and other stakeholders. The Trustees annually review and approve the material matters which inform the Scheme's strategic objectives for the coming year.



OUR FIVE STRATEGIC THEMES

- Caring for our members
- Scheme sustainability and membership growth
- Regulatory and policy developments
- Governance excellence
- People management and development

The Trustees review the prior year's objectives and performance against them, and subsequently approve the annual strategy while maintaining oversight over its implementation.

Oversight over certain aspects of the strategic performance is delegated to relevant Board Committees, according to their terms of reference. The Scheme Office[1] interfaces with these Committees and the Board, and reports regularly on performance, operational oversight, monitoring, and mitigation of emerging risks.

The Scheme's objectives are closely tied to our performance management methodology, designed to reward our employees for excellence and foster a culture of continuous improvement, learning and development.

Our strategic opportunities inform the determination of our material matters. As such, our strategic themes indicate how we are managing the constraints to our capital inputs, and what actions we are taking to achieve our intended outcomes.

See our business model for more information *pg 27*

1 *The Scheme Office consists of the Principal Officer, executive team and administration staff. The Principal Officer is accountable for the day-to-day management of the Scheme.*

Reviewing our 2025 strategic themes; mapping our way forward

Caring for our members

More on PHP and PHF *pg 43*

Resources, support and information for our members *pg 40*

Some other care programmes and benefits for our members *pg 43*

Driving value-based care centred on our members informs all strategies to expand existing and implement new care programmes, utilising innovative alternative reimbursement models wherever possible. Our funding policies aim to manage healthcare inflation while expanding appropriate interventions in response to the needs of our members.

The Scheme membership's burden of disease is driven by chronic diseases such as cardiometabolic conditions, cancer, mental health, and musculoskeletal conditions, with approximately one in three of our members living with a chronic disease.

In response, we utilise a population health management approach targeted at appropriate interventions and providing Scheme benefits across the entire continuum of care. This includes health promotion and screening for chronic diseases and cancer, treatment, care, rehabilitation and advanced illness management. We leverage digital and virtual health platforms to optimise member health outcomes and the effectiveness of care pathways, and, where appropriate, use artificial intelligence and machine learning to support human resources, such as health coaches who assist members enrolled in disease care programmes. In recognition of the growing burden from mental health illness, we leverage predictive analytics to identify members at risk of developing depression (where it has not yet been diagnosed) and provided risk funding for GP or psychologist consultations, as well as access to risk-funded mental wellbeing coaches.

Our Personal Health Fund (PHF) and Discovery Health's Personal Health Pathways (PHP) managed care programme have proven highly successful in engaging members in their healthcare, by guiding them to take the most important actions for their individual health, and giving them access to additional funding through the PHF, covering a range of out-of-hospital healthcare services.

We also continue to develop and enhance initiatives for greater access to affordable quality healthcare by promoting primary healthcare and care co-ordination through primary care providers.

Our Personal Health Fund (PHF) and Discovery Health's Personal Health Pathways (PHP) managed care programme have proven highly successful in engaging members in their healthcare, by guiding them to take the most important actions for their individual health, and giving them access to additional funding through the PHF, covering a range of out-of-hospital healthcare services.

In 2026, we have augmented the PHF with additional risk funding accessible to members, and our focus will be on increasing PHP engagement to optimise disease management and promote healthy behaviours, including the promotion of healthy sleep habits and funding of sleep related conditions, as well as prompting members to participate in physical activity and targeted health challenges to inculcate healthy behaviours. An additional area of focus will be the review of the contracting framework with major health service providers, including additional appropriate quality measures to drive health outcomes, and closely monitoring the effective and efficient administration of Scheme benefits and managed care.

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Scheme sustainability and membership growth

More about how medical schemes price contributions ***pg 7***

Our performance ***pg 84***

The Scheme's growth, demographics, financial strength, ability to pay claims and sustainability over the long term are critical for our members' continued access to healthcare.

In 2025, the principal members increased slightly by 9 008 principal members (2024: 14 485 decrease), while overall membership continued to decrease by 0.37% (2024: 1.90% decrease). These trends reflect an ongoing shift in family composition within our medical scheme plans, as well as persistent economic pressures experienced by consumers which impact scheme membership. This is further exacerbated by anti-selection, further contributing to stagnant industry membership. The Scheme closely monitors and measures its performance on these and other metrics to ensure that critical performance levels are met. The introduction of innovative plans tailored to the needs of young people and families over the last few years has demonstrated DHMS' value to these consumers, mitigating these trends to some extent.

To enhance this positive trajectory, we continue to focus on Scheme growth and member retention strategies to ensure long-term stability and sustainability of the Scheme. These include responsible pricing strategies which, where appropriate, utilise excess solvency to support members. In 2026, our excess solvency enabled the Scheme to defer contribution increases and enhance benefits, including additional value through the Personal Health Fund.

DHMS actively engages with regulators on policy reform that may affect membership, including advocating for the introduction of Low-Cost Benefit Options (LCBOs) in the medical schemes environment. These would enable medical schemes to provide primary healthcare benefits – as select exempted insurers outside the Medical Schemes Act (the Act) provisions are currently able to do – and allow the uncovered population of our country to access private healthcare in a significantly more affordable price range and benefit from access to the tax credits. We also work to ensure that our plans and benefits appeal to the full range of current and potential members.

We set ambitious targets for competitiveness, including lower contribution increases than other open medical schemes, and we drive effective marketing and distribution strategies to ensure awareness of and attraction to DHMS as the medical scheme of choice for members, employers and financial advisers. Conscious of misperceptions about the role and operations of medical schemes, and of the deeply personal nature of healthcare, we continue to work to ensure that stakeholder perceptions of the Scheme are aligned with our values, our conduct and our commitment to members' long-term protection.

In 2025, DHMS launched the highly successful Active Smart plan, with competitive benefits that appeal to young and healthy members. Building on its success, in 2026 we launched the Smart Saver Series that includes two affordable new plans designed to meet the healthcare needs of young, growing families. They offer extensive in-hospital cover blended with day-to-day benefits for healthcare priorities and flexible funding to cover discretionary healthcare.

In 2025 we also transitioned our highly successful WELLTH Fund into the PHF, which provides additional risk funding to members who take actions to maintain their health through engagement in PHP, Discovery Health's managed care programme. PHF continues into 2026, allowing members to access additional funds throughout the year.

Our investment strategy continues to receive close attention due to the ongoing high level of economic and geopolitical instability in the environment, with the aim of maximising returns within specified risk margins while maintaining statutory solvency at the required levels. Our asset managers, with consideration for responsible investing practices, integrate environmental, social and governance (ESG) factors into their investment strategies, using the Scheme's assets to have a positive influence on the world while earning excellent returns to safeguard our members' continued access to healthcare.

In 2026, we will continue to optimise our investment strategy, aligned to our risk appetite, and implement it to ensure that our required solvency level is maintained, and that we are able to maximise returns to support the Scheme sustainability.

In 2025, DHMS launched the highly successful Active Smart plan, with competitive benefits that appeal to young and healthy members. Building on its success, in 2026 we launched the Smart Saver Series that includes two affordable new plans designed to meet the healthcare needs of young, growing families. They offer extensive in-hospital cover blended with day-to-day benefits for healthcare priorities and flexible funding to cover discretionary healthcare.

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Regulatory and policy developments

More about our engagement with regulatory matters ***pg 78***

The Scheme closely monitors regulatory developments and conducts extensive and detailed analysis required to respond appropriately to policy and regulatory changes. We do this in order to advocate for a regulatory environment that is conducive to the sustainability of medical schemes, to the improved management of healthcare inflation, and for broad-based access and better health outcomes for members.

Industry engagements and broader policy deliberations also take place through our industry body, the Health Funders Association, and the Health Policy Subcommittee of Business Unity South Africa. We also participate in the International Federation of Health Plans conferences and focused networks to learn from international frameworks, enabling legislation and experience to determine what could be beneficial to the South African environment. We are committed to maintaining and enhancing our relationships and working collaboratively with regulatory authorities and industry stakeholders, as we believe this is key to ensuring beneficial outcomes for all.

In 2025 the Scheme continued to participate actively in the engagement and litigation processes around the NHI Act, signed into law in 2024, through the Health Funders Association. We continue to engage with the CMS on various regulatory and policy matters, including the PMB Review Project, recommendations emanating from the Section 59 Report, and LCBOs. We also engaged with the Competition Commission regarding their draft regulations for an interim block exemption for tariffs determination in the healthcare sector and look forward to the next version of these regulations, which have potential to support the management of healthcare inflation.

In 2026, the Scheme will continue to advance medical scheme regulatory and policy reform in support of both industry sustainability and the broader social good, including active engagement on National Health Insurance (NHI) developments where appropriate. We will also pursue opportunities to expand access to private healthcare through LCBOs and continue to strengthen our regulatory and industry relationships in support of these objectives.

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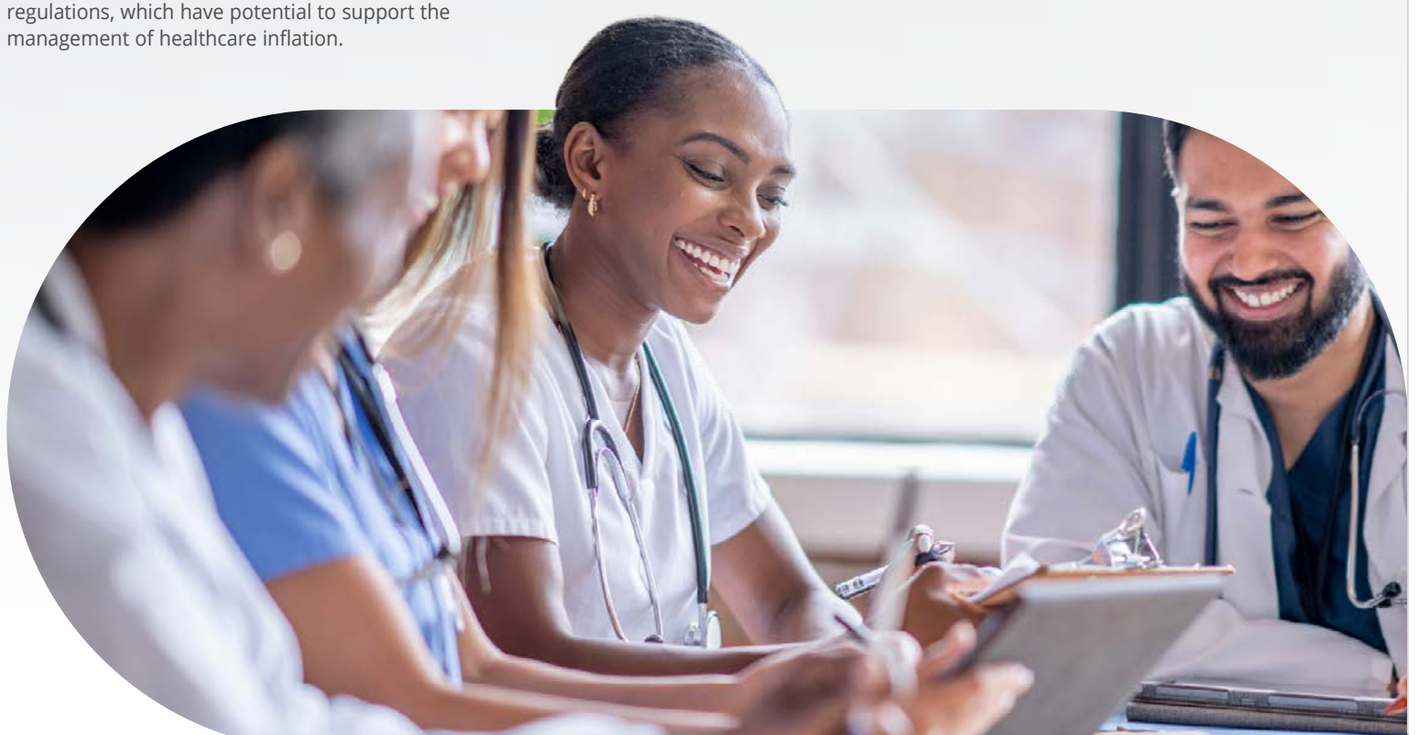

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Governance excellence

More about how we are governed ***pg 50***

More about Vested and the value provided by Discovery Health ***pg 47***

To fulfil their accountability to our members, the Trustees foster an environment that drives growth, resilience, and long-term sustainability of the Scheme by closely overseeing the work of the Scheme Office and Discovery Health in its capacity as the Scheme's administration and managed care provider. This includes ensuring that the Scheme's outsourcing and procurement arrangements and processes support independence, good governance and business decisions, and assist the Trustees in executing their fiduciary duties. Our robust governance structures and processes are compliant with the Medical Schemes Act and all other applicable legislation. We take guidance from best practice corporate governance principles and frameworks from across the world as well as the King IV[1] Report on Corporate Governance for South Africa 2016.

DHMS proactively makes submissions and provides responses to various regulatory bodies on issues relating to governance and regulatory compliance. Furthermore, the Scheme implements detailed and transparent systems for decision making, risk management, and daily operations, ensuring accountability. This supports legal and ethical compliance and helps the Scheme to respond to challenges. From setting policies and decision-making hierarchies to establishing reporting requirements, these processes foster clarity and consistency. The outcomes of our approach to governance are detailed in our business model, and in relevant chapters of this Report.

Vital to the success of the Scheme is the successful operation of our Vested outsourcing model, which governs our relationship with Discovery Health. We regularly review the status of this model to ensure that our operations are responsive to fiduciary duties and governance, and that the model continues to be aligned to the implementation of a best practice Vested relationship.

We held a successful virtual Annual General Meeting (AGM) and Trustee elections in 2025, enabling members to participate and vote regardless of where they were. In considering increasing stakeholder engagement with the Scheme's values and approaches to doing business, the Trustees also developed a framework to support decision-making in external engagements where the careful consideration of the differing needs and concerns of stakeholder groups is required.

In 2026, we will focus on a robust and carefully considered approach to the appointment of our administration and managed care provider, which delivers essential services to the Scheme and its members across a wide range of specialised activities. We will also conduct a holistic review of our oversight and management of these services to ensure their continuity, quality and sustainability over the long term.

1. *King V has been released and will come into effect for the Scheme's reporting from 01 January 2027.*

People management and development

Our business model ***pg 27***

Our values ***pg 32***

The Scheme Office is staffed by a small but highly capable, diverse and knowledgeable team, focused on the business activities of the Scheme Office as a centre of governance excellence. These activities follow a cycle of setting strategy and standards; overseeing implementation and delivery; monitoring, adapting and improving processes; and executing day-to-day work. Daily management of the Scheme includes investment and operations management; stakeholder engagement and responsible corporate citizenship; regulatory engagement, governance, advocacy and compliance; finance, procurement, legal, contractual, ethics and dispute management; strategic planning and implementation; and talent, culture and leadership management. The expertise and capability required means that people management and development is a core enabler of the Scheme's success.

The Scheme utilises a hybrid working model designed to optimise productivity by accounting for types of work and engagement required while actively supporting our culture, and giving employees flexibility and a better work-life balance. Regular interventions take place to promote team engagement, learning, desired culture, values and behaviours, and to equip employees to manage adversity and challenges.

Employees have access to a wide range of development opportunities, considered by the Scheme to be particularly important in an environment where succession planning is challenging given the size of the team. Internal and external training continues to be offered to strengthen our skills base and support retention. The Scheme Office's culture of development and learning in a values-driven environment continues to be highly effective in the hybrid work model that the Scheme utilises.

In 2026, DHMS will focus on strengthening team capacity in response to the increasing volume and complexity of demands on the team. We also plan to review the service providers that support employee benefits and retention to ensure they remain fit for purpose. We will continue to embed a culture of compliance and ethical conduct through structured policy training and ongoing initiatives that promote resilience and wellbeing in a demanding work environment. These efforts are intended to ensure that our team remains equipped and capable of effectively implementing the Scheme's strategic objectives.

The Scheme Office's culture of development and learning in a values-driven environment continues to be highly effective in the hybrid work model that the Scheme utilises.

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Our residual risks

Introduction

DHMS closely monitors the highly regulated and rapidly changing healthcare and funding landscape to identify and mitigate risks, and to optimise value outcomes for our members.

The Scheme continually scans the internal and external environment to assess risks and opportunities associated with our material matters, strategic themes and the core capitals[1] used and affected by the Scheme. The Scheme utilises an enterprise risk management framework and a risk appetite framework and statement to assess risks, which are reviewed and approved by the Trustees each year to ensure ongoing appropriateness. Identified risks are rated on a five-point scale ranging from low to catastrophic and according to likelihood and impact. This process enables us to monitor risks to the financial, operational and relational wellbeing of the Scheme and opportunities arising from effectively managing these risks.

Our risk assessments cover the Scheme's dependence on those resources and relationships that pertain directly to our core service to our members and business activities, as well as to broader environmental factors, ensuring that emerging risks are included in the scope of assessment. Risk responses and mitigation plans are developed and monitored by Scheme Executives, designed to manage the risks to an appropriate level within the risk appetite framework. Risks that remain above appetite are given close attention with activities undertaken to lower the risk. Management conducts regular reviews and reports to the Risk Committee, to other Board Committees where relevant, and to the Trustees. Some risk areas are considered to span across the categories we describe below, as their current and potential consequences have an impact on the industry and the Scheme as a whole. These risks include geopolitical uncertainty, which not only influences the economy, sentiment, and financial stability of the country, but also has a direct impact on healthcare. Another such area is the National Health Insurance Act in its current form, which has wide-reaching and potentially destructive implications for the industry as a whole.

Risk Committee *pg 69*

1. *Financial, human and intellectual, and social and relationship capitals. See our Business Model for more information.*

Our risk environment informs the determination of our material matters, and as such indicates the potential constraints to our capital inputs. In turn, the intended outcomes we achieve for our stakeholders mitigate our risks.

All of the Scheme's risks are below catastrophic level, and a description of the Scheme's high and medium-high residual risks and associated mitigation strategies follows.

RISK CATEGORIES:

- Scheme sustainability, affordability of contributions and medical inflation
- Governance, policy, regulatory and compliance
- Technology and information
- Stakeholders

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RISK

Scheme sustainability, affordability of contributions and medical inflation

RISK DESCRIPTION AND IMPACT

Our regulatory environment is constrained and incomplete, lacking required mechanisms for sustainability such as risk equalisation, effective supply-side regulation and mandatory membership for the employed population, and has limited regulatory tools to manage anti-selection and expand access, all of which exists in an environment of financial and economic pressures. This exacerbates above-inflation increases in healthcare costs, driven by demand-side factors (such as age, gender, chronic status, and anti-selective behaviour[1]) and supply-side factors (such as health technology, pricing and provider-driven increases in utilisation), as well as cost pressures from fraud, waste, abuse and errors. Medical schemes have to adjust contributions to keep pace with medical inflation.

1. *Where members may select not to be on medical schemes, or stay on lower contribution plans, until they need high-cost medical cover.*

MITIGATING ACTIONS

- Each year, the Trustees assess utilisation forecasts, solvency requirements, membership growth, the membership's demographic and disease profile, the Scheme's market competitiveness and the benefit plans we offer to ensure the short- and long-term sustainability of the Scheme, while considering the healthcare needs and affordability constraints of members. We continuously consider product and benefit differentiation and optimisation to meet different members' needs. For 2026, building on the success of the Smart Series, including the launch of Active Smart in 2025, designed for young and healthier members, the Scheme launched the Smart Saver Series, tailored to the needs of young families.
- Risk management interventions to ensure that care is accessed at the most appropriate and optimal level across secondary and primary level care settings, supported by health provider networks focused on quality of care, and alternative reimbursement models. This includes consideration of innovations and interventions that lower healthcare costs while ensuring members have access to quality healthcare.
- Carefully negotiated tariffs with major healthcare providers such as hospital groups, radiology and pathology practices, corporate pharmacies and others, direct payment arrangements, and Designated Service Provider (DSP) networks assist to mitigate PMB exposure. DSP networks are also utilised to benefit members through new efficiency discount options. Coming off a low base, value-based contracting is increasingly being implemented by working closely with healthcare professionals to ensure appropriate risk-sharing arrangements.
- Developing and enhancing managed care programmes underpinned by a population health management approach, aimed at the prevention and management of non-communicable diseases and conditions, with a focus on multiple conditions, to support co-ordinated care and better-quality health outcomes.
- Continuous healthcare delivery innovation, including customer-centric digital healthcare solutions that can improve efficiency and lower healthcare costs, incorporating machine learning and AI to promote ease of access to information, and promoting appropriate settings of care including home-based programmes.
- Personal Health Pathways (PHP) promotes science-based disease prevention and mitigation through physical and mental wellbeing to stem the trends in chronic diseases of lifestyle and mental disorders, utilising technology and rewards to reinforce the formation of good habits and member health. Engagement in PHP unlocks the Personal Health Fund, which provides members with additional day-to-day benefits.
- On behalf of the Scheme, Discovery Health implements funding policies and actively monitors and negotiates prices of medicines and other health technologies including medical devices, treatments and services offered to members. This includes health technology assessments, evaluating supply chain dynamics and sourcing alternatives where appropriate.
- The Trustees satisfy themselves that value for money is obtained from Discovery Health, along with other providers and suppliers, and that the Scheme's budget and expenditure is closely monitored and appropriately managed.
- Extensive marketing and distribution strategies are developed and implemented to attract and retain members, particularly those who are likely to enable effective cross-subsidisation, in keeping with the social solidarity principles on which the Scheme operates.
- Engagements with regulators take place to address concerns and propose appropriate guardrails in regulatory amendments to help protect the sustainability of the Scheme.
- Advocating for the introduction of Low-Cost Benefit Options within schemes to promote accessibility, membership growth and a healthier population.
- Active participation in measures to combat fraud, waste, abuse and errors, including the design and oversight of internal dispute resolution channels available to providers; contributing to the development of industry codes of good practice; mandating Discovery Health to engage in activities to recoup funds disbursed as a result of fraud, waste, abuse and errors; and participating in an industry complaint to the Competition Commission, led by the HFA, regarding overpricing for PCR[2] tests during COVID-19, which estimates that medical schemes were overcharged by approximately R1 billion. We engage in litigation where needed to protect the sustainability of the Scheme. Our contracts also require ethical commitments from suppliers.
- Participating in industry activity towards optimising regulations and guidelines for measures that contain healthcare costs, for example the Prescribed Minimum Benefits Review Project.

2. *Polymerase chain reaction.*

RISK

Governance, policy, regulatory and compliance

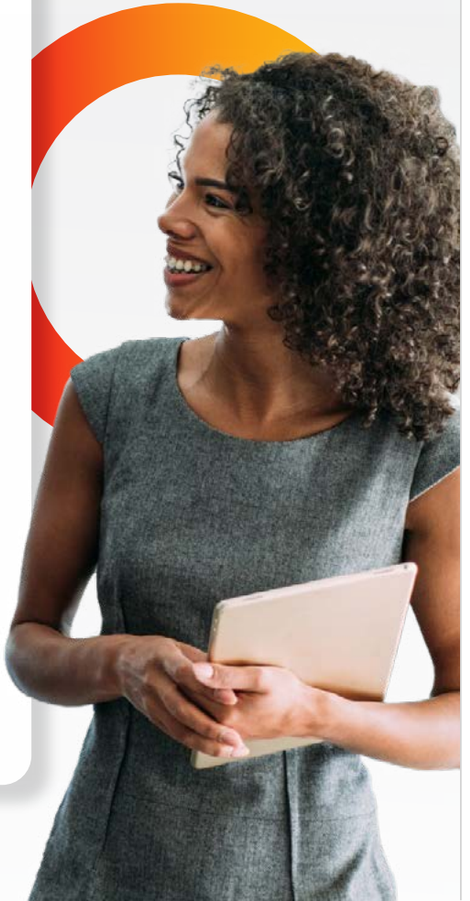
RISK DESCRIPTION AND IMPACT

Managing changes in the regulatory environment presents challenges to the healthcare industry. These changes may have operational, compliance, governance, financial and strategic impacts on the Scheme. Areas contributing to change or potential change include the National Health Insurance Act, Low-Cost Benefit Options and primary care packages, the Prescribed Minimum Benefits Review Project and proposed new mechanisms for tariff negotiations.

Reforms may change the structure and operating requirements of the industry, introducing the risk of being assessed as not compliant or only partially compliant with legislation, Scheme Rules and self-regulated Scheme standards and codes of conduct, including those related to our values and ethics. This may impact the Scheme's ability to operate effectively and efficiently. Specific regulatory changes may also negatively impact on our key stakeholders, and so the broader system must be taken into account in considering them.

MITIGATING ACTIONS

- Through its membership of the Health Funders Association as well as directly, DHMS maintains open lines of communication with the CMS and other regulators. Carefully considered submissions and responses are made timeously and proactively wherever required.
- Regular, detailed and proactive engagement with regulators and relevant stakeholders at all stages of the regulatory change process, enabling advocacy and an exchange of information and views, and greater certainty on changes the Scheme must make. This enables the Scheme to develop and implement compliance strategies that are both comprehensive and pre-emptive in anticipation of regulatory changes.
- Proposed regulatory amendments are subject to thorough assessment, including detailed research and analysis regarding potential impacts on the Scheme, our members and other key stakeholders, the healthcare industry, and the regulatory universe as a whole. Where appropriate, collaborative submissions are made with industry partners and/or representatives.
- The Scheme's views and positions are developed from our own monitoring and assessments, and with input from independent advisers, industry associations and Discovery Health's extensive policy and regulatory monitoring capabilities. The Scheme utilises a risk-based approach for all external engagements, taking the rights and needs of relevant stakeholders into consideration.
- Participation at public and industry forums, both individually and through industry associations, building consensus with stakeholders on effective and enabling regulatory and legislative frameworks, detailed review of publications requiring commentary, and submission of considered and well supported responses to enable positive change for the industry.
- Active engagement with the CMS regarding strategic and operational matters ensures the CMS is kept well informed regarding the Scheme, and that the Scheme is able to incorporate the CMS' feedback to ensure alignment with requirements.
- Operating in a highly regulated and complex environment requires extensive controls to ensure compliance. The Scheme safeguards compliance in all areas by utilising established and appropriate operational, oversight and assurance processes. Where gaps are identified, analysis to establish root causes takes place and plans are implemented to fill these.
- A focus on proactive, robust governance, and the establishment and implementation of frameworks designed to safeguard and promote organisational knowledge.
- Regulatory change is monitored closely, and plans are made well in advance of implementation dates to ensure requirements are addressed ahead of time.
- Existing processes are reviewed and improved, especially where gaps, vulnerabilities and system irregularities are identified, with the input of relevant stakeholders where required, to ensure continued compliance and responsiveness to external change, with independent assessments commissioned as necessary.



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Glossary

RISK

Technology and information

RISK DESCRIPTION AND IMPACT

The Scheme's environment is heavily reliant on information technology for storage, communication, business processes and management. Information security considerations, compliance and a well-considered governance approach is critical to ensure that we protect the privacy of our stakeholders' information. The opportunities presented by technology include the enhanced provision of service and benefits, access to healthcare and information. Some of these use rapidly growing new technologies such as machine learning and AI, the incorporation of which potentially brings great benefits to members but also introduces risks. Technology brings risks of inadvertent, accidental, or maliciously driven system outages, errors, data breaches, financial loss and business disruption, all of which can impact the integrity and availability of information assets and the security of personal information. This may also have regulatory implications.

MITIGATING ACTIONS

- Robust and constantly monitored information security measures enable us to ensure the protection of Scheme information, particularly the personal information of our members.
- Cyber and information risk, including global trends of increasing malicious attacks by third parties, is closely monitored by the Scheme's IT Governance Forum, consisting of representatives of the Scheme and Discovery Health.
- Discovery Health, which provides the Scheme's systems infrastructure and applications, reports extensively on any breaches, the associated risks, controls and compliance with service levels.
- New processes, systems controls and standards, including infrastructure and security measures, offering improved risk mitigation are continually assessed and implemented where appropriate.
- Reports are obtained from independent assurance providers regarding key risks and the associated controls.

RISK

Stakeholders

RISK DESCRIPTION AND IMPACT

Effective stakeholder engagement, incorporating appropriate processes and controls where necessary, enables the development of improved understanding and information, achieving consensus where necessary and co-operation where possible, and the development of a stronger and more robust private healthcare industry.

Given the complexities of the healthcare funding industry and healthcare in general, the Scheme may be perceived to have a negative impact on some stakeholders, often due to a misunderstanding of the nature of the Scheme and the drivers and constraints in its environment. Ineffective stakeholder engagement, negatively impacting the Scheme's ability to perform optimally, and its reputation in the eyes of members, regulators and other stakeholders, could impact the Scheme's sustainability.

MITIGATING ACTIONS

- The Scheme, and Discovery Health on behalf of the Scheme where appropriate, engages proactively, reactively and frequently with all stakeholder groups, including our Regulator, to understand their needs, engender better understanding of the Scheme, and promote alignment with its objectives. Where gaps and opportunities are identified, improvements in processes and governance of stakeholder relationships are instituted.
- In principle, the Scheme's approach to stakeholder engagement and working relationships is to attempt to find solutions beneficial to, or (at a minimum) acceptable to, all parties.
- The Scheme conducts ongoing engagements and environmental scanning, and reviews regular reporting to identify possible risks related to our key stakeholders, which may affect business continuity, and develops or amends specific engagement strategies to deal effectively with these.
- Even though not legally required, the Trustees embrace the Treating Customers Fairly (TCF) principles and framework prescribed for other financial institutions, and receive regular reports on the performance of Discovery Health on key TCF indicators, as well as other stakeholder engagements conducted on behalf of the Scheme.
- Specific incidents with significant member impact receive detailed and frequent attention from the Trustees and the management team, with a close consideration of all the factors required to achieve the best possible outcome for the Scheme and its members. This attention enables the Scheme to amend approved processes where new information and changes require it.
- The Scheme proactively shares evidence-based information with stakeholders to support their healthcare access and needs, awareness of quality outcomes, regulatory changes, and the non-profit status of the Scheme.
- The Scheme's use of the Vested contracting model in our engagement and working relationship with Discovery Health prioritises outcomes beneficial to both parties, which cascade into additional value and quality experienced by our members.
- The Scheme and Discovery Health have developed an enhanced procurement and related party governance process, enabling the Scheme to assess and mitigate risks associated with contracting with individual vendors. Contractual arrangements also include ethical undertakings from both parties, to establish an integrity-based foundation and expected behaviours for the working relationship.
- Where specific stakeholder groups express dissatisfaction, frustration or a lack of understanding, engagement focus and communication strategies are implemented to hear and address, insofar as possible, the stakeholders' concerns.

Creating stakeholder value *pg 31*

Leadership reviews

Our Chairperson's statement

The Scheme's members have two key interests: affordable access to the best possible healthcare services and the sustainability of the Scheme. The Scheme – as a non-profit entity funded by member contributions – must balance individual members' healthcare needs against the collective healthcare needs of all its members, while ensuring the ongoing viability of the Scheme. It does so in a complex and challenging operating environment.

MICHELLE NORTON, SC

The Personal Health Pathways programme, introduced in January 2025, provides all adult members and beneficiaries with personalised recommendations aimed at prevention and early detection of disease.

In 2025 and into early 2026, South Africa's economy has remained constrained, with modest growth and persistent fiscal pressure and unemployment, albeit with some positive developments in energy supply infrastructure, rail and port logistics, and policy reform. Globally, heightened geopolitical tensions and tariff fluctuations have contributed to currency volatility and uncertainty in emerging markets, including South Africa. While inflation currently remains within the Reserve Bank's targeted band, households continue to face cumulative cost-of-living strain, subdued real income growth and debt burdens. Discretionary spending remains under pressure.

A steady increase in chronic disease in our members – reflecting a global phenomenon – continues to drive increased utilisation of healthcare services. The cost of healthcare services continues to increase at rates above the Consumer Price Index, and innovative technologies and medicines that offer life changing benefits to individual members come at a significant cost to the Scheme as a whole.

In the year under review the Scheme has adopted a range of measures to address these challenges, drawing on the extensive technological and innovative resources of its contracted administration and managed care provider, Discovery Health (Pty) Ltd.

The Personal Health Pathways (PHP) programme, introduced in January 2025, provides all adult members and beneficiaries with personalised recommendations aimed at prevention and early detection of disease. PHP take-up has been excellent, demonstrating our members' willingness to participate actively in managing their health outcomes. Individual members who have shared their positive experience of PHP include Sameshni Moodley (who benefitted from an early detection of cancer as a result of a PHP prompt), Antoinette Mazibuko and Bets Gericke.

Sameshni Moodley's story
Antoinette Mazibuko's story
Bets Gericke's story
More about PHP and PHF

The Personal Health Fund (PHF) benefits unlocked by members' participation in PHP can be utilised for day-to-day medical expenses, including GP and specialist consultations, medication, radiology, and pathology services. We encourage all our members to activate PHP and have made further funds available to members who do so by funding R1000 per member into their PHF during 2026.

The Scheme continues to implement a range of interventions aimed at containing the costs of healthcare services. Supply-side interventions include alternative reimbursement mechanisms with health care providers and Designated Service Provider (DSP) networks, which are key mechanisms for securing cost-effective care of the required quality through negotiated tariffs. Targeted programmes promote more appropriate treatment pathways, such as conservative spinal care before surgery, and are complemented by care models that reduce unnecessary hospitalisation, including short-stay surgical pathways, home-based care and digital consultations. Collectively, these measures help to moderate healthcare cost increases while supporting better clinical outcomes and preserving the affordability of contributions for members.

The combined effects of these measures and positive investment results allowed the Scheme to end the year in a strong solvency position and to defer its contribution increases from 01 January 2026 to 01 April 2026, saving members a collective R1.5 billion.

Our Chairperson's statement *continued*

The Scheme constantly strives to cater for the different needs of different members through differentiated benefit options. In 2026 we have extended our plan series with the Smart Saver plans, which are designed to meet the needs of young and growing families.

Plan and benefit information for 2026

Discovery Health has continued to provide the Scheme with administration and managed care services in accordance with the Vested outsourcing model that governs this relationship. The Scheme continuously monitors the quality and value of those services. A comprehensive peer-reviewed assessment of the value provided to the Scheme by Discovery Health is conducted every year (for the preceding year): the 2025 assessment showed that in 2024, for every R1.00 paid to Discovery Health by the Scheme, members received R2.10 worth of value[1]. This is equivalent to nominal added value of R10.4 billion in 2024 (2023: R9.6 billion), over and above the fees paid to Discovery Health of R9.4 billion in 2024 (2023: R8.8 billion).

Value provided by Discovery Health ***pg 100 – 101***

While Discovery Health has generally maintained a very high level of operational performance, the Scheme and a sub-group of its members were affected by a claims system error that occurred in 2025, resulting in the overpayment of claims from the Above Threshold Benefit. The Scheme authorised a process to recover the overpaid amounts from the affected members, in accordance with its obligation to protect the funds of the Scheme and the interests of all its members, but was able to terminate that process when Discovery Health undertook to pay the full costs incurred by the Scheme as a result of the system error. The Scheme has received confirmation that the error has been corrected and contained, and requested a full investigation and report on, among other things, the cause and steps required to prevent a recurrence of the error.

The Scheme continues to operate within a mature and robust governance framework. The Board of Trustees has an excellent balance of the legal, clinical, governance, actuarial and financial acumen required for the strategic oversight and sound management of the Scheme, which covers a wide field: regulatory compliance; the sustainability of the Scheme; strategic risk management; protection of beneficiaries' interests; stakeholder relations and communication; benefit design and implementation; procurement of administration and managed care services; maintenance and improvement of operational, financial and other control systems; and investment strategy and returns.

In the past year we have reviewed and updated key policies and introduced a framework for decision-making on the Scheme's external engagements. The Trustees and Scheme Executives have studied the recently published King V Code on Corporate Governance for South Africa 2025 and taken cognisance of its insights and recommended practices for governing bodies. Of particular salience to the Scheme is King V's focus on governance in an operational environment that has been substantially reshaped by rapid advancements in data, information and technology. Highlighting the expanding application of AI systems, King V identifies the values that should be applied in their deployment and the importance of establishing accountability for AI-driven outcomes.

In a Board effectiveness review facilitated by the Institute of Directors in South Africa in early 2026, the Trustees developed an action plan to strengthen governance practices in accordance with the recommendations in King V and the Board's own learnings over the past year.

There is a strong culture of independent thought and robust debate in meetings of the Board and Board Committees, ensuring that all voices are heard and views carefully considered. We value diversity in all its dimensions and in early 2026 benefitted from a Diversity, Equity and Inclusion training session that was aimed at building our awareness of differences and the role of unconscious bias in our decision-making.

A strong regulatory environment is critical for the continued sustainability of the medical scheme industry and the protection of medical scheme members' interests. The Scheme engages regularly with the Council for Medical Schemes (CMS) on issues of concern to the CMS and the Scheme. In the past year these have included the Scheme's proposal to introduce Low-Cost Benefit Options; the CMS's ongoing review of Prescribed Minimum Benefits; the management and mitigation of fraud, waste, abuse and errors; DSP guidelines; and the CMS's concerns arising from the claims system error that occurred in 2025.

The National Health Insurance (NHI) Act, which was signed into law on 15 May 2024, is the foremost regulatory challenge for the medical scheme industry. The Scheme, while fully supportive of the objective of national health coverage, has identified provisions in the Act that pose substantial risks to the South African healthcare sector as a whole and to medical schemes and their members. While hopeful that the areas of concern can be addressed through engagement, the Scheme is also closely involved in the legal challenge to the Act that has been brought by the Health Funders Association (HFA) on behalf of its members. The HFA challenge is based on detailed independent economic and financial analysis of the impact of the NHI Act in its current form.

More about the HFA's challenge

The Scheme held its first fully virtual AGM In 2025. The AGM was very well attended and as this format provides equitable access to all members, regardless of their geographic location, the forthcoming AGM on 25 June 2026 will also be fully virtual.

The Scheme has continued to benefit from the excellence and dedication of its Trustees, Independent Committee Members, Scheme Executives, and the staff of the Scheme Office.

In June 2025, Mr Marius du Toit and Dr Max Price took their leave after completing their first terms as Trustees. We thank them both for their substantial contribution to the Scheme. We welcomed three Trustees whose combined experience and expertise will undoubtedly enrich the work of the Board: Ms Joan Adams, who was re-elected for a second term; Mr David King, who returns to the Board after a previous tenure that ended in 2022; and Professor Cornelius Schutte, who was newly elected.

We benefit considerably from the high calibre of our Independent Committee Members. In the last year, we have taken our leave of Dr Alewyn Burger (Audit and Risk Committees), Mr Bongani Hlophe (Remuneration Committee), Ms Busisiwe Mathe (Audit Committee), Ms Boitumelo Lekoko (Nomination Committee), and Mr Eric Mackeown (Audit, Investment and Risk Committees) and thank them for their commitment and contributions. We have welcomed Ms Lwazi Nopece and Mr Victor Muguto to the Audit Committee, and Dr Thinus Bekker to the Audit and Risk Committees.

The engagement and sound judgement of my fellow Trustees have enabled the Board to make well-grounded decisions in an increasingly complex operating landscape. The Scheme's Principal Officer, Ms Charlotte Mbewu, has continued to direct the Scheme with steady and insightful leadership, supported by a capable and dedicated Scheme Office that serves the Board with professionalism and excellence.

We face the year ahead with a steady commitment to ethical and effective leadership of the Scheme in the best interests of all its members and beneficiaries.

M L Norton

MICHELLE NORTON, SC
Chairperson

1. *The value received per Rand of fees is expressed in real terms.*

Our Principal Officer's Review

The healthcare environment remained under sustained pressure throughout 2025 and into early 2026. An aging population, the growing prevalence of chronic and lifestyle-related conditions – including mental health conditions, rare diseases and cancer – and persistent affordability constraints continue to shape demand for medical scheme cover and access to care. Although general inflation remains moderate and sentiments remain largely positive, healthcare costs remain structurally elevated, influenced by increasing utilisation, advances in high-cost medical technology, the complexity of multi-morbid conditions, and inadequate cross-subsidisation compounded by the effects of unemployment in younger age groups. Simultaneously, the signing of the NHI Act into law in 2024 has exacerbated ongoing policy uncertainty in the healthcare funding landscape.

MS CHARLOTTE MBEWU

The growing prevalence of artificial intelligence and its use in the healthcare landscape – be it for diagnostic purposes or servicing of medical scheme members – has the potential to greatly benefit members, which must be balanced with associated high costs of new technologies and risk considerations.

The increasing disease burden, together with members living with multiple chronic conditions and the continued introduction of new health technologies – including pharmacological interventions and new medical devices – continues to necessitate new considerations around disease management programmes, Scheme benefits and their sufficiency whilst balancing these with utilisation. These dynamics have implications for maintaining member contribution levels and, to this end, we utilise designated service providers, establishing networks for specific areas of focus to better manage complex disease and the careful treatment considerations required. We include considerations of health outcomes and quality care in these developments and are seeing positive results in our maternity pilot which is designed to support the optimisation of maternal and neonatal care through a global fee for multi-disciplinary teams, which also eliminates member co-payments for uncomplicated deliveries.

The growing scope and application of artificial intelligence and its use in the healthcare landscape – be it for diagnostic purposes or servicing of medical scheme members – has the potential to greatly benefit members, but this must be balanced with the associated risk and costs of new technologies. Our approach is careful assessment within an appropriate operational and governance framework, incorporating ethical considerations and processes required to critically assess the value, cost implications and risk profile of such tools.

These intersecting forces reinforce the importance of carefully calibrated innovation. Medical schemes must respond with an objective to improve member experience, strengthen preventative and co-ordinated care models, apply data and technology more effectively, enable benefit design considerations and proactive approach to care needs, and engage constructively in regulatory processes to support a sustainable and resilient healthcare system over the long term. At the same time, we must ensure that our members remain at the centre of care, and that digital innovation does not replace, but enhances meaningful human interaction and personal support.

We continue to be highly concerned by the proportion of our members living with more than one chronic condition and those who are at risk of developing a chronic condition, with the increasing burden of disease being driven by mental health conditions, cancer, cardiovascular, and kidney related diseases which all have the potential to impact members' quality of life if not managed appropriately. Preventative care, including a holistic approach to population health management, is of utmost importance to the Scheme. In 2025 we introduced the world-first Personal Health Pathways (PHP) programme, providing members with recommended healthcare and physical actions to improve and maintain their health[1] by building strong health habits. PHP, which was developed by Discovery Health, is underpinned by robust clinical research and data science, as well as a remarkable set of clinical data.

1. *Where recommended actions have a cost attached, these are funded according to each member's plan benefits. Please see the description provided per action for more information.*

To encourage and support our members to create and maintain their health habits, in 2026 we are introducing sleep actions and Personal Health Challenges in PHP. Each health challenge is a personalised series of health actions to be completed within a defined period. Achieving good sleep of 7-8 hours a night[1] has a significant impact on health including preventing the onset of chronic conditions like diabetes, decreasing the likelihood of casualty visits, and lowering the risk of all-cause mortality by up to 30%.

Alongside offering PHP to our members, the Scheme introduced the Personal Health Fund (PHF) benefit, providing funding for additional risk-funded day-to-day benefits based on PHP engagement. In 2025, our members used over R269 million from their PHF for pharmacy, GP, pathology, dentistry and optometry claims, amongst others. To encourage members to take charge of maintaining their health, we funded R1 000 per member activating PHP, exercise and sleep tracking, and doing their health checks before 01 January 2026. Our solvency position has enabled us to extend this to an additional R1 000 per member or dependant taking these actions during the course of 2026.

We are already observing encouraging early indicators of the positive impact of the PHP programme for our members. Since its introduction, more than 30 000 individuals have completed physical activity actions for the first time. PHP also reinforces the importance of screening and engaging in one's healthcare. Screening rates across major cancer types have improved, with prostate screenings and mammograms increasing by 15% and 24% respectively. There is a 10% higher five-year survival rate with early diagnosis of prostate cancer, a 28% higher five-year survival rate with early diagnosis of breast cancer, and members with chronic conditions who use a nominated GP, vs multiple GPs, have a 30% decrease in hospital admission rate.

1. *Cappuccio, F.P., et al. (2010) Sleep Duration and All-Cause Mortality: A Systemic Review and Meta-Analysis of Prospective Studies. Sleep, 33, 585.*
2. *Available on all Discovery Health Medical Scheme plans except Essential Smart, Essential Dynamic Smart, Active Smart and KeyCare plans. Subject to the Scheme's clinical entry criteria, treatment guidelines and managed care protocols.*
3. *Prior to IFRS 17, known as member funds and renamed from "insurance liability to future members" in our previous Integrated Report.*

Given the importance of managing chronic conditions at a population level, it is particularly encouraging that 67% of all completed actions were undertaken by members with chronic conditions.

In caring for our members' needs, in 2026 we have introduced the Nurture at Home[2] benefit programme, designed to support parents with newborns who have to spend an extended period in a neonatal intensive care unit due to premature birth or medical complications before going home. We also provided our members with access to perinatal bereavement counselling to provide support for families who have suffered the loss of pregnancy, a still birth, or loss of their baby immediately post birth. For elderly members of the Scheme who are at high risk of being admitted to hospital following a visit to the emergency department, we have provided a "basket of care", which includes a virtual consultation which can be utilised as an alternative to an emergency department visit, and virtual coaching and support to enhance care co-ordination, health education and access to the Scheme's care programmes where relevant. We have also made a palliative care consultation available as part of the oncology basket of care for members who wish to make use of this.

Other 2026 changes include the introduction of Smart Saver Series plans, tailored to the healthcare needs of young families, and expanding accessibility of the KeyCare Start Regional plan by adding new delivery systems in Potchefstroom, Welkom and Kimberley.

Caring for our members includes ensuring efficient and reliable servicing, an area in which we faced some challenges during 2025, particularly for some of our members fighting cancer. We recognise that some servicing paths are complicated by the nuances of individual treatment plans, and we strive to ease the burden on members facing severe health impacts, while paying extremely close attention to this matter to ensure improvement. Additionally, a claims system error affected some members on our Priority, Comprehensive and Executive plans in late 2025. While the member impact has been resolved by Discovery Health covering the cost of the overpaid claims, we are conducting a detailed investigation and deep root-cause analysis and extending our oversight and auditing mechanisms to mitigate any risk of similar occurrences in the future.

More about our Above Threshold Benefit claims system error ***pg 51***

In caring for our members' needs, in 2026 we have introduced the Nurture at Home benefit programme, designed to support parents with newborns who have to spend an extended period in a neonatal intensive care unit due to premature birth or medical complications before going home.

For the year ended 31 December 2025, the Scheme's insurance revenue (previously referred to as contribution income) was R86 653 million (2024: R80 673 million). Taking claims paid on behalf of members and other expenses directly attributable to membership into account, the Scheme generated an insurance service result before amounts attributable to future members of R565 million (2024: negative R350 million), better than was budgeted. In terms of our investment strategy, the Scheme generated investment income of R2 985 million (2024: R2 828 million), strongly supporting our financial position and, to a certain extent, allowing us to continue shielding members from healthcare inflation.

Liability to members for future benefits[3] increased to R38.8 billion (2024: R31.6 billion), resulting in solvency of 32.58% (2024: 31.01%) at 31 December 2025 – well above the regulated 25% solvency level. The Scheme remains in a strong financial position and able to meet members' needs, and we continue to work to find ways of utilising our solvency levels to the benefit of members. This year, we have been able to defer our annual contribution increases to 01 April 2026, saving members R1.5 billion collectively.

Due to better than budgeted results and Discovery Health's capabilities in supporting the Scheme to continue introducing strategies that deliver healthcare utilisation efficiency, we have been able to keep our contribution increases to a weighted average 7.2% across our plans, with 65% of members experiencing a lower increase of 6.9%. Active Smart plan members have had a 0.0% increase. Contributions for the balance of members increased by 7.9%, reflecting the higher impact of supply- and demand-side utilisation on their plans.

Our Principal Officer's Review *continued*

On regulatory matters, we continue to advocate for the introduction of primary healthcare benefit packages in the form of Low-Cost Benefit Options (LCBOs) as these would offer significant social protection to currently uninsured South Africans. If these benefit packages were offered through medical schemes, these individuals could access medical scheme tax credits which they cannot access through insurance products. In line with the importance that we place on these options and the ability of medical schemes to broaden funding and consequently access to private healthcare, DHMS applies on an annual basis to the CMS for an exemption to be able to offer them. All of these applications have been declined. In 2026 we have lodged an appeal against the CMS' decision to decline our most recent application.

We are engaging on industry activity regarding the recommendations emanating from the Section 59 Investigation[1] report, which provide an opportunity to develop industry guidelines for more effective management of fraud, waste, abuse and errors while ensuring fair treatment of all stakeholders. However, if regulations were amended which limited the ability of schemes to effectively recover funds unlawfully paid out, these would impede on schemes' fiduciary duties to its members. We also remain concerned about misrepresentation of the findings of the report, in which the investigation panel stated that it could not make any findings of unfair discrimination perpetrated by any schemes. This misrepresentation may impede the ability of schemes to continue to protect the funds of its members.

We also look forward to a next iteration of the Competition Commission's draft regulations on block exemptions for tariff negotiations. The Competition Commission has led a number of constructive and positive engagements with industry stakeholders, including the Scheme, and is in the process of considering input received. We submitted a response to the first iteration, including our concern that the challenges of utilisation should be addressed through alternative reimbursement models rather than through a sole focus on tariffs, as the key issue is better management of healthcare inflation to the benefit of members, in accordance with the recommendations of the Health Market Inquiry[2].

Since the signing of the NHI Act into law in 2024, no sections of the Act have been brought into operation, but draft regulations dealing with limited processes relating to the Act were published for public comment. Several stakeholders have launched legal action against the NHI Act. In February 2026 the President undertook to not proclaim any provisions of the Act, and the Minister of Health committed to halting its implementation, pending the Constitutional Court's upcoming judgments in the public participation-related challenges.

The Scheme is participating in the legal action led by the HFA, and that legal action is also stayed, by order of the court, until after the Constitutional Court has delivered its judgment. This pause in NHI implementation does not impede the urgently needed improvements that can be made in the healthcare industry in the interim. Improvements can be made to both the public and private sectors, and DHMS fully supports positive regulatory, strategic and operational changes, and a collaborative approach between private and public sectors in achieving universal health coverage within a social solidarity framework[3].

More about the status of the NHI ***pg 80***

We continue to actively engage with the CMS and the Registrar, Dr Musa Gumede, on a range of operational and strategic matters. We welcome the CMS' openness to discussion to achieve a better understanding of the complex challenge of balancing health-economic, actuarial and sustainability factors while maintaining regulatory compliance, all in the best interests of members, which both schemes and the CMS are charged with safeguarding.

I extend my appreciation to my colleagues in the Scheme Office for their commitment, breadth of perspective and professional expertise, all of which materially strengthen the work of the Scheme. The Trustees and Independent Committee Members remain actively engaged, and their considered guidance and steady oversight are central to the Scheme's ongoing ability to meet members' needs.

We are also appreciative of the constructive engagement with our key stakeholders and industry partners, whose collaboration supports the protection of members' interests and the sustainability of healthcare in South Africa. Finally, we thank our members for the confidence they continue to place in the Scheme to support them in their healthcare journeys.

C Mbewu

MS CHARLOTTE MBEWU
Principal Officer

1. *The Section 59 Investigation was an independent inquiry into allegations of unfair treatment and racial discrimination by medical schemes and administrators in South Africa when identifying and penalising healthcare providers for fraud, waste, abuse and errors (FWAE).*
2. *The Health Market Inquiry was an inquiry by the Competition Commission into the private health industry to determine whether there are aspects of the market which distort, restrict or prevent competition. The Competition Commission's Health Market Inquiry Final Findings and Recommendations Report was published in September 2019.*
3. *The use of a model which includes multiple private and public funders, designed to support cross-subsidisation for health and financial status.*

On regulatory matters, we continue to advocate for the introduction of primary healthcare benefit packages in the form of Low-Cost Benefit Options (LCBOs) as these would offer significant social protection to currently uninsured South Africans.

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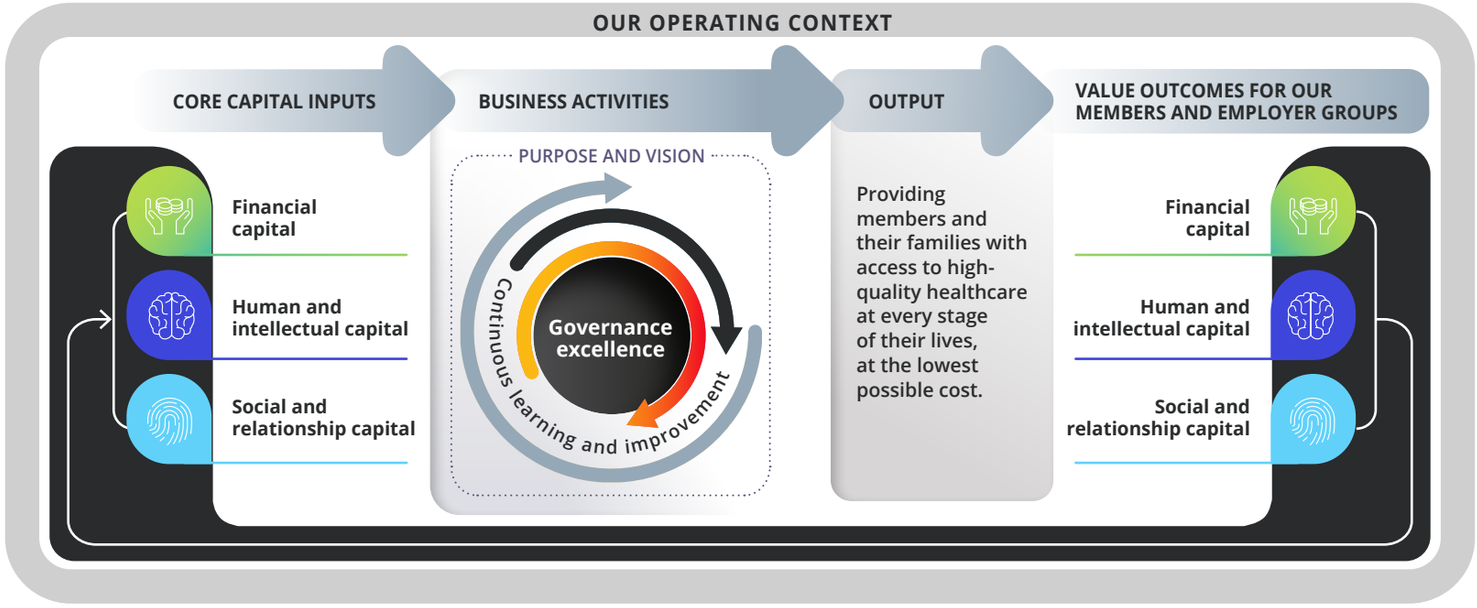
Our business model

The primary need of our members is access to affordable, high-quality healthcare now and in the future. Our business model is designed to fulfil that need through sustaining the financial, operational and relational wellbeing of Discovery Health Medical Scheme (DHMS or the Scheme).

Our business model centres on delivering excellence and innovation in our core service to our members through best practice governance and thought leadership in the medical schemes industry.

As a funder connecting our members to the private healthcare value chain, we oversee a complex ecosystem of relationships with our members at the centre. The Scheme's business model is therefore people led, capability driven, and relationship based, which is clearly reflected in our core capital inputs and value outcomes.

Securing access to our core capital inputs in order to create sustainable value outcomes for our members, employer groups and society, depends on the quality of our relationships with our other stakeholders in the healthcare ecosystem.



Our material matters are pertinent to these capital inputs and the value outcomes we are expected to deliver to our members and our other stakeholders. Responding effectively to them enables us to deliver on the objectives associated with our strategic themes and to mitigate our residual risks to secure the financial, operational and relational wellbeing of the Scheme in fulfilment of our purpose and in pursuit of our vision.

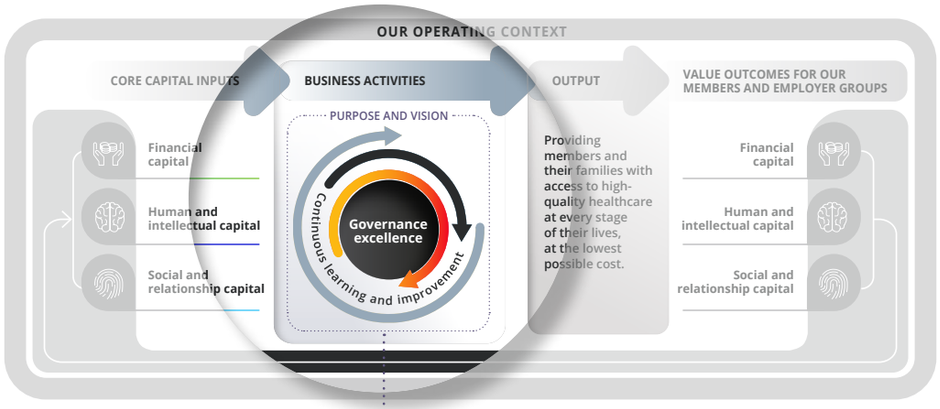
Critical to our business model is the administration and provision of managed care, implemented according to global best practice. We apply the Vested® outsourcing model to govern the working relationship with our accredited administration and managed care provider, Discovery Health (Pty) Ltd (Discovery Health). Vested outsourcing applies an outcomes-driven approach characterised by:

- A shared vision and aligned objectives, with both organisations committed to the success of each other;
- Transparency, flexibility and trust;
- Working together to find the best solutions; and
- Fair risk and reward for both parties, leading to fairness, sustainability and the best outcomes.

The principles of this model strengthen strategic alignment and encourage a value-driven relationship. By contracting for results and not activities, both organisations are able to do what they do best, which drives innovation, improved service, and continuous value creation.

Key elements of our business model are discussed in:

- Our operating context *pg 7*
- Our residual risks *pg 18*
- Material matters *pg 10*
- Creating stakeholder value *pg 31*
- Our strategic themes *pg 13*

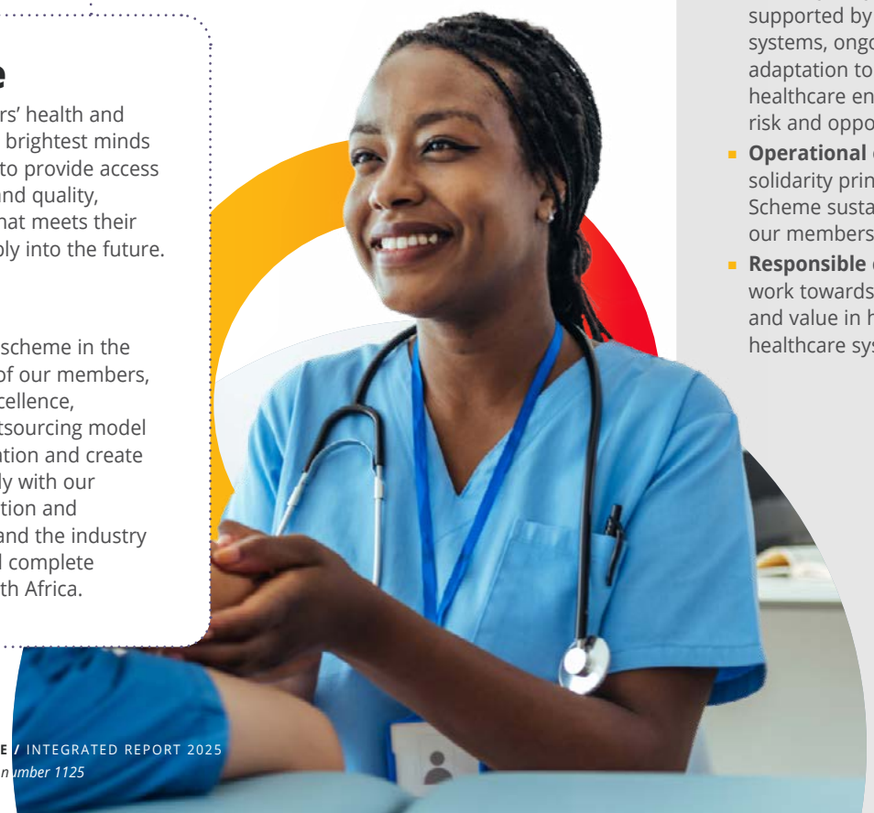


Our purpose

is to care for our members' health and wellness by engaging the brightest minds and innovative solutions to provide access to affordable, equitable and quality, value-based healthcare that meets their needs now and sustainably into the future.

Our vision

is to be the best medical scheme in the country. In the interests of our members, we will always pursue excellence, leveraging the Vested outsourcing model to lead healthcare innovation and create value. We will work closely with our regulator, our administration and managed care provider, and the industry to shape an inclusive and complete healthcare system in South Africa.



Business activities

DHMS undertakes its business activities in line with its operating model, which defines the Scheme as a centre of governance excellence enabled by a culture of continuous learning and improvement, and led by a capable, knowledgeable team. This means that the Scheme is focused on:

- **Regulatory compliance:** discharging our fiduciary duty and compliance obligations, supported by mature governance systems, ongoing monitoring and adaptation to a complex and dynamic healthcare environment, and managing risk and opportunity effectively.
- **Operational excellence:** guided by social solidarity principles, we work to ensure Scheme sustainability for the benefit of all our members.
- **Responsible corporate citizenship:** we work towards greater quality, efficiency and value in healthcare delivery and value in healthcare system reform in South Africa.

- Investment management
- Operations management
- Responsible corporate citizenship
- Stakeholder engagement
- Finance and procurement
- Disputes, legal and contracting
- Regulatory compliance
- Clinical, legal and business risk management
- Planning and reporting
- Talent, culture and leadership management
- Advocating for an improved healthcare system

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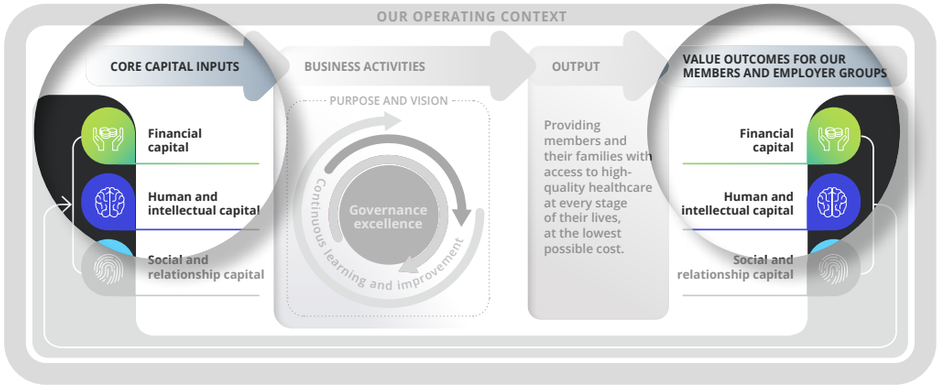
Value snapshot

FOR THE YEAR ENDED 31 DECEMBER 2025



Financial capital

CORE CAPITAL INPUTS

Gross member contributions of

R101.5 billion

(2024: R94.6 billion)

Investment income generated from scheme assets

R3.0 billion

(2024: R2.9 billion)

OUTCOMES ACHIEVED

- Largest open medical scheme, with 2 725 122 beneficiaries[1] and 57.7%[2] market share.
- Financial strength, with R38.8 billion in Liability to members for future benefits[3], a 32.58% solvency level, and an AAA credit rating confirming the Scheme's ability to meet large, unexpected claim variations.
- DHMS gross administration expenditure as a proportion of gross contribution income (GCI) was the fifth lowest[4] out of 16 schemes in the open scheme market in 2024.
- Contribution increases deferred to 01 April 2026, saving members collectively R1.5 billion – around R1 100 per average membership.
- Additional day-to-day benefits through the Personal Health Fund (PHF) for members who participated in specific Personal Health Pathways (PHP) actions of R1 000 per member to start 2025, and another R1 000 per member during 2026.

RELEVANT KEY STAKEHOLDER RELATIONSHIPS:

- Members *pg 39*
- Our employees *pg 48*
- Financial advisers *pg 46*
- Regulatory bodies *pg 49*
- Discovery Health *pg 47*

Human and intellectual capital

CORE CAPITAL INPUTS

- Skilled, knowledgeable, independent Board accountable for effective oversight and delivery of the Scheme's mandate.
- Mature governance frameworks, processes and structures.
- Effective, efficient and agile business model with optimised outsourcing.
- Strong and specialised management team with appropriate capability and capacity, enabled by continuous learning and improvement initiatives.
- Values-based culture that drives the highest ethical standards in the conduct and decisions of the officers of the Scheme.

OUTCOMES ACHIEVED

Board of Trustees and Board Committees

In early 2026, a Board effectiveness review was facilitated by the Institute of Directors in South Africa, during which an action plan was developed to address areas identified for further consideration. Board Committee evaluation results for 2025, also conducted in early 2026, were not available by the time of publication. In the prior evaluations conducted by an independent assessor against the principles of the King IV Report on Corporate Governance, the Board and all Committees scored 98% and higher.

Employees

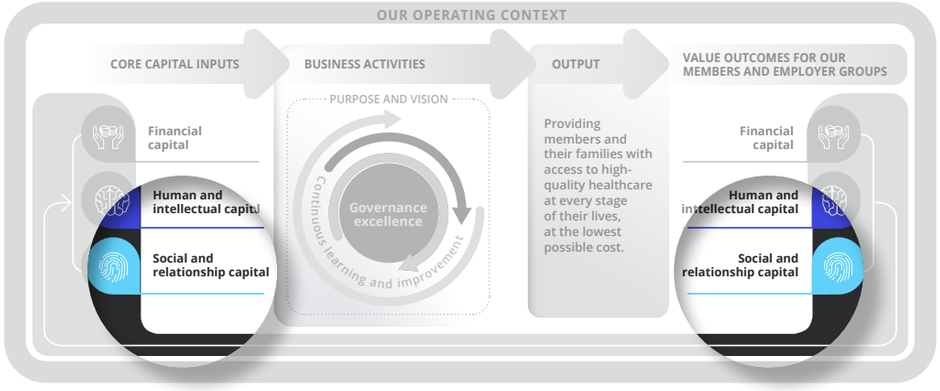
- The Scheme's value proposition to employees includes protecting their dignity, safety and health, providing decent work, fair remuneration, development, and equitable and ethical treatment. The Scheme is a diverse workplace with a focus on transformation and inclusion.
- The Scheme Office workplace culture is regularly assessed and informs our people management priorities, including wellbeing strategies.
- Training and development for all employees takes place on a regular basis.
- The Principal Officer and management team's expertise encompasses a broad range of capabilities including medicine, actuarial science, risk management, accounting, business management, strategic development, financial management, investment, governance, law, ethics, compliance and research.

RELEVANT KEY STAKEHOLDER RELATIONSHIPS:

- Members *pg 39*
- Discovery Health *pg 47*
- Our employees *pg 48*
- Regulatory bodies *pg 49*
- Healthcare professionals *pg 42*

1. *At 31 December 2025.*
2. *Based on beneficiaries, according to the Council for Medical Schemes (CMS) Industry Report for the year ended December 2024 (https://www.medicalschemes.co.za/wp-content/CMSIndustryReport2024_4Dec.pdf). At the end of 2024 there were 16 open schemes registered with the CMS, with approximately 51.7% of the total medical schemes market and 55 restricted schemes, with approximately 48.3% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately 2.4 million beneficiaries.*
3. *Prior to IFRS 17, known as member funds and renamed from "insurance liability to future members" in our previous Integrated Report."*
4. *7.6% for 2024, vs the weighted average gross administration expenditure for open schemes as a proportion of GCI, which was 7.9% excluding the Scheme. Based on the CMS Annual Report 2024-2025. Industry data for 2025 not yet available.*

Value snapshot *continued*



Social and relationship capital

CORE CAPITAL INPUTS

- Maintaining our social licence to operate in the best interests of our members.
- Attracting and retaining a substantial membership base to support cross-subsidies, efficiency and sustainability.
- Maintaining collaborative partnerships with all our stakeholders.
- Balancing constructive relationships and oversight related to our Vested outsourced partner, Discovery Health, and other suppliers.
- Reputation for stability, reliability, accessibility, integrity and thought leadership.
- Reputation as a responsible and involved corporate citizen.
- Supporting healthcare reform towards an effective and equitable healthcare system.

RELEVANT KEY STAKEHOLDER RELATIONSHIPS:

- Members ***pg 39***
- Healthcare professionals ***pg 42***
- Financial advisers ***pg 46***
- Regulatory bodies ***pg 49***
- Discovery Health ***pg 47***

OUTCOMES ACHIEVED

Responsive, high-quality, value-based healthcare

- Driving access and better health outcomes through value-based partnerships with healthcare providers, focused on efficiency and quality of care, the ongoing development of population health management, managed care programmes, innovation and integration.
- Supporting members with personalised recommendations to make better health choices.
- In 2025, the DHMS HIV Care Programme won two global awards: Best Health & Wellness Offering at the Global Insurance Innovation Awards 2025 and Gold (first place) in the category "Best Customer Experience for Vulnerable Customers" in the International Customer Experience Awards[1].

Celebrating HIV mortality improvements for HIV registered members

Plan choice

- Our full spectrum of 25 plan options for 2026 offers our members sufficient choice to meet their medical and financial needs.
- Low movements between plans reflect member satisfaction and appropriate benefits and pricing. For the period December 2025-January 2026, 95.86% of members did not change their plans.

Value of benefits[2]

- Members receive substantial value in terms of their healthcare benefits when they need to claim. The largest hospital claim made during 2025 would require 273 years of contributions by the member to cover that particular claim, based on the plan that the member is on; put another way, it would take 370 years of contributions based on the average risk contribution of R2 676 per beneficiary per month.
- For an average risk contribution of R2 676 per month, R75 billion was paid out in risk claims for the period ending December 2025. This includes:
  - R4 770 per beneficiary with a chronic condition for out of hospital costs (768 780 beneficiaries);
  - R74 613 per admission (649 060 hospital admissions);
  - R160 289 per beneficiary undergoing oncology treatment (43 993 beneficiaries).
- 15.6% of beneficiaries claimed more than their contributions.

Affordability[3]

- Average contributions for our members in 2026 are 17.7% lower than the average of the average contributions of the next seven largest open medical schemes.
- The Scheme is more affordable than the average of the next seven largest open schemes across all plan categories in 2026 (income capitated: -2.5%; hospital: -6.7%; limited day-to-day: -22.9%; extensive day-to-day: -10.9%).

Value for money

- The Trustees conduct a formal evaluation of the value for money Discovery Health (Pty) Ltd (Discovery Health) provides to the Scheme every year. In 2024, DHMS received R2.10 of value added by Discovery Health for each Rand paid to it[4].

More about the value provided by Discovery Health and how this is calculated ***pg 100 – 101***

Digital capabilities and innovation[5]

- The Discovery Health app gives our members easy access to their health plan information and other convenient functionality to assist them in managing their healthcare needs.
- An average of 2 771 doctors regularly used HealthID in treating our members during 2025, with over 3.2 million individuals having consented to their doctors accessing their records on HealthID[6], creating a single view of the patient's health records. This supports care co-ordination and pathways, and reduces fragmentation of care, improving quality of care and clinical outcomes. Benefits for the provider include administrative efficiency.
- 348 812 virtual consultations were conducted during 2025, facilitating ease of access for members and convenience for providers, and enabling consultations under circumstances where patients are unable to attend a physical consultation.

Member satisfaction

- Member perception score of 9.47 out of 10.[7]

Society

- Private healthcare funding benefits society by giving individuals access to quality healthcare and protecting them, organisations and the economy from the adverse effects of ill health. It also reduces the burden on the public healthcare system. The Scheme seeks to amplify these benefits by working towards an improved healthcare system, as well as advocating for policy and regulatory changes to sustain and expand access to medical schemes.

1. *See https://thedigitalbanker.com/awards/global-insurance-innovation-awards/#2025 and https://internationalcxaward.com/hall-of-fame.*
2. *All figures are for the period October 2024 to September 2025, with the exception of the number of Scheme members with a chronic condition and number of DHMS members undergoing oncology treatment, where the figures are at September 2025.*
3. *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes. Contribution rates on individual plans of other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*
4. *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2024, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.10 (2023: R2.08) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year. A pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied since 2014, and the Trustees assess the results annually. The Scheme engaged NMG Consultants and Actuaries (Pty) Ltd (NMG) to perform an actuarial review on the reasonability of the data, methodology and results. NMG concluded that the methodology is appropriate, that the change in value added from 2023 to 2024 is reasonable, and that they did not encounter any significant anomalies in the data and calculations reviewed.*
5. *For members of all schemes that Discovery Health provides administration services to.*
6. *HealthID, the only comprehensive funder electronic health record in South Africa, allows members to consent to the sharing of health records with their doctors, improving quality of care and reducing administration for doctors.*
7. *Average member perception score for the year, based on responses to surveys sent to members by Discovery Health.*

Creating stakeholder value

Our approach to stakeholder engagement is grounded in our commitment to act as an engaged and responsible corporate citizen, invested in caring for our members, the sustainability of our industry and the wellbeing of our broader society. This commitment is embedded in governance and policy frameworks that hold us to rigorous standards of ethical conduct.

Responsible corporate citizenship

Discovery Health Medical Scheme (DHMS or the Scheme) engages actively, continuously and extensively with our stakeholders, responding to their needs in keeping with our strategic, long-term approach to responsible corporate citizenship. Our responsible corporate citizenship framework guides the alignment of all our relationships with our core intention of protecting our members while contributing to positive reform and developments in society.

In line with the requirements of the King IV Report on Corporate Governance for South Africa 2016 (King IV), the Stakeholder Relations and Ethics Committee is mandated to oversee all aspects of the Scheme's responsibility as a corporate citizen. As such, the responsible corporate citizenship framework employed by the Committee provides the principles, parameters, operating requirements, and environmental factors pertinent to the Scheme's responsible corporate citizenship approach. The framework serves as a guide for the Trustees, Board Committees and Scheme Executives, as well as relevant legislation and governance requirements, ethics, stakeholder engagement, the Scheme's impact on society and vice versa, sustainability, and associated measuring and reporting requirements. While the Scheme's non-profit status and governing regulations constrain our ability to invest in specific social responsibility activities, we work with relevant stakeholders to improve the effectiveness of the healthcare system in South Africa. The Committee receives regular reports, recommendations and presentations on areas covered by the framework, enabling it to monitor progress and provide input on related activities.

Discovery Health Medical Scheme (DHMS or the Scheme) engages actively, continuously and extensively with our stakeholders, responding to their needs in keeping with our strategic, long-term approach to responsible corporate citizenship.

Sustainability Position Statement ***pg 33***

The Scheme's support of the shared value model of Discovery Health – which engages stakeholders in working together towards better healthcare access, quality and affordability, and beneficial regulatory reform – extends the Scheme's influence to drive positive change in our industry. This includes the Scheme's contribution to broader environmental, social and governance (ESG) imperatives. Our Sustainability Position Statement discusses our view of sustainability, its governance, our priorities, and how our direct impacts map to the UN Sustainability Development Goals (SDGs).

Index
Glossary

Our ethics, values and culture

We operate in accordance with the highest ethical standards with relevant policies that are binding on the Trustees, Independent Committee Members and employees of the Scheme and, where appropriate, we extend this to third parties through ethics clauses in our contracting.

Policies set the standard of behaviour expected of our Trustees, Independent Committee Members and employees in areas such as legal compliance, protecting personal information, human rights, employee rights and sound business practices.

The effectiveness of the Scheme's Board and Board Committees is assessed regularly, as are the management and oversight of ethics, with reference to the King Code as governance best practice. Ongoing focus on ethics in the Scheme Office is supported by an experienced executive who is a certified Ethics Officer[1], and whose portfolio includes legal and ethics matters.

As related policies are developed or updated, training is conducted for the Scheme Office team and where appropriate, for the Trustees and Independent Committee Members. In 2025/6, training was conducted on ethics, conflicts of interest, safe and ethical use of artificial intelligence, and gifts.

The Scheme and all its stakeholders have access to an independently operated facility for reporting fraud or unethical behaviour. Employees also have access to internal ethics and fraud reporting facilities. Anonymous reporting is supported on both platforms.

Reporting unethical behaviour ***pg 206***

1. *As per the Ethics Officer Certification Programme run by The Ethics Institute.*

Moral duties and ethical values

The Scheme's standards of behaviour take guidance from King IV, which requires that the governing body should lead ethically and effectively, achieving four governance outcomes: an ethical culture, good performance, effective control and legitimacy. To achieve these outcomes, King IV recommends that Trustees cultivate and exhibit integrity, competence, responsibility, accountability, fairness, and transparency.

The scheme also aligns with the expectations of the Council for Medical Schemes (CMS):

OUR VALUES GUIDE OUR BEHAVIOURS AND INTERACTIONS

INTEGRITY
We will do the right thing. We will take personal accountability for our actions and, in our actions and decisions, hold true to our promise that we care.

MUTUAL RESPECT
We will be courteous and treat others as we would want to be treated ourselves. We will listen to what people say, and ask for and value other people's inputs.

ADAPTABILITY AND AGILITY
We will be sensitive to the external environment and to the needs of others, while remaining responsive to changing needs and adapting to the pace of change.

TEAMWORK, SUPPORT AND CARE
We will support and care for ourselves and others. When working together, we will share the load and work interdependently.

PURSUIT OF EXCELLENCE
We will focus on continuous improvement, development and quality, with learning core to how we work.

RESILIENCE
We will remain resilient and persevere, with the ability to bounce back when required.

SOCIAL RESPONSIBILITY
We will act responsibly and in the best interest of our members and society.

Our Sustainability Position Statement

Who we are

Discovery Health Medical Scheme (DHMS or the Scheme) is a non-profit open[1] medical scheme operating under the Medical Schemes Act (the Act). The Scheme exists to fund the healthcare of its members in accordance with social solidarity principles.

These are:

cross-subsidisation (members contribute to a shared pool of funds and access funds from the pool when needed for their healthcare).

community rating (everyone contributes the same amount according to their chosen plan, without limitations for age or state of health[2]).

DHMS operates in the private healthcare sector[3] in South Africa, serving members who pay their contributions primarily from post-tax discretionary income.

DHMS has appointed Discovery Health to provide it with administration and managed care services. In practice, this means that a large proportion of the Scheme's operations are outsourced to Discovery Health, which conducts activities on behalf of DHMS. The relationship between the two organisations is governed by a Vested® outsourcing arrangement which is based on prioritising outcomes through each organisation focusing on what it does best. Amongst its other priorities, the DHMS Scheme Office is focused on governance excellence and oversight of these outsourced operations.

How we govern sustainability

The DHMS Board of Trustees has adopted a responsible corporate citizenship framework, which provides the parameters, operating requirements, principles and environmental factors within which the Scheme engages in responsible corporate citizenship. The framework serves to guide the Scheme's decision-making regarding governing principles relating to strategy, policy and tactical plans for responsible corporate citizenship.

This statement of our position on sustainability is part of the framework and will also be published or referred to in relevant documents such as this Report.

Other documents which operationalise our sustainability position include our Procurement Policy and Socially Responsible Investing Policy. Other related policies and guidelines will be created and updated over time to reflect our position.

How we define sustainability

In accordance with our stakeholder-oriented worldview and our approach to responsible corporate citizenship, we believe that value for the Scheme, its members and the world around us is created through a system of resources and relationships. As such, we must manage and monitor our impact to ensure the balanced continuation of this system – this is both fundamental to our continued ability to operate and central to our core values as a Scheme.

We think of sustainability in two ways: the Scheme's sustainability, ensuring its ongoing ability to ensure access to affordable, quality healthcare for its members; and the Scheme's impact on the world around it, both positive and negative.

Sustainability assessment and reporting is currently in flux, with several frameworks, guidelines and sometimes conflicting definitions in use[4]. The Scheme is not required by its governing legislation to report in this regard[5], but our view as a responsible corporate citizen is that it is best practice for us to assess our impact, develop targets where appropriate, and work to achieve them.

The Scheme views its own impacts as direct, and those impacts created by the activities of Discovery Health and other stakeholders such as asset managers, healthcare providers and financial advisers on behalf of the Scheme, as indirect impacts of the Scheme.

Our sustainability priorities

As a medical scheme, our funds are safeguarded for the benefit of our members and how we spend and invest funds is strictly regulated[6]. Our highest priority is that our members are able to access the healthcare they need, and therefore, the sustainability of the Scheme (financial, operational and relational) is essential. In support of this and in service to our members' interests, we remain committed to improving the health outcomes and the quality, value and type of care that our members can access, positively influencing the effectiveness of the South African healthcare landscape as a whole, and ensuring the Scheme is governed in accordance with best practice.

We consider business decisions related to sustainability in light of the nature and resulting priorities of the Scheme, and our actual or potential impact. This gives rise to the need to make trade-offs which we consider and manage carefully. For example, while the Scheme's direct environmental impact is minimal, its impact on healthcare systems (and related socio-economic impact) is extensive. Our focus on working with stakeholders to encourage the adoption of quality of care initiatives and measures may therefore be prioritised over environmental matters.

1 *Anyone can join the Scheme, as opposed to closed schemes which have restricted membership based on, for example, employment.*
2 *Very limited waiting periods may be imposed in certain conditions, in accordance with the Act. This is to protect members who have already been contributing to the pool.*
3 *Versus the public sector, which is tax funded and is accessible by any South African who pays for care according to a means test.*
4 *For example the United Nation's Sustainable Development Goals; the Johannesburg Stock Exchange Sustainability Disclosure Guidance; Global Reporting Initiative Standards; International Financial Reporting Standards (IFRS) Sustainability Disclosure Standards; the various industry standards of the Sustainability Accounting Standards Board; the Integrated Reporting Framework; and various concern-focused frameworks such as the Task Force on Climate-related Financial Disclosures (TCFD).*
5 *IFRS is the accounting standard that is required by the Act to be utilised by the Scheme. Should specific sustainability disclosures be required by IFRS, they will be incorporated.*
6 *For example, the Scheme cannot make charitable donations, or engage in corporate social investment and/or socio-economic development spending.*

Our sustainability journey

Although our own sustainability, our members' interests and responsible corporate citizenship have long been at the heart of the Scheme's values, our formal sustainability assessment and reporting journey is in early stages. Our intention is to map our existing impacts, positive and negative; develop an assessment utilising an appropriate framework, such as the Sustainable Development Goals; incorporate sustainability impacts more explicitly into our strategy; align related policies and other documents; and develop appropriate targets and report on them.

We will report on our progress as we refine our approach to sustainability and develop plans to increase our net positive impact. We will also continue to monitor the consolidation and alignment of various global sustainability frameworks, standards and guidelines, to stay abreast of those that may be relevant to the Scheme.

How this statement was developed

In collaboration with independent consultants, the Scheme Executives engaged in a sustainability workshop with the primary aim of giving careful consideration to DHMS' position on sustainability and how to clearly communicate this to our stakeholders – with reference to both our current position and our intent for the future. The workshop also marked the first early and formal phase of sustainability strategy development – a process that is ongoing – the ultimate aim of which will be integration into the Scheme's overall strategy.

Mapping DHMS to the SDGs

In 2024, the Scheme Office extensively mapped DHMS's current direct impacts against the UN Sustainability Development Goals (SDGs), the results of which are presented on the pages that follow.

SUSTAINABILITY IMPACT IN THE MEDICAL SCHEMES INDUSTRY

Medical schemes are non-profit, social solidarity-based organisations funded through voluntary contributions. They contribute towards the SDGs by providing a social protection system with equitable inclusion and access to treatment.

Additionally, they provide cross-subsidisation to the public sector through medicine pricing and reducing the burden on the public sector as members privately fund their own healthcare. Income and health cross-subsidies also operate within medical schemes through ranges of plans – offering varied pricing and corresponding benefits – which members can switch between as their needs change.

All medical schemes are required to provide cover for the legislated Prescribed Minimum Benefits. These cover a wide range of conditions and include many that are targeted by the SDGs, for example emergency and trauma care related to road accidents, maternity benefits and waterborne diseases.

Medical schemes promote inclusive and sustainable economic growth through careful utilisation of member funds and through trade-offs they have to make about cover provision in light of limited resources.

A well-regulated and well-run private healthcare sector generates significant economic value for the country by providing jobs, enabling healthcare providers and facilities to operate, and keeping people healthy and economically active.

The items specified alongside are deliberate initiatives and strategies undertaken by DHMS above and beyond these factors. They are non-exhaustive but are illustrative of how DHMS' actions are aligned with and supportive of the SDGs.

Sustainable Development Goals towards which DHMS activities contribute:

SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture.

SDG 3: Ensure healthy lives and promote well-being for all at all ages.

SDG 5: Achieve gender equality and empower all women and girls.

SDG 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.

SDG 9: Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation.

SDG 10: Reduce inequality within and among countries.

SDG 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.

SDG 17: Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development.

Mapping DHMS to the SDGs *continued*

Affordable, equitable, inclusive access to quality healthcare

DHMS ACTIONS	RELATED TARGETS
Working to combat healthcare inflation and so keep contributions as low as possible.	**3.8** Achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.
Promoting sustainable routes to universal health coverage in South Africa through a private-public multi-funder model and risk equalisation.	**8.10** Strengthen the capacity of domestic financial institutions to encourage and expand access to banking, insurance, and financial services for all.
Advocating for medical schemes to be able to offer low-cost benefit options; negotiating for lower-cost cover through regional and targeted networks.	**9.5** Enhance scientific research, upgrade the technological capabilities of industrial sectors in all countries, in particular developing countries, including, by 2030, encouraging innovation and substantially increasing the number of research and development workers per 1 million people and public and private research and development spending.
Calling for regulatory changes to contain healthcare costs.	**10.2** By 2030, empower and promote the social, economic, and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion, or economic or other status.
Combatting fraud, waste and abuse in healthcare.	**10.3** Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies, and practices and promoting appropriate legislation, policies, and action in this regard.
Negotiating for value-based healthcare, incorporating quality measures.	**10.4** Adopt policies, especially fiscal, wage, and social protection policies, and progressively achieve greater equality.
Fostering collaboration between the public and private sectors to mobilise and share knowledge, expertise, technology, and resources.	**17.16** Enhance the Global Partnership for Sustainable Development, complemented by multi-stakeholder partnerships that mobilize and share knowledge, expertise, technology, and financial resources to support the achievement of the Sustainable Development Goals in all countries, particularly developing countries.
Driving the update of telemedicine and virtual healthcare to increase access and lower costs.	
Championing the use of standardised, evidence-based health technology.	

Ethical governance, accountability, human rights and justice

DHMS ACTIONS	RELATED TARGETS
Operating robust and independent conflict resolution mechanisms for stakeholders.	**5.5** Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic, and public life.
Establishing, embedding and monitoring strict anti-corruption policies and practices.	**8.5** By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value.
Promoting and adhering to ethical business practices, conducting all engagements and transactions with integrity and transparency, and with ethical undertakings required in our contracting.	**8.7** Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking, and secure the prohibition and elimination of the worst forms of child labour, including recruitment and use of child soldiers, and by 2025 end child labour in all its forms.
Operating with transparency and accountability through governance and management structures, and reporting.	**10.3** Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies, and practices and promoting appropriate legislation, policies, and action in this regard.
Upholding human rights in healthcare, research and access to information, data privacy and security.	**16.5** Substantially reduce corruption and bribery in all their forms.
Utilising fair, inclusive, non-discriminatory employment policies and practices and promoting gender equality.	**16.6** Develop effective, accountable, and transparent institutions at all levels.
	16.10 Ensure public access to information and protect fundamental freedoms, in accordance with national legislation and international agreements.
	16.16b Promote and enforce non-discriminatory laws and policies for sustainable development.

Mapping DHMS to the SDGs *continued*

Supporting healthcare infrastructure, supply chain and innovation

DHMS ACTIONS

Actively support innovation, e.g. through digital health and mobile applications, and the use of partners in our supply chain to promote economic development and healthcare quality and accessibility.

Enabling beneficial and SDG goals-related research by sharing relevant data with specified recipients under strict governance and privacy controls.

RELATED TARGETS

9.5 Enhance scientific research, upgrade the technological capabilities of industrial sectors in all countries, in particular developing countries, including, by 2030, encouraging innovation and substantially increasing the number of research and development workers per 1 million people and public and private research and development spending.

9.b Support domestic technology development, research, and innovation in developing countries, including by ensuring a conducive policy environment for, inter alia, industrial diversification and value addition to commodities.

Comprehensive coverage for key health conditions

DHMS ACTIONS

Targeting coverage for infectious, chronic and non-communicable diseases through comprehensive chronic care programmes, screenings, preventative care and targeted benefits.

Driving the embedding of habit and behaviour changes to improve base health levels.

Monitoring medicine and treatment adherence and quality of care, and promoting a value-based care.

Promoting a multi-disciplinary approach to value-based care to optimise health outcomes.

Expanding mental health benefits and support through care programmes and coaching, including the treatment of substance abuse.

Supporting women and mothers with prenatal, maternal and postnatal cover, including fertility treatment funding; and health and wellness programmes, including nutrition guidance.

RELATED TARGETS

2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons.

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases.

3.4 Reduce premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being.

3.7 By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information, and education, and the integration of reproductive health into national strategies and programs.

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

5.1 End all forms of discrimination against all women and girls everywhere.

5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

Economic growth, employment and decent work

DHMS ACTIONS

Providing employees with access to workplace support and wellness programmes, including mental health.

Supporting mothers and fathers through parental leave benefits.

Promoting women in leadership.

Utilising policies that create safe, inclusive, and supportive work environments for women.

Utilising our investments for positive economic and social impact by:

- Contributing to the transformation of the asset management industry, creating opportunities for previously disadvantaged individuals and furthering gender equality.
- Appointing managers that invest in sustainable development.

RELATED TARGETS

5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure, and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

5.5 Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic, and public life.

8.8 Protect labour rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment.

Treating Customers Fairly

Treating Customers Fairly (TCF) is a concept prescribed by the Financial Sector Conduct Authority for financial institutions regulated by it. It is based on six fairness outcomes, founded on sound business principles and best governance practice. The Scheme embraces these outcomes, recognising their relevance to the quality of service we provide to our members.

Even though the Scheme is not legally required to follow the principles of TCF, we have adopted the principles as they are the right thing to do in terms of how we treat our members and other stakeholders. As a registered Financial Service Provider in terms of the Financial Advisory and Intermediary Services Act 37 of 2002, our administration provider, Discovery Health, has implemented a framework to support the following TCF desired outcomes:

Culture and governance
Customers are confident that they are dealing with financial institutions in which the fair treatment of customers is central to their culture.

Product design
Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly.

Clear communication
Customers are given clear and relevant information, and are kept appropriately informed before, during and after they sign on the dotted line.

Suitable advice
Customers are given advice that takes account of and is suitable to their circumstances.

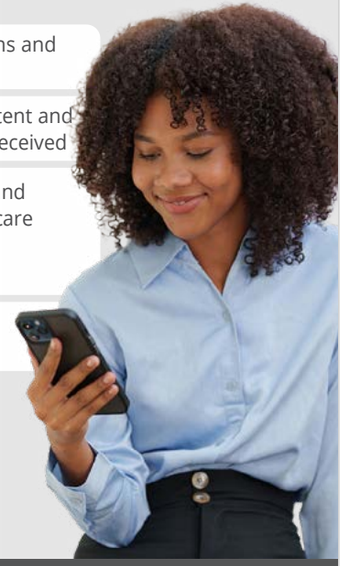
Performance and standards
Customers are provided with products that perform as financial institutions have led them to believe, and the services associated with those products are of an acceptable standard and in agreement with what they have been led to expect.

Claims, complaints and changes
Customers do not find themselves faced with unreasonable post-contract barriers to change the product, switch provider, submit a claim or register a complaint.

To assess its TCF performance, Discovery Health monitors TCF objectives measured by key fairness indicators. These indicators include:

- Plan movements
- Communication and completion of interactions with members
- Embedding of TCF culture
- Opportunities for process improvement
- Fair treatment of customers relating to privacy of information
- Correction of errors made
- Consistency of decisions and delivery
- The total number, content and causes of complaints received
- The establishment of and participation in healthcare programmes to assist vulnerable members
- TCF-related training completion rates

Perception scores of members, financial advisers, healthcare providers and employer groups are measured and monitored. In addition, the ratings that stakeholders give the different channels used to interact with Discovery Health are obtained and reported on.



The Stakeholder Relations and Ethics Committee reviews and considers regular reports on Discovery Health's performance of key fairness indicators related to the objectives of TCF. Members are able to lodge disputes with the Scheme if they feel they have been treated unfairly, and the independent Dispute Committee which hears these cases can seek an advisory opinion from a specially convened TCF Committee when it believes that matters regarding the fair treatment of members may influence its deliberations in pending dispute hearings.

More about TCF
Compliments, complaints and disputes

Engaging with our Stakeholders

The Scheme strives to balance the needs and expectations of all our stakeholders in the South African healthcare system so that we achieve the best possible outcomes for our members.

The Stakeholder Relations and Ethics Committee oversees all stakeholder engagement activities and reports to the Trustees on these matters. The Committee uses a defined framework and methodology to identify stakeholder groups, assess their needs and interests, and evaluate the impact of these on the Scheme, and vice versa. According to the degree of impact and alignment, stakeholders are then prioritised for more detailed assessments regarding key concerns, degree of mutual trust, related risks and engagement plans. Trust ratings are also considered, in line with key principles of the Vested® outsourcing model that is formally applied in our contractual arrangement with Discovery Health, and which informs our interactions with our other stakeholders.

The results of these assessments are reported to the Committee, informing its priorities and the formulation and management of engagement plans. In addition, ad hoc matters are reported to the Committee as they arise for assessment and to recommend alternative strategies if required. The Committee monitors the effectiveness of these plans as well as the resolution of specific incidents and stakeholder concerns.

More about Vested

Stakeholders can contact the Scheme Office and the Principal Officer directly and, as the Scheme's administration and managed care provider, Discovery Health conducts certain stakeholder engagement work on our behalf as per the contractual agreements governing our relationship. Discovery Health reports to the Scheme on these interactions and escalates items to the Scheme Office for direct involvement where necessary. This assessment process ensures that the Committee and the Scheme Office fulfil their oversight and governance accountabilities in this regard, and Scheme Office representatives attend Discovery Health forums where matters affecting stakeholders are addressed. The Committee receives regular reports from Discovery Health on stakeholder engagement and perceptions, supplemented by presentations and discussions on matters of concern to the Scheme.

Discovery Health has extensive stakeholder engagement capacity and experience; specialised teams either respond to requests and queries received or engage proactively according to the Scheme's initiatives, strategic requirements and industry activity. Material items are presented to executive-level forums on a weekly basis or escalated to the appropriate executives, including the Chief Executive Officer of Discovery Health. These are also addressed by the Scheme Office and the Principal Officer as needed.

How to contact us ***pg 205***

Some activities conducted on behalf of the Scheme include:

- Responding to member queries and requests via call centres, chat platforms, the Discovery Health app and website.
- Interacting with member groups regarding healthcare concerns or opportunities.
- Engaging with employer groups regarding their needs and concerns.
- Engaging at healthcare provider events to discuss Scheme initiatives and support healthcare providers in addressing their challenges and concerns, and attending thought leadership events on topics that are relevant to the sustainability of the industry.
- Developing and implementing innovative managed care programmes with healthcare providers and their societies to increase quality of care, and decrease fragmentation and control costs for our members and the Scheme.
- Supporting the Scheme's regulatory and policy engagement through gathering information and working with stakeholders.
- Providing training, support and analysis to financial advisers on the Scheme's products and the state of the industry.

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OUR MEMBERS

Our purpose is to serve our members, who have placed their trust in us to manage their healthcare funding and facilitate access to beneficial programmes and treatments. With this responsibility at the forefront, the Scheme is focused on maintaining contribution affordability amid a challenging economic landscape marked by high healthcare inflation and uncertainty. Striking the right balance between affordability and long-term sustainability is essential to preserving members' access to the highest possible quality of care. Strong and enduring relationships with our stakeholders play a vital role in enabling us to achieve these goals.

In 2026, DHMS has been able to defer contribution increases to 01 April 2026 through its strong solvency position, saving members collectively R1.5 billion. The Scheme has extended this initiative during 2026 through a PHF Boost, allowing members who activate PHP, enable exercise and sleep tracking, and complete their health check during 2026 to earn a further R1 000 per member.

A key strategic priority for the Scheme is value-based healthcare, which places members at the centre of care and prioritises health outcomes over the volume of services delivered. By reimbursing healthcare providers based on outcomes rather than inputs, we enable our members to access facilities, care programmes, and professionals dedicated to continuous quality improvement. This approach also fosters collaboration among healthcare providers, ensuring holistic, high-quality patient care for our members.

DHMS collaborates with patient advocacy groups to foster a mutual understanding of needs and constraints, working together to improve healthcare access and clinical outcomes while upholding the Scheme's commitment to equitable treatment for all members. These engagements provide opportunities for meaningful collaborations that may influence Scheme benefits.

Discovery Health's infrastructure and member support systems provide a range of engagement options for our members, including comprehensive information on the website. Members can make contact via the call centre, a chat platform, or the member app. Members can contact the Principal Officer and Scheme Office directly if required, and in addition, we empower members with timely, relevant information based on their needs. On admission, members have access to benefit specialists in many hospitals throughout the country who facilitate their healthcare journeys and support and advise them on their plan entitlements.

These support mechanisms provide members with easy access to information about their benefits, claims and other plan information. The Scheme ensures that our members are consistently informed of changes in benefits and contributions, and have access to formularies and the Scheme Rules governing their health plans. This enables our members to make informed decisions about the benefit options best suited to their healthcare and affordability needs, even as they change.

Various customer satisfaction and operational metrics are monitored to assess whether our members' service expectations are being met. Dissatisfied members can access a complaints and disputes process and, in the case of escalation, these members can elect to have a hearing before an independent Dispute Committee in terms of Scheme Rule 27. Alternatively, or if dissatisfied with the outcome of the dispute process, members may choose to take a complaint to the CMS in terms of Section 47 of the Act.

More about how to submit a complaint, compliment or dispute

MEASURING MEMBER SATISFACTION

The Scheme maintained a high average member perception score in 2025 of 9.47 out of 10 (2024: 9.09). We track members' perceptions of service received at multiple points and locations, including after-claims processes and the call centre. Follow-up surveys are also frequently conducted with members after their interactions with us.

FOR OUR MEMBERS

There is no one quite like you.
Take control of your unique healthcare journey by

- Engaging in Personal Health Pathways

to

- Accumulate funds in your Personal Health Fund

and

- Get a Personal Health Fund Boost

Make sure that you

- Get the best care, by having one doctor who co-ordinates your care

Digital care for ease of access

- Virtual Urgent Care
- Internet-based cognitive behavioural therapy for mental health
- Find what you need on the Discovery Health app

Caring for members with specific conditions

- Cardio Care
- Kidney Care
- Diabetes Care
- Mental Health Programme

Going to hospital?

- All the information you need

Get quality home-based care services in the comfort of your home

- Hospital at Home

The Advanced Illness Member Support Programme, for members who are dealing with life-changing or advanced illness

- Advanced Illness Member Support Programme

Post-discharge care for babies who have been in a neonatal intensive care unit

- Nurture at home

Information and help

- Plan and benefit information
- About DHMS and Scheme Rules
- Choose the best plan for you and your family
- Benefits and cover; understanding your plan
- Medical scheme terminology
- Need something? Here's how you can reach us
- Insights about the health of DHMS members
- Looking for something else?

EMPLOYER GROUPS

With over 6 300 employer groups on South Africa's largest open scheme, DHMS partners with employers across a wide range of industries and workforce profiles to support the health, wellbeing and productivity of employees and their families.

For many employers, medical scheme membership is a core component of their employee benefit package, which employers can fund through a specified subsidy or a structured salary package. During 2025, employers continued to place increasing emphasis on more precise and personal employee wellbeing, preventative care, mental health support and the long-term sustainability of benefit design.

PROVIDING EMPLOYER GROUPS WITH AN INTEGRATED, PERSONALISED HEALTH AND WELLNESS SOLUTION

During 2025, Discovery Health delivered an integrated, personalised health and wellness solution for DHMS employer groups, designed to support improved health outcomes and sustainable benefit design. Central to this was the introduction of Personal Health Pathways (PHP) and the Personal Health Fund (PHF). Building on the success of the WELLTH Fund, PHP embeds personalisation across the member health journey, enabling tailored health recommendations and guiding members towards the most appropriate next steps for their individual health needs. Key components of the integrated employer solution include:

- Market leading benefits such as access to the DHMS PHF, enabling members to accumulate additional funding for healthcare expenses by engaging in their Personal Health Pathways and managing their health proactively;
- Physical and digital wellness screenings, funded through DHMS benefits, enabling wellness specialists to identify members at risk and refer them for appropriate care;
- Continued enhancement of the Employer Zone, a unique platform which provides employers with both employee intelligence and the ability to seamlessly manage administration of benefits;
- Ongoing thought leadership and guidance about pertinent issues faced by employers, including regulatory and healthcare policy updates, the digitisation of healthcare, mental illness trends and the importance of improving screening and prevention behaviour;
- Comprehensive employee education and onboarding support, promoting understanding of benefits including PHP and PHF; and
- National training on product and benefit enhancements for 2026 for key decision makers, supported by comprehensive employee training sessions.

Independent industry-wide surveys regularly assess employer and employee satisfaction with the administration of their medical scheme. Discovery Health, the administration and managed care provider to the Scheme, consistently emerges as the leading provider. In PMR.africa's 2025 survey[1], Discovery Health achieved a mean score of 8.54 out of 10, maintaining its position as the top-ranked administrator among employer groups. These results reinforce DHMS' confidence in Discovery Health's ability to deliver high-quality, reliable and innovative services to employer group members on the Scheme's behalf.

1. *Source: PMR Africa National Survey on Accredited Medical Scheme Administrators (pmrafrica.com).*

HEALTHCARE PROFESSIONALS AND PROFESSIONAL SOCIETIES

DEMONSTRATING VALUE TO OUR CLINICAL PARTNERS

South African healthcare professionals continue to operate in a complex environment shaped by uncertainty in national health policy development and evolving regulatory requirements, increasing patient volumes as the burden of chronic, cancer and mental health conditions increases, and ongoing resource constraints. The healthcare landscape in 2026 is further influenced by the need for integrated digital health solutions, and the imperative to align clinical care with value-based outcomes. Additionally, healthcare funders face heightened pressure to optimise cost efficiency while supporting improved patient engagement and adherence to evidence-based interventions.

Our 2025 initiatives were designed to address practical challenges faced by healthcare professionals in support of the care they provide to Scheme members: reducing administrative burden, supporting clinical excellence and improving patient outcomes. The following are some examples of how the Scheme and Discovery Health have partnered with healthcare professionals to support measurable improvements in care.

Engagement

In 2025, engagement with healthcare professionals continued at scale across a range of touchpoints throughout the year. These engagements made use of conferences and relationship-based forums to support meaningful professional exchange, strengthen trust reciprocity and connectedness, and create opportunities for collaboration on issues affecting both clinical practice and the sustainability of the healthcare system. Through structured discussion and thought-leadership platforms, clinicians were able to engage with peers and experts on emerging trends and practical challenges in the healthcare environment.

Across flagship conferencing activity, delivery was scaled through 27 speakers and 57 speaker sessions, allowing broader participation and more consistent dissemination of information while making efficient use of shared platforms. Topics presented at medical conferences in 2025 included healthcare system trends, the role of digital self-care and AI-enabled decision support, advances in precision medicine, the application of data science in managing and funding medical care sustainably, and the importance of data security and compliance with privacy legislation, alongside initiative-specific content relevant to clinical practice.

Educational events and webinar-style engagements further supported knowledge sharing and practical application. For example, a thought-leadership webinar on AI in healthcare attracted more than 4 000 delegates and is now expanding into a series. These forums also provided space for discussion about the shared challenges facing clinicians and funders, including the need to manage finite healthcare resources responsibly through optimisation and standardisation, and reduce fragmentation while supporting high-quality patient care.

Overall, the engagement programme strengthened healthcare professional partnerships and created opportunities for clinicians to remain connected to emerging developments in healthcare practice, policy and technology, while contributing their perspectives to ongoing dialogue about the future of the healthcare system.

Improving patient adherence to health promotion, prevention and science-based disease management interventions

Personal Health Pathways (PHP) and Personal Health Fund (PHF)

In 2025, Discovery Health and the Scheme respectively launched Personal Health Pathways and the Personal Health Fund. PHP enables doctors to prescribe personalised care pathways and endorse lifestyle interventions alongside clinical treatment through HealthID, creating a more integrated approach to care. Members benefit from tailored “next best actions” that enhance engagement and improve adherence to their treatment plans. The incentive design further reinforces preventive care, strengthens co-ordination, and supports better adherence to the clinical treatment plans. Additionally, the practical digital interface for PHP interaction reduces administrative burden for providers while supporting high-quality documentation. The Scheme’s PHF benefit is earned through completion of next best actions, enhanced by members’ day-to-day funds, thereby supporting access to care.

In 2025, PHP and the PHF demonstrated measurable clinical and engagement gains, supported by increased doctor adoption of the HealthID platform. Medication adherence among PHP participants improved by 14% versus 2024 baselines, alongside a 9% reduction in avoidable hospital admissions, reflecting the impact of integrated clinical and lifestyle care. Member engagement strengthened, with over 68% completing at least one next best action within 60 days, compared to 42% in non-participating cohorts. Platform usage data shows 7 679 total PHP health professional users, with 1 308 lifestyle, 1 804 screening, and 1 525 clinical member pathways created. Clinicians actively prescribed and endorsed care, resulting in 104 000 PHP prescriptions and 62 501 actions endorsed, while members responded positively, activating 17 149 prescriptions and completing 12 185 endorsements, reinforcing PHP’s role in driving actionable, personalised care at scale.

New PHP enhancements in 2026, such as sleep tracking and PHP Health challenges along with additional efforts to communicate the value of members and health professional practices, will continue to unlock value for all stakeholders.

Personal Health Pathways for healthcare professionals

Personal Health Fund information

HealthID

Endoscopy utilisation management (Scope Quality Network)

Professional society engagement addressed colonoscopy utilisation concerns, resulting in a 17% decrease in procedures misaligned with best practice guidelines among participating practices in 2025. Transparent benchmarking helped practices with sub-optimal care utilisation align with clinical norms, with 86% of the group demonstrating measurable improvement in adherence to peer level utilisation rates within six months. A co-payment option exists but has not been implemented due to strong co-operation as 94% of practices met collaborative targets without triggering the safeguard. This approach protects member access while supporting cost sustainability. Peer-led, data-driven dialogue reinforced trust and shared accountability in aligning care with clinical best practice.

Spinal Conservative Care Programme (SCCP) outcomes

In 2025, we focused on conservative spinal care pathways ahead of surgical options. Among enrolled patients, 68% experienced clinically significant improvements in pain scores (≥30% reduction on standardised scales) and 61% reported enhanced functional mobility within six months of programme initiation. Outcome tracking includes pain, function, and patient-reported experience across pathways, with 84% of participants rating their care as "good" or "excellent" in follow-up surveys. Longitudinal data has revealed a 27% reduction in progression to surgical intervention compared to historical controls. Insights were presented at the Spine20 International Congress in 2025, where programme results demonstrated significant improvements in patient disability indices. Clinicians also see direct benefit from actionable data and international benchmarking, supporting continuous quality improvement and alignment with global standards.

In 2026, the SCCP will prioritise system and process enhancements – including expanded digital integration and streamlined workflows – to increase patient access and further support high-risk populations.

Healthcare Professional Guide to the Care Programmes

Clinical practice variation insights

Clinical practice variation analysis leverages predictive analytics to identify clinical and cost efficiency outliers early in the care cycle. This programme enhances overall network efficiency and reduces disputes, while providing health professionals with proactive peer support for complex cases and variation management. Continuous monitoring is in place to ensure durable improvements and shared learning across the disciplines. Annualised practice quality reports offer practice-level profiles with comparative data such as admissions and bed-days, driving quality and efficiency. New profiling tools are being developed for obstetricians and surgeons to expand the existing suite. Physician engagements began in August 2025, with half of these engagements having been completed. We received positive feedback and collaborative participation for these engagements. Initial results show admission rates among physicians initially identified with higher utilisation patterns decreased by 1.3% compared to expectations, and average length of stay dropped by 5.2% versus projections. Although paediatric admission volumes remain low post-pandemic, paediatric length of stay is actively monitored to maintain performance and quality standards.

Streamlining and expanding access to high-quality care

Short-Stay Surgical Initiative

The Short-Stay Surgical Initiative leverages shared value funding for procedures with admissions that are less than two days. It simplifies benefit authorisations and streamlines the approval process. This approach provides predictable healthcare professional reimbursement through bundled payment methods, which helps reduce variability in billing and administrative procedures.

Early data indicates that the Initiative has resulted in quicker patient recoveries, as demonstrated by a median length of stay of just 1.2 days.

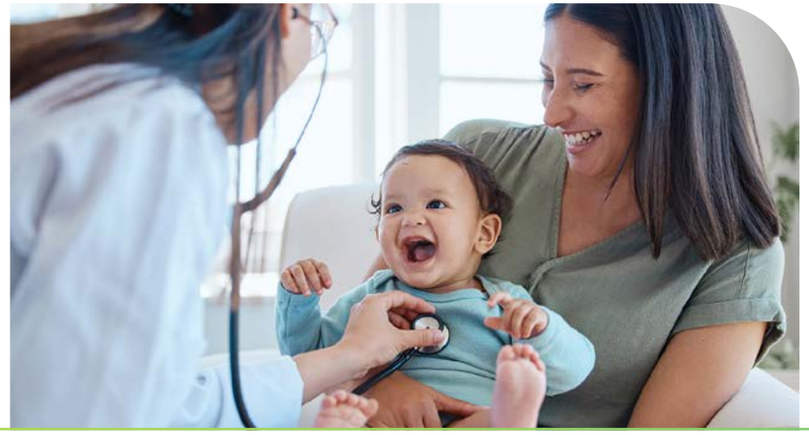
Patient experience scores are notably high, with a 92% satisfaction rate reported in post-discharge surveys, attributed to shorter hospital stays and clear communication throughout care. Additionally, physicians experience significant benefits, including a 30% reduction in pre-authorisation steps and a smoother peri-operative flow, evidenced by a 15% decrease in average turnaround time for scheduling procedures.

MATERNITY PILOT

Development of a high-quality team-based maternity care service

The maternity pilot was initiated to address fragmented maternity care pathways and structural barriers contributing to early deliveries and suboptimal maternal and neonatal care. This programme implements a global fee for obstetrician-led, multi-disciplinary teams, eliminating member co-payments for uncomplicated deliveries. By enrolling patients of up to 20 weeks gestation, the initiative promotes early engagement and continuity of care. Both healthcare professionals and members have reported positive outcomes, referencing operational effectiveness in claims processing and care co-ordination. The primary goal is to enhance maternal and neonatal health outcomes.

Building on these foundations, the maternity team-based care service is being developed to increase access to maternity care through high-quality facilities adhering to best practice guidelines. This service will emphasise accessibility and affordability, aiming to minimise unexpected out-of-pocket expenses for patients. Integrated digital tools and streamlined authorisation procedures reinforce continuity of care throughout the maternity period. Continued health professional engagement ensures consistent quality standards across participating sites, and the service is structured for scalable deployment to improve patient experiences while reducing administrative complexities.



Facial Cancer Network

The Facial Cancer Network brings together multi-disciplinary teams specialising in oncology, reconstructive surgery, and psychosocial care to provide comprehensive support for patients. By orchestrating the treatment pathway, the network effectively reduces delays and enhances both functional and health outcomes. Shared planning tools are utilised to facilitate collaborative decision-making for complex cases, ensuring that clinicians have access to rapid expert input and co-ordinated operating room scheduling. Additionally, the network emphasises ongoing outcomes tracking, which informs continuous improvements and the adoption of best practices. This integrated approach is designed to streamline care delivery, optimise patient experiences, and foster innovation in facial cancer treatment and will be expanding during 2026.

Update on dentistry for healthcare professionals

The latest update on dentistry for healthcare professionals highlights several advancements aimed at improving efficiency and support. The HealthID dentistry quote tool now enables streamlined benefit checks and faster quote generation, leading to a significant reduction in call volume and decreased reliance on the call centre. This efficiency is reflected in positive perception scores, indicating that healthcare professionals appreciate the dedicated support offered. Additionally, the Dentistry HealthID Webinar held in February 2025 received a strong rating of 4.3 out of 5, with participants providing positive feedback. To further enhance the user experience, the upcoming launch of the Customer Effort Score (CES) will inform ongoing improvements to the platform's usability. These initiatives collectively demonstrate a commitment to effective healthcare professional support and continuous iteration based on user feedback.

HealthID

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Supporting Clinical Excellence and Training

GP mental health training

The GP mental health training offering provides evidence-based education that strengthens general practitioners' abilities in both diagnosing and managing mental health conditions. Surveys conducted after the training indicate healthcare professionals experience high levels of confidence and find the content highly practical for their day-to-day work. By supporting integrated care, the programme helps to reduce referral bottlenecks, enabling smoother patient journeys, and supports the early identification and intervention of mental health conditions. The training aligns with continued professional development requirements and is designed to fit within the constraints of real-world practice, ensuring accessibility and relevance. Comprehensive toolkits and follow-up resources are provided to help clinicians embed the learning in everyday practice. Healthcare professionals are notified of the programme and its benefits, supporting wider access to practical mental health support in primary care.

Doctor 360° Programme

The Doctor 360° Programme provides comprehensive support for healthcare professionals, addressing wellbeing, financial literacy, and mental health. By offering personalised resources and incentives, the programme aims to reduce the risk of burnout and foster a more sustainable practice environment. Practical modules are included to help clinicians strengthen practice sustainability and increase staff engagement. Designed to provide holistic support, the integration of Active Rewards encourages and reinforces healthy lifestyle habits for doctors, resulting in enhanced wellbeing with the understanding that the healthier they are, the better equipped healthcare professionals are to deliver high-quality care across the healthcare system.

Active Rewards for Doctors

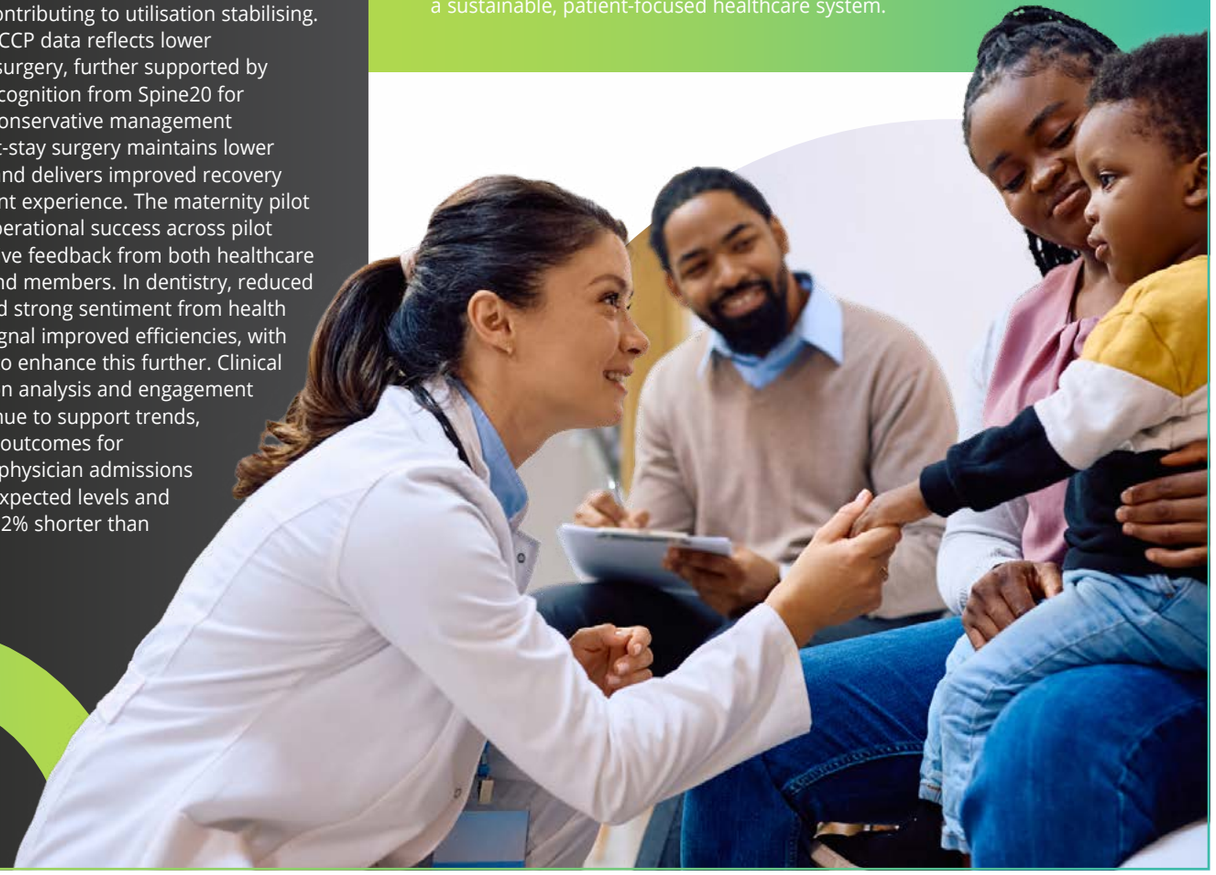
Tools and information at the Healthcare Professional Zone

2025 impact snapshot

The PHP programme continues to reinforce higher adherence to recommended health pathways and a resulting reduction in avoidable admissions, while endoscopy shows strong alignment with care pathways without requiring co-payments, contributing to utilisation stabilising. In spinal care, SCCP data reflects lower progression to surgery, further supported by international recognition from Spine20 for strengthening conservative management pathways. Short-stay surgery maintains lower per-case costs and delivers improved recovery times and patient experience. The maternity pilot has achieved operational success across pilot sites, with positive feedback from both healthcare professionals and members. In dentistry, reduced call volumes and strong sentiment from health professionals signal improved efficiencies, with CES rollout set to enhance this further. Clinical practice variation analysis and engagement initiatives continue to support trends, enhancing best outcomes for members, with physician admissions at 1.3% below expected levels and length of stay 5.2% shorter than projected.

Why This Matters

Every initiative in 2025 was designed with one goal: to make practice more efficient, care more effective, and patients healthier. We continue to invest in tools and partnerships that put healthcare professionals at the centre of a sustainable, patient-focused healthcare system.



FINANCIAL ADVISERS (BROKERS)

The private healthcare sector in South Africa is complex and nuanced and comprises numerous types of healthcare providers and funding structures, as well as a variety of facilities, that come together to meet individual patient needs. Financial advisers play a critical role within this environment by providing independent, professional guidance to individuals and employers, enabling informed decision-making when selecting appropriate healthcare cover.

Advisers connect individuals and employers with a wide range of medical schemes, enabling the comparison of benefits, pricing, service levels, and the strengths and weaknesses of different options. They assist in aligning financial and healthcare needs with the most appropriate medical scheme and plan. Beyond the onboarding of new members, financial advisers provide ongoing support through annual reviews, keeping members and employers informed about benefit and service updates, and assisting with claims resolution when needed.

Financial advisers are reimbursed for their services according to legislated fees and their contractual arrangements with the Scheme – members do not pay advisers directly, but all members are entitled to the services of a designated financial adviser. Financial advisers must be registered with, and are regulated by, the Financial Sector Conduct Authority and must comply with the Financial Advisory and Intermediary Services Act. They must also be accredited by the CMS to provide advice on private healthcare cover.

DHMS ensures that our health plan information and marketing material is easily understood and accessible for the benefit of both members and advisers. Discovery Health engages extensively with financial advisers on the Scheme's behalf, providing in-depth training, continued professional development opportunities and assessment sessions across both current product information and industry knowledge. This is further supplemented by annual product and benefit update launches, webinars and in-person engagements. We ensure that our health plan information and marketing material is easily understood and accessible for the benefit of both members and advisers.

ENGAGEMENTS IN 2025

In 2025, the Scheme conducted a series of dedicated adviser listening sessions. These sessions provided a platform for advisers to share valuable insights, perspectives and feedback on all aspects of the medical scheme offering, from product design through to servicing. These insights have been instrumental in shaping solutions that more closely align with the needs of our members and employer groups. This ongoing collaboration underscores our commitment to continuously improving the services and support we provide for our members.

In addition to regular engagements, two national in-person and virtual roadshows were held during the year for corporate brokerages. These sessions provided insights on the Scheme's strategies, industry position, financial results, and risk management initiatives.

Financial advisers have ongoing access to competitor and industry analysis, sales aids and marketing material to support and better understand the Scheme's differentiated offerings. In addition, the Discovery Health Insights hub is updated regularly to provide advisers, employers and members with access to the latest insights on health systems, the impact of healthy living and condition management.

SERVICE ENHANCEMENTS

Discovery Health continues to invest significantly in digital tools and platforms to support financial advisers and improve the ease of doing business. Key areas of focus include:

- Advanced data science and analytics, enabling more personalised and precise service for advisers and members.
- Ongoing enhancement of Adviser360, providing insights and tools to support advisers in guiding members along more personalised healthcare journeys.
- Expanded digital communication channels, including virtual agents and WhatsApp, delivering responsive and convenient service support.
- Continued evolution of the Discovery Health app, empowering members to manage their cover more independently and access information easily, reducing avoidable service demand and allowing advisers to focus on higher-value advisory engagement.

ANNUAL PRODUCT LAUNCH

The annual update of the Scheme's 2026 product and benefit enhancements was presented at the Discovery Day product launch, which was broadcast to more than 8 200 financial advisers. This flagship event provided a comprehensive overview of the Scheme's strategic priorities, benefit enhancements and affordability measures for the year ahead.

Following Discovery Day, the 2026 product update was rolled out nationally to a broader external audience of more than 5 300 participants. Over 40 training sessions were held with business consultants, employer representatives and financial advisers across the country, focusing on the introduction of new products and benefits including enhancements to Personal Health Pathways and the Personal Health Fund, and the introduction of the new Smart Saver series. Updates also included other benefit changes, the communication of member contributions for 2026, and the announcement of the contribution deferral to 01 April 2026, which collectively saves members R1.5 billion – around R1100 per average membership – thereby supporting member affordability.

All financial advisers had access to year-end marketing material, including training videos, brochures, articles, FAQs and thought leadership insights providing information on updates and benefit changes for 2026.

DISCOVERY HEALTH

Discovery Health (Pty) Ltd is a leader in healthcare administration and managed care with a proven track record of excellent service and innovation. Providing services to over 3.5 million medical scheme beneficiaries, Discovery Health provides administration and managed care services to DHMS, as well as 18 other restricted schemes.

The Scheme and Discovery Health have an arm's length contractual relationship that governs all activities outsourced by the Scheme to Discovery Health. Our working relationship is governed by the outcomes-based Vested model which is characterised by a shared vision and aligned objectives to ensure the partnership works in the best interests of our members.

Discovery Health is appointed by the Scheme's Board and reports extensively to the Trustees, the Board Committees and the Scheme Office on a regular basis. The Trustees are responsible for ensuring that Discovery Health meets agreed strategic and operational requirements.

In 2023, after an extensive assessment of the services provided by Discovery Health, the agreements in place between DHMS and Discovery Health were renewed for five years until the end of 2027. As part of the agreements renewal process, a Vested Compatibility and Trust (CaT) assessment was carried out to assess the quality of the relationship against Vested criteria, the results of which, and related qualitative feedback, were discussed at a workshop. The DHMS-Discovery Health relationship scored as "very healthy", and no material problems affecting the relationship were identified.

The Board established the Ad Hoc Committee, which was renamed the OPEX Budgeting Committee in September 2025, to assist the Board in its deliberations and decisions related to the potential renewal or termination of the administration and managed care services agreements with Discovery Health, which expire at the end of 2027. The Committee will also provide guidance to and oversight of the Scheme Office on any aspects related to the process. The Committee's mandate encompasses assessing whether to renew these agreements or not and, if so, determining the terms of renewal as well as whether to explore alternative avenues for procuring the services included in the agreements. The Scheme will follow a Board-approved roadmap for this process and is required to inform Discovery Health of their intention to renew or not by 31 December 2026.

Vested training was conducted for nine operational teams in Discovery Health, and training assessments are conducted annually across an expanding selection of operational teams. Professor Kate Vitasek's[1] Vested assessment in 2024 indicated that the quality of the Scheme's relationship with Discovery Health ranks among the top 1% of those measured internationally[2].

The Trustees monitor and measure Discovery Health's performance against extensive service level requirements contained in the agreement between the Scheme and Discovery Health. Engagement between the organisations is frequent and focuses on:

- Implementation of the Scheme's strategy;
- Product design and implementation of Scheme benefits;
- Scheme performance and strategic risk management;
- Operational performance;
- Fraud and forensics management;
- Marketing and sales;
- Member and other key stakeholder communication;
- Regulatory and industry matters;
- Combined assurance, risk management, compliance and internal audit; and
- Stakeholder engagement on behalf of the Scheme, including escalation to the Scheme Office for direct involvement when required.

Two management committees comprised of DHMS and Discovery Health executives, the Relationship Management Committee and the Innovation Committee, support enhanced governance and relational dynamics relating to the Vested relationship between DHMS and Discovery Health and provide scope for continued innovation. These committees meet a minimum of twice per year according to their terms of reference, and function as effective mechanisms to enhance the working relationship and maintain a joint focus on innovation for the benefit of our members. The committees report regularly to the Scheme's Stakeholder Relations and Ethics Committee and Risk Committee respectively.

How Discovery Health supports the Scheme's value creation ***pg 100 – 101***

1. *Kate Vitasek is an international authority for her award-winning research and Vested® business model for highly collaborative and strategic relationships, and is a Distinguished Fellow at the University of Tennessee's Global Supply Chain Institute. The Scheme engages with the Vested experts to assess the relationship when necessary.*
2. *Based on a Combined Vested Deal Index, compared with 232 international organisations' relationships as measured by the University of Tennessee's Vested experts.*

OUR EMPLOYEES

The Scheme is dedicated to upholding the dignity, safety, and wellbeing of our employees by fostering a supportive work environment, offering fair remuneration, and providing opportunities for training and development. Guided by our responsible corporate citizenship framework and good employer practices, we are committed to inclusivity, diversity, and ensuring that all employees are treated fairly and equitably. Our values shape our employee interactions, and we have implemented managerial leadership practices that promote transparent communication and engagement, aligned with the Scheme's strategic objectives.

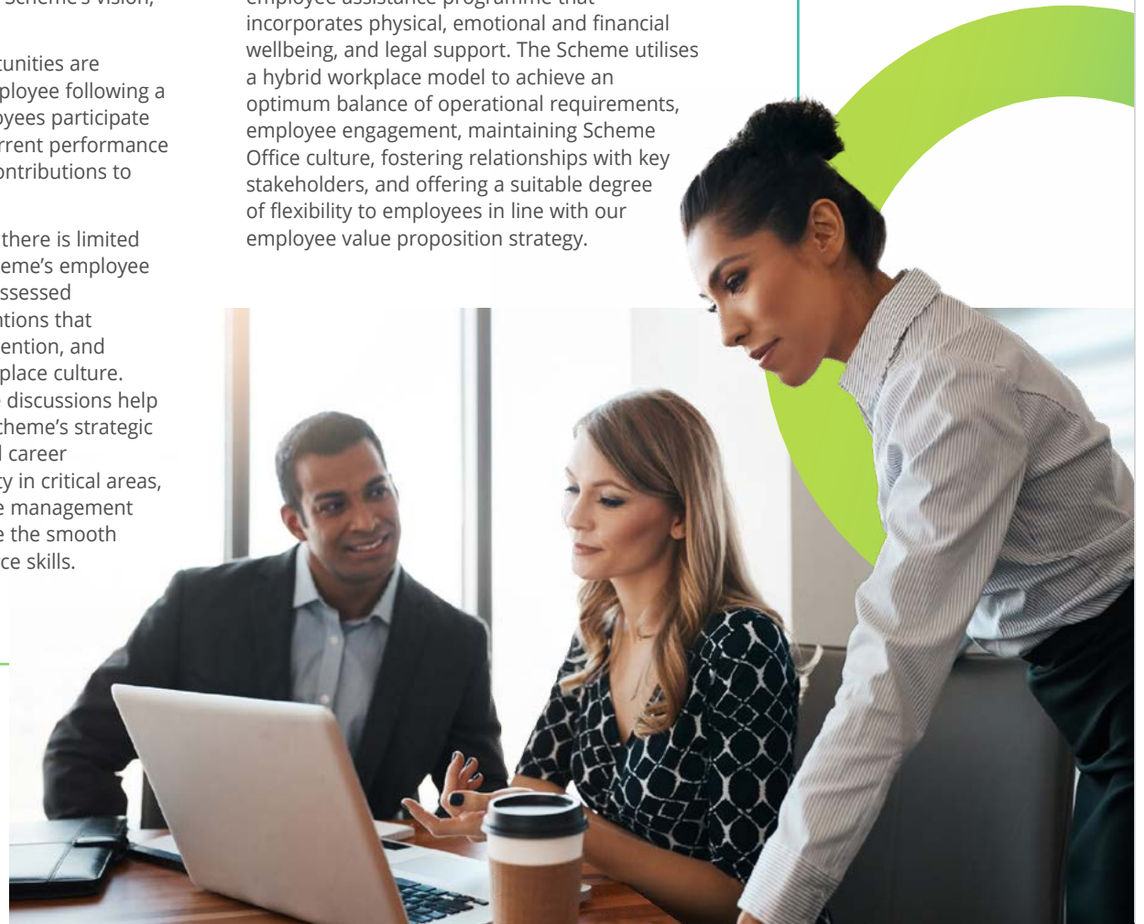
Our human resource policies are regularly reviewed by the Remuneration Committee and approved either by the Committee or the Board, as stipulated by the delegation of authority framework. Embedded throughout the Scheme's human resources lifecycle, these policies ensure consistency and fair treatment of employees, while also translating our values into practice. The Principal Officer holds ultimate accountability for employee-related matters, and all employees have access to the full suite of human resource policies.

With a small and specialised team of 13 employees, the Scheme remains agile in responding to industry developments and strategic initiatives. This includes the daily oversight of services and operations performed by Discovery Health on behalf of the Scheme, ensuring effective operations and long-term sustainability. Employee roles are developed in close relation to the Scheme's vision, purpose, and objectives.

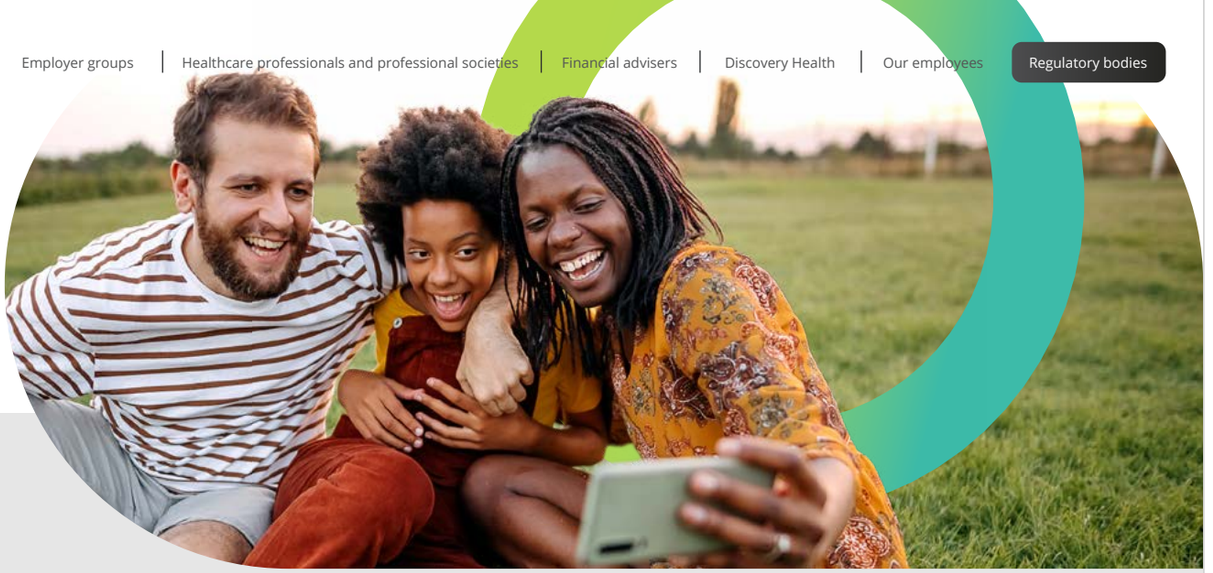
Training and development opportunities are regularly identified, with each employee following a tailored development plan. Employees participate in training that enhances their current performance as well as their potential future contributions to the Scheme.

As a flat organisational structure, there is limited scope for promotion, and the Scheme's employee culture and value proposition is assessed periodically. This enables interventions that promote staff satisfaction and retention, and support a healthy, engaging workplace culture. Additionally, regular performance discussions help employees stay focused on the Scheme's strategic goals, role-specific objectives, and career development. To ensure continuity in critical areas, the Scheme employs a knowledge management and retention strategy to facilitate the smooth transition and onboarding of scarce skills.

All employees and their dependants[1] have access to Discovery Healthy Company, a comprehensive employee assistance programme that incorporates physical, emotional and financial wellbeing, and legal support. The Scheme utilises a hybrid workplace model to achieve an optimum balance of operational requirements, employee engagement, maintaining Scheme Office culture, fostering relationships with key stakeholders, and offering a suitable degree of flexibility to employees in line with our employee value proposition strategy.



1. *Dependants are spouses, children, parents, or anyone living in the same household as the main member who are financially dependent on the main member. An employee's dependants can access advice and assistance with episode management, including telephonic support and counselling with a Discovery Healthy Company coach, legal adviser, or debt or trauma counsellor, or through face-to-face consultations with registered psychologists or social workers.*



REGULATORY BODIES

The Scheme and Discovery Health are required to adhere to strict legislation, with the Scheme primarily governed by the Medical Schemes Act. We work co-operatively with our regulatory bodies and relevant stakeholders, advocating for effective regulatory reform to drive positive change in the healthcare industry, including contributing towards health policymaking and amendments to legislation.

Maintaining constructive relationships with our industry regulators is critical to the Scheme's ability to create value. We work hard to build and maintain a collaborative working approach and to keep lines of communication open with the relevant authorities.

The Scheme and Discovery Health continue to engage the CMS and the National Department of Health on matters affecting the sustainability of the broader industry, including advocating for broad-based access to private healthcare, managing fraud, waste, abuse and errors, and in promoting positive regulatory change. The Scheme also engages on industry-related matters with regulators through our industry representative body, the Health Funders Association (HFA), and through the Health Policy Subcommittee of Business Unity South Africa. We engage with the Information Regulator, Competition Commission, and other regulators as required.

Regulatory and industry matters dealt with in 2025 ***pg 78***

COUNCIL FOR MEDICAL SCHEMES

The CMS regulates all medical schemes in South Africa, and its role includes:

- Protecting and educating the public regarding their medical scheme cover;
- Assessing and registering schemes' rules and benefits;
- Handling complaints and disputes between the public and medical schemes;
- Ensuring that schemes comply with the Act and maintain a high standard of governance and management; and
- Working with the National Department of Health regarding regulatory and policy interventions.

The Scheme engages actively with the CMS on matters of health policy, application and interpretation of rules, benefit design, Scheme finances and resolution of complaints and disputes with members. In 2025, the CMS published 48 circulars. The Scheme engaged with the content and submitted responses as required, as well as responding to other ad hoc and formal enquiries from the CMS. The CMS also publishes annual reports, providing a detailed overview of the state of the medical schemes industry. The Scheme seeks required approvals from the CMS for annual Scheme Rules, benefit updates and new plans. Regular meetings are also held with the CMS to discuss any concerns and questions, provide the CMS with an update on DHMS activities and plans, and obtain the CMS' views on various matters.

CMS publications

THE NATIONAL DEPARTMENT OF HEALTH

The Scheme interacts with the National Department of Health whenever required, either directly or through the HFA. DHMS supports the objectives of universal health coverage as well as the need for the healthcare sector to respond to the needs of patients within our social, economic and demographic context. DHMS closely monitors activity related to the NHI Act and is participating in the HFA's legal action regarding the Act.

More about NHI ***pg 80***

SECTION 06

Governance and leadership

How we are governed

The industry in which we operate is highly complex, making best practice governance both central to our business model (guiding our strategy, approach to risk and daily operations) and our continued ability to operate.

We go beyond compliance, maintaining thought leadership and ensuring that we meet the needs and expectations of our members, providing them with sustainable access to affordable and equitable healthcare, and creating and protecting value for them and other key stakeholders, while limiting value erosion.

More about our business model ***pg 27***

All medical schemes in South Africa are governed by the Medical Schemes Act (the Act). Discovery Health Medical Scheme (DHMS or the Scheme) Rules are developed in accordance with the Act and approved annually by the Council for Medical Schemes (CMS).

1. *For our purposes, fit and proper refers to honesty and integrity, competency, and operational ability requirements for all Trustees, key individuals, and Scheme representatives.*

Additional governance guidance was taken from the King IV Report on Corporate Governance for South Africa 2016 (King IV), which has been the standard for good corporate governance in South Africa and has been internationally recognised as best practice. King IV defines corporate governance as the exercise of ethical and effective leadership by boards to achieve:

Effective control | **Good performance** | **An ethical culture** | **Legitimacy**

The Board of Trustees (the Trustees or the Board) embraced the principles of King IV in achieving optimal governance outcomes for the Scheme and within the Scheme environment. According to the Scheme Rules, the Scheme's affairs must be managed by a fit and proper[1] board. Trustees are entrusted to lead ethically and effectively, both individually and as part of the Board, and must conduct themselves with requisite competence, integrity, accountability and transparency.

DHMS will continue to innovate and strengthen its governance processes in alignment with the principles of the new King V™ Report on Corporate Governance for South Africa and will report against them in 2026. King V represents an evolution in governance thinking with deeper accountability for the consequences of actions on the economy, society, and environment for long-term value creation.

The King V™ Report on Corporate Governance for South Africa 2025 was published on 31 October 2025 by the Institute of Directors in South Africa and the King Committee of South Africa, and is effective for financial years beginning on or after 01 January 2026. The Scheme engaged external consultants to perform a gap analysis in preparation for alignment, and we will report against King V from 01 January 2027.

In 2025, our Board Charter and Gifts, Gratuities and Business Courtesies Policy were extensively reviewed and improved. Independent experts ensured that our Gifts, Gratuities and Business Courtesies Policy is robust, and aligned with current legislative requirements and social developments.

Above Threshold Benefit
Claims System Error

In December 2025, the Trustees were informed by Discovery Health of an error in the claims processing system that inadvertently altered the accumulation of medicine claims to the Above Threshold Benefit (ATB) for some members on the Executive, Comprehensive and Priority plans during 2025.

As a result, for those members, risk funded benefits became available earlier than they should have, with the Scheme consequently funding claims that should have been paid out of pocket. While the system error originated from a claims system update in January 2025, it only became apparent later in the year due the nature of the error.

The Trustees and Scheme Executives met with Discovery Health to assess the impact on members and the Scheme, understand the status of the error, and determine the steps required to resolve it. Consideration was given to compliance, legal, stakeholder, operational and financial aspects, as well as Discovery Health's experience in similar matters.

Taking legal obligations and the need to protect the pooled funds of all members into consideration, a decision was taken to recover overpayments from affected members. In January 2026, however, Discovery Health offered to cover the full cost of overpaid amounts arising from the error. The Trustees accepted this offer on the basis that members who had already repaid amounts would be reimbursed, and no member would be disadvantaged.

The Scheme informed the Council for Medical Schemes (CMS) of the matter and has continued to provide updates. The CMS received complaints from members and member organisations, and initiated an enquiry with the Scheme to which the Scheme is in the process of responding.

The Trustees and the Scheme Office have investigated all the circumstances relevant to the occurrence and detection of the error, with the support of independent external experts. A detailed root cause analysis of the error, reporting and escalation processes was performed, and the system defect was remediated. Enhancements have been implemented to prevent recurrence.

More about ATB error and actions taken ***pg 95***

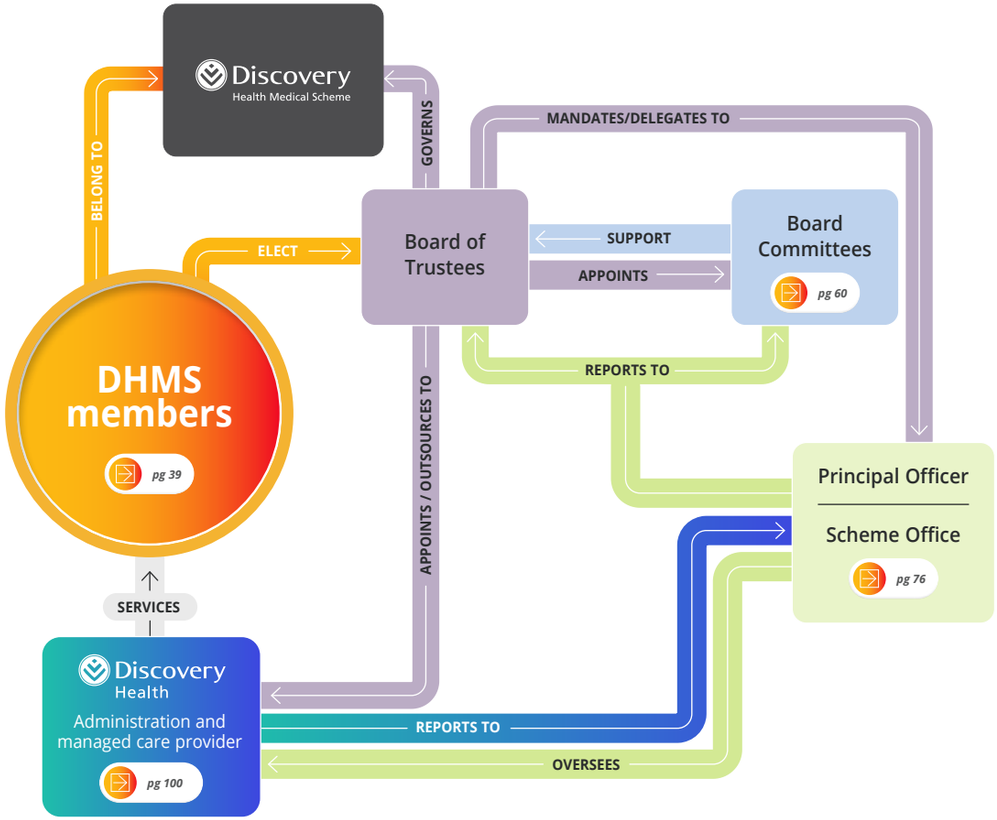
The Board of Trustees

DHMS is governed by an independent Board, responsible for overseeing the business of the Scheme. The Trustees hold decision-making power and are ultimately responsible for overseeing the Scheme's material matters, developing and implementing the Scheme's strategy, and responsibly managing its business and policies.

Furthermore, Trustees have a duty of care to the Scheme, whereby they are expected to:

- Act with honesty and integrity
- Avoid conflicts of interest
- Act in the members' interests
- Keep members' information confidential
- Comply with the Scheme Rules and relevant legislation

Our governance structures



Trustees are accountable to the Scheme's members, and their foremost objective is to ensure that the best interests of Scheme members are served equitably while safeguarding the sustainability of the Scheme.

The Board comprises independent, highly skilled professionals with a diverse range of expertise, experience and professional backgrounds, bringing multiple perspectives to bear in discussion and debate, ensuring robust oversight and strategic decision-making. Our Trustees' expertise extends across various fields including legal, actuarial, accounting, economics, governance, medical, mental health, financial, financial reporting, and investment. The Trustees discharge their fiduciary duties to ensure effective leadership and stewardship beyond attendance at meetings.

Composition and functioning

The Scheme is governed by a Board comprising no fewer than five and no more than eight individuals. At any given time, at least half of the Trustees must be elected by Scheme members from among their peers at the Scheme's Annual General Meeting (AGM), with the remaining Trustees appointed by those who are serving on the Board. The number of appointed Trustees may not at any time exceed three.

The Scheme does not influence the election process or composition of the Board. Given its limited capacity for planning succession, the Board may appoint additional Trustees to address any identified gaps in knowledge, experience, or skills, and may re-appoint such Trustees as needed.

Trustees who were elected or appointed before 14 July 2023 serve for three years, whereas those appointed after that date serve for four years. All Trustees may be re-elected or re-appointed for a second term, followed by a mandatory two-year cooling-off period after serving two consecutive terms should they be elected or appointed for a subsequent term.

Trustees may seek external professional advice, as deemed necessary, to ensure the effective discharge of their fiduciary responsibilities.

The role of the Trustees

The Trustees are responsible for strategic oversight and sound management of the Scheme, together with protecting members' interests, avoiding conflicts of interest and ensuring impartiality. Trustees must ensure that measures are in place to assess any conflicts of interest that may arise and manage them in accordance with best practice governance and any relevant legal requirements. In this regard they:

- Monitor, evaluate and make decisions regarding the equitable treatment of and benefits for all Scheme members in the interests of both members and the sustainability of the Scheme;
- Evaluate, direct and monitor the Scheme's strategy, ensuring alignment with the purpose and value drivers of the Scheme, alongside the legitimate interests and expectations of members and other stakeholders;
- Evaluate the services offered by the administration and managed care provider Discovery Health (Pty) Ltd (Discovery Health) and whether they meet the needs of and offer value for money to the Scheme and its members;
- Monitor innovation, and oversee the functioning of the Scheme Office and the improvement of the Scheme's operations at all levels;
- Monitor adherence to Scheme Rules and the provisions of the Medical Schemes Act in the day-to-day running of the Scheme's affairs; and
- Consider stakeholder perceptions and their impact on the Scheme's reputation.

The Trustees appoint a Principal Officer for day-to-day operations and to oversee financial matters, including record-keeping and submission of financial statements to the regulatory authority. At all times, the Trustees must act with due care, diligence, skill and good faith in the best interests of the Scheme and its members.

The duties of the Trustees, set out in the Act and the Scheme Rules

- To appoint, delegate and evaluate oversight functions to the Principal Officer;
- To ensure the keeping of proper registers, books and records of all operations of the Scheme, and proper minutes of all resolutions passed by the Trustees;
- To ensure that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and responsibilities in terms of the rules of the Scheme;
- Take all reasonable steps to ensure that contributions are paid timeously in accordance with the Medical Schemes Act and the Scheme Rules;
- Take all reasonable steps to ensure that the interests of beneficiaries, in terms of the Scheme Rules and the provisions of the Act, are protected at all times while acting with impartiality in respect of all beneficiaries;
- Ensure the proper management of the Scheme by applying sound business principles to ensure its strong financial position;
- Take all reasonable steps to protect the confidentiality of medical records concerning the state of health of the Scheme's members, and ensure that the Scheme Rules, operations and administration comply with the provisions of the Act and all other applicable laws;
- Oversee and direct the management of the Scheme's outsourced activities performed by the administration and managed care provider;
- Ensure that the rules, operation and administration of the Scheme comply with the provisions of the Medical Schemes Act and all other applicable laws; and
- Ensure that proper control systems and record keeping are employed by and on behalf of the Scheme.

The Trustees are responsible for strategic oversight and sound management of the Scheme, together with protecting members' interests, avoiding conflicts of interest and ensuring impartiality. Trustees must ensure that measures are in place to assess any conflicts of interest that may arise and manage them in accordance with best practice governance and any relevant legal requirements.

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Glossary

Activities of the Board in 2025

STRATEGIC AND PERFORMANCE MATTERS

- Considered the impact of the Scheme's operating environment on the Scheme and its members, taking into account the regulatory environment, the general South African healthcare landscape which encompasses high contribution increases and economic pressures on scheme members, and the need to broaden access to healthcare.
- Considered the Personal Health Pathways (PHP) managed care agreement, including healthcare service parameters and data privacy matters, taking into account external independent advice from Insight Actuaries & Consultants and the Scheme's legal advisers.
- Monitored and considered the performance of PHP, Personal Health Fund (PHF), and related implementation initiatives, governance and monitoring processes.
- Approved a proposal, supported by the joint Audit and Product Committees, to allow each DHMS member to unlock an additional benefit of R1 000 per adult in the PHF at the start of each year from 2026, subject to the relevant requirements.
- Deliberated on the behavioural impact and return on investment of PHP.
- Considered business plans and positioning to address affordability gaps with more competitive pricing, and new benefit plans subject to associated changes to the Scheme Rules.
- To promote access to healthcare for the currently uninsured population through primary care (low-cost benefit) options, noted updates to the Prime Care options and approved submission of a business plan under the proposed new name "AccessCare".
- Reviewed the results of the calculation of value provided by Discovery Health to the Scheme as an administration and managed care provider.
- Approved various benefit, pricing and administration fee changes, and gave direction for updates to be made to Scheme Rules, valuation reports, the Scheme's independent actuarial report and related governance documentation in alignment with these changes.
- Considered the 2026 Actuarial Report and Independent Actuarial Review, proposed benefit and Rule changes for 2026, and recommended the year-end benefit design operationalisation programme for implementation.
- Reviewed regular reports from Discovery Health relevant to its administration and managed care activities for the Scheme.
- Discussed the Scheme's 2025 strategy, including the 2024 strategic performance and consideration of material matters.
- Received a presentation on Discovery Health's 2025 strategy, considered the relevance, appropriateness and level of risk to the Scheme, and continued to monitor feedback on the strategy throughout the year in relation to its impact on the Scheme.
- Reviewed and assessed the go-to-market strategy, received a comprehensive update on the product launch, post-launch rollout, sales performance and market analysis, and considered concessions in implementation for stakeholders in consideration of their operational requirements.
- Adopted an Investment in Innovation Framework, and received presentations on supply side innovation and investment in healthcare.
- Considered the intended Value Added Tax (VAT) increase[1] and its potential effect on members, and resolved to absorb the VAT impact through Scheme reserves.

GOVERNANCE

- Received regular feedback from all its Board Committees on their activities.
- Considered the input from relevant Board Committees and approved various policies, statements and frameworks including the Investment Policy, IT Governance Framework, Financial Crime Risk Management Policy, Risk Appetite and Management Framework, Outsourcing Policy, Gifts, Gratuities and Business Courtesies Policy, External Engagement Framework, Leave Policy, Disciplinary Policy, Grievance Policy, Terms of Reference and Delegation of Authority.
- Considered insurance and liability policy requirements and confirmed the absence of any circumstances that may lead to a claim.
- Received regular updates from the Nomination Committee and Independent Electoral Body on the Trustee election process, and discussed risks to the 2025 AGM.
- Considered the validity of motions proposed to be tabled at the 2025 AGM.
- Considered concerns around member access to the IT platform during the 2025 AGM and approved an extension of the voting period to ensure that all members were able to vote.
- Reviewed feedback from the IT platform supplier, received assurance from the Independent Electoral Body and the Nomination Committee, and accepted the validity of the voting process and outcomes, enabling it to reconstitute the Board and its Committees following the election of three Trustees.
- Participated in an operational overview session, which included demonstrations across key Discovery Health functions.
- Reviewed a report on related party services provided by Discovery Health and its related entities.
- Noted the introduction of the King V code.

1. *The VAT increase was ultimately not implemented by the Minister of Finance.*

Activities of the Board in 2025 *continued*

REGULATORY MATTERS

- Monitored the progress of the Health Funders Association's challenge to the National Health Insurance legislation, which DHMS is participating in, as well as updates on NHI funding and implementation, noting the potential detrimental impact on medical schemes.
- Considered the Low-Cost Benefit Option Framework as published by the Minister of Health, and approved the submission of the Scheme's comments and recommendations.
- Monitored litigation of the South African Society of Physiotherapy which includes an application to declare Section 59 of the Medical Schemes Act unconstitutional that, if successful, would prevent medical schemes from recovering funds fraudulently or inappropriately paid out.
- Received regular updates on CMS' and related healthcare industry activities and the Scheme's engagements with CMS representatives, including through the Health Funders Association.

MEMBER AND STAKEHOLDER MATTERS

- Considered stakeholder concerns arising from the Future of Health Summit hosted by Discovery Health in 2024.
- Assessed increased stakeholder activism related to the 2025 AGM and Trustee elections and, taking into account considered heightened security risks for the AGM; contingency protocols and legal advice; venue capacity constraints; and industry precedent for virtual AGMs, resolved to transition from a hybrid to a fully virtual AGM.
- Reviewed and approved operational and communications requirements and plans.
- Instructed the development of a decision-making framework to assist the Board in handling complex issues in respect of external engagements.
- Considered how operational processes and error corrections impact members' trust and healthcare choices, and how ensuring precision and efficiency is essential to maintain trust.
- Reviewed cases of Scheme members requiring complex medical care.
- Discussed an error in Discovery Health's claims system which resulted in the overpayment of certain claims to a small group of members, considered the fiduciary duty of the Trustees to protect the funds of all members, and approved the recovery of the overpaid funds from the affected members in light of the Scheme's loss.

HUMAN CAPITAL MANAGEMENT AND REMUNERATION

- Considered Trustee remuneration and benchmarking analysis by a commissioned independent expert.
- Approved Trustee and Scheme employee remuneration, as well as the Trustee Remuneration Policy. The Remuneration Policy is tabled at every AGM for a non-binding advisory vote.

REPORTING AND ASSURANCE

- Noted the reaccreditation of Discovery Health as a managed care organisation by the CMS to 31 December 2026.
- Considered the conditions stipulated by the CMS for Discovery Health's administration accreditation, which was granted by the CMS to 31 December 2027. The conditions are carried forward from previous accreditation periods and are the subject of two appeals awaiting set down dates.
- Considered the CMS' views on cashflow classification of investment income and IFRS 17 disclosures, and supported enhanced related party disclosures in the Annual Financial Statements to enhance transparency and compliance.
- On the Audit Committee's recommendation, approved the 2024 Integrated Report and Annual Financial Statements and the preparation of the Annual Financial Statements for the year ended 31 December 2024 on a going concern basis.

Trustee remuneration

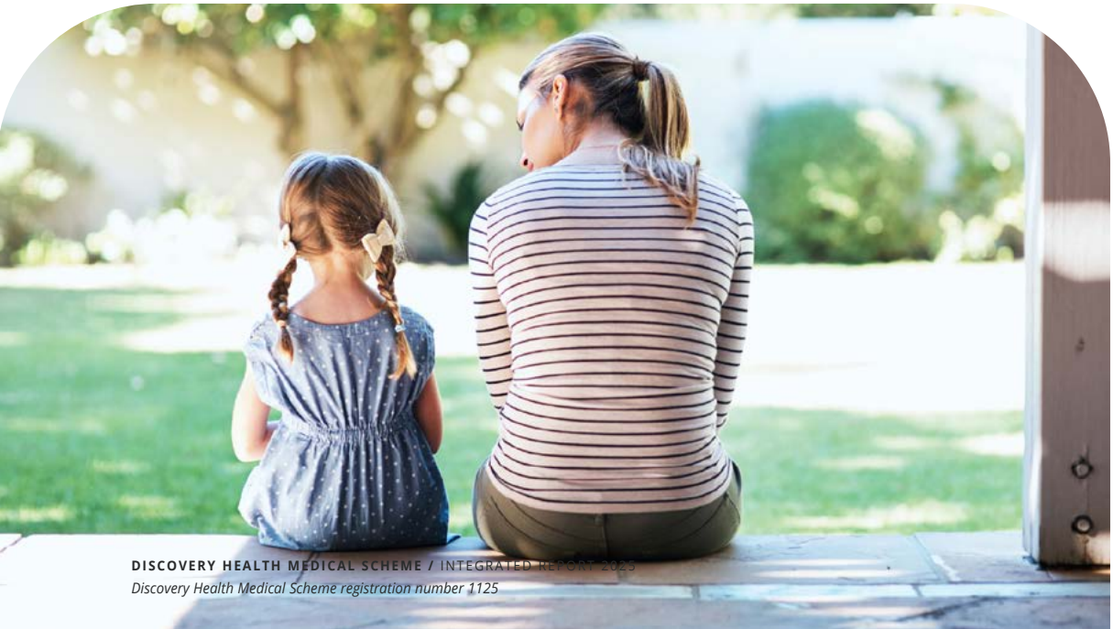
Trustees are remunerated for their services in accordance with the Scheme's Remuneration Policy. The professional fees for Trustees and Board Committee Members are benchmarked and subject to a discount, reflecting the non-profit nature of the Scheme.

Our approach to remuneration ***pg 75***

Board evaluations

In early 2026, the Trustees conducted their 2025 Board effectiveness review in a workshop facilitated by the Institute of Directors in South Africa, during which the Board also developed an action plan to address areas identified for further consideration.

The Board is satisfied that the diverse skills and experience of its members enable it to competently execute its duties and fulfil its responsibility to the Scheme's members. In addition, the Board is satisfied that it has fulfilled its mandate in accordance with the Board Charter and the Medical Schemes Act, having carried out its duties in an ethical, responsible and equitable manner throughout the year.



Trustee terms[1]

TRUSTEE	Appointed/Elected	Start of term	End of term
Mrs Lalita Harie	Elected	01 Sep 21	31 Aug 24
	Elected	27 Jun 24	2027 AGM
Ms Joan Adams SC	Elected	23 Jun 22	22 Jun 25
	Elected	26 Jun 25	2029 AGM
Mr Marius du Toit	Elected	23 Jun 22	22 Jun 25
Dr Max Price	Elected	23 Jun 22	22 Jun 25
Ms Michelle Norton SC	Appointed	01 Jan 23	31 Dec 25
Dr Rendani Mbuvha	Appointed	01 Aug 23	31 Jul 27
Dr Dhesan Moodley	Appointed	01 Sep 23	31 Aug 27
Prof Cornelius Schutte	Elected	26 Jun 25	2029 AGM
Mr David King	Elected	26 Jun 25	2029 AGM

1 Trustees who were elected or appointed before 14 July 2023 serve for three years, whereas those appointed after that date serve for four years. All Trustees may be re-elected or re-appointed for a second term but cannot serve more than two consecutive terms, followed by a mandatory two-year cooling-off period after serving two consecutive terms should they be elected or appointed for a subsequent term. All elected Trustees' terms run from the AGM at which they were elected to the date of the AGM at the end of their term. The dates of the AGMs differ slightly from year to year, but are usually scheduled in June.

The Board is satisfied that the diverse skills and experience of its members enable it to competently execute its duties and fulfil its responsibility to the Scheme's members.

2025 Trustee meeting attendance

Board Meetings attendance in 2025		06 Feb[A]	13 Feb[A]	19 Feb	20 Feb	31 Mar[A]	16 Apr	13 Jun	17 Jun[A]	19 Jun[A]	23 Jun[A]	AGM 26 Jun	26 Jun[A]	09 Jul[A]	11 Jul[A]	14 Jul[A]	16 Jul[A]	27 Aug[A]	17 Sep	22 Sep[A]	27 Nov
Trustee Chairperson	Ms Michelle Norton SC[1]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ms Joan Adams SC[2]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓
	Mrs Lalita (Gita) Harie	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Marius du Toit[3]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	–	–	–	–	–
	Dr Max Price[4]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	–	–	–	–	–
	Dr Dhesan Moodley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Dr Rendani Mbuvha	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr David King[5]	–	–	–	–	–	–	–	–	–	–	♦	–	–	–	–	✓	✓	✓	✓	✓
Trustees	Prof Cornelius Schutte[6]	–	–	–	–	–	–	–	–	–	–	♦	–	–	–	–	✓	✓	✓	✓	✓
Chairperson: Audit Committee	Mr Eric Mackeown[7]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	–	–
	Ms Melanie Bosman[8]	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	✓	✓	✓
Chairperson: Remuneration Committee	Mr Bongani Hlophe[9]	–	–	–	–	–	–	✓	–	–	–	✓	–	–	–	–	–	–	–	–	–

1. *First 3-year tenure ended on 31 December and re-appointed for a second 3-year term.*
2. *Re-elected as Trustee at the 2025 AGM for a 3-year tenure effective from15 July 2025.*
3. *Marius du Toit was appointed as a caretaker Chairperson of the meeting held on 20 February 2025, as the Chairperson was not available to chair the meeting. Term ended on 26 June 2025.*
4. *Term ended on 26 June 2025.*
5. *Elected as Trustee at the 2025 AGM for a 4-year tenure effective from 15 July 2025.*
6. *Elected as Trustee at the 2025 AGM for a 4-year tenure effective from 15 July 2025.*
7. *Second 3-year term ended on 31 August 2025.*
8. *Appointed as Chairperson of the Audit Committee as of 01 September 2025.*
9. *First 3-year tenure ended on 30 June 2025.*

A – Ad hoc meetings:

Ad hoc meetings may be shorter than scheduled Board meetings and are convened for a specific purpose. Trustees are remunerated according to the duration of such meetings.

- *A meeting was held on 06 February to discuss the PHP Agreement as well as the KeyCare Start and Active Smart second submissions.*
- *A meeting was held on 13 February to further discuss amendments to the PHP agreement.*
- *A combined Audit and Board meeting was held on 31 March to discuss the impact of the VAT increase on Discovery Health Medical Scheme.*
- *A meeting was held on 17 June to further discuss the closed session of the meeting of the 13 June – Continuation 1.*
- *A meeting was held on 19 June to further discuss the closed session of the meeting of the 13 June – Continuation 2.*
- *A meeting was held on 23 June to discuss proposed motions and to further discuss outstanding items to the closed session of the meeting of the 13 June – Continuation 3.*
- *A meeting was held on 26 June to discuss technical challenges experienced at the 2025 AGM.*
- *A meeting was held on 09 July to discuss 2025 AGM feedback.*
- *A meeting was held on 11 July to further discuss 2025 AGM feedback of the meeting of the 09 July – Continuation 1.*
- *A meeting was held on 14 July to further discuss 2025 AGM feedback of the meeting of the 09 July – Continuation 2.*
- *A meeting was held on 16 July to discuss the Committee Composition post 2025 AGM results.*
- *A meeting was held on 27 August to discuss the 2026 Product and Benefit Proposals.*
- *A meeting was held on 22 September to further discuss the 2026 Active Smart and KeyCare contribution increase.*

x Apology tendered.
– Not required to attend.
♦ Attended as a member candidate for election.

Ad hoc Above Threshold Benefit Claims System Error Meeting attendance in 2025		22 Dec
Trustee Chairperson	Ms Michelle Norton SC	✓
Trustee	Mrs Lalita (Gita) Harie	✓
Independent Committee Member	Ms Melanie Bosman	✓

A - Ad hoc meetings:

Ad hoc meetings may be shorter than scheduled Board or Committee meetings and are convened for a specific purpose. Trustees and ICMs are remunerated according to the duration of such meetings.

- *A meeting was held between Chairpersons of the Board, Audit and Risk Committees on 22 December to obtain clarity on the Above Threshold Benefit claims system error.*

Our Trustees[1]

Ms Michelle Norton SC 64

BA LLB; D Phil

Ms Norton SC is a practising advocate and a member of the Cape Bar and the Johannesburg Bar. She was appointed Senior Counsel in 2015. She specialises in public law, competition law, and general commercial law. She has served as an acting judge of the Western Cape High Court and acted as an arbitrator. She has served on the Cape Bar Council, chaired the Cape Bar's pro bono committee and transformation committee, and is a trustee of the Equal Education Law Centre.

Ms Norton was appointed as a Trustee effective from 01 January 2023. She serves on the Stakeholder Relations and Ethics, Product and Remuneration Committees, and was appointed Chairperson effective 14 June 2023.

Ms Joan Adams SC 62

Bluris LLB; MInstD

Ms Adams SC has been an advocate for over 36 years. She was previously a Senior State Advocate and Senior Family Advocate and served for five years on two presidentially elected Commissions of Inquiry addressing fraud and corruption. She was appointed Senior Counsel in early 2018. She is an experienced commercial forensic practitioner and a member of the Legal Practice Council, the Gauteng Society of Advocates and the Institute of Directors of Southern Africa.

Ms Adams SC has considerable experience in medical law and ethics, has chaired numerous professional conduct inquiries, and has presented various ethics seminars.

She was elected as a Trustee in 2017 and served on the Clinical Governance, Risk, Audit and Stakeholder Relations and Ethics Committees until her term ended in June 2020. She was re-elected in June 2022, served on the Investment Committee, currently chairs the Stakeholder Relations and Ethics Committee, and serves on the Remuneration and Risk Committees after her re-election in June 2025.

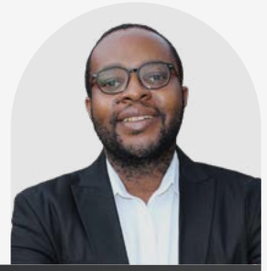
Mrs Lalita (Gita) Harie 67

BA (Social Work); BA (Hons) Social Science (Psychology); Certified Director (IoDSA[2])

Mrs Harie has more than 40 years' experience in the mental health field, 19 years of which was as executive director of one of the largest mental health non-governmental organisations (NGOs) in the country. She is currently serving as a non-executive director on the boards and standing committees of the Health Systems Trust, and the Professional Board for Psychology of the Health Professions Council of South Africa. Mrs Harie has also been appointed by the Legal Services Ombud onto the Database of Lay Persons to serve on the disciplinary committees of the Legal Practice Council and its Appeal Tribunal.

She has received numerous awards in recognition of her leadership, governance, and innovative services and was twice selected for the International Visitors Leadership Programme (IVLP) by the United States Department of State to visit the USA for mental health programmes, the second visit being as an IVLP Gold Star Alumni participant.

Mrs Harie was elected as a Trustee in 2021 for a three-year term. She chaired the Risk Committee and also served on the Clinical Governance and Stakeholder Relations and Ethics Committees. She was re-elected in June 2024, and currently chairs the Risk Committee and serves on the Clinical Governance and Stakeholder Relations and Ethics Committees.



Dr Rendani Mbuvha 35

BSc (Hons); MSc; PhD; FIA[3]; FASSA[4]; CERA[5]

Dr Mbuvha is an associate professor in Actuarial Science at the University of Manchester. He has extensive expertise in actuarial practice and machine learning research and has had roles in these capacities at ABSA and Milliman. Additionally, he has been an associate professor in Actuarial Science at the University of Witwatersrand, and the Google DeepMind Academic Fellow in Machine Learning at Queen Mary University of London.

Dr Mbuvha served as an independent non-executive director at Bidvest Life Limited, where he chaired the remuneration committee. He currently chairs the Climate Index subcommittee of the Actuarial Society of South Africa and holds honorary research associate positions at University College London and United Nations University Institute for Water, Environment and Health.

Dr Mbuvha was appointed as a trustee in August 2023 and serves on the Audit, Investment, Product and Risk Committees. He also serves on the Ad Hoc Committee of the Board.

1. *All ages are at 31 December 2025.*
2. *Institute of Directors in South Africa.*
3. *Fellow of the Institute of Actuaries UK.*
4. *Fellow of the Actuarial Society of South Africa.*
5. *Chartered Enterprise Risk Actuary.*

Mr David King 62

BSc (Hons); MBA, Health Risk Management and Managed Care Certificate

Mr King is a seasoned business executive with over 25 years' multinational experience. He spent 12 years as Human Resources Director of Brandhouse Beverages and was instrumental in their becoming a formidable competitor in the South African drinks industry. He previously chaired the board of Oxygen Medical Scheme and is an expert in executive leadership and employee engagement.

Mr King was elected as a Trustee in June 2025. In addition to chairing the Remuneration Committee, Mr King serves on the Investment and Stakeholder Relations and Ethics Committees. Mr King also previously served two three-year terms as a Trustee, having first been elected in 2016 and then re-elected in 2019.

Dr Dhesan Moodley 63

Masters in Metabolic, Functional and Anti-aging Medicine; MMed (Sports Science); MBChB; MBA; EDP Economics; Chartered Director (IoDSA[1])

Dr Moodley is currently in private practice in Functional and Anti-aging Medicine. He is a non-executive director of the Smile Foundation, an NGO that conducts corrective surgery for children with conditions such as cleft palate and burns. Previously, he was president of Alexander Proudfoot North America and Africa, Chief Executive Officer (CEO) of Bluepeter Consulting, partner of Ethos Private Equity Technology Fund, associate partner at Accenture, and principal at Gemini Consulting. He has deep expertise in health insurance and healthcare. His past and present affiliations include the Health Professionals Council of South Africa, South African Medical Association, American Academy of Anti-aging Medicine, Young Presidents' Organisation, World Presidents' Organisation, Black Management Forum of South Africa, the Institute of Directors in Southern Africa and American Chamber of Commerce.

Dr Moodley served the Scheme as Chairperson and a Trustee between 2001 and 2011. In 2016, he was re-elected as a Trustee, chaired the Clinical Governance and Investment Committees, and served on the Product, and Stakeholder Relations and Ethics Committees. His tenure ended on 22 June 2022, and he was appointed as a Trustee with effect from 01 September 2023, after his cooling off period. He now serves on the Clinical Governance and Product Committees, and chairs the Investment Committee and the Ad Hoc Committee of the Board.

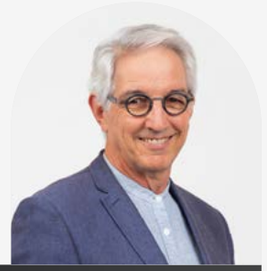
Prof Cornelius Schutte 62

B. Eng (Industrial Engineering); B. Eng (Industrial Engineering) (Hons); M. Eng (Industrial Engineering); PhD (Industrial Engineering)

Prof Schutte has been an academic at Stellenbosch University for 21 years and is currently the vice dean: Research & Industry Liaison of the Faculty of Engineering. He has 20 years' industry experience (local and international) and was awarded the Kris Adendorff award in 2022, for prominence in South African Industrial Engineering.

He has a PhD in Engineering, is a professionally registered engineer (PrEng), an honorary fellow of the South African institute of Industrial Engineering, an FSCA certified trustee, and a member of the Institute of Directors of South Africa.

Prof Schutte was elected as a Trustee in June 2025, and serves on the Audit, Product and Risk Committees.



Dr Max Price 70

MBBCh; BA; MSc; Postgraduate Diploma in Occupational Health

Dr Max Price is qualified in medicine and public health. Most recently he was vice chancellor of the University of Cape Town for ten years, before which he was dean of the Wits Faculty of Health Sciences for ten years. His earlier academic work was in health economics and policy, and he was instrumental in the creation of the Wits Donald Gordon Private Academic Hospital. He is currently an independent consultant in leadership and higher education. He also serves, or has served, on the boards of several public benefit organisations and has previously served as a trustee of another medical aid scheme.

Dr Price was elected as a Trustee in June 2022, chairs the Clinical Governance Committee, and serves on the Product, Stakeholder Relations and Ethics and Remuneration Committees.

Mr Marius Du Toit 63

BCom (Mathematics); FASSA[2]

Mr du Toit has extensive experience as a professional actuary, as well as in long-range strategic planning and policy decision making, revision and creation of legislation, actuarial governance, and compliance. He has advised retirement funds on various aspects including funding requirements, investment strategy, benefit structures and reinsurance requirements. His roles have included that of divisional executive of the FSCA[3], and Acting Chief Financial Officer and Chief Actuary of the FSB[4].

Mr du Toit has served on various committees of the International Association of Actuaries and the Actuarial Society of South Africa, and he has served as a trustee of two pension funds.

He was elected as a Trustee in June 2022, chaired the Product Committee and served on the Audit, Investment, and Services Renewal Committees. He also served on the Ad Hoc Committee of the Board.

1. *Institute of Directors in South Africa.*
2. *Fellow of the Actuarial Society of South Africa.*
3. *Financial Sector Conduct Authority.*
4. *Financial Services Board (now the Financial Sector Conduct Authority).*

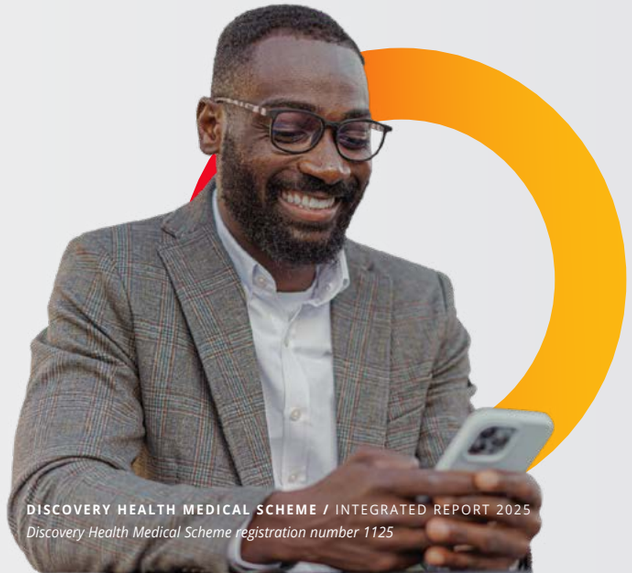
Board Committees

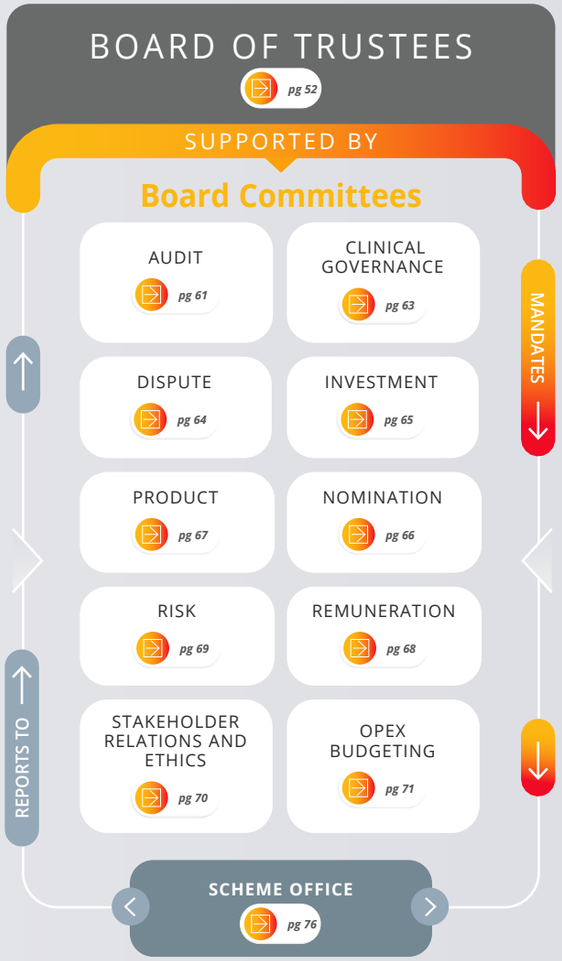
In compliance with the Medical Schemes Act and in line with best practice governance principles, the Board has established appropriate governance structures to navigate and manage the complex operating environment, risks and strategic objectives of the Scheme.

The Board is supported by nine Committees, each established and structured based on the Scheme's needs to assist the Board to perform its fiduciary and oversight responsibilities. These Committees include both Trustees and Independent Members, depending on what each Committee requires.

Independent Committee Members (ICMs) who were appointed before 14 July 2023 serve for three years, whereas those appointed after that date serve for four years. All ICMs may be re-appointed for a second term but cannot serve more than two consecutive terms. ICMs are compensated for their work according to the Scheme's Remuneration Policy.

The Committees each have terms of reference and clear procedures for reporting, and report to the Board regularly and as and when required. The terms of reference for each Committee's role and responsibilities are reviewed annually to ensure continued relevance to the business of the Scheme. The Committees make recommendations to the Board for approval of decisions to be taken, and for any changes required to their terms of reference.





Board Committee evaluations

Board Committee evaluations contribute to the effectiveness of the Committees and the Board as a whole, form part of their accountability duties, and allow a greater granularity of governance scrutiny within the Scheme.

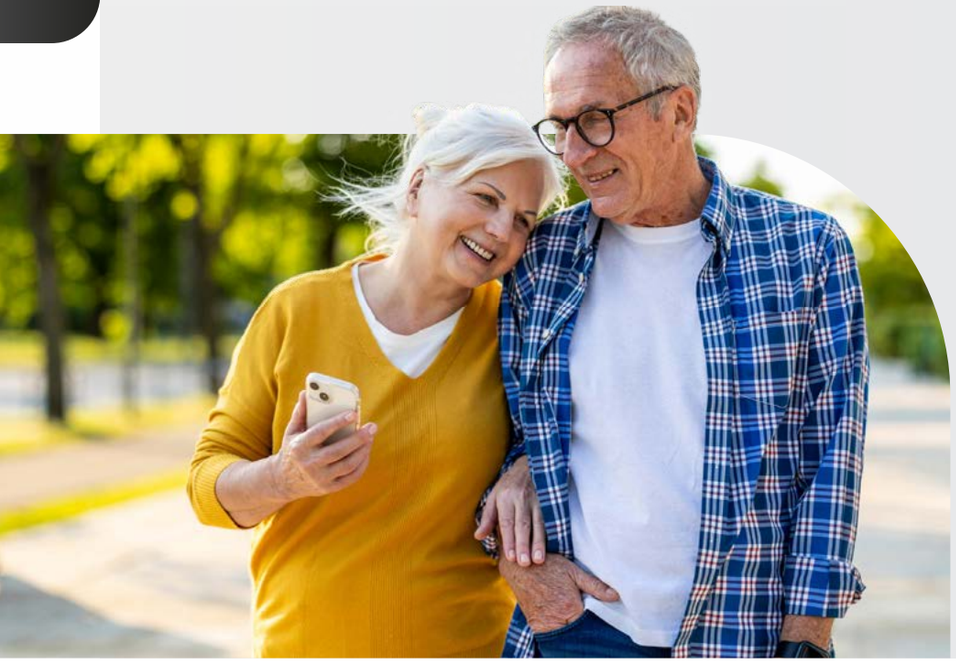
The 2025 Committee evaluations were conducted by means of targeted surveys in early 2026. The results will be considered by the Committees during 2026, and relevant action plans developed to address gaps where appropriate.

The Dispute Committee and the Nomination Committee exclude any Trustee representation to maintain impartiality and independence in fulfilling their duties.

Our committees' mandates, activities, attendance and future focus

AUDIT COMMITTEE

The Audit Committee is a statutory committee established in line with the requirements of Sections 36(10) to (13) of the Medical Schemes Act. Chaired by an Independent Committee Member, it comprises a minimum of five skilled and experienced members with extensive financial, actuarial, governance, and IT governance expertise and knowledge. At least two members of the Committee must be Trustees, and the majority must be Independent Committee Members. The Committee assists the Board in discharging its responsibilities relating to safeguarding assets, operating adequate and effective internal control systems, and preparing fairly presented financial statements in compliance with all applicable legal and regulatory requirements and accounting standards.



The responsibilities of the Committee include:

- Providing oversight for and ensuring the integrity of the Scheme's Integrated Report, Financial Statements and related procedures;
- Considering the impact of any financial, fraud, information technology, regulatory and other risks on the integrity of the Scheme's financial results;
- Reviewing the basis on which the Scheme has been determined to be a going concern;
- Reviewing the statutory solvency requirements of the Scheme;
- Reporting to the Board on the acceptability of the Scheme's accounting policies;
- Considering and recommending the appointment and/or termination of the external auditor, including their audit fee, independence and objectivity, and determining the nature and extent of any non-audit services;
- Overseeing external and internal auditors;
- Evaluating the expertise and experience of the Internal Audit and outsourced finance functions;
- Evaluating the independence and objectivity of the Internal Audit function;
- Evaluating the performance of the Chief Financial Officer;
- Monitoring the effectiveness and appropriateness of the combined assurance model;
- Monitoring matters relating to the sustainability of the Scheme to the extent that these impact the financial results; and
- Considering and recommending annual contribution increases for approval by the Board.

Combined assurance

The Scheme's combined assurance model, which was approved by the Committee during the year, is based on three lines of defence:

FIRST LINE
Scheme Executives

SECOND LINE
The Risk function, Compliance function and Forensics

THIRD LINE
Internal Audit, appointed external auditors, appointed independent actuary and other independent assurance providers

The combined assurance assessment showed that adequate assurance was provided and received in respect of all significant risks for the 2025 benefit year. The members of the Audit Committee and Trustees are satisfied with the level and type of assurance the Scheme obtains.

Activities during 2025

In 2025, the Committee maintained focused oversight on the comprehensive implementation of IFRS 17: *Insurance Contracts* in the Scheme's Annual Financial Statements, incorporating insights from industry groups and the CMS regarding key lessons learned during the initial phase of implementation. The Committee welcomed Deloitte & Touche as the Scheme's newly appointed auditors, ensuring a smooth and well-managed transition for Deloitte & Touche in their role as first time auditors of the Scheme.

The Committee continued to support the Trustees in fulfilling their governance and oversight responsibilities during the year. The Committee is satisfied that its activities, reporting and recommendations to the Board during 2025 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2025

In 2025, the Audit Committee comprised two Trustees and four Independent Committee Members, with one serving as Chair of the Committee. Melanie Bosman was appointed Chair of the Committee on 01 September 2025, succeeding Eric Mackeown, who completed his second term as an Independent Committee Member and Chair.

The Committee met four times as scheduled in its annual plan. The Audit and Product Committees jointly considered the actuarial valuation and proposed contribution increases for the 2026 benefit year; Deloitte & Touche and Insight Actuaries & Consultants, the Scheme's external auditors and independent actuaries, were invited to attend. In addition to the scheduled meetings, an additional ad hoc meeting was held together with the Board in March 2025 to discuss the impact of the VAT increase announced in the National budget. Additionally, two ad hoc meetings were held in September together with the Product Committee to discuss the 2026 Product and Benefits recommendations.

The external and internal auditors met regularly with the Committee without the administration and managed care provider and Scheme Executives present.

The external auditor, internal auditor, Scheme Executives and heads of the outsourced administration functions attend all Committee meetings by invitation, to provide information and insight into their areas of responsibility. They also have unrestricted access to the Chairperson of the Audit Committee.

The Committee may consult any expert or specialist to assist in performing its duties. The Independent Actuarial function is regularly invited to Committee meetings to provide information and assurance in accordance with the applicable agreements in place.

Report of the Audit Committee ***pg 107***

Audit Committee attendance in 2025

		31 Mar[A]	03 Apr	21 Aug	26 Aug	12 Sep[A]	22 Sep[A]	09 Oct
Independent member Chairperson	Mr Eric Mackeown[1]	✓	✓	✓	✓	–	–	–
	Ms Melanie Bosman[2]	✓	✓	✓	✓	✓	✓	✓
Trustees	Dr Rendani Mbuvha	✓	✓	x	✓	✓	✓	✓
	Mr Marius du Toit[3]	✓	✓	–	–	–	–	–
	Prof Cornelius Schutte[4]	–	–	✓	✓	✓	x	✓
Independent Committee Members	Dr Alewyn Burger[5]	✓	✓	✓	✓	✓	✓	✓
	Ms Busisiwe Mathe[6]	✓	✓	–	–	–	–	–
	Ms Lwazi Nopece[7]	–	–	–	–	–	–	✓
	Mr Victor Muguto[8]	–	–	–	–	✓	✓	✓

1. Second 3-year term ended on 31 August 2025.
2. Appointed as Chairperson of the Audit Committee as of 01 September 2025.
3. Not re-elected as Trustee at the 2025 AGM.
4. Appointed as Committee Member on 16 July 2025.
5. Second 3-year term ended on 31 December 2025.
6. Resigned from the Committee as of 01 July 2025.
7. Appointed as Committee Member on 01 October 2025.
8. Appointed as Committee Member on 01 September 2025.
A - Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Board or Committee meetings and are convened for a specific purpose.
- *An ad hoc combined Audit and Board meeting was held on 31 March to discuss the impact of the VAT increase on Discovery Health Medical Scheme.*
- *An ad hoc combined Audit and Product meeting was held on 12 September to discuss the Product and Benefit Recommendations.*
- *An ad hoc combined Audit and Product meeting was held on 22 September to discuss the 2026 Benefits and Contributions.*

x Apology tendered.
– Not required to attend.

Future focus areas

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. The Committee will continue to assess how best to balance the Scheme's solvency requirements with the provision of future benefits, managing increased utilisation and maintaining affordable contributions, particularly in the current context of industry-wide constrained growth.

The Committee will focus on the implementation of IFRS 18: *Presentation and Disclosure in Financial Statements*, which becomes effective on 01 January 2027. This Standard replaces IAS 1: *Presentation of Financial Statements*, and sets out overall requirements for the presentation and disclosure in financial statements.

CLINICAL GOVERNANCE COMMITTEE

The Clinical Governance Committee has been established in terms of Scheme Rule 19.3, which empowers the Board to appoint and delegate authority to a subcommittee consisting of Board members and other experts it may deem necessary. This Committee was established to ensure compliance with the Medical Schemes Act and alignment with best practice governance principles. The Committee comprises members proficient in the complexities of healthcare funding and includes medical professionals with specialist expertise in areas relevant to the Scheme's burden of disease, such as primary healthcare, mental health, oncology, and health economics.

The Committee assists the Board with oversight on matters related to clinical governance, including evidence-based funding policies and strategic risk management initiatives designed to improve the health and wellness of members and manage healthcare utilisation risk. It also provides clinical governance related inputs to the Product Committee to ensure that the Scheme's product and benefit design are medically appropriate. Additionally, it oversees the functions performed by Discovery Health in terms of the managed care agreement, including management of clinical exceptions and ex-gratia funding, pilot projects, member complaints, appeals and disputes, and health benefit formulation.

The Committee also oversees engagement strategies with healthcare providers facilitated by Discovery Health, to foster shared purpose and value, including reducing inefficiencies in healthcare delivery and improving quality of care and health outcomes.

In line with its annual strategic themes and priorities, the Committee periodically engages with various experts in the healthcare system. The Committee also engages with Health Quality Assessment (HQA), an independent industry body that measures and reports on quality of care in the private sector. The Scheme is represented in the HQA Board of Directors by the Scheme's Chief Medical Officer.

Activities during 2025

The Committee held four meetings as per the annual work plan, providing oversight on clinical governance strategies including review and monitoring of key strategic risk management initiatives implemented by Discovery Health. Selected examples include strategies to support healthy aging (as the Scheme membership is aging, with concomitant increase in disease burden). In line with the successful launch of Personal Health Pathways, and early indications of its positive impact on members' compliance with evidence-based personalised health pathways, the Committee considered and endorsed the introduction of sleep-related Next Best Actions in PHP, and enhanced benefits for sleep disorders, as a critical health and wellness driver.

More about the link between sleep and good health ***pg 102***

The Committee engaged with relevant risk intelligence and risk management reports, which included key indicators on Scheme demographic and claims utilisation risk as well as programme-specific reports. Reports that the Committee has oversight of include ex-gratia funding decisions; exceptional, high-cost and clinically complex cases; and pilot projects. New pilots approved by the Committee included initiatives designed to mitigate the incidence and prevalence of cardiometabolic disease including weight management strategies, and value-based care programmes to improve maternal and neonatal health outcomes.

To ensure that the Scheme remains up to date with healthcare innovations, technology, diagnostics and treatment approaches, the Clinical Governance Committee regularly hosts experts from fields specific to the Scheme's strategic focus areas. In 2025, these included experts on sleep health and aging. The Committee also hosted HQA to deliberate on the Scheme's annual (2024) health quality results.

Composition and meetings in 2025

At the end of 2025, the Committee comprised three Trustees (one of whom chaired the Committee), two Independent Committee Members and the Chief Medical Officer of the Scheme. Regular attendees of Committee meetings include other Scheme Office executives, and experts from Discovery Health's clinical and risk management teams.

Clinical Governance Committee attendance in 2025

		27 Mar	05 Jun	19 Aug	06 Nov
Trustee Chairperson	Dr Max Price[1]	✓	✓	–	–
	Dr Dhesan Moodley[2]	✓	✓	✓	✓
Trustee	Mrs Lalita (Gita) Harie	✓	✓	✓	✓
Independent Committee Members	Dr Dineo Tshabalala	✓	✓	✓	✓
	Prof Laurel Baldwin-Ragaven	✓	✓	✓	x
Executive	Dr Unati Mahlati (Chief Medical Officer)	✓	✓	✓	✓

1. *Not re-elected as Trustee at the 2025 AGM.*
2. *Appointed as Committee Chairperson on 16 July 2025.*

x Apology tendered.
– Not required to attend.

Future focus areas

The Committee will remain focused on championing partnerships with healthcare providers to progressively scale up value-based care and improve members' health outcomes, while ensuring the broader sustainability of healthcare providers and the healthcare system. The Committee will continue to monitor and evaluate the impact of benefits, funding policies, and risk management initiatives on members and healthcare providers. Key focus areas in 2026 will include monitoring and evaluation of the impact of the Personal Health Pathways programme, and scaling up new and existing wellness and managed care interventions to mitigate the impact of the Scheme's aging profile and increasing burden of disease. The Committee will continue to exercise due care and responsibility in fulfilling its mandate.

DISPUTE COMMITTEE

The independent Dispute Committee hears and adjudicates transparently and equitably on all formally lodged member and forensic-related healthcare provider disputes. It is the Committee's responsibility to make fair and consistent decisions that are in accordance with the provisions of the Act, applicable laws and the latest registered Scheme Rules. The Committee may not make discretionary rulings or rulings which contravene applicable legislation or the latest registered Scheme Rules. The Committee can, however, at its discretion, refer relevant questions to a specially convened Treating Customers Fairly (TCF) Committee. In these instances, the TCF Committee provides specialist insight into issues of fairness in accordance with recognised TCF standards, and makes non-binding recommendations to the Dispute Committee. In the event of a member being dissatisfied with a Dispute Committee ruling, a complaint can be lodged with the CMS in terms of Section 47 of the Act.

The responsibilities of the Committee include:

- Receiving submissions from members or healthcare professionals involved in a dispute, as well as from Scheme representatives;
- Convening dispute hearings in person, virtually, telephonically or in absentia (if selected by the member/provider). The preference is to convene in-person hearings where practically possible;
- Ensuring that it has sufficient information to adjudicate cases objectively;
- Adjudicating disputes and drafting rulings with due regard for all facts presented at hearings and in line with relevant legislation and the Scheme Rules;
- Referring questions of fairness that are not catered for in either the Scheme Rules or the Act to a specially convened TCF Committee to provide a non-binding recommendation; and
- Ensuring that the process at hearings and in adjudicating disputes is managed as efficiently as possible and without undue delay.

Members have access to the Committee, as do healthcare providers in respect of forensic (fraud, waste, abuse and error-related) disputes. Healthcare professionals who wish to lodge a dispute about forensic processes and investigations are encouraged to do so through the Dispute Committee for independent, expeditious and cost-effective resolution of such disputes.

Activities during 2025

In 2025, a subset of 942 (82%) of the 1 148 disputes in terms of Rule 27[1] were settled or withdrawn prior to a hearing (2024: of the 1 315 disputes, 1 217 or 94% were settled or withdrawn).

A total of 31 Dispute Committee hearings were convened in 2025, with 26 rulings issued as at December 2025, 21 of which were in favour of the Scheme, four in favour of members, and one partially in favour of both the Scheme and the given member. Of these 31 dispute hearings in respect of which rulings were issued, only two were subsequently referred to the CMS as a complaint in terms of Section 47 of the Act.

The Scheme also tracks the number of total dissatisfied beneficiaries, which for this purpose is defined as the combination of disputes and CMS complaints duly lodged. The ratio of total dissatisfied beneficiaries per 10 000 lives improved from 6.36 in 2024 to 5.96 in 2025.

As the Committee's work covers the full spectrum of stakeholder concerns, its activities are overseen by the Stakeholder Relations and Ethics Committee (SREC) on behalf of the Board. The Dispute Committee considered the results of the self-evaluations of its effectiveness and is satisfied that it has fulfilled its responsibilities in accordance with its operating framework, and reported such to the SREC.

1. *Rule 27 of the DHMS Rules deals with complaints and disputes. The Rules are available to members on www.discovery.co.za/medical-aid/scheme-rules.*

Composition and meetings in 2025

All Dispute Committee panellists have either legal or medical expertise. Each panel must include at least one legal and one medical expert and consist of three members drawn from the greater Committee, according to availability. An attorney is always the Chairperson of each hearing. Dispute hearings are scheduled as and when required and individual panels can be constituted several times a week if needed. Committee Members are independent and not employed by the Scheme but are remunerated for their time and expertise regardless of the outcome of the hearings. All hearings during 2025 were properly constituted. Due to the frequency of hearings and variation of panellists, an attendance register is not shown.

Future focus areas

The Committee will continue to exercise due care and responsibility in fulfilling its mandate.

INVESTMENT COMMITTEE

The Investment Committee recommends and oversees the implementation and maintenance of investment policies and mandates. It advises the Trustees on strategic and operational matters relating to investing the Scheme's reserves, ensuring that investments made are in the best interest of members and within the Scheme's risk appetite, as determined by the Trustees. The Committee assists the Board and supports the Scheme Executives with investment analysis and management of service provider inputs. It also makes recommendations to the Board for consideration and approval.

The responsibilities of the Committee include:

- Recommending Investment, Credit Risk, Responsible Investing and Investment Industry Transformation Policies for the Scheme to the Trustees, with due regard that invested assets are required to maximise returns while earning at least what the Scheme's actuary has assumed and maintaining solvency;
- Monitoring the effectiveness and implementation of the Investment Policy;
- Making recommendations to the Trustees regarding strategic asset allocation strategies and approving plans for implementation;
- Approving tactical allocation strategies;
- Reviewing investment strategies, performance of the investment portfolio, asset classes and asset managers against established benchmarks, and reporting to the Trustees quarterly on the performance of the portfolio;
- Reporting to the Trustees annually on overall investment performance;
- Making recommendations to the Trustees on the appointment of asset consultants and asset managers, including fees payable and the conditions of appointment;
- Approving dis-investment from non-cash asset managers that are outside the Scheme Office mandate;
- Supervising the safekeeping and handling of the Scheme's investments;
- Monitoring all reported investment activities in line with the Scheme's policies and statutory requirements, and where there is deviation from the policies, investigating the reasons and recommending corrective action to the Trustees;
- Assisting the Trustees in preparing their annual report on investment performance and compliance.

Activities during 2025

- Recommended an updated Investment Policy for Board approval.
- Considered the Scheme's strategic asset allocation across various asset classes with due consideration for the prevailing economic outlook;
- Considered and approved tactical asset allocation strategies affecting asset allocation, investment manager weightings, and currency and equity derivatives;
- Monitored developments within investment managers that are on the Scheme's watchlist[1].
- Reviewed the investment strategies and performance of asset managers relative to their benchmarks.
- Considered the optimisation of the allocation of assets to the money market investment managers.
- Assessed the investment decision making process for securitisation assets at one of the Scheme's money market managers.
- Considered a scenario analysis of the potential impact of forced dis-investments or repricing of Scheme investments in carbon intensive assets.
- Reviewed the results of the Scheme's annual due diligence exercise conducted across its asset managers, which included onsite visits by the Scheme.
- Approved an Investment Industry Transformation Scorecard for monitoring its asset managers.
- Considered the impact of key staff changes within the appointed investment consultant.
- Reviewed the effectiveness of the services provided by the investment consultant.
- Oversaw the application for renewal and subsequent granting by the Council for Medical Schemes of two investment related exemptions.
- Considered the results of the Committee effectiveness review.
- Reviewed its terms of reference with appropriate changes being approved by the Trustees.

The Committee considered the results of the 2024 committee effectiveness review, and is satisfied that its activities, recommendations and reporting to the Board during 2025 fulfilled its responsibilities in accordance with its terms of reference.

1. *The Scheme closely monitors the performance of investment managers relative to their specific mandate and benchmark. If, over time, managers are not achieving the results required by DHMS, their mandate may be amended or removed.*

Composition and meetings in 2025

At the end of 2025, the Committee consisted of three Trustees and two Independent Committee Members. The Committee receives investment advice and quarterly reports from the Scheme's investment consultants, RisCura, which attends all Committee meetings. Asset managers are invited to attend meetings on a rotational basis to report on their strategy and performance.

Investment Committee attendance in 2025		04 Mar	29 May	31 Jul	13 Oct[4]	30 Oct
Trustee Chairperson	Dr Dhesan Moodley	✓	✓	✓	✓	✓
Trustee	Mr Marius du Toit[1]	✓	✓	–	–	–
	Mr Rendani Mbuvha	✓	✓	✓	✓	✓
	Mr David King[2]	–	–	✓	✓	✓
Independent Committee Members	Ms Henda van Deventer	✓	✓	✓	✓	✓
	Mr Eric Mackeown[3]	✓	✓	✓	–	–
	Ms Melanie Bosman[4]	–	–	–	x	✓

1. *Not re-elected as Trustee at the 2025 AGM.*
2. *Appointed as Committee Member on 16 July 2025.*
3. *Second 3-year term ended on 31 Aug 25.*
4. *Appointed as Committee Member on 01 September 2025.*

x Apology tendered.
– Not required to attend.

Future focus areas

During 2025, the Committee will review the Scheme's asset allocation across the various asset classes to account for changes in market conditions and the Scheme's risk appetite. This will include continued optimisation of the selection of asset managers.

NOMINATION COMMITTEE

The Nomination Committee is an independent committee of the Board, comprised of members who are not Trustees of the Scheme. The Committee's scope does not extend to it determining the skill set requirements and/or composition requirements of individual Trustees and Independent Board Committee candidates, which is at the sole discretion of the Board.

The Committee is established by the Board to oversee the nomination and election processes as set out in the Framework for the Nomination and Election of Trustees, which includes:

- Oversight of the nominations process from a governance perspective as well as overseeing the nominations process implemented by the Independent Electoral Body (IEB).
- Oversight of the following to the extent that they relate solely to the election and appointment of Trustees:
  - AGM and/or special general meeting (SGM) voting processes;
  - Proxy processes.
- All other aspects of the AGM or SGM remain the ultimate responsibility of the Trustees unless specific formal requests are made of the Committee. This is to ensure that independence related to elections and appointments is maintained.
- For the 2025 AGM and Trustee election, the Board approved the appointment of Forvis Mazars South Africa as the independent third-party service provider to assist the Committee.

Furthermore, and for purposes of the Board filling vacancies outside of the election processes, the Committee assists in vetting candidates to be considered to serve on the Board as appointed and co-opted Trustees, as well as candidates to be considered for appointment and co-option to serve as Independent Committee Members. Such vetting is aligned to the criteria as set out in the Scheme Rules and as applied when vetting candidates nominated by members.

Activities during 2025[1]

The 2025 AGM and Trustee elections were successfully convened on 26 June 2025. The Committee oversaw this process from a governance perspective in terms of its mandate. This process and the following activities were undertaken by Forvis Mazars in 2025 as an independent third-party service provider in assisting the Committee to:

- Vet candidates standing for election;
- Review the notice of the AGM;
- Oversee and manage the proxy appointment process;
- Receive motions from members and provide them to the Scheme;
- Manage the registration of attendees at the AGM;
- Oversee any other aspects that members are required to vote on;
- Oversee any other aspects related to the election of three Trustees;
- Ensure the integrity and validity of the voting results; and
- Prepare final reports for the Board and submission to the CMS.

The Committee reported to the Trustees on its activities for the 2025 AGM and fulfilled its responsibilities in accordance with its terms of reference.

1. *The Nomination Committee is not included in committee effectiveness reviews as it is independent, and excludes Trustee representation to maintain impartiality and independence in fulfilling its duties.*

Composition and meetings in 2025

As at the end of 2025, the Committee comprised two independent members, with one member having resigned from the committee in August due to the potential conflict of interested due to their new executive role. Meetings of the Committee are attended by the IEB and its representatives.

Nominations Committee attendance in 2025		14 Jan	23 Jan	30 Jan	06 Feb	13 Feb	27 Feb	05 Mar	07 Mar	10 Mar	10 Mar	20 Mar	27 Mar	03 Apr	10 Apr	15 Apr	16 Apr	23 Apr	24 Apr	01 May	09 May	29 May	05 Jun	10 Jun	11 Jun	12 Jun	19 Jun	20 Jun	26 Jun	27 Jun	30 Jun	02 Jul	03 Jul	05 Jul	07 Jul	10 Jul	14 Jul	15 Jul	22 Jul	30 Jul	01 Aug	07 Aug	15 Sep	09 Oct	13 Oct	30 Oct	03 Nov
Independent Member Chairperson	Mr Andrew Bryce	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Independent Committee Members	Ms Alexandra Muller	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ms Boitumelo Lekoko[1]	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	–	–	–	–

1. *Resigned as Committee Member effective 30 September 2025.*

x *Apology tendered.*

– *Not required to attend.*

Meetings are convened as and when required to discuss any matter related to the Annual General Meeting and/or Trustee elections. This includes meetings dedicated for AGM and election document formulation and review, including vetting of nominees standing for election and vetting of candidates being considered for appointment as Trustees or Independent Committee Members. Committee members are remunerated according to the duration of such meetings.

Future focus areas

The 2026 Annual General Meeting is scheduled to take place on 25 June 2026. The Committee will supervise all aspects of the AGM, maintaining transparency and accountability through established governance procedures, in collaboration with the Scheme's IEB partner. This approach is designed to ensure both independence and integrity in the AGM proceedings and voting processes on the day. While 2026 is not an elective year, members are still able to participate in voting for the following:

- Non-binding advisory vote on the Trustee Remuneration Policy.
- 2026 Trustee remuneration.
- Appointment of auditors for 2026.
- Motions received for the 2026 AGM (if any).

PRODUCT COMMITTEE

The Product Committee was established in terms of Scheme Rule 19.3, as the Trustees consider it necessary to ensure compliance with the legislative and regulatory requirements of the Act, as well as best practice governance principles pertaining to benefit and product development. The Committee comprises members with the requisite skills, including actuarial and medical expertise.

The Committee oversees product development, including amendments to benefits, and related communication and marketing materials. In doing so, they consider clinical appropriateness, financial affordability, sustainability, competitiveness and the interests of members and healthcare providers.

Activities during 2025

The Committee held five meetings during 2025, two of which were ad hoc combined meetings with the Audit Committee. As per its annual work plan, the Committee considered matters pertaining to the Scheme's research and development strategy, marketing strategy and plan, financial performance, impact of benefit changes, current benefits utilisation, and other competing products in the market.

For the 2026 product changes, the Committee considered and approved the introduction of the new Smart Saver plan series and resubmissions of primary care benefit options, benefit proposals including enhancements to Personal Health Pathways and the Personal Health Fund, the actuarial valuation report, proposed Scheme Rule changes, and marketing and communication for the 2026 products and benefits enhancements while accounting for demographic risks, the needs of members and the competitor landscape, and made recommendations for the Board's approval. The Committee continuously monitors developments in the policy and regulatory space, including those pertaining to the NHI and Low-Cost Benefit Options (LCBOs) framework development.

Composition and meetings in 2025

At the end of 2025 the Committee comprised five Trustees, one of whom chaired the Committee, one who is the Chairperson of the Board, and one who is the Chairperson of the Clinical Governance Committee (which serves to facilitate the required sharing of information between the two committees).

The Principal Officer is also a member. The Committee obtains regular reports and presentations from Discovery Health, and relevant individuals are regularly invited to Committee meetings for this purpose.

The Product and Audit Committees jointly considered the actuarial valuation and contribution increases, and invited the Scheme's external auditors, Deloitte & Touche, and the Scheme's independent actuaries, Insight Actuaries & Consultants, to attend the meetings.

Product Committee attendance in 2025

		15 May	22 Jul	26 Aug	12 Sep[A]	12 Sep[A]	22 Sep[A]
Trustee Chairperson	Mr Marius du Toit[1]	✓	–	–	–	–	–
	Dr Rendani Mbuvha[2]	✓	✓	✓	✓	✓	✓
Trustee	Dr Max Price[3]	✓	–	–	–	–	–
	Ms Michelle Norton SC	✓	✓	✓	✓	✓	✓
	Dr Dhesan Moodley	✓	✓	✓	✓	✓	✓
	Prof Cornelius Schutte[4]	–	✓	✓	✓	✓	x
Executive	Ms Charlotte Mbewu (Principal Officer)	✓	✓	✓	✓	✓	✓

1. *Not re-elected as Trustee at the 2025 AGM.*
2. *Appointed as Committee Chairperson on 16 July 25.*
3. *Not re-elected as Trustee at the 2025 AGM.*
4. *Appointed as Committee Member on 16 July 2025.*

A - Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Board or Committee meetings and are convened for a specific purpose. Trustees and Committee members are remunerated according to the duration of such meetings.
- *An ad hoc Product meeting was held on 12 September to discuss the Product and Benefit Recommendations.*
- *An ad hoc combined Audit and Product Committees meeting was held on 12 September to discuss the Product and Benefit Recommendations.*
- *An ad hoc combined Audit and Product Committees meeting was held on 22 September to discuss the 2026 contributions.*

x Apology tendered.
– Not required to attend.

Future focus areas

The Committee will continue to exercise due care and responsibility in fulfilling its mandate to ensure the Scheme remains the leading open medical scheme in the industry. This is done through continuous product and benefit innovations and enhancements while also ensuring the Scheme is sustainable and compliant with the regulated reserves, and able to meet the healthcare needs of members.

REMUNERATION COMMITTEE

The Committee assists the Board in ensuring that the Scheme's remuneration practices are fair, responsible and transparent. It also assists with overseeing human capital strategies and related policies, and ensuring implementation of these policies. The Committee is also responsible for overseeing the implementation of the Remuneration Policy, which includes determining and reviewing the remuneration for Trustees and Independent Committee Members. It formulates recommendations regarding remuneration structures and submits these recommendations to the Board. All proposals concerning trustee and ICM remuneration must also be presented at the Scheme's AGM for approval by the Scheme membership.

Finally, it ensures that reporting disclosures relating to remuneration are made according to regulatory guidelines, and that a formal, rigorous and transparent process is followed for the appointment of executive level staff.

The responsibilities of the Committee include:

- Annually considering and recommending a remuneration policy and associated practices that are fair, in line with best practice and responsible for all staff levels in the Scheme.
- Considering best-in-class industry practice, professional executive recruitment organisations' publications, and the independent remuneration industry report(s) for the purposes of benchmarking the Scheme's remuneration policies in respect of the Principal Officer, staff, Trustees and Independent Board Committee Members.
- Benchmarking and recommending remuneration fees of Trustees and Independent Committee Members.
- Annually reviewing the Scheme's employee value proposition to ensure its suitability.
- Annually considering and approving employee training requirements and/or requests.
- Ensuring, where possible[1], that succession plans are in place to maintain an appropriate balance of skills in the Scheme's management and governance structures.

1. *At least half of the Trustees must be elected by Scheme members, from amongst Scheme members, at any time. Succession planning is therefore not possible for these positions.*

Activities during 2025

- Recommended Trustee and Independent Committee Member remuneration to the Board for approval and advised the Board on regulatory aspects of remuneration implementation, including tabling the matter at the Scheme's 2025 AGM.
- Considered and recommended the Trustee and Independent Committee Member Remuneration Policy to the Board and Scheme members for approval.
- Considered and recommended employee remuneration to the Trustees for approval.
- Considered and recommended Scheme human resources policies to the Board for approval.
- Considered and approved training and development requirements for Scheme employees.
- Considered the results of the 2024 Committee effectiveness review, making changes where required.
- Considered and recommended the filling of Board Committee and committee vacancies.

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2025 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2025

At the end of 2025, the Committee comprised three Trustees and one Independent Committee Member. The Principal Officer attends Committee meetings by invitation.

Remuneration Committee attendance in 2025

		31 Mar[A]	07 Apr[A]	14 Apr[A]	19 May[A]	21 May	06 Jun[A]	13 Nov
Independent Member Chairperson	Mr Bongani Hlophe[1]	✓	✓	✓	✓	✓	✓	–
Trustee/Chairperson	Mr David King[2]	–	–	–	–	–	–	✓
Trustees	Ms Joan Adams SC[3]	✓	✓	✓	✓	✓	✓	✓
	Ms Michelle Norton SC	✓	✓	✓	✓	✓	✓	✓
	Dr Max Price[4]	✓	✓	✓	x	✓	✓	–
Independent Committee Members	Ms Tirelo Sibisi	✓	✓	✓	✓	✓	✓	✓

1. *First 3-year tenure ended on 30 June 2025 and was re-appointed.*
2. *Appointed as Committee Chairperson on 16 July 2025.*
3. *Re-appointed as Committee Member on 16 July 2025.*
4. *Not re-elected as Trustee at the 2025 AGM.*

A - Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Committee meetings and are convened for a specific purpose. Committee members are remunerated according to the duration of such meetings.
- *A meeting was held on 31 March to discuss Trustee benchmarking analysis.*
- *A meeting was held on 07 April to discuss Variable Incentive Salient Features.*
- *A meeting was held on 14 April to discuss Trustee benchmarking analysis.*
- *A meeting was held on 19 May as a continuation of the Trustee benchmarking discussion.*
- *A meeting was held on 06 June to further discuss the short-term incentives of the meeting of 24 May.*

x Apology tendered.
– Not required to attend.

Future focus areas

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. Key focus areas will include:

- Completing the review of the Remuneration Policy together with the remuneration architecture to ensure its relevance and to make progressive improvements;
- Continuing to engage with the Principal Officer and Board on the Scheme's Remuneration Policy and ensuring the appropriateness of remuneration and reward arrangements and/or systems;
- Reviewing the Scheme's remuneration practices where appropriate, and ensuring these comply with changing legislative and regulatory requirements, including those relating to King IV; and
- Continuing to review the Scheme's succession planning processes to ensure that the Scheme can adequately respond to vacancies.

RISK COMMITTEE

The Risk Committee oversees risk management, compliance, IT governance, fraud, ethics, whistleblowing, legal and regulatory matters, non-healthcare expenses, outsourcing, operations and the Shariah Compliant Arrangements. The purpose of the Committee is to exercise ongoing oversight of risk management, and its responsibilities include:

- Assessing the risks and opportunities emanating from the triple context in which the Scheme operates and the capitals that the Scheme utilises and affects;
- Integrating and embedding risk management in the Scheme's culture, business planning and activities, and decision-making through continual risk monitoring and identification;
- Assessing both the potential opportunities and negative effects inherent in risks that may impact on organisational objectives;
- Assessing the organisation's dependence on resources and relationships represented by the various forms of capital;
- Designing and implementing appropriate risk responses by continually assessing mitigation plans and their implementation by management, and recommending measures which may enhance the risk management process; and
- Establishing and implementing business continuity arrangements that allow the organisation to operate under volatile conditions and to withstand and recover from acute shocks.

Compliance management

The Trustees recognise their responsibility to internal and external stakeholders in terms of the regulatory requirements applicable to the Scheme. The Scheme has implemented a co-ordinated compliance framework to ensure all operations are conducted in accordance with applicable legal, regulatory and supervisory requirements and guidelines. Certain compliance activities are outsourced to the Discovery Group Compliance function. The framework is structured to facilitate the process of obtaining information from Discovery Health to monitor and oversee the outsourced operations, and a compliance monitoring plan is approved on an annual basis. Changes to regulations that could impact the Scheme's strategy and operations are monitored. Where required, action plans implemented by management are monitored and reported to the Committee.

Risk management

The Trustees recognise that risk management is an integral part of the strategy-setting process and delegates the responsibility of designing, implementing and monitoring the risk management process and system to the Scheme Executives. Risk management is facilitated by the Chief Operations Officer who ensures that it is embedded in daily management activities with second line support from the Discovery Group Risk function.

The Trustees are satisfied that the risk management process effectively and continuously identifies and evaluates risks and ensures they are managed in line with the business strategy.

Activities during 2025

- Participated in the annual risk register assessment, which included representatives of the Committee, the Scheme Office, and the administration and managed care provider.
- Regularly considered risk management reports and key risk indicators, and reviewed the risk appetite which was recommended to the Trustees for approval.
- Regularly reviewed compliance reports and monitored exposure and actions taken to mitigate compliance risks.
- Reviewed reports to assist in managing the Scheme's IT governance obligations.
- Recommended the Scheme's Outsourcing Risk Assessment to the Board for approval.
- Considered the status of the annual disaster recovery and business continuity tests.
- Reviewed and monitored reports on the service levels delivered by Discovery Health and its forensic activities.
- Assessed the value added to the Scheme by Discovery Health and obtained independent assurance on the calculations.
- Considered Discovery Health's Operations Strategy.
- Considered the administrator's data privacy controls and privacy breaches.
- Reviewed the Scheme's non-healthcare expenses against budget and compliance with the Procurement Policy.
- Received report backs from the Innovation Committee.
- Reviewed reports on the Shariah Compliant Arrangements.
- Dealt with various governance related policies and recommended them to the Board for approval.
- Considered the results of the 2024 Committee effectiveness review.
- Reviewed the Committee's terms of reference.

Composition and meetings in 2025

At the end of 2025, the Committee comprised two Independent Committee Members, two members of the Scheme Office, and four Trustees, one of whom chaired the Committee. The external auditors as well as the Discovery Group Risk Management function and Discovery Group Compliance function attend every Committee meeting. Representatives from Discovery Health also attend to provide detailed operational insight.

Risk Committee attendance in 2025		19 Mar	24 Jul	01 Oct	16 Oct
Trustee Chairperson	Mrs Lalita (Gita) Harie	✓	✓	✓	✓
Trustees	Dr Rendani Mbuvha	✓	✓	✓	✓
	Ms Joan Adams SC[1]	✓	✓	✓	✓
	Prof Cornelius Schutte[2]	–	✓	✓	✓
Independent Committee Members	Mr Eric Mackeown[3]	✓	✓	–	–
	Dr Alewyn Burger[4]	✓	✓	✓	✓
	Ms Melanie Bosman[5]	–	–	✓	✓
Executive	Ms Charlotte Mbewu (Principal Officer)[6]	✓	✓	✓	✓
	Mr Selwyn Kahlberg (Chief Operations Officer)[7]	✓	✓	✓	✓

1. *Re-appointed as Committee Member on 16 July 2025.*
2. *Appointed as Committee Member on 16 July 2025.*
3. *Second 3-year term ended on 31 August 2025.*
4. *Second 3-year term ended on 31 December 2025.*
5. *Appointed as Committee Member on 01 September 2025.*
6. *Scheme Executive. All other Committee Members are non-executive.*
7. *Scheme Executive. All other Committee Members are non-executive.*

x Apology tendered.
– Not required to attend.

Future focus areas

The Committee will continue to exercise due care and responsibility in fulfilling its mandate. Key focus areas will include managing the risks related to the Scheme's delivery of high-quality affordable benefits, and monitoring developments in the regulatory landscape and cyber risks.

STAKEHOLDER RELATIONS AND ETHICS COMMITTEE

The purpose of the Stakeholder Relations and Ethics Committee is to assist the Trustees in overseeing stakeholder relationship management, responsible corporate citizenship, and the ethics activities and culture of the Scheme. The roles and responsibilities of the Committee are as follows:

Ethics and society

- Assist the Board of Trustees to ensure that the Scheme has an ethical culture and is a good corporate citizen.
- Provide oversight, evaluation and monitoring of the Scheme's ethics in a way that supports its ethical culture.
- Provide oversight, evaluation and monitoring of the Scheme's corporate citizenship to underpin its reputation as a responsible corporate citizen.
- Provide oversight and monitor the development of adequate processes and procedures for the management of the Scheme's ethics and corporate citizenship.
- Provide feedback to the Board regarding risks identified in terms of ethical/societal problems, and provide steps or enhanced process recommendations to mitigate such risks.

Stakeholder relations

- Identify material stakeholder groupings and individuals, as well as their legitimate needs, interests and expectations.
- Provide oversight and monitor the development of adequate processes and procedures for stakeholder engagement, as well as provide oversight, monitor and evaluate the management of and engagement with DHMS' material stakeholders.
- Provide feedback and updates to the Board regarding stakeholder interactions, risks identified or opportunities for new channels of engagement.

The Committee may rely on the governance frameworks and structures of other Board Committees, the Scheme Office and, where appropriate, the administration and managed care provider in fulfilling its governance and oversight responsibilities.

Activities during 2025

- Considered the Scheme's landscape of healthcare providers with which it contracts, and the related challenges and stakeholder impact.
- Monitored the developments leading up to the Scheme's AGM, with attendant stakeholder activism, and discussed how best to navigate relations in an environment of divergent stakeholder interests.
- Reviewed the latest Social and Ethics Committee Trends Survey Report for insights relevant to its operations.
- Considered research relevant to its mandate, including the links between physical activity and cancer progression; gender equality in South Africa; and ethical and legal considerations in healthcare AI.
- Received a presentation on ethics and governance considerations in the implementation of AI at Discovery Health.
- Satisfied itself with its updated Responsible Corporate Citizenship Framework.
- Received in-depth training on an engagement report and related operations.
- Considered the impact on the industry emerging from the publication of the Section 59 Report, including the reactions of healthcare professionals.
- Was informed about Discovery Health's work with key DHMS stakeholders to review goals and commitments relating to its journey towards net zero greenhouse gas emissions.
- Considered an in-depth report on the operations and improvements to managed care and complex clinical case management by Discovery Health on the Scheme's behalf.
- Reviewed a public engagement framework and the revised Gifts, Gratuities and Business Courtesies Policy for recommendation to the Board.
- Satisfied itself with its terms of reference and annual calendar for the forthcoming year, and considered the Committee's training needs and opportunities.
- Reviewed reports relating to the Committee's social and ethics mandate, including overall stakeholder engagement and risk, disputes and complaints, customer engagement, the Scheme's workplace, Treating Customers Fairly and high-risk and complex medical cases.
- Reviewed the activities of the Dispute Committee, and the Relationship Management and Research Governance management committees.
- Considered the results of the 2024 committee effectiveness review conducted by PG Governance. The Committee received a score of 100% and was considered by PG Governance to be 'excellent'. The evaluator made no significant conclusions or suggestions for the Committee.

The Committee is satisfied that its activities, recommendations and reporting to the Board during 2025 have fulfilled its responsibilities in accordance with its terms of reference.

Composition and meetings in 2025

At the end of 2025, the Committee comprised four Trustees, one of whom chaired the Committee, one Independent Committee Member, and the Principal Officer.

The Committee obtains regular reports from Discovery Health, which engages in some stakeholder relations activity on the Scheme's behalf. Individuals from Discovery Health are regularly invited to Committee meetings in this regard. External experts are also occasionally invited to address the Committee.

Stakeholder Relations and Ethics Committee attendance in 2025

		06 Mar	24 Jul	23 Oct
Trustee Chairperson	Ms Joan Adams SC[1]	✓	✓	✓
Trustees	Mrs Lalita (Gita) Harie	✓	✓	✓
	Dr Max Price[2]	✓	–	–
	Ms Michelle Norton SC	✓	✓	✓
	Mr David King[3]	–	✓	✓
Independent Committee Members	Dr Dineo Tshabalala[4]	–	✓	✓
Executive	Ms Charlotte Mbewu (Principal Officer)[5]	✓	✓	✓

1. *Re-appointed as Committee Member on 16 July 2025.*
2. *Not re-elected as Trustee at the 2025 AGM.*
3. *Appointed as Committee Member on 16 July 2025.*
4. *Appointed as Committee Member on 16 July 2025.*
5. *Scheme Executive. All other Committee Members are non-executive.*

x Apology tendered.
– Not required to attend.

Future focus areas

The Committee will continue to exercise due care and responsibility in fulfilling its mandate, including an ongoing consideration of the impact of the Scheme on its members and other stakeholders. In 2026, work to be done by the Committee includes overseeing the continued implementation of the Scheme's ethics management plan and related policies, as well as considering opportunities to further support the healthcare system in line with its mandate of responsible corporate citizenship.

AD HOC COMMITTEE OF THE BOARD OF TRUSTEES/ OPEX BUDGETING COMMITTEE[1]

The Board appointed an ad hoc Committee to review the Scheme's other operating expenses budget. It is expected to meet at least once annually to review the other operating expenses budget and thereafter make a recommendation to the Board.

Activities during 2025

The Committee convened once during 2025 to review the other operating expenses budget for recommendation to the Board for approval.

Composition and meetings in 2025

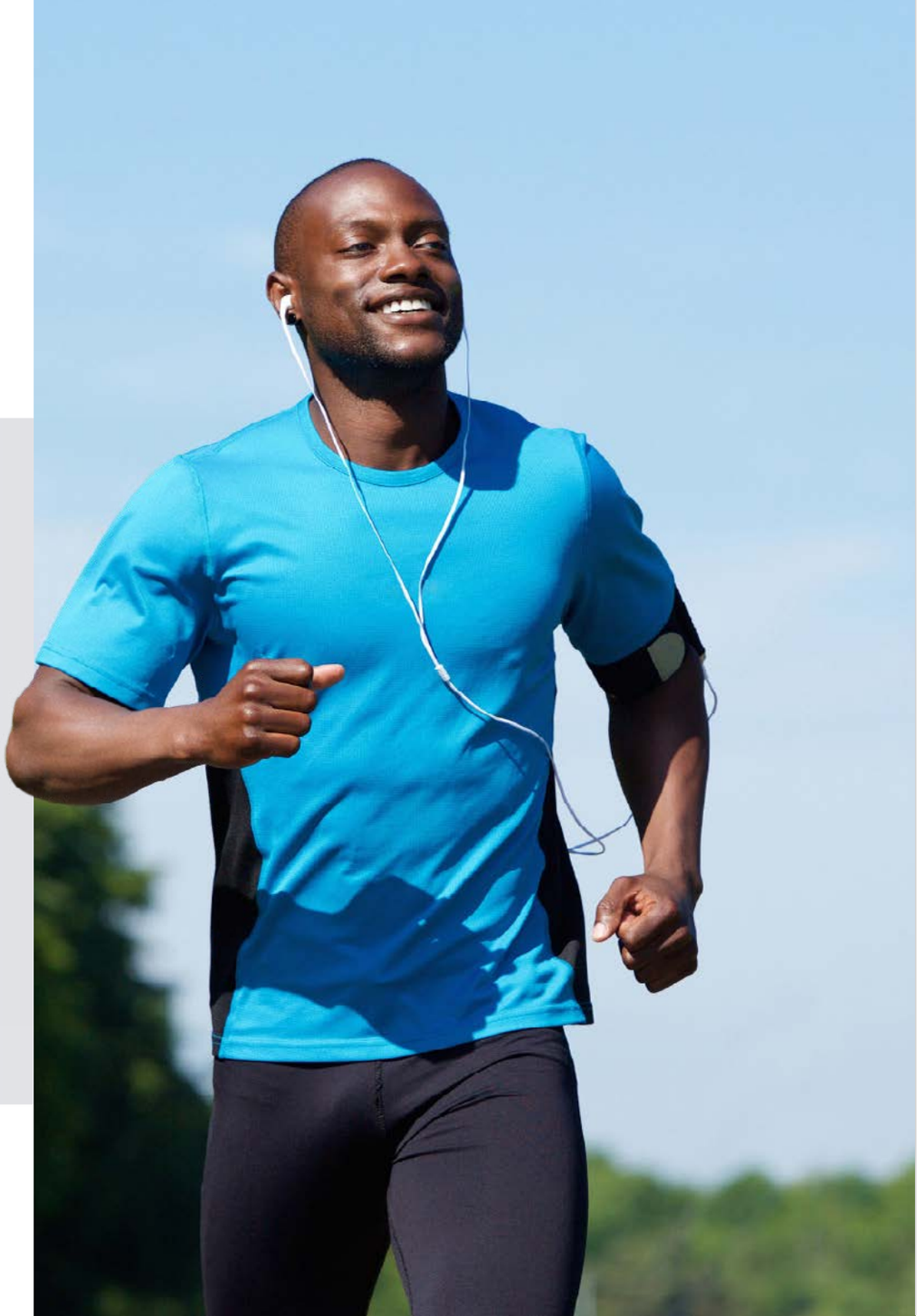
The Committee comprised three Trustees.

OPEX Budgeting Committee[1] attendance in 2025		23 Oct
Trustee Chairperson	Dr Dhesan Moodley	✓
Trustees	Mr David King[2]	✓
	Dr Rendani Mbuvha	✓

1. Renamed from Ad hoc Committee of the Board in September 2025.
2. Appointed as Committee Member on 16 July 2025.
A - Ad hoc meetings:
Ad hoc meetings may be shorter than scheduled Board meetings and are convened for a specific purpose. Trustees are remunerated according to the duration of such meetings.
• A meeting was held on 23 October to discuss the operational expenditure and budget for 2026.
x Apology tendered.
– Not required to attend.

Future focus areas

Future focus areas to be determined by the Board as required.



1. This Committee was renamed the OPEX Budgeting Committee in September 2025.

Independent Committee Member terms[1]

INDEPENDENT COMMITTEE MEMBER	Committees served on	Start of term	End of first term	End of second term
Mr Eric Mackeown	Audit, Investment, Risk	01 Sep 19	31 Aug 22	31 Aug 25
Dr Alewyn Burger	Audit, Risk	01 Jan 20	31 Dec 22	31 Dec 25
Ms Henda van Deventer	Investment	01 Jan 22	31 Dec 24	31 Dec 28
Ms Melanie Bosman	Audit, Investment, Risk	01 Jan 22	31 Dec 24	31 Dec 28
Ms Alexandra Muller	Nomination	01 Jan 22	31 Dec 24	31 Dec 28
Mr Andrew Bryce	Nomination	01 Jan 22	31 Dec 24	31 Dec 28
Dr Prof Laurel Baldwin Ragaven	Clinical Governance	01 Feb 22	31 Jan 25	31 Jan 29
Mr Bongani Hlophe[2]	Remuneration	01 Jul 22	30 Jun 25	N/A
Mrs Busisiwe Mathe[3]	Audit	01 Jun 23	30 May 26	N/A
Dr Dineo Tshabalala	Clinical Governance	01 Jun 23	30 May 26	N/A
Ms Boitumelo Lekoko[4]	Nomination	01 Jul 24	30 Jun 28	N/A
Ms Tirelo Sibisi	Remuneration	01 Oct 24	30 Sep 28	N/A
Mr Victor Muguto	Audit	01 Sep 25	31 Aug 29	N/A
Mr Lwazi Nopece	Audit	01 Oct 25	30 Sep 29	N/A
Dr Thinus Bekker	Audit, Risk	01 Jan 26	31 Dec 29	N/A

1 Independent Committee Members who were appointed before 14 July 2023 serve for three years, whereas those appointed after that date serve for four years. All ICMs may be re-appointed for a second term but cannot serve more than two consecutive terms. Due to the variation of Dispute Committee panellists, members are not listed. Each Dispute Panel consists of three Independent Members drawn from the greater Dispute Committee, each of whom have either legal or medical expertise. Dispute hearings are scheduled as and when required, and draw from the legal and medical panellists available at the time. If required, the Committee can be constituted several times a week to attend to increased caseloads.

2 First 3-year tenure ended on 30 June 2025.

3 Resigned effective 30 June 2025.

4 Resigned effective 30 September 2025.

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Independent Board Committee Members[1]

Prof Laurel Baldwin-Ragaven

Member of the Clinical Governance Committee

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AB (Smith College)[2]; MDCM (McGill)[3]; FCFP(Canada)[4]; FCFP(SA)[5]

Internationally experienced academic family physician, health and human rights advocate, and medical ethics teacher and researcher. Vast clinical expertise in primary care, knowledge of public health systems and passion for interventions into the social determinants of health and disease.

Ms Melanie Bosman

Chairperson of the Audit Committee and member of the Risk and Investment Committees

54

CA(SA), BCom, BAcc

Experienced non-executive director in the financial services industry, notably short-term and life insurance. Formerly an audit partner at a large accounting firm. Expertise in governance, International Financial Reporting Standards (IFRS) and financial sector regulation.

Dr Thinus Bekker

Member of the Audit and Risk Committees

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PhD. Digital governance in support of infrastructure asset management; Certified Director; Project Management Professional; IT Service Management Foundation Certification; M. Com: Informatics; B. Com: Honours: Informatics; B. Com: Informatics; Records Management Certificate; Property & Casualty and Life Insurance Certificate of Proficiency

CTO/CIO and non-executive director with more than 30 years of experience focused on digital technology and information at both South African and international organisations. Previously chaired various IT committees and has a successful track record in knowledge and information management, shared services, research and innovation, and risk management.

Mr Andrew Bryce

Member of the Nomination Committee

70

CA(SA); BSc (Hons) Biochemistry; BCompt (Hons)

Extensive corporate experience at executive level, particularly in corporate governance, risk management, business and internal controls. Previously chaired a pension fund and audit committee of a medical scheme, and has served as a director on several companies within a group.

Dr Alewyn Burger

Member of the Audit and Risk Committees
Term ended in 2025

74

MSc (Mathematical Statistics); PhD (Mathematical Statistics); Advanced Executive Programme (UNISA); Advanced Management Programme (Harvard Graduate School)

Extensive experience in IT architecture; implementation and operations; and governance, planning, strategy, research, and development at global CTO, CIO and global group executive director level. Previously chaired various IT risk governance committees. Experienced banking institutions board member and an IT expert board member.

Ms Henda Van Deventer

Member of the Investment Committee

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CA(SA); BA Law

Independent consultant with over 20 years' financial services experience in credit and investment, including in development finance, investment banking, alternative assets, and credit risk policy development and implementation. Track record as non-executive member or chair of various investment and credit committees and similar governance forums.

Mr Bongani Hlophe

Chairperson of the Remuneration Committee
Term ended in 2025

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BA Law; BA (Hons) (Human Resources Management); Dip Company Direction; ECOOP[6]; Bus Strategy Specialisation

23 years spent as an HR professional in the mining, higher education, and banking sectors, with significant knowledge of the employee benefits industry. Formerly a senior management consultant, chair, and non-executive chair of several national and international entities, as well as a member of the King III Sustainable Development Reference Group. Served as the Independent Advisory Board Chairman and transformation committee member at the Africa division of a global audit firm. Currently a majority shareholder in a management consultancy.

1. *Note: all ages as at 31 December 2025.*
2. *AB: Bachelor of Arts.*
3. *MDCM: Doctor of Medicine and Master of Surgery.*
4. *FCFP (Canada): Fellowship in the College of Family Physicians of Canada.*
5. *FCFP (SA): Fellowship of the College of Family Physicians of South Africa.*
6. *The Emerging COO Executive Programme offered by Stanford.*

Ms Boitumelo Lekoko

Member of the Nomination Committee
Term ended in 2025

42

Certified Fraud Examiner; BCom: Acc; Dipl: Acc Sc; High Dpl: Criminal Justice & Forensic Investigation

Founder and Managing Director of a forensics, election governance and ethics advisory firm, with over 17 years' experience. Extensive experience in Trustees election and ICM appointments with niche expertise in elections governance. Further proficiency in nominations, vetting, proxy and hybrid voting processes, objections management and governance risk mitigation to ensure credible election outcomes. Previously served as IEB and trusted adviser to boards on complex governance and strategic risk matters.

Ms Lwazi Nopece

Member of the Audit Committee

46

Registered Auditor; CA(SA)

Independent consultant with 25 years' experience across various industries, including ten years as a partner at a large professional services firm. Expertise in governance, risk, audit, finance, audit transformation and change, learning and leadership development. Currently serving as an independent non-executive director across multiple sectors.

Mr Eric Mackeown

Chairperson of the Audit Committee and member of the Risk and Investment Committees
Term ended in 2025

68

CA(SA)

More than 40 years' experience in the accounting and auditing profession. Was lead audit partner for numerous major multinational and JSE-listed companies. Non-executive director and chairperson of the audit committee of Assore Holdings. Thorough and deep understanding of the health and medical aid industries.

Mrs Busisiwe Mathe

Member of the Audit Committee
Term ended in 2025

45

CA(SA)

Independent consultant with over 15 years' experience at a professional services firm, seven of which as a partner. In-depth knowledge in governance, risk, audit, information technology, cybersecurity, and data privacy. Track record of leading external and internal and IT audits, digital transformation, cybersecurity, and data privacy projects at listed and unlisted companies across multiple sectors. Currently serving as an independent non-executive director; chairperson and member of the audit and risk committee and the social and ethics committee of JSE-listed companies.

Mr Victor Muguto

Member of the Audit Committee

66

CA(SA); MBA; BCompt (Hons)

Experienced independent non-executive director for asset management, life and non-life insurance companies. Prior to that, 37 years' financial services experience in a Big 4 professional services firm, 27 of those years as partner working with banks, insurers, asset managers and large medical schemes.

Mrs Alexandra Muller

Member of the Nomination Committee

49

CA(SA)

20 years spent at a professional services firm, ten of which as a partner specialising in governance, risk and internal audit. Significant knowledge of medical schemes, having provided services to such organisations in addition to other financial services businesses, both listed and unlisted. Currently serving as an independent non-executive director for various companies.

Ms Tirelo Sibisi

Member of the Remuneration Committee

57

MBA Henley University; B Soc Sc (SW) Hons; Advanced Executive Human Resources Program (Michigan University)

Independent Consultant with extensive experience in the field of Human Resources & Development. Currently Deputy Chair of Council at the University of the Free State with over 25 years spent as an HR Leader in multiple industries including mining, telecommunications, information and communication technology, and Health. Track record as non-executive member or chair of various Human Resources and Remuneration committees and similar governance forums.

Dr Dineo Tshabalala

Member of the Clinical Governance Committee

42

MBChB (UKZN); MMed Int Med (WITS); FCP(SA); Cert Medical Oncology(SA)

A senior lecturer and consultant in the Department of Internal Medicine Division of Medical Oncology at Charlotte Maxeke JHB Academic hospital. Currently joint staff at WITS University Medical School, working as a medical oncologist and pursuing her research interests.

Our approach to remuneration

In accordance with King IV Principle 14, which states "The governing body should ensure that the organisation remunerates fairly, responsibly and transparently to promote the achievement of strategic objectives and positive outcomes in the short, medium and long term", the Board is responsible for the development and implementation of a Remuneration Policy for the Trustees and Board Committee Members.

The Board of Trustees has delegated oversight of Scheme remuneration to our Remuneration Committee, a Board Committee established in terms of the DHMS Board charter, which assists the Board in fulfilling its remuneration governance and oversight obligations and responsibilities in terms of the Act, Scheme Rules and best practice governance principles.

Our full Remuneration Policy

When required, the Committee uses independent expert consultants and independent market benchmarking to assist with developing and implementing best remuneration practices, as detailed in the approved Remuneration Policy. Trustee remuneration disclosure occurs:

- At the AGM;
- To the CMS, the Scheme's Regulator; and
- In the Scheme's Integrated Report.

Trustee remuneration is based on a professional hourly rate, discounted due to the Scheme's non-profit status. This forms the foundation of all Trustee and Board Committee remuneration and is the rate that members are required to vote on annually via ballot at the AGM.

The purpose of the Remuneration Policy is to:

- Provide the guiding principles underpinning the Scheme's employee remuneration philosophy;
- Set out the guiding principles and application for each component of reward (i.e. short- and long-term incentives);
- Stipulate the role and function of the Remuneration Committee; and
- Define the remuneration procedures of the Scheme

The Remuneration Policy is based on the requirement set out by the CMS in Circular 41 of 2014 and was presented to members for the first time at the 2014 AGM, where it was approved by a majority of members in attendance. The Policy is reviewed annually by the Committee for Board approval and tabled each year at the AGM for a non-binding vote by members.

The total remuneration paid to Trustees is determined by the following elements:

- Number of meetings planned per year;
- Preparation time for each meeting;
- Duration of meetings;
- Estimated time required between meetings[1]; and
- The actual number of meetings attended.

In addition to their other duties, Trustees are members of Board Committees, each of which differ regarding preparation time, duration of meetings, and number of meetings in the year.

The total annual fees payable to Trustees and Board Committee Members are calculated based on the number of planned Board and Board Committee meetings (per the annual meeting plan) and are split into:

- An annual base fee (70% of total annual fees, paid as a quarterly retainer in arrears); and
- A fee per meeting (30% of total annual fees, paid at the end of the month in which the meeting took place).

If an unplanned ad hoc meeting is required outside of the annual meeting plan, the attendee is remunerated at the hourly rate.

Trustee and/or Board Committee Member fees are exclusive of VAT. Where Trustees and/or Board Committee Members are registered for VAT, they issue a tax invoice to the Scheme clearly reflecting the VAT amount in addition to their total fees for the period.

1. *The Chairperson of the Board is required to make additional preparations for Board meetings and is expected to attend to various requirements between meetings as an inherent part of the role.*

Managing the Scheme Office

As part of their fiduciary duties, the Trustees appoint and delegate accountability for the day-to-day management of the Scheme to the Principal Officer, who is the chief executive and accounting officer of the Scheme. The Principal Officer is required to execute the decisions of the Trustees and bears ultimate responsibility for all management functions. The Principal Officer must be fit and proper to hold this office and may appoint any staff, in accordance with the approved human capital plan, required for the proper execution of the business of the Scheme.

The Principal Officer is supported by an executive management team to execute the strategic objectives of the Scheme. The team works in collaboration with, and oversees work done by the Scheme's administration and managed care provider, Discovery Health, and other service providers to ensure accordance with the contractual agreements in place.

The management team's expertise encompasses a broad range of capabilities including medicine, actuarial science, risk management, accounting, business management, strategic development, financial management, investment, governance, law, ethics, compliance and research.

Delegation of authority

To ensure effective accountability and responsibility within the Scheme, the Board of Trustees can confer certain powers to its Committees and Scheme Executives through a formal delegation of authority process. This process provides a framework for the Committees and Scheme Executives to:

- Achieve strategic priorities;
- Effectively manage the Scheme within legislative compliance requirements;
- Balance the interests of Scheme stakeholders;
- Minimise and avoid conflicts of interest;
- Ensure checks and balances; and
- Practice good corporate governance.

The delegation of authority is reviewed and updated periodically to ensure relevance to operating requirements and alignment with the accountabilities and authorities of Scheme employees.

Our employees and their remuneration

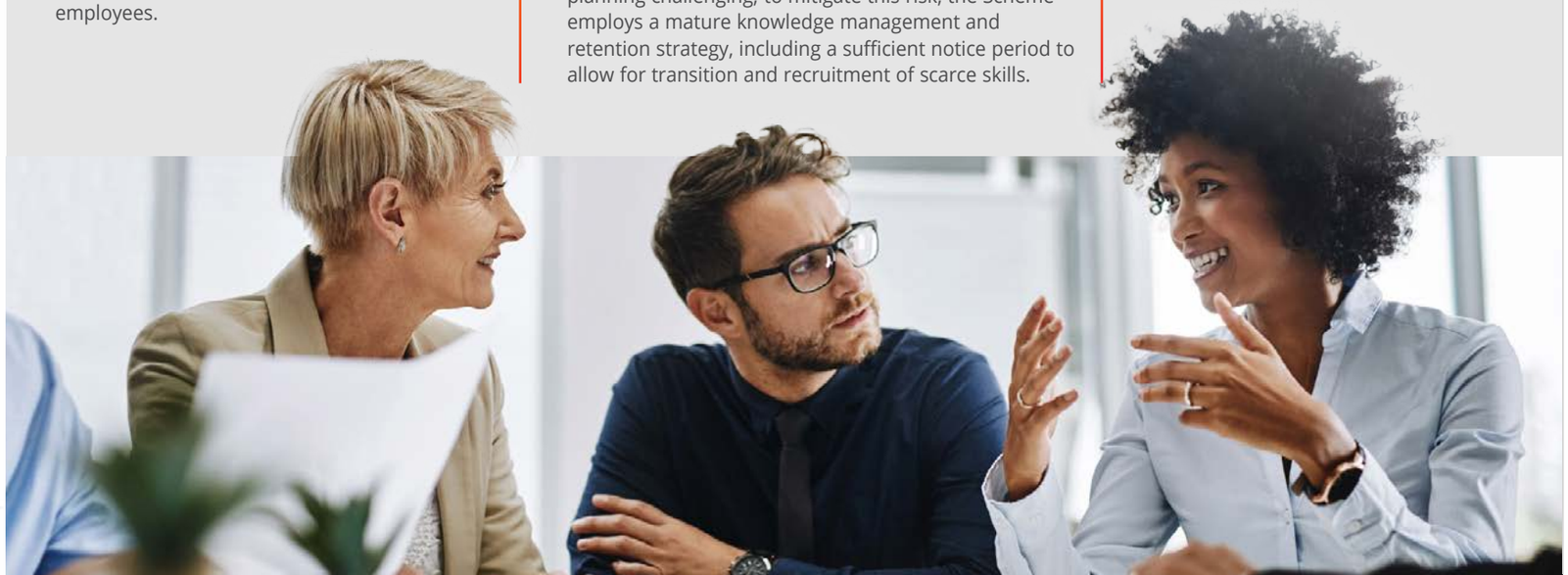
The Trustees, with the support of the Remuneration Committee, direct and oversee remuneration for employees of the Scheme. Informed by best practice, remuneration is carefully structured and independently benchmarked according to experience and skills required. The remuneration practices of the Scheme are carefully monitored to ensure that they are market-related, competitive and enable the Scheme to attract and retain high-calibre staff capable of managing and overseeing its complex operations.

Albeit with our small staff complement, the Scheme prides itself on creating a diverse and inclusive work environment that supports a high-performance culture.

In 2025, the Scheme Office consisted of 13 staff members, including a team of six executives who report to the Principal Officer and are supported by the Scheme Secretariat and administration departments. This lean employee complement makes succession planning challenging; to mitigate this risk, the Scheme employs a mature knowledge management and retention strategy, including a sufficient notice period to allow for transition and recruitment of scarce skills.

Scheme Secretariat

The Scheme Secretariat ensures sound, best practice corporate governance, and the efficient and effective functioning of the Board and its Committees. It facilitates communication between the executive team and the Trustees, and the development, management and review of governance policies and procedures. The Secretariat function further facilitates the induction and ongoing training of Trustees and Independent Committee Members, and ensures that the appointment of Trustees and ICMs is executed in accordance with the policies of the Scheme and as directed by the Trustees.



Executive team

Ms Charlotte Mbewu
PRINCIPAL OFFICER

BCom (Hons) Accounting; CA(SA)

Council member of iFHP[1], Deputy Chairperson of HFA[2] and a member of SAICA[3] Medical Schemes Project Group.

Chief Executive Officer of the Scheme.

Ms Michelle Culverwell
HEAD: SPECIAL PROJECTS AND STAKEHOLDER RELATIONS (HSPSR)

BA (Hons); MBA in Executive Management

Member of the HFA[4] technical advisory committee and member of the iFHP Sustainability Network.

The HSPSR advises on and oversees effective stakeholder relations, ethics and responsible corporate citizenship, and engages in special projects to enhance the strategic direction and sustainability of the Scheme.

Mr Selwyn Kahlberg
CHIEF OPERATIONS OFFICER (COO)

BSc (Hons) Actuarial; CFA[5]; FASSA[6]; FIA[7]

The COO advises on and oversees investments, enterprise risk management and outsourced operations, ensuring the optimisation of Scheme investment performance in the best interest of members, as well as operational efficiency and adherence to the Scheme's defined risk appetite.

Dr Unati Mahlati
CHIEF MEDICAL OFFICER (CMO)

MBChB; FCPHM[8]; MMed; MBA

Member of the board of HQA[9], member of the iFHP[1] Medical Effectiveness High Cost Drugs Network.

The CMO advises on and oversees clinical governance, strategic risk management, product development and marketing. The CMO also ensures that Scheme resources in this regard are fully optimised in the best interest of members and sustainability.

Mrs Joy Malete
CHIEF FINANCIAL OFFICER (CFO)

BCom (Hons) Accounting; CA(SA); CIMA[10]; MPhil (Corporate Strategy)

Member of SAICA[3] Medical Schemes Project Group

The CFO advises on and oversees strategic and operational finance and audit matters, and ensures that Scheme resources are optimised fully in the best interest of members and the Scheme's sustainability.

Mrs Lusani Nelufule-Mugivhi
HEAD: COMPLIANCE AND GOVERNANCE (HCG)

LLB; Postgraduate Diploma in Compliance Management; Postgraduate Certificate in Data Protection and Privacy; Certified Ethics Officer; CGISA[11] (Chartered Secretary – in progress)

Board member of the Mobile Applications Laboratory NPC.

The HCG is responsible for governance effectiveness and legislative compliance, and ensuring adherence to global best practice to ensure informed and legally sound decision making.

This includes responsibility for, and the management and co-ordination of the Scheme Secretariat and Compliance functions.

Mr Howard Snoyman
HEAD: LEGAL AND ETHICS (HLE)

LLB; MSc Med (Bioethics and Health Law); Certified Deal Architect[12]; Certified Ethics Officer; Certified Fraud Examiner; PhD (Bioethics, Health Policy and Health Law – in progress)

Co-Chair of the 2027 World Congress for Medical Law; Chairperson of the South African Association for Bioethics and Health Law; Board member of the Marketing Code Authority, member of the Independent Regulatory Board for Auditor's Committee for Auditor Ethics (until December 2025); member of the Fraud, Waste Abuse and Errors Committee of the iFHP[1]; member of the World Association for Medical Law.

The HLE advises on, formulates, and oversees strategic, operational, regulatory, reputational, legal and ethics policies, frameworks and activities – including contractual matters, escalated member disputes and complaints – and ensures the incorporation of all relevant requirements into the legislative universe of the Scheme.

1. *iFHP: International Federation of Health Plans.*
2. *HFA: Health Funders Association. Elected to the Board on 30 September 2022.*
3. *SAICA: South African Institute of Chartered Accountants.*
4. *HFA: Health Funders Association.*
5. *CFA: Chartered Financial Analyst.*
6. *FASSA: Fellow member of the Actuarial Society of South Africa.*
7. *FIA: Fellow of the Institute of Actuaries UK.*
8. *FCPHM: Fellow of the College of Public Health Medicine of South Africa.*
9. *HQA: Health Quality Assessment.*
10. *CIMA: Chartered Institute of Management Accountants.*
11. *CGISA: Chartered Governance Institute of Southern Africa.*
12. *The Vested® Certified Deal Architect programme, offered by the University of Tennessee, certifies individuals as experts in the field of collaborative supply chain optimisation, contracting and negotiations.*

Regulatory and industry matters dealt with in 2025

Fraud, waste, abuse and errors

Fraud, waste, abuse and errors (FWAE) have a severe impact on medical schemes and their members. Schemes price member contributions to cover expected claims, based on healthcare utilisation. Usage is increased by unnecessary utilisation of healthcare services and/or improper purchase of healthcare goods. Where claims are inflated, the resulting excess expenditure must ultimately be funded through member contributions, translating into materially higher contribution increases.

Effective deterrence, detection, mitigation and recovery of FWAE is therefore an important mechanism to minimise avoidable contribution increases. In 2025 alone, Discovery Health recovered over R576 million on behalf of the Scheme. In recognition of the extent of FWAE on industry, the CMS has held FWAE summits and, taking industry submissions into account, developed a code of good practice and rules for establishing a tribunal that will assist with resolving FWAE matters. In addition, the CMS has established an FWAE Advisory Committee, which the Scheme is part of, to strengthen the industry's response to FWAE. These developments should aid in standardising good practice across the industry and result in more efficient processing and consideration of FWAE-related matters.

CMS matters

For the protection of our greater membership, in 2016 the Scheme sought to register an amendment to Rule 11 of the Scheme Rules to prevent members re-joining DHMS immediately after committing fraud or due to an intentional material non-disclosure made at the time of application. The CMS declined to register the amendment. Two unsuccessful appeals were lodged that year and, following legal advice, on 17 May 2017 the Scheme lodged a High Court application for review of the non-registration of this Rule in terms of the Promotion of Administrative Justice Act. The High Court review has yet to be scheduled.

The explanatory notes to Annexure A of the Regulations to the Act acknowledge that, due to constantly changing medical practice and health technology, Prescribed Minimum Benefits (PMBs) must be reviewed every two years taking cognisance of the impact, effectiveness and appropriateness of the PMB package. In 2017 the CMS convened the PMB review project with industry stakeholders, including medical schemes and administrators, represented in the advisory and costing committees. A draft primary healthcare package was published in October 2019 and the Scheme contributed to the HFA's submission on behalf of the industry in November 2019.

In January 2024 the CMS re-established the PMB review advisory committee, in which the Scheme is represented. In 2025, the review committee met once, and reviewed a draft discussion document regarding a base benefit package, which recognised the need to balance affordability and access in reviewing and developing the PMBs. Work in progress includes the development of indicative costing to support the objective priority setting of inclusions and exclusions. The Scheme will continue to participate in these processes, with a focus on ensuring that any proposed changes are evidence-based, costed, appropriately tested and carefully implemented.

In 2019, the CMS convened an inquiry on the scope and use of Section 59 of the Act which confers medical schemes the power to recover funds unduly paid to either members or healthcare professionals, which may have resulted from errors, fraud, waste or abuse. Various healthcare professionals, facilities, medical schemes, and medical scheme administrators testified at the inquiry, including Discovery Health and DHMS. The Scheme and Discovery Health explained the processes and principles of their activities to combat FWAE, demonstrated that they are legal and ethical, and made written submissions in support of this testimony.

An interim report was published for stakeholder comment in early 2021. The interim report found no fault with the processes and practices operated by Discovery Health on DHMS' behalf.

On 07 July 2025, the Final Report of the Section 59 Investigation Panel was handed to the Minister of Health. The Panel referred to the interim report findings regarding the significant challenge that medical schemes face with respect to FWAE related claims and the obligation on trustees to ensure that member funds are protected.

The Panel found no evidence of explicit bias in the FWAE processes or in the algorithms employed by Discovery Health. In addition, the vast majority (78%) of investigations conducted by Discovery Health on behalf of DHMS arise from tip-offs and complaints rather than being identified through the analytical algorithms. The Panel did not make findings of unfair discrimination in terms of section 9 of the Constitution or the Promotion of Equality and Prevention of Unfair Discrimination Act, and also noted that the evidence presented indicated that there was room for improvement in the risk ratio methodology used.

The Panel made recommendations including:

- Early warning systems about potential FWAE concerns for providers;
- Limiting audit and recovery periods (with scope for exceptions);
- Mechanisms to assist providers during investigations;
- Disclosure of algorithms (without compromising integrity);
- Possible review of section 59(3) of the Medical Schemes Act to enhance the detail regarding FWAE systems and processes for greater oversight.

The CMS convened a meeting on 14 July 2025 to develop a roadmap for implementation and proposed establishing a multi-stakeholder committee to operationalise the recommendations. In addition, in its Annual Report 2024/25, it indicated that it will be planning a summit to consolidate efforts, including the process to implement the recommendations of the Section 59 Report. In early 2026, the CMS and the Minister of Health met with various stakeholder groups to discuss proposed next steps.

CMS matters *continued*

In December 2019, CMS Circulars 80 and 82 announced that no further Low-Cost Benefit Options[1] (LCBO) exemptions would be granted by the CMS, and that all existing products exempted from the requirements of the Act in terms of the Demarcation Exemption Framework must be wound up before March 2021. However, LCBO products offered through insurance companies continue to be exempted and in Circular 9 of 2025 the CMS further extended the exemption period to 31 March 2027.

To develop a roadmap for LCBOs, the CMS subsequently held stakeholder engagements and established two advisory committees incorporating stakeholders from the insurance and medical scheme industries. The CMS, with the input of the industry, developed draft LCBO guidelines and subsequently briefed the Minister of Health on these, and handed a report to him to make a determination. In February 2025, the Minister published the LCBO Report together with a media notice calling for public comments as well as on the recommendations contained within it. He noted his concerns regarding the Report and his intention to make amendments to the Medical Schemes Act to make provision for a basic benefit package as proposed by the Health Market Inquiry. Submissions were made in response. The Minister also confirmed that the CMS is able to grant exemptions to medical schemes to offer these products, as it continues to do to insurers.

Each year the Scheme submits LCBO applications to the CMS, with consideration of the circumstances brought about by the existence of primary care products in the insurance sector, to the exclusion and detriment of the medical schemes industry, and also prejudicing policyholders of these products who cannot benefit from tax credits in terms of the Income Tax Act, nor benefit from the protection afforded members of medical schemes. Had LCBOs been approved for medical schemes to offer, they would have expanded private healthcare to a segment of the population which has previously not had such access, with the added benefit of reducing pressure on public sector resources and infrastructure, and in line with the objectives of the universal health coverage. In February 2026, DHMS lodged an appeal regarding the CMS' refusal to grant its application, which is set down to be heard by the Appeal Board on 05 May 2026.

The Scheme also notes that the Board of Healthcare Funders (BHF) initiated legal proceedings in 2022 against the CMS, alleging that the CMS has been delaying the implementation of primary care benefit options despite a 2015 resolution to adopt a framework for these options. The BHF argues that these lower cost options could be implemented immediately and provide much-needed relief to those struggling to afford healthcare, and that the CMS must be compelled to grant exemptions to medical schemes that wish to offer such cover. The CMS claims that the delay in rolling out primary care benefit options is due to the passing of the National Health Insurance (NHI) Act, as the NHI will ultimately provide universal health coverage. The matter was heard in the North Gauteng High Court in January 2025, and was decided in favour of the CMS in April 2025. The BHF has been granted leave to appeal.

The CMS inspection in terms of Section 44(4)(a) of DHMS initiated in 2017 was completed in 2018; the Scheme submitted a response to the CMS and awaits finalisation of the matter.

In 2022, the CMS initiated a routine inspection of DHMS in terms of Section 44(4)(b) of the Act. The Scheme has submitted documentation to the CMS in line with the request for information accompanying the notice of inspection. In early 2023, we engaged with the CMS on subsequent queries and provided additional information required. The CMS has subsequently issued a draft report to the Scheme, to which the Scheme responded. The Scheme is still awaiting the issuance of the final report.

In 2024, the Scheme received notice of an inspection in terms of Section 44(4)(a) of the Act regarding specific aspects of the Scheme's operations, including procurement and Committee appointments. The Scheme submitted a response to the CMS and received an interim/draft report which was responded to. Currently, the Scheme awaits finalisation of the matter.

In 2017, the National Department of Health (DoH) published a notice of intent to declare certain practices regarding designated service provider (DSP) networks and co-payments relating to the use of non-DSPs, undesirable. Submissions were made to the CMS in response. In April 2021, DoH Notice 214 of 2021 was published, declaring certain practices pertaining to the selection of DSPs and imposition of excessive co-payments undesirable. The notice indicated that the CMS would publish guidelines on the selection of DSPs and imposition of co-payments. On behalf of its members, the HFA lodged a request under the Promotion of Administrative Justice Act to the Registrar and Council at both the CMS and the DoH to understand how the declaration was determined, and also lodged a Section 50 Appeal regarding the declaration. The CMS has indicated that the development of guidelines has been put on hold, pending the outcome of the appeal. We await a date for the hearing.

During 2021, the CMS notified DHMS that the Scheme was not compliant with Explanatory Note 2 of Annexure B as the Scheme's assets in category 1(a)(i) and 1(a)(ii) of Annexure B fell below 20% of the Scheme's Regulation 30 assets. This assessment by the CMS was conducted using the aggregate fair value of liabilities and total accumulated funds rather than "minimum accumulated funds" as stated in Regulation 29.

The Scheme measures the assets against the aggregate fair value of liabilities and "minimum accumulated funds", namely 25% of gross annual contributions as stated in Regulation 29, on which basis the Scheme is compliant. The Scheme further obtained a legal opinion from Knowles Husain Lindsay Inc. on 25 February 2022 to confirm the application of the Act and its Regulations, which demonstrated that the Scheme is compliant with Explanatory Note 2 of Annexure B. In November 2022 the CMS advised the Scheme that, while the parties engage to resolve the matter, the Scheme is not expected to perform any action to correct any alleged non-compliance. At the date of this Report, the Scheme has had no further correspondence from the CMS.

Had LCBOs been approved for medical schemes to offer, they would have expanded private healthcare to a segment of the population which has previously not had such access, with the added benefit of reducing pressure on public sector resources and infrastructure, and in line with the objectives of the universal health coverage. In February 2026, DHMS lodged an appeal regarding the CMS' refusal to grant its application, which is set down to be heard by the Appeal Board on 05 May 2026.

1. *Also known as primary healthcare options.*

Discovery Health accreditation

All third-party administration and managed care providers are required to renew their CMS accreditation every two years. Renewal entails a thorough assessment of policies, processes and systems by the CMS which, if satisfied, then issues a certificate of accreditation which may contain certain conditions to be met.

ADMINISTRATION ACCREDITATION

In December 2025, the CMS granted administration accreditation to Discovery Health for two years to 31 December 2027 subject to compliance with the conditions stipulated. The conditions are carried forward from previous accreditation periods and are the subject of two appeals awaiting set down dates. The appeals relate to questions asked in the Scheme's application form and the processes followed for the processing and communication of non-confirmed PMBs.

The Trustees and Principal Officer closely monitor the fulfilment of these conditions in line with their governance responsibilities and fiduciary duties.

MANAGED CARE ACCREDITATION

Discovery Health received its reaccreditation as a managed care organisation for December 2024 to December 2026 at the end of December 2024. No conditions are attached to the reaccreditation.

National Health Insurance

The NHI Act was signed into law by the President in 2024. As yet, no sections of the Act have been brought into operation, but draft regulations dealing with nominations and selection processes were published in March 2025 for public comment.

DHMS fully supports the progressive realisation of universal health coverage for all South Africans. However, the NHI Act as it currently stands, specifically Section 33 thereof, will limit medical scheme cover upon its full implementation. This will reduce access to and the quality of healthcare services for medical scheme members, and introduce a number of systemic risks which may undermine access to healthcare for all South Africans. It is our firm view that the Act requires amendment to ensure it is workable while also addressing certain constitutional concerns.

Several stakeholders have launched legal action against various aspects of the NHI Act including on procedural and constitutional grounds. The Scheme is participating in the legal action led by the HFA on behalf of its members. DHMS supports a collaborative approach (between private and public sectors) to achieving universal health coverage within a social solidarity framework[1].

In February 2026, the President undertook to not proclaim any provisions of the Act, and the Minister of Health committed to halting its implementation, pending the Constitutional Court's upcoming judgments in the public participation-related challenges. These undertakings were made an order of the Court, and in effect stayed the various High Court matters.

Members and other stakeholders should be assured that, even if the Act is not amended, medical schemes will continue to cover all of the healthcare services they currently cover for the foreseeable future due to the phased implementation required to establish and support the NHI. We foresee that the Act will be the subject of litigation for quite some time, and actual and practical implementation of relevant provisions of the Act would be in the distant future.

Understanding the NHI Act

1. *The use of a model which includes multiple private and public funders, designed to support cross-subsidisation for health and financial status.*

Index
Glossary

Road Accident Fund (RAF)

RAF TARIFFS

The RAF provides compulsory statutory cover to all users of South African roads against injuries sustained or death arising from accidents involving motor vehicles within the borders of South Africa. This cover is in the form of indemnity insurance to persons who cause the accident, as well as personal injury and death insurance to victims of motor vehicle accidents and their families. All road users, including all medical scheme members, contribute to the RAF via a levy included in the fuel price.

In January 2022, the RAF unilaterally set tariffs for refunds which are inadequate to cover costs, despite a prior Constitutional Court ruling that a tariff that denies a road accident victim treatment in the private health sector is "not rationally related to the objectives sought to be achieved"[1]. The proposed tariffs for medical treatments and related care were approximately 62% lower than general medical scheme tariffs in 2022. This would have the effect of leaving large co-payments for non-medical scheme members that seek private medical care, meaning that the vast majority of these will have no option but to be treated in a State facility. Additionally, for claimants who are medical scheme members, this would translate into dramatically lower recoveries on behalf of DHMS and other schemes, once the RAF reimburses the claimant for any medical expense already incurred. Representing the medical schemes and their members, the HFA has made several submissions, including evidence that the tariffs deprive victims of road accidents of effective remedy and are unreasonable.

In December 2022 the Gauteng High Court, on application by the National Council for Persons with Disabilities, interdicted the implementation of the tariffs retrospectively from January 2022. A further application was heard in May 2023, in which the court was asked to review and set aside the tariffs. A request was made for discovery of the documents relating to the RAF's decision to implement the impugned tariffs. The RAF has refused to provide these documents, and hence the aspect of the application dealing with the setting aside of the tariffs has been postponed sine die. The interdict (referred to above) accordingly remains in place. In the interim, the RAF published new tariffs which were, broadly speaking, more acceptable to the industry. Given that the RAF is still refusing to pay claims for past medical expenses that have been covered by medical schemes (see alongside), we are not yet able to determine how the new tariffs are being applied.

RAF REFUSING TO REFUND MEDICAL SCHEME MEMBERS

On 12 August 2022, a directive was issued by the acting head of claims at the RAF that no medical expense claims arising from road accidents should be paid in respect of medical scheme members, proposing that there is no liability to the member as they are insured elsewhere, which is contrary to the RAF's mandate. On behalf of the schemes it administers, including DHMS, Discovery Health successfully interdicted the directive from being implemented by the RAF in October 2022. However, at the time of publication, the RAF continues to deny these claims and the legal action continues with a definitive ruling on the breach by the RAF and its CEO of their constitutional obligations yet to be issued.

Discovery Health had sought to hold the CEO of the RAF in contempt of court (in the High Court), on account of his overt public statements to the effect that he intended to use various mechanisms to avoid repaying medical schemes for their disbursement for the past medical expenses of members injured or killed in motor vehicle accidents. That contempt application was heard in June 2024. The ruling was handed down in December 2024, with two judges finding against Discovery Health's application, and one in favour. Discovery Health has since sought leave to appeal. As at January 2025, Discovery Health has valid court orders in the sum of R240 million against the RAF for past medical expenses that have been covered and paid by medical schemes it administers, court orders which remain valid, enforceable and payable notwithstanding the ruling on Discovery Health's contempt application.

As of February 2026, the CEO of the RAF has been suspended, initially due to corruption allegations and now for insubordination, which could impact ongoing legal cases, particularly the contempt case currently awaiting appeal. The Scheme continues to accumulate outstanding cases, with the total amount now exceeding R250 million, as court rulings continue to indicate that members are entitled to recovery even when their medical scheme covered the costs. At the time of writing, Discovery Health's appeal as regards the Contempt Application against the RAF CEO is still pending.

On 12 August 2022, a directive was issued by the RAF that no medical expense claims arising from road accidents should be paid in respect of medical scheme members, proposing that there is no liability to the member as they are insured elsewhere, which is contrary to the RAF's mandate. At the time of publication, the RAF continues to deny these claims and the legal action continues with a definitive ruling on the breach by the RAF and its CEO of their constitutional obligations yet to be issued.

1. *Judgment in the case of the Law Society of South Africa and Others v Minister for Transport and Another (CCT 38/10) [2010] ZACC 25; 2011 (1) SA 400 (CC); 2011 (2) BCLR 150 (CC) (25 November 2010).*

Competition Commission

COVID-19 PCR TESTS PRICING MATTER

In October 2021, the CMS lodged a complaint with the Competition Commission against the three main private pathology groups regarding COVID-19 polymerase chain reaction (PCR) test prices. The HFA's complaint is on a similar basis to that of the CMS, which resulted in an immediate 41% reduction in the price of COVID-19 PCR tests, from R850 to R500.

On behalf of 36 participating medical schemes, including DHMS and representing over 5.6 million scheme members, in March 2023 the HFA submitted a complaint to the Competition Commission regarding the high prices charged for COVID-19 PCR tests by the three largest private pathology laboratory groups in South Africa during the COVID-19 pandemic in 2020 and 2021.

The HFA's complaint aims to ensure that the excess costs borne by medical schemes associated with any excessive pricing of COVID-19 PCR tests during this period are refunded to medical schemes for the members' benefit. These recoveries represent member funds and will accrue to the reserves of medical schemes; the reserves have a direct bearing on schemes' abilities to pay claims and may impact future contribution increases for members.

The Competition Commission declined to refer the complaint to the Competition Tribunal based on the consent agreements which were entered into with the respective pathology labs in December 2021, but did not rule on the merits of the case. This was expected, and the HFA has subsequently self-referred the matter to the Tribunal. The matter is continuing, with a data discovery hearing provisionally scheduled for September 2026.

INTERIM BLOCK EXEMPTION FOR TARIFFS DETERMINATION IN THE HEALTHCARE SECTOR

In February 2025, the Minister of Trade, Industry, and Competition published draft regulations that will establish a framework for healthcare providers and medical schemes to collectively determine tariffs for healthcare services. The draft regulations propose to temporarily exempt certain healthcare-related agreements and practices from the restrictions contained in sections 4(1)(a), 4(1)(b)(i), and 5(1) of the Competition Act.

The objective of the draft regulations, which is to address excessive healthcare inflation, is strongly supported by the Scheme. The draft regulations, however, raise a number of concerns. First, they have not been introduced along with other measures that the Health Market Inquiry recommended should be implemented as a package. Second, they do not fully encompass the Health Market Inquiry's recommendation on tariff determination. Third, they may inadvertently exacerbate the reliance of the industry on fee for service payment arrangements, which are inflationary and do not take healthcare outcomes or quality into account. We are also concerned by the lack of independence of the two bodies proposed to be established: independence was a requirement specified by the HMI.

During 2025, the Competition Commission engaged extensively with industry representatives including DHMS and HFA, and indicated that it is taking concerns raised into account.

In February 2025, the Minister of Trade, Industry, and Competition published draft regulations that will establish a framework for healthcare providers and medical schemes to collectively determine tariffs for healthcare services. The objective of the draft regulations, which is to address excessive healthcare inflation, is strongly supported by the Scheme.

National Department of Health

Medicine prices are regulated by the National Department of Health (DoH), through the Medicines Act, deploying a Single Exit Price (SEP) with annual inflationary adjustments capped by the DoH. Stakeholder submissions on the SEP adjustment methodology are considered by the DoH's pricing committee.

Increasing medicine prices are of concern to schemes as, together with an increasing new high-cost medicine demand, they contribute to overall healthcare inflation. Annual healthcare inflation is expected to be significantly above ordinary inflation every year due to a combination of tariff and utilisation increases, driven by increased availability of healthcare services as well as changes in demographic profiles. Schemes' contributions have to track healthcare inflation and expected utilisation for the scheme concerned in order to fund members' healthcare, and so all drivers of healthcare inflation directly impact on members' costs.

On behalf of the Scheme, Discovery Health regularly makes submissions to the DoH's pricing committee regarding the severe impact on members of blanket and compounded annual SEP increases and South Africa's support of global price transparency; the latter results in higher visible pricing for South Africa and precludes the benefit of confidential price discounting that is commonplace globally. Pharmaceutical companies are allowed to set the market entry prices of medicines without any regulatory adjudication beyond an annual capped increase. The DoH announced a single exit price adjustment of 1.47% for 2026. The pharmaceutical industry has, however, opposed this increase which is below the expected 3.2% (in line with CPI), seeking an additional 1.73%. Industry representatives argue that this low cap undermines operational viability and discourages investment in local manufacturing, a key government priority. Discovery Health has made a submission to the pricing committee, noting that the calculation method used in recent years yielded 1.51% in July 2025, and that subsequent further currency strengthening indicates that the DoH's increase seems reasonable.

More about healthcare inflation and claims costs ***pg 90 – 91***

Information Regulator (IR)

In February 2025, the Scheme was served with a notice to conduct an own initiative compliance assessment in terms of section 77h(1) of the Promotion of Access to Information Act, 2000 (PAIA). The assessment is part of the 2024/25 financial year annual performance plan of the Information Regulator and is an endeavour to promote voluntary compliance with the provisions of PAIA. On this basis, the IR decided to conduct own initiative compliance assessments on medical schemes. This target-based approach assessment focuses on whether the Scheme complies with section 51 of PAIA, as amended.

The IR issued a final report indicating best practice recommendations to be implemented. All recommendations by the IR were adopted, Scheme documents updated and proof provided to the IR.

Financial Service Conduct Authority (FSCA)

Sections 291 and 292 of the Financial Sector Regulation Act, 2017 provide transitional arrangements for regulatory oversight of medical schemes, collective investment schemes, pension funds, and friendly societies. Under these provisions, the Council for Medical Schemes continues to perform functions related to medical schemes.

Initially set for three years from the establishment of the Prudential Authority and FSCA, these arrangements have been extended multiple times since 2020. In November 2025, the Minister of Finance granted a final extension for medical schemes until 31 March 2029. The purpose of these extensions is to ensure an orderly transition and the development of fit-for-purpose regulatory and supervisory frameworks. Collaborative efforts between authorities are ongoing, and further updates will be communicated to the industry.

Our performance

Scheme performance for the 2025 financial year

Discovery Health Medical Scheme's limited sources of financial capital (derived only from member contributions and returns from investing member funds) require that we carefully balance the resources needed to meet our strategic objectives in caring for our members, ensuring Scheme stability and sustainability, and meeting the regulatory solvency requirements set out in the Medical Schemes Act (the Act).

The Scheme has a fiduciary obligation to maximise investment returns with due regard for related risks, requiring that we consider issues that can impact longer-term investment performance.

Overview

For the year ended 31 December 2025, the Scheme delivered a positive insurance service result, before accounting for amounts attributable to future members, of R565 million (2024: negative R350 million). This was better than what was assumed in the budget. The Scheme generated investment income of R2 985 million (2024: R2 828 million). The total comprehensive income for the year is R7 174 million (2024: R2 896 million).

Liability to members for future benefits increased to R38.8 billion (2024: R31.6 billion) with a solvency level of 32.58% (2024: 31.01%), exceeding the 25% statutory requirement.

The Scheme received an AAA credit rating for the 26th consecutive year from Global Credit Rating Co, an independent credit rating agency. This is the highest possible rating for medical schemes and confirms the Scheme's financial strength and claims paying ability. The Board of Trustees believe that, despite challenging market conditions characterised by difficult economic conditions impacting the growth of schemes, the Scheme ended 2025 in a strong financial position and remains well placed to meet members' needs for the foreseeable future.

Key performance information *pg 85*

Financial Statements *pg 106*

Investment income
R2 985 million
(2024: R2 828 million)

Net surplus for the year before mutualisation
R7 174 million
(2024: R2 896 million)

Solvency level
32.58%
(2024: 31.01%)

Liability to members for future benefits
R38.8 billion
(2024: R31.6 billion)

Credit rating
AAA
The scheme has achieved the highest possible rating for a medical scheme in South Africa for the **26th consecutive year**

Key performance information

ENSURING THE SCHEME'S SUSTAINABILITY

The Scheme's financial strength, its ability to pay claims, and its long-term sustainability are crucial to members. A summary of key sustainability outcomes metrics for the Scheme is presented alongside and on the next page, together with an explanation of why we consider these important.

Growth and sustainability

Membership growth

Growth in the number of young and healthy members improves risk pooling through cross-subsidisation principles and reflects the attractiveness and competitiveness of the Scheme.

Net membership increase
0.66%
(2024: 1.05% decrease)

Net beneficiary decrease
0.37%
(2024: 1.90% decrease)

Average age at year-end[1]
38.15
(2024: 37.56)

Pensioner ratio[2]
13.65%
(2024: 13.00%)

Annualised lapse rate
5.52%
(2024: 5.99%)

Plan movements

Low movement between plans indicates member satisfaction and appropriate benefit design and pricing.

Plans did not change
95.86%

Plans were upgraded
2.47%

Plans were downgraded
1.67%

Membership size

Greater risk pooling makes for more predictable claims experiences and pricing accuracy, leading to stable performance.

1 368 387
Principal members at 31 December 2025
(2024: 1 359 379)

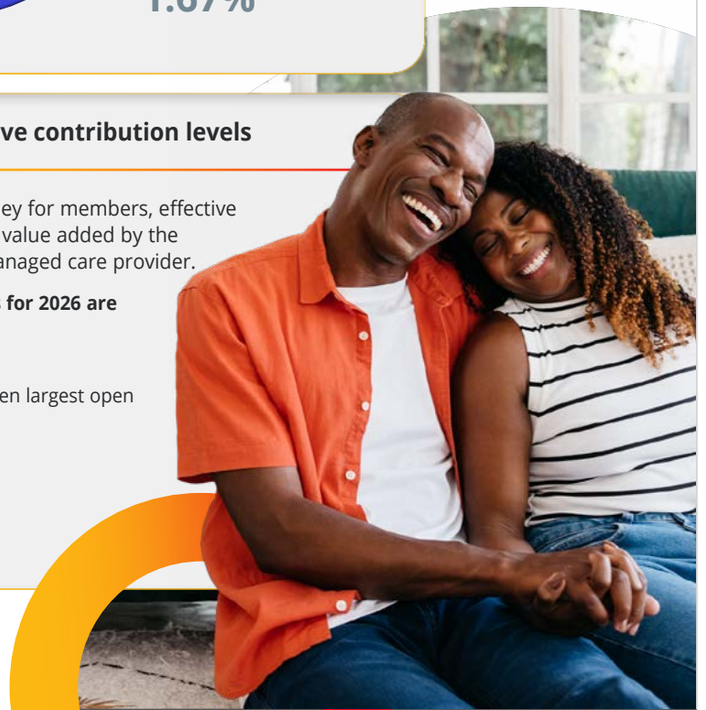
2 725 122
Beneficiaries at 31 December 2025
(2024: 2 735 204)

57.7%[3]
Share of open scheme market
(2024: 58.0%)

Relative contribution levels

Reflects value for money for members, effective risk management and value added by the administration and managed care provider.

Average contributions for 2026 are
17.7%
lower than the next seven largest open schemes[5]
(2025: 12.7%)



1. *Based on beneficiaries' age as at 01 January of the report year. An increase of less than one year per annum is favourable as this indicates that young people are joining the Scheme.*
2. *Based on beneficiaries' age as at 01 January of the report year.*
3. *Based on beneficiaries, according to the Council for Medical Schemes (CMS) Industry Report for the year ended December 2024 (https://www.medicalschemes.co.za/wp-content/CMSIndustryReport2024_4Dec.pdf). At the end of 2024 there were 16 open schemes registered with the CMS, with approximately 51.7% of the total medical schemes market and 55 restricted schemes, with approximately 48.3% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately 2.4 million beneficiaries.*
4. *We monitor plan movements closely, especially when our contributions are increased and members are able to change their plans.*
5. *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes. Contribution rates on individual plans of other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*

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Financial strength and management

Absolute reserves

Demonstrates our ability to meet large, unexpected variation in claims.

Accumulated funds expressed as a percentage of gross annual contributions

32.58%
(2024: 31.01%)
exceeding the statutory solvency requirement of 25%

AAA
Independent credit rating for claims paying ability[1]
(2024: AAA)

Prudent investment management

Ensuring that investment returns, to bolster member funds, are maximised within an acceptable level of risk.

Gross return on investments

20.04%
(2024: 12.47%)

Pricing sufficiency

The Scheme's solvency level currently exceeds what the Scheme deems necessary for long-term sustainability. As a result, contributions and benefits are carefully calibrated to gradually reduce solvency to a sustainable level, still well above 25%, in the coming years. This enables the Scheme to provide some financial relief to our members by passing on the benefit of excess reserves. As long as there is excess solvency in the Scheme, a managed trajectory towards operating breakeven is the optimal strategy, as it keeps member contribution increases as low as possible.

Insurance service result for the year

R565 million
(2024: R350 million negative)

Net surplus for the year before mutualisation

R7 174 million
(2024: R2 896 million)

More about providing financial relief to our members ***pg 89***

Value-added administration and managed care

For every R1.00 spent by the Scheme on administration and managed care fees in 2024, our members received

R2.10
(2023: R2.06)
in value from the activities of Discovery Health (Pty) Ltd (Discovery Health)[2]. This is equivalent to nominal added value of R10.4 billion in 2024 (2023: R9.6 billion), over and above the fees paid to Discovery Health of R9.4 billion in 2024 (2023: R8.8 billion).

Administration fees

7.20%
of gross contributions
(2024: 7.37%)

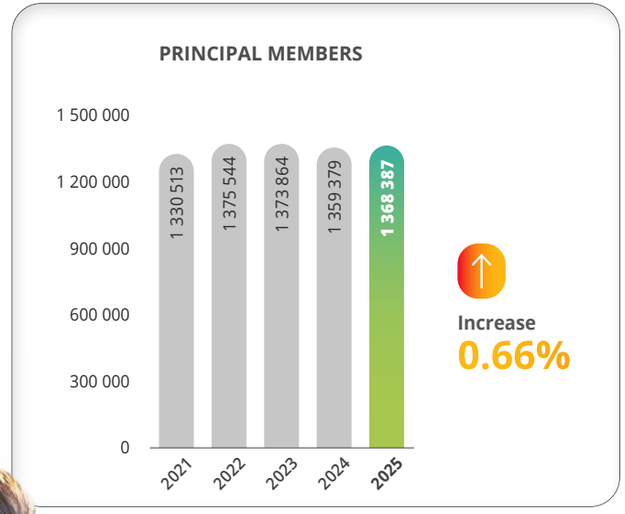
Managed care fees

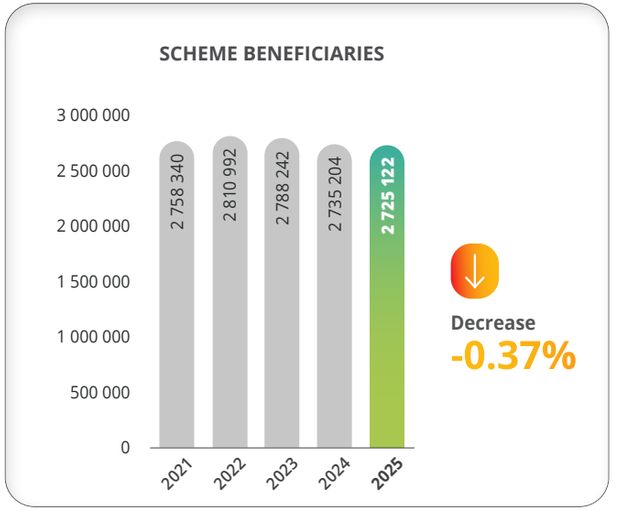
2.66%[3]
of gross contributions
(2024: 2.52%)

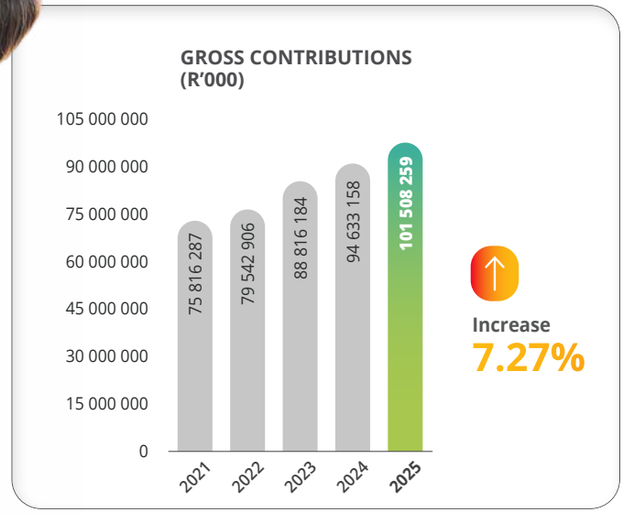
1. *Rating affirmed in April 2026; this refers to how many times the Scheme is able to cover its monthly claims expense with its liquid investments.*
2. *As the assessment uses industry information reported by the CMS, results are only available for the preceding year. The value added of R2.08 that was reported in the 2024 Integrated Report has been restated to R2.06, which reflects the inclusion of updated data published by the CMS on industry statistics for 2023.*
3. *The increase is due to the inclusion of fees for the PHP managed care programme, new in 2025, which is calculated at R8 per eligible life for the reporting period.*

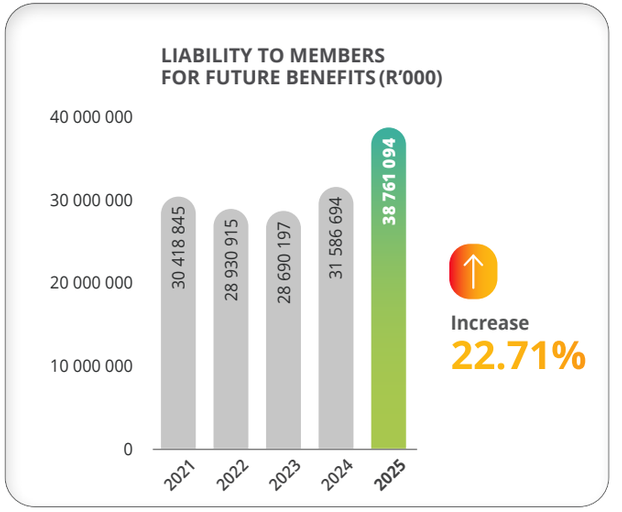
HISTORICAL PERFORMANCE INDICATORS

Consistent with the stagnant South African economy, the medical scheme industry has remained stagnant over the past decade, with a slight increase in membership of 0.45% in 2024 compared to 2023[1]. The Liability to members for future benefits[2] is sufficient to assure members that the Scheme is able to take care of their healthcare needs.









1. *According to the 2024 CMS report, a total of 9 168 534 beneficiaries were covered, up from 9 127 453 at the end of 2023.*
2. *Prior to IFRS 17, known as member funds and renamed from "insurance liability to future members" in our previous Integrated Report.*

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Member disputes and CMS complaints

We thoroughly investigate and review all disputes formally lodged by Scheme members, aiming to resolve as many as possible internally so that members do not need to lay complaints with the CMS. The Dispute Committee process is also available to healthcare providers wishing to escalate disputes regarding billing practices and forensic investigations with the Scheme.

The Committee is not empowered to make discretionary rulings or any contravening applicable legislation and the latest registered Scheme Rules. However, at its discretion, the Committee can refer relevant questions to a specially convened Treating Customers Fairly (TCF) Committee. The TCF Committee provides specialist insight into issues of fairness in accordance with recognised TCF standards and makes non-binding recommendations to the Dispute Committee.

More about TCF ***pg 37***

More about the Dispute Committee ***pg 64***

With a total of 55 841 777[1] claims made in 2025, only 470 resulted in complaints to the CMS by Scheme members[2] (2024: 422 relative to 55 464 900[3] claims). In absolute terms, there was a 12% increase in the number of complaints from 2024; however, internal dispute resolution (pursuant to Rule 27) has improved significantly over time — in 2025, there were 2.44 internal disputes for every one complaint escalated to the CMS, up from a ratio of 0.39 to one in 2015.

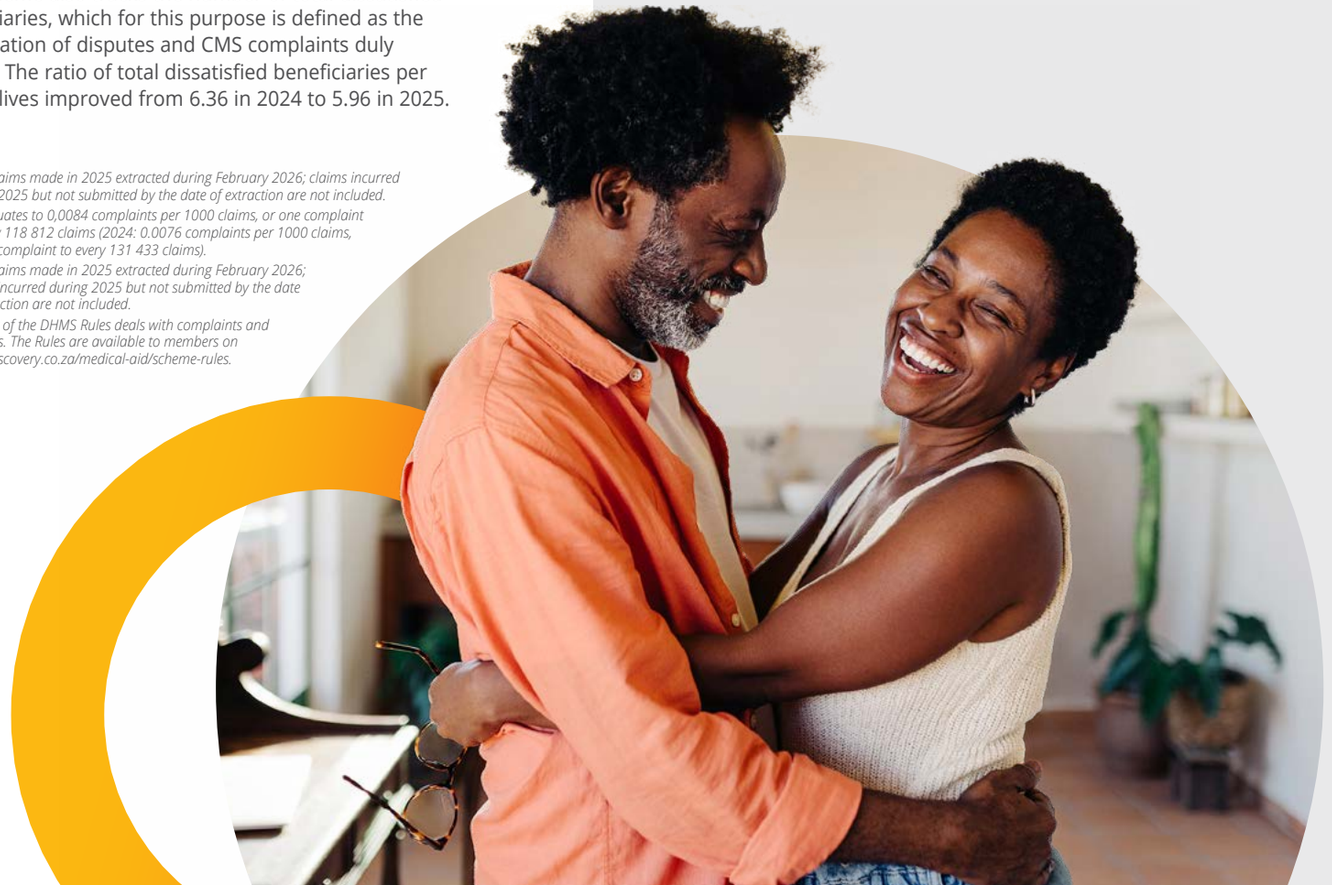
The majority of dispute cases are resolved amicably and efficiently through the Scheme's disputes mechanism, without the member requiring a Dispute Committee hearing as the matter is sufficiently ventilated and explained in the process. In 2025, a subset of 942 (82%) of the 1 148 disputes in terms of Rule 27[4] were settled or withdrawn prior to a hearing (2024: of the 1 315 disputes, 1 217 or 94% were settled or withdrawn).

A total of 31 Dispute Committee hearings were convened in 2025, with 26 rulings issued as at December 2025, 21 of which were in favour of the Scheme, four in favour of members, and one partially in favour of both the Scheme and the given member. Of these 31 dispute hearings in respect of which rulings were issued, only two were subsequently referred to the CMS as a complaint in terms of Section 47 of the Act.

The Scheme also tracks the number of total dissatisfied beneficiaries, which for this purpose is defined as the combination of disputes and CMS complaints duly lodged. The ratio of total dissatisfied beneficiaries per 10 000 lives improved from 6.36 in 2024 to 5.96 in 2025.

1. *Total claims made in 2025 extracted during February 2026; claims incurred during 2025 but not submitted by the date of extraction are not included.*
2. *This equates to 0,0084 complaints per 1000 claims, or one complaint to every 118 812 claims (2024: 0.0076 complaints per 1000 claims, or one complaint to every 131 433 claims).*
3. *Total claims made in 2025 extracted during February 2026; claims incurred during 2025 but not submitted by the date of extraction are not included.*
4. *Rule 27 of the DHMS Rules deals with complaints and disputes. The Rules are available to members on www.discovery.co.za/medical-aid/scheme-rules.*

In 2025, only one CMS complaint was made for every 118 812 claims made by members.



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Gross contribution income

The Scheme improved its competitiveness with average contributions for 2026 that are 17.7 % lower[1] than the average of the contributions of the next seven largest open medical schemes (2025: 12.7%). This is predominantly due to our ability to contain the impact of healthcare inflation.

On 01 April 2026, contributions increased by a weighted average 7.2% across the various DHMS plans, with 65% of members experiencing a lower increase of 6.9%. Active Smart plan members had a 0.0% increase. Contributions for the balance of members increased by 7.9%, reflecting the higher impact of supply- and demand-side utilisation on their plans. Contributions were not increased for the new Smart Saver series, launched 01 January 2026.

The Scheme's strong solvency position of 32.58% at the end of 2025 allowed the contribution increases to be deferred until 01 April 2026, providing members with financial relief during the first three months of 2026. By maintaining 2025 contribution levels for the first three months, members will collectively save R1.5 billion – around R1 100 per average membership.

Our strong financial position has enabled us to make additional day-to-day benefits available to members who participate in the Personal Health Pathways (PHP) managed care programme through the Personal Health Fund (PHF), introduced in 2025. Members who activated PHP, enabled exercise and sleep tracking, and completed their health check by 01 January 2026 began the year with an additional R1 000 per member allocated to their PHF.

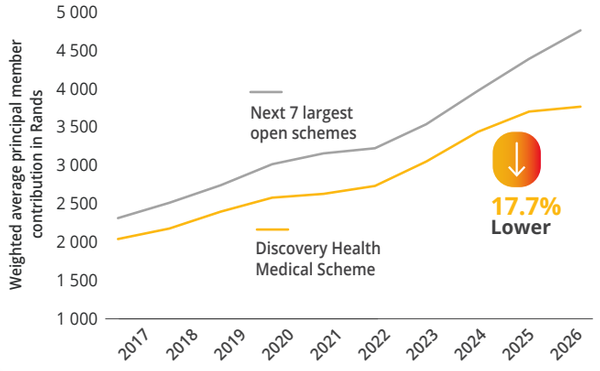
The Scheme has extended this initiative during 2026 through a PHF Boost, allowing members who complete these actions during 2026 to earn a further R1 000 per member.

Gross contribution income (GCI) for 2025 rose 7.27% to R101.5 billion (2024: R94.6 billion). The most significant net membership growth contributing to the increase in GCI was recorded in mid- to low-tier options, where the Smart series grew by 38 264 net members (2024: 21 085). With a net principal membership decline of 18 481, the KeyCare series experienced the largest reduction (2024: 22 001).

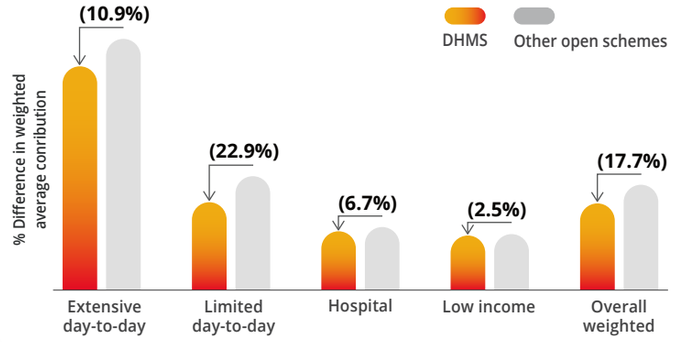
More about how we price contributions *pg 7*

Barriers to lower contribution rates *pg 8*

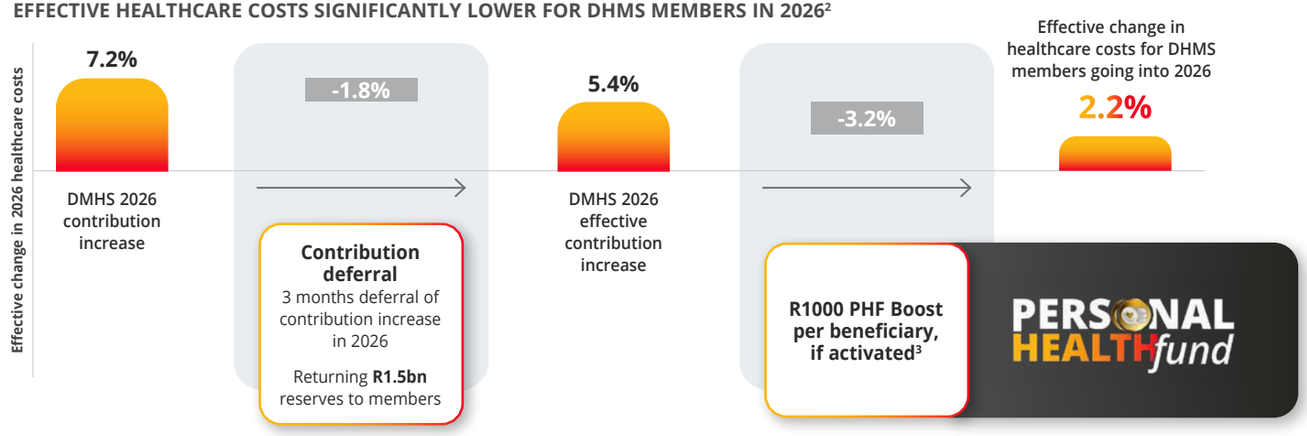
DHMS CONTRIBUTIONS ARE 17.7% LOWER THAN THE NEXT SEVEN LARGEST OPEN MEDICAL SCHEMES IN 2026



DHMS IS MORE AFFORDABLE ACROSS ALL PLAN CATEGORIES IN 2026



EFFECTIVE HEALTHCARE COSTS SIGNIFICANTLY LOWER FOR DHMS MEMBERS IN 2026[2]



1. *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes. Contribution rates on individual plans of other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*
2. *Based on average contributions for families across DHMS plans, and weighted by the distribution of members across plans.*
3. *By eligible members and beneficiaries who activate PHP, enable exercise and sleep tracking, and complete their health check during 2026.*

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Net claims incurred

Net claims incurred increased by 6.18% to R74.9 billion (2024: R70.5 billion).

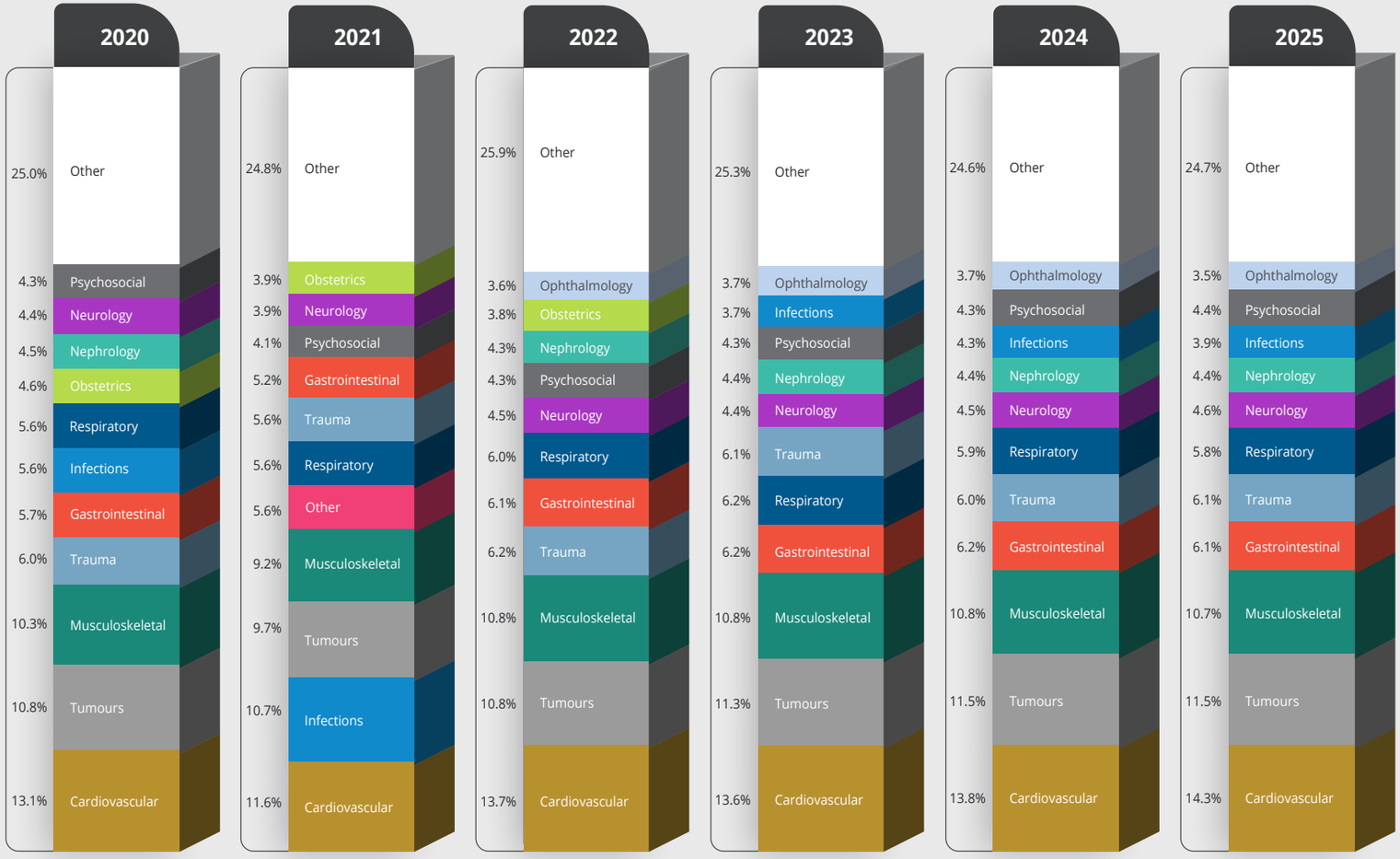
The gross claims ratio[1] decreased to 88.34% (2024: 90.24%) the result of a pricing strategy designed to work towards an operating breakeven position. The Scheme's administration and managed care provider continues to provide robust risk management interventions to reduce claims costs and thereby contain contribution increases for members.

Claiming patterns are influenced by a changing burden of disease, demographics and benefit design. Based on an analysis of the Scheme's claims experience, cardiovascular remains the disease episode with the highest risk spend, accounting for the highest proportion of the Scheme's overall claims cost. While tumours have surpassed musculoskeletal claims (which have remained proportionally consistent from 2022 to 2025), increase in the former is partially driven by benefit availability. Mental health disease prevalence (included here in the psychosocial category) has increased in line with other conditions, not relative to them, and has a significant impact on the cost of other existing conditions.

The infections disease episode does not appear in the 2022 graph among the top 11 drivers of overall claims costs, which was unexpected given the continued occurrence of COVID-related admissions. In 2022, infections ranked 12th, just outside the top 11 disease episodes shown in the graph.

1. *The percentage of risk contributions utilised to fund relevant healthcare expenditure (net claims incurred, accredited managed healthcare services fees and net income/(loss) on risk transfer arrangements).*

CLAIM COST INCREASE BY DISEASE EPISODE



Shifting claims patterns in DHMS over time. The experience of other medical schemes would differ based on their benefit design and the demographics of the scheme concerned.

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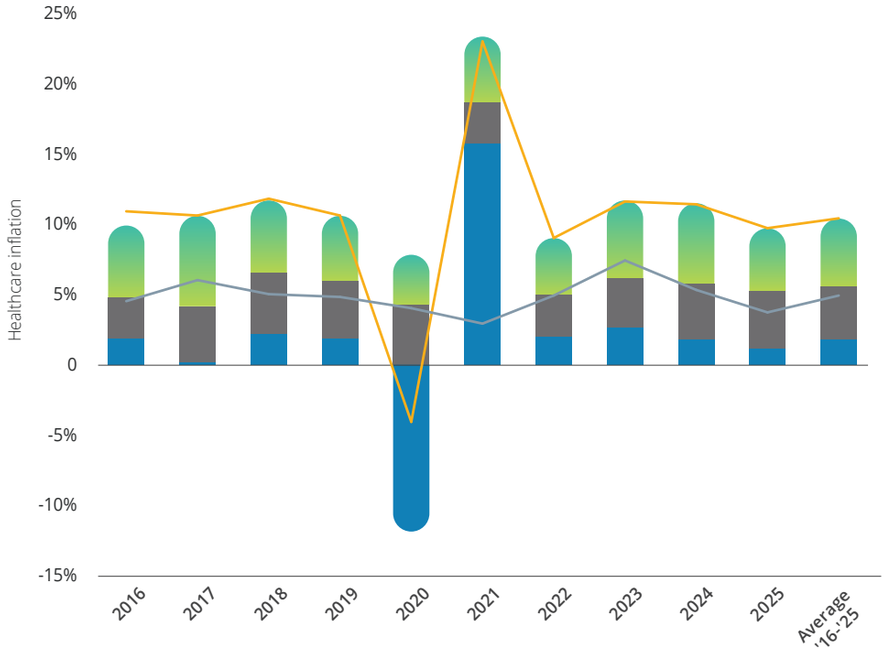
Net claims incurred *continued*

The impact of healthcare inflation

Consistently above consumer price index (CPI) inflation, healthcare inflation continues to be a concern for medical schemes. The primary driver of healthcare inflation is the extent of healthcare services utilisation due to demand- and supply-side effects.

Higher supply-side utilisation is driven by an increase in available services, such as new hospitals, and technological developments in healthcare. Increases in demand-side utilisation, on the other hand, pertain to change in the demographic profile of beneficiaries, for example the average age and burden of chronic non-communicable diseases. Healthcare inflation is also influenced by annual tariff adjustments, whether through contractual escalations agreed with providers or reimbursement tariff decisions. Many of these drivers are only partially within a medical scheme's control or ability to influence. As medical schemes use member contributions to fund healthcare claims, increases in the cost of care place upward pressure on contributions over time.

ANNUALISED INFLATION[1]



	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Average '16-'25
Supply-side impact	1.90%	0.20%	2.20%	1.90%	-11.90%	15.90%	2.00%	2.70%	1.80%	1.20%	1.80%
Demand-side impact	3.90%	4.00%	4.40%	4.10%	4.30%	2.90%	3.00%	3.50%	4.00%	4.10%	3.80%
Total utilisation	***5.80%***	***4.20%***	***6.60%***	***6.00%***	***-7.60%***	***18.70%***	***5.00%***	***6.20%***	***5.80%***	***5.40%***	***5.60%***
Tariff increase	5.20%	6.50%	5.20%	4.70%	3.60%	4.40%	4.10%	5.60%	5.80%	4.50%	4.90%
Total healthcare inflation[2]	**11.00%**	**10.70%**	**11.90%**	**10.70%**	**-4.00%**	**23.10%**	**9.10%**	**11.70%**	**11.50%**	**9.80%**	**10.50%**
CPI at Sep of prior year	4.60%	6.10%	5.10%	4.90%	4.10%	3.00%	5.00%	7.50%	5.40%	3.80%	5.00%

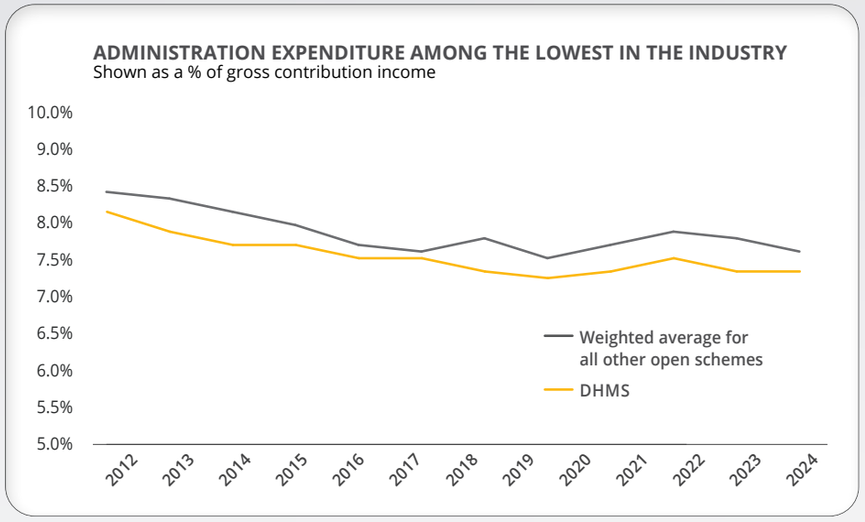
1. *The annualised inflation graph is produced prior to the finalisation of the financial data used. Any discrepancies that may occur between publication and finalisation of the data are amended in the following year's Integrated Report.*
2. *Total healthcare inflation shown here represents real inflation as experienced by DHMS members, as it includes adjustments for changes in choice of plan. This is higher than experienced by the Scheme as the average new member tends to join the Scheme on lower plans with lower contributions and claims, thus reducing the increase seen by the Scheme. The numbers shown above are rounded.*

Gross administration expenditure

Gross administration expenditure comprises administration fees and other operational Scheme expenditure, of which the most significant component is administration fees paid to the Scheme's administration provider, Discovery Health. During 2025, gross administration fees increased by 4.72% to R7 304 billion (2024: R6 974 billion), driven by an increase in the average administration fee per member of 4.68% to R450.27 (2024: R430.14), largely due to an annual CPI-linked increase.

The Scheme's analysis of the CMS Annual Report 2024-2025 shows that, at 7.6% for 2024, DHMS continued to rank below the weighted average gross administration expenditure for open schemes when considered as a proportion of gross contribution income (GCI), which was 7.9% excluding the Scheme. The Scheme's gross administration expenditure is the fifth lowest out of 16 open medical schemes in the market[1].

The graph below depicts the continued decrease in gross administration expenses as a proportion of GCI, compared to the weighted average of other open medical schemes.



1. *Based on the CMS Annual Report 2024-2025. Industry data for 2025 not yet available.*

Accredited managed care services costs

Accredited managed care services are services provided by a CMS-accredited organisation to support the clinical and financial management of healthcare, with the aim of promoting appropriate care and cost-effective utilisation of healthcare services for members.

The increase in accredited managed care services costs of 12.24% to R2.7 billion (2024: R2.4 billion) is predominantly attributable to the introduction of PHP at a cost of R8 per illegible lives, as well as the CPI-linked increase from R148.35 to R166.44, in accredited average managed care costs per member per month. Managed care costs as a percentage of GCI increased from 2.54% in 2024 to 2.66% in 2025.

An analysis of the CMS Annual Report 2024-2025 demonstrates that the Scheme's managed care cost as a proportion of GCI was 2.5% compared to the weighted average of other open schemes (2.6%[2]). Our managed care costs are slightly lower than those of other open schemes, reflecting the claims cost savings generated by managed care services and the overall value for money provided to our members by our administration and managed care provider, despite the complexity of the Scheme's benefits and the breadth of managed care services available to our members.

In 2024, claims cost savings of R353.77 (2023: R295.98) per average beneficiary per month were realised through claims review processes, protocols implemented, price negotiations and drug utilisation reviews[3]. This equates to a saving of R3.81 (2023: R3.30) for every Rand paid in managed care costs, an exceptional return on investment of 381% (2023: 330%).

Investment results

The Scheme's investment portfolio is suitably diversified and managed to optimise returns within our approved risk appetite. Asset allocation is managed and monitored from an asset and liability perspective, while ensuring sufficient liquid funds are available to meet claims and other liabilities as they fall due. Given the short-term nature of Scheme liabilities, a significant portion of our assets are invested in cash, money market instruments and other liquid securities. Allocations are also made to longer duration bonds (local and foreign) and equities.

The Scheme earned a gross investment return of

20.04%

(2024: 12.47%)

2. *Weighted average excludes DHMS. Industry data for 2025 not yet available.*
3. *Source: The Value-Added Assessment report presented to the Trustees; figures are only available for the preceding year.*

Solvency

The Act requires the Scheme to maintain accumulated funds of 25% of gross annual contributions for the accounting period, in terms of Regulation 29(2).

At 31 December 2025, the Scheme's solvency level of 32.58% (2024: 31.01%) of gross annual contributions exceeded the 25% minimum statutory solvency requirement by R7.7 billion (2024: R5.7 billion). Medical scheme solvency calculations exclude unrealised fair value gains on investments to prevent volatility in market values from artificially inflating the solvency ratio.

R'000	2025	2024
Liability to members for future benefits	**38 761 094**	31 586 694
Less: cumulative unrealised net gain on re-measurement of investments	**(5 686 089)**	(2 236 225)
Accumulated funds (Regulation 29)	**33 075 005**	29 350 469
Gross annual contributions	**101 508 259**	94 633 158
Solvency ratio	**32.58%**	31.01%
Average accumulated funds per member at year-end	**24 171**	21 591

The Act requires the Scheme to maintain accumulated funds of 25% of gross annual contributions for the accounting period, in terms of Regulation 29(2).

Prudent financial management

The Scheme has a duty to timeously collect all contributions due. The table below indicates the high level of contribution collection management achieved during the year, with average outstanding collection days at 12.37 for 2025 (11.85 in 2024). At year-end, only a very small proportion of contributions had not yet been collected.

Year ended	2025	2024
Gross contributions	**101 508 259**	94 633 158
Total outstanding – excluding December contributions	**53 508**	82 295
% Outstanding	**0.05**	0.09

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Liability for Incurred Claims (outstanding claims)

Note 8 in the Financial Statements ***pg 136***

Matters of non-compliance for the year ended 31 December 2025

Circular 11 of 2006 issued by the CMS deals with issues to be addressed in the audited financial statements of medical schemes. This includes the requirement that all instances of non-compliance be disclosed in the audited financial statements, irrespective of whether the auditor considers them to be material or not.

During 2025, the Scheme did not comply with the following Sections and Regulations of the Act, and a directive issued by the CMS.

Sustainability of benefit plans

In terms of Section 33(2) of the Act, each benefit plan is required to be self-supporting in terms of membership and financial performance and be financially sound.

Section 33(2) of the Act pertains to specific financial requirements applicable to medical schemes and outlines the statutory reserves that medical schemes are required to maintain. However, IFRS 17 provides a comprehensive framework for accounting for insurance contracts, including the recognition, measurement, presentation, and disclosure of insurance contracts. In this context, Liability to members for future benefits, as determined under IFRS 17, are not subject to the specific provisions of Section 33(2) of the Act, and are excluded from the non-compliance testing related to Section 33(2) of the Medical Schemes Act.

For the year ended 2025 the following plans did not comply with Section 33(2):

Benefit plan	Net healthcare result (R'000)	Net deficit (R'000)
Executive	**(498 717)**	**(464 295)**
Classic Comprehensive	**(199 721)**	**177 904**
Classic Priority	**(124 560)**	**184 217**
Coastal Saver	**(50 459)**	**633 151**
Coastal Core	**(262 153)**	**46 682**
KeyCare Plus	**(1 148 958)**	**(283 701)**
KeyCare Core	**(5 450)**	**86 677**

The performance of all benefit options is monitored on a continuous basis with a view to improving their financial outcomes. Different strategies are continually evaluated to address the deficit in these plans while considering the overall financial stability of the Scheme.

When structuring benefit options, the financial sustainability of all the options and the requirements of the CMS are considered. The different financial positions reflect the different disease burdens in each option, among many other factors. The Scheme's strategy for plans' sustainability must balance short- and long-term financial considerations, fairness to both healthy and sick members, and continued affordability of cover for members with different levels of income and healthcare needs. While the Scheme is committed to complying wherever possible with applicable legislation, it also focuses intensively on the overall stability and financial position of the Scheme as a whole and not only individual benefit plans.

DHMS continually provides the CMS with updates on both the Scheme and individual benefit option performance through monthly management accounts and quarterly monitoring meetings.

Investments in employer groups and medical scheme administrators

Section 35(8)(a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide and the CMS has granted DHMS exemption for a three-year period effective from 01 December 2025.

Investments in other assets in territories outside the Republic of South Africa

The Scheme's offshore bond managers utilise derivative instruments to aid with efficient portfolio construction and management, and to reduce the overall risk within our portfolios. The derivatives used are highly liquid and are either exchange traded or governed by International Swaps and Derivatives Association agreements. The derivative instruments are not used for speculation and there is no gearing or leverage applied.

Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7(b) of Annexure B to the Regulations of the Act. The CMS has granted DHMS exemption for a three-year period effective from 01 December 2025.

Contributions received after due date

Section 26(7) of the Act states that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment becomes due. There are instances where the Scheme received contributions after the three-day period, however, there are no contracts in place agreeing to this practice. It is important to note that the Scheme has no control over the timely payment of contributions. The legal obligation resides with the members/employers to pay contributions within the prescribed period. The Scheme employs robust credit control processes dealing with the collection of outstanding contributions, including suspending membership for non-payment.

Matters of non-compliance for the year ended 31 December 2025 *continued*

Claims paid in excess of 30 days

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".

During the year, there were instances where claims were not paid within 30 days. These represent a negligible amount of total claims paid for the year. There is a defined process to identify claims that have not been paid within 30 days to ensure that these claims are paid expeditiously.

Direct or indirect borrowing of money

In terms of Section 35(6)(c) of the Act, a medical scheme shall not directly or indirectly borrow money without the prior approval of the CMS or may only do so subject to directives the CMS may issue. There were instances during the year where the Scheme's bank accounts, administered by some of its asset managers, inadvertently went into an overdrawn position due to the timing of investment related inflows and outflows. Additional processes have been implemented to mitigate the risk of re-occurrence.

Incorrect funding of intra-muscular injection claims from PMSA

The incorrect funding of intra-muscular injection claims from members' PMSAs constituted a breach in terms of Section 32 of the Medical Schemes Act, which provides that the rules of a medical scheme and any amendments thereof are binding on the scheme, its members, officers, and any person claiming benefits under those rules.

During the implementation of the benefit rule for Short Stay Arthroplasty, which allows for a two-day post-procedure stay, a defect in the system applied a forced OH rule to IM injection NAPPI codes. As a result, these codes were either rejected incorrectly or funded from day-to-day benefits, even in cases where members were hospitalised with a valid hospital authorisation.

The impact of this error affected, a total of 1 220 members and 295 providers experienced incorrect claim payments, with R107 165 mistakenly deducted from members' PMSAs instead of being funded from the appropriate OH risk benefits.

In addition, 401 healthcare providers and 2 801 members experienced incorrect claim rejections, amounting to R294 250.

The cause of the failure was a system defect in the application of benefit rules.

Corrective action has since been taken, with all affected claims reversed and reprocessed to ensure proper risk benefit funding and prevent member liability.

Incorrect payment of dental claims from risk benefit

The incorrect funding of a subset of dental claims from the risk benefit instead of from members' Personal Medical Savings Accounts (PMSA) constituted a breach in terms of Section 32 of the Medical Schemes Act, which provides that the rules of a medical scheme and any amendments thereof are binding on the scheme, its members, officers, and any person claiming benefits under those rules. This non-compliance further represents a failure to administer claims in accordance with Rule 15.1 of the Scheme Rules, read together with Regulation 18(2)(b) of the Medical Schemes Act, which requires that the administrator administer the business of the scheme in line with the Act and the Scheme's registered rules.

During the implementation of Active Smart Plans as part of the year-end 2025 programme, system configuration changes were applied to dental benefit rules. A defect in the system resulted in certain dental codes being incorrectly funded from the risk benefit instead of being allocated to members' PMSA balances, contrary to the Scheme's registered benefit rules.

The impact of this error affected 15 DHMS plan types and 17 499 members, resulting in incorrect claim payments amounting to R9 976 642, which were paid from risk instead of from PMSA.

The cause of the failure was a system configuration error arising from the implementation of benefit rule changes during the Active Smart Plans deployment.

Corrective action has since been taken, including the identification and quantification of all affected claims, reallocation of claim payments in accordance with Scheme rules, member and provider communication, and the implementation of system fixes to prevent recurrence.

Incorrect accumulation of tiered medicine claims towards ATB

The incorrect accumulation of tier 2, 3 and 7[1] medicine claims towards the Annual Threshold Benefit (ATB) constituted a breach in terms of Section 32 of the Medical Schemes Act, which provides that the rules of a medical scheme are binding on the scheme, its members, officers and any person claiming benefits under those rules. This non-compliance represents a failure to administer benefits in accordance with the Scheme's registered rules relating to tiered medicine reimbursement and accumulation towards the ATB.

A system defect introduced on 01 January 2025 resulted in tier 2, 3 and 7 medicine claims accumulating towards the ATB at 100% of the Discovery Health Rate[2], instead of at their designated tiered reimbursement rates. As a result, affected members reached their self-payment gap earlier than intended and obtained premature access to ATB risk funding, contrary to Scheme rules.

The impact of this error affected 16 658 members, representing 10.5% of Executive, Comprehensive and Priority members, and resulted in an overpayment of R148 million from the risk benefit.

The root cause of the non-compliance was a system defect introduced during system configuration changes, which incorrectly applied accumulation logic for tiered medicines.

Corrective action has been implemented, including the identification and correction of all affected claims. Discovery Health elected to absorb the full financial impact, ensuring that the Scheme was placed in the same financial position it would have been in had the error not occurred.

The system defect was remediated, and enhancements were implemented to ensure that tiered medicines now accumulate correctly towards the ATB in accordance with Scheme rules, thereby preventing recurrence.

Communication was issued to affected members, brokers, employers and staff, the Regulator was formally notified, and independent agreed-upon procedures reviews were performed to provide assurance that all impacted claims were fully reworked and completed. Furthermore, an independent review of the claims system will be undertaken.

1. *Certain medicine claims across three medicine categories for 2025, including ethical medicines, non-preferentially priced medicines, and over-the-counter medicines.*
2. *The rate paid for healthcare services from hospitals, pharmacies, healthcare professionals and other healthcare providers. The applicable rate may vary depending on the type of healthcare discipline and the specific healthcare service rendered.*

DHMS plans and beneficiary distribution in 2025

In 2026, we introduced our new Smart Saver series, designed to meet the healthcare needs of young, growing families (not shown alongside).

Click on each button to see the plan guides

Benefit options
17
(2024: 16)

Network efficiency discount options
6*
(2024: 6)

For more information on plans and benefits

Distribution of Scheme beneficiaries on various plans in 2025

Saver series
53.6%
- Classic Saver
- Essential Saver
- Coastal Saver
- Classic Delta Saver*
- Essential Delta Saver*

Executive series
0.5%
- Executive

Priority series
5.4%
- Classic Priority
- Essential Priority

Core series
12.6%
- Classic Core
- Essential Core
- Coastal Core
- Classic Delta Core*
- Essential Delta Core*

KeyCare series
11.3%
- KeyCare Plus
- KeyCare Core
- KeyCare Start
- KeyCare Start Regional*

Comprehensive series
5.9%
- Classic Comprehensive
- Classic Smart Comprehensive

Smart series
10.7%
- Classic Smart
- Essential Smart
- Active Smart[1]
- Essential Dynamic Smart*

1. *We added the Active Smart plan in 2025.*

Operational statistics per benefit plan[1]

for the year ended 31 December 2025

2025	EXECUTIVE	COMPREHENSIVE		PRIORITY		SAVER			CORE			SMART			KEYCARE			TOTAL
	EXECUTIVE	CLASSIC COMP	CLASSIC SMART COMP	CLASSIC PRIORITY	ESSENTIAL PRIORITY	CLASSIC SAVER	ESSENTIAL SAVER	COASTAL SAVER	CLASSIC CORE	ESSENTIAL CORE	COASTAL CORE	CLASSIC SMART	ESSENTIAL SMART	ACTIVE SMART	KEYCARE PLUS	KEYCARE CORE	KEYCARE START	
Number of members at the end of the accounting period	7 260	78 661	2 655	65 367	4 474	359 212	180 897	144 095	41 474	55 689	60 007	80 057	78 914	23 259	161 898	17 775	6 693	**1 368 387**
Number of beneficiaries at the end of the accounting period	14 297	155 523	4 725	138 392	8 667	774 159	374 709	312 213	88 119	121 141	133 723	164 569	95 480	30 740	270 540	29 328	8 797	**2 725 122**
Average number of members for the accounting period	7 382	81 177	2 710	65 955	4 461	356 718	177 382	146 193	41 508	54 327	60 688	78 085	73 487	13 919	164 469	16 848	6 406	**1 351 714**
Average number of beneficiaries for the accounting period	14 656	161 158	4 817	139 969	8 659	768 537	367 991	316 959	88 312	118 213	135 360	160 395	88 011	18 242	275 563	27 869	8 368	**2 703 079**
Average insurance revenue per member per month (R')	13 919.29	11 206.31	10 145.52	7 398.59	6 634.78	5 715.96	4 618.09	5 490.85	6 220.81	4 879.38	5 521.89	4 610.48	2 329.38	1 698.60	3 240.97	2 561.24	2 068.72	**5 342.15**
Average insurance revenue per beneficiary per month (R')	7 010.89	5 644.72	5 708.23	3 486.28	3 418.41	2 653.08	720.35	2 532.58	2 923.85	2 242.41	2 475.71	2 244.50	1 944.99	1 296.06	1 934.36	1 548.34	1 583.49	**2 671.42**
Average insurance service expenses per member per month (R')	19 550.97	11 413.35	7 575.45	7 557.71	5 178.81	5 539.91	3 990.13	5 520.99	6 189.78	4 642.25	5 883.15	4 462.71	2 145.49	1 167.23	3 884.56	2 588.19	1 646.59	**5 315.92**
Average insurance service expenses per beneficiary per month (R')	9 847.46	5 749.01	4 262.21	3 561.26	2 668.26	2 571.37	1 923.36	2 546.48	2 909.26	2 133.43	2 637.68	2 172.57	1 791.45	890.62	2 318.49	1 564.64	1 260.37	**2 658.30**
Insurance service expenses ratio (%)	140.46%	101.85%	74.67%	102.15%	78.06%	96.92%	86.40%	100.55%	99.50%	95.14%	66.98%	203.57%	666.87%	68.72%	1480.60%	119.86%	101.05%	**99.51%**
Average relevant health care expenditure per member per month	18 985.46	10 845.47	7 007.35	6 990.33	4 611.89	4 972.40	3 432.93	4 955.06	5 625.44	4 089.04	5 327.88	3 912.58	1 631.85	799.99	3 433.32	2 298.60	1 250.21	**4 775.57**
Average relevant health care expenditure per beneficiary per month	9 562.63	5 462.96	3 942.58	3 293.91	2 376.16	2 307.95	1 654.77	2 285.45	2 644.02	1 879.19	2 388.72	1 904.75	1 362.56	610.41	2 049.17	1 389.57	956.97	**2 388.09**
Relevant health care expenditure ratio (%)	136.40%	96.78%	69.07%	94.48%	69.51%	86.99%	74.34%	90.24%	90.43%	83.80%	96.49%	84.86%	70.06%	47.10%	105.93%	89.75%	60.43%	**89.39%**
Average net claims incurred per member per month (R')	18 816.28	10 676.48	6 841.26	6 822.62	4 446.36	4 806.26	3 266.09	4 788.50	5 465.55	3 922.13	5 160.21	3 747.40	1 469.98	638.01	3 333.54	2 137.01	1 121.17	**4 617.76**
Average net claims incurred per beneficiary per month (R')	9 477.41	5 377.84	3 849.13	3 214.88	2 290.88	2 230.84	1 574.35	2 208.63	2 568.87	1 802.49	2 313.55	1 824.33	1 227.41	486.81	1 989.61	1 291.89	858.19	**2 309.18**
Average directly attributable insurance service expenses per member per month (R')	734.69	736.87	734.18	735.09	732.45	733.66	724.05	732.49	724.23	720.12	722.94	715.32	675.51	529.23	551.02	451.18	525.42	**698.16**
Average directly attributable insurance service expenses per beneficiary per month (R')	370.05	371.17	413.08	346.38	377.38	340.53	349.01	337.85	340.40	330.95	324.12	348.23	564.04	403.81	328.87	272.75	402.18	**349.13**
Directly attributable insurance service expenses ratio (%)	5.20%	6.47%	7.12%	9.78%	10.87%	12.63%	15.43%	13.34%	11.46%	14.52%	13.09%	15.52%	29.00%	31.16%	17.00%	17.62%	25.40%	**13.07%**
Average administration costs per member per month (R')	473.95	473.95	473.95	473.95	473.95	473.95	473.95	473.95	473.95	473.95	473.95	473.95	473.95	331.76	317.28	222.45	317.28	**449.55**
Average administration costs per beneficiary per month (R')	238.72	238.73	266.66	223.33	244.19	219.99	228.46	218.60	222.76	217.81	212.49	230.73	395.74	253.14	189.37	134.48	242.86	**224.80**
Average managed care: Management services per member per month (R')	171.05	170.99	167.66	169.45	166.79	167.33	165.94	167.93	168.52	168.18	168.94	165.91	162.22	162.12	161.22	161.59	160.66	**166.44**
Average managed care: Management services per beneficiary per month (R')	86.16	86.13	94.33	79.85	85.94	77.66	79.99	77.46	79.20	77.29	75.75	80.77	135.45	123.70	96.22	97.69	122.97	**83.23**
Average non-healthcare expenses per member per month	61.15	61.14	61.15	61.17	61.16	61.18	61.19	61.17	61.17	61.19	61.17	61.20	61.23	47.61	45.69	36.40	45.79	**58.77**
Average non-healthcare expenses per beneficiary per month	30.80	30.80	34.40	28.82	31.51	28.40	29.50	28.21	28.75	28.12	27.42	29.79	51.13	36.33	27.27	22.01	35.05	**29.39**
Total non-healthcare expenses as a percentage of risk contributions (%)	0.44%	0.55%	0.60%	0.83%	0.92%	1.07%	1.33%	1.11%	0.98%	1.25%	1.11%	1.33%	2.63%	2.80%	1.41%	1.42%	2.21%	**1.10%**
Average family size	1.99	1.99	1.78	2.12	1.94	2.15	2.07	2.17	2.13	2.18	2.23	2.05	1.20	1.31	1.68	1.65	1.31	**2.00**
Average age of beneficiaries (years)	48.43	48.00	49.80	44.20	41.73	37.85	35.23	39.52	44.53	41.28	43.61	34.62	37.68	31.79	34.36	37.38	36.97	**38.15**
Pensioner ratio (beneficiaries over 65 years)	32.05%	28.50%	32.04%	21.14%	17.03%	13.17%	9.63%	14.67%	22.10%	17.74%	20.68%	8.25%	7.26%	3.03%	12.09%	16.23%	11.48%	**13.65%**
Net surplus/(deficit) per benefit plan	(464 295)	177 904	97 382	184 217	98 924	2 435 374	2 171 259	633 151	231 379	434 049	46 682	539 838	543 547	172 813	(283 701)	86 677	69 202	**7 174 401**

1. *Efficiency discount options (Delta, KeyCare Start Regional) are incorporated into their parent plans for operational statistics reporting purposes. For 2026, a new series, Smart Saver, was launched (not shown in the table). For more information on 2025 plans and benefits, see https://www.discovery.co.za/medical-aid/product-benefit-enhancements.*

2024	EXECUTIVE	COMPREHENSIVE			PRIORITY		SAVER			CORE			SMART		KEYCARE			TOTAL
	EXECUTIVE	CLASSIC COMP	ESSENTIAL COMP	CLASSIC SMART COMP	CLASSIC PRIORITY	ESSENTIAL PRIORITY	CLASSIC SAVER	ESSENTIAL SAVER	COASTAL SAVER	CLASSIC CORE	ESSENTIAL CORE	COASTAL CORE	CLASSIC SMART	ESSENTIAL SMART	KEYCARE PLUS	KEYCARE CORE	KEYCARE START	
Number of members at the end of the accounting period	7 123	88 307	–	3 057	66 627	4 648	344 957	179 240	154 329	43 156	55 027	64 095	71 775	72 191	181 078	17 142	6 627	**1 359 379**
Number of beneficiaries at the end of the accounting period	14 220	177 050	–	5 513	142 968	9 061	744 945	374 130	336 977	91 735	119 475	142 961	146 537	85 984	306 614	28 342	8 692	**2 735 204**
Average number of members for the accounting period	7 260	91 370	–	3 157	67 353	4 667	343 059	176 362	156 149	43 224	53 578	64 722	69 706	65 044	182 940	16 289	6 332	**1 351 211**
Average number of beneficiaries for the accounting period	14 579	183 863	–	5 761	144 841	9 110	741 203	368 508	341 343	92 036	116 518	144 662	142 311	76 833	310 609	26 880	8 266	**2 727 322**
Average insurance revenue per member per month (R')	12 786.47	10 165.11	–	9 114.87	6 774.03	6 056.16	5 293.72	4 289.21	4 966.01	5 651.31	4 436.75	4 968.83	4 266.41	2 161.69	2 980.80	2 415.25	1 966.68	**4 975.36**
Average insurance revenue per beneficiary per month (R')	6 366.96	5 051.52	–	4 994.39	3 150.00	3 102.34	2 450.15	2 052.74	2 271.73	2 654.12	2 040.13	2 223.05	2 089.74	1 830.03	1 755.61	1 463.64	1 506.50	**2 464.97**
Average insurance service expenses per member per month (R')	16 809.23	10 906.38	–	7 160.59	6 815.58	4 949.02	5 159.62	3 714.52	5 073.06	5 680.46	4 272.22	5 371.65	4 075.81	1 919.22	3 492.68	2 405.87	1 421.25	**5 002.16**
Average insurance service expenses per beneficiary per month (R')	8 370.07	5 419.89	–	3 923.56	3 169.33	2 535.19	2 388.08	1 777.71	2 320.70	2 667.81	1 964.48	2 403.27	1 996.39	1 624.76	2 057.09	1 457.95	1 088.70	**2 478.24**
Insurance service expenses ratio (%)	131.46%	107.29%	16.02%	78.56%	100.61%	81.72%	97.47%	86.60%	102.16%	100.52%	96.29%	108.11%	95.53%	88.78%	117.17%	108.11%	117.17%	**100.54%**
Average relevant healthcare expenditure per member per month	16 268.43	10 363.00	–	6 623.09	6 270.05	4 403.97	4 613.94	3 179.88	4 526.76	5 142.45	3 743.41	4 837.21	3 548.34	1 427.46	3 101.61	2 156.97	1 078.03	**4 488.44**
Average relevant healthcare expenditure per beneficiary per month	8 100.78	5 149.86	–	3 629.05	2 915.65	2 255.99	2 135.52	1 521.84	2 070.79	2 415.14	1 721.32	2 164.16	1 738.02	1 208.45	1 826.76	1 307.12	825.79	**2 223.73**
Relevant healthcare expenditure ratio (%)	127.23%	101.95%	9.21%	72.66%	92.56%	72.72%	87.16%	74.14%	91.15%	91.00%	84.37%	97.35%	83.17%	66.03%	104.05%	89.31%	54.81%	**90.21%**
Average net claims incurred per member per month (R')	16 116.81	10 209.40	–	6 475.17	6 120.91	4 255.66	4 465.81	3 031.22	4 378.86	4 998.44	3 595.44	4 689.36	3 401.19	1 280.43	2 991.26	2 010.91	943.86	**4 345.29**
Average net claims incurred per beneficiary per month (R')	8 025.29	5 073.53	–	3 548.00	2 846.30	2 180.01	2 066.96	1 450.69	2 003.13	2 347.50	1 653.28	2 098.02	1 665.95	1 083.98	1 761.76	1 218.61	723.01	**2 152.81**
Average directly attributable insurance service expenses per member per month (R')	692.42	696.98	–	685.42	694.67	693.36	693.81	683.30	694.20	682.03	676.78	682.29	674.63	638.79	501.42	394.96	477.39	**656.87**
Average directly attributable insurance service expenses per beneficiary per month (R')	344.79	346.36	–	375.57	323.03	355.18	321.12	327.01	317.57	320.31	311.20	305.26	330.44	540.78	295.32	239.35	365.69	**325.43**
Directly attributable insurance service expenses ratio (%)	5.33%	6.74%	6.79%	7.39%	10.09%	11.45%	12.89%	15.66%	13.98%	11.87%	15.00%	13.73%	15.81%	29.55%	16.82%	16.35%	24.27%	**13.20%**
Average administration costs per member per month (R')	456.83	456.84	–	456.85	456.84	456.85	456.84	456.84	456.84	456.84	456.84	456.84	456.84	456.84	285.02	182.80	285.01	**429.47**
Average administration costs per beneficiary per month (R')	227.48	227.03	–	250.33	212.44	234.03	211.44	218.64	208.98	214.55	210.07	204.39	223.77	386.75	167.87	110.77	218.32	**212.77**
Average managed care: Management services per member per month (R')	151.81	152.07	–	148.66	149.65	148.78	148.63	148.03	148.74	148.65	148.57	148.63	147.53	147.22	146.06	146.06	146.06	**148.35**
Average managed care: Management services per beneficiary per month (R')	75.59	75.57	–	81.46	69.59	76.22	68.79	70.84	68.04	69.81	68.31	66.50	72.26	124.63	86.03	88.51	111.88	**73.50**
Average non–healthcare expenses per member per month	58.05	58.05	–	58.03	58.05	58.07	58.06	58.07	58.05	58.05	58.07	58.05	58.06	58.09	41.12	31.04	41.14	**55.36**
Average non-healthcare expenses per beneficiary per month	28.91	28.85	–	31.80	26.99	29.75	26.87	27.79	26.56	27.26	26.70	25.97	28.44	49.18	24.22	18.81	31.51	**27.43**
Total non-healthcare expenses as a percentage of risk contributions (%)	0.45%	0.57%	0.00%	0.64%	0.86%	0.96%	1.10%	1.35%	1.17%	1.03%	1.31%	1.17%	1.36%	2.69%	1.38%	1.29%	2.09%	**1.11%**
Average family size	2.01	2.01	–	1.83	2.15	1.95	2.16	2.09	2.19	2.13	2.17	2.24	2.04	1.18	1.70	1.65	1.31	**2.02**
Average age of beneficiaries (years)	48.29	47.07	–	49.36	43.24	41.18	37.30	34.45	38.69	43.84	40.62	42.84	33.85	36.73	33.15	36.93	36.62	**37.59**
Pensioner ratio (beneficiaries over 65 years)	31.34%	26.84%	–	31.86%	19.82%	16.18%	12.43%	8.81%	13.52%	21.05%	16.76%	19.39%	7.20%	6.22%	10.50%	15.08%	10.68%	**13.00%**
Net surplus/(deficit) per benefit plan	(334 419)	(613 603)	12 429	82 222	116 362	72 391	1 317 668	1 607 935	147 112	100 352	246 908	(143 010)	342 693	362 756	(531 674)	49 985	60 341	**2 896 448**

Personal Medical Savings Accounts

Personal Medical Savings Accounts (PMSAs) enable members to manage their day-to-day healthcare expenses. If members select a plan with a PMSA, they pay 10% – 25% of their gross contributions, depending on plan choice, into their PMSA. The Scheme advances the full annual amount to members for immediate use, although members only contribute monthly.

PMSAs provide a variety of benefits to members for medical expenses such as day-to-day medicines, visits to general practitioners and specialists, dental care and optometry.

While PMSAs are often the most visible benefit to members because they are used for routine day-to-day healthcare expenses, they are only one component of a medical scheme's overall benefits. Members always have access to Prescribed Minimum Benefits and depending on the rules of their chosen plan, to substantial risk benefits funded from the risk pool, including hospital cover, cover for approved chronic conditions and other major healthcare events. The depletion of a PMSA therefore does not mean that a member's medical scheme cover has come to an end.

The balance remaining in the PMSA at the end of each calendar year is carried over to the following year for the benefit of the member. PMSAs are reported with the balance of the Scheme's assets.

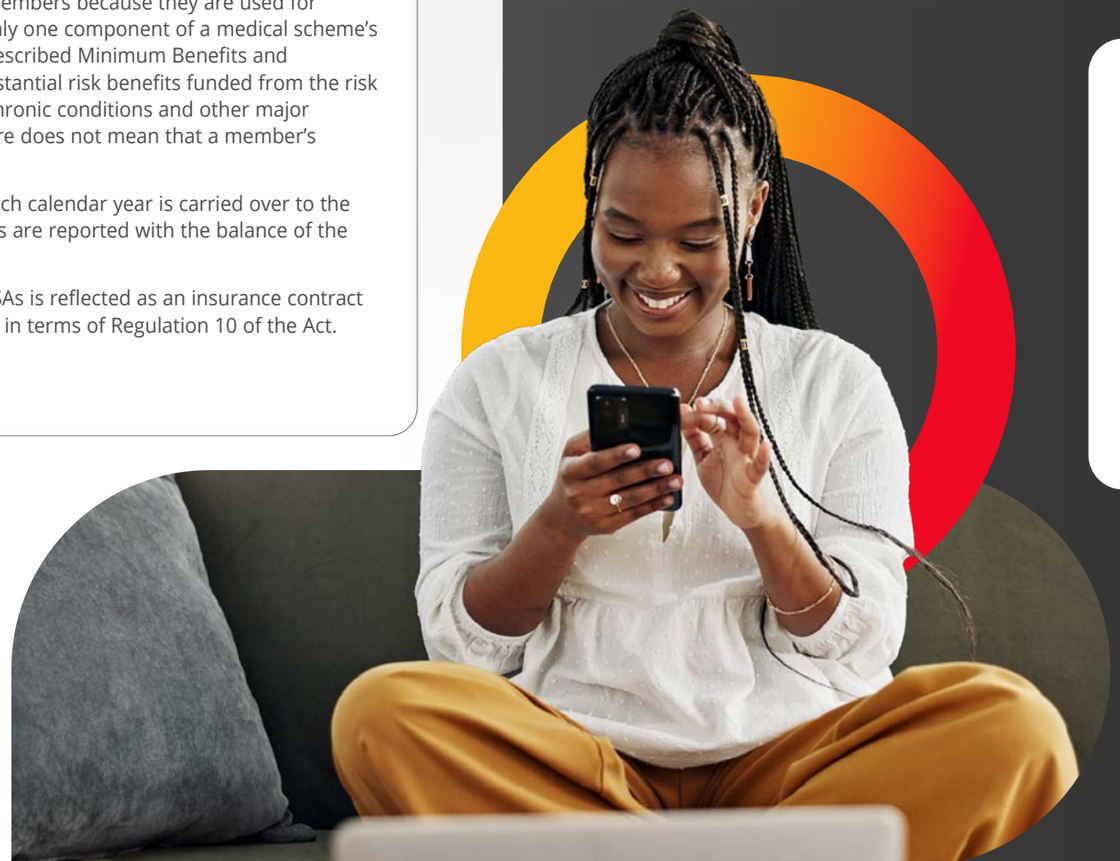
The Scheme's liability to members in respect of PMSAs is reflected as an insurance contract liability in the Financial Statements and is repayable in terms of Regulation 10 of the Act.

Note 8 in the Financial Statements ***pg 136***

PMSAs are only one component of a medical scheme's overall benefits. Members always have access to Prescribed Minimum Benefits and depending on the rules of their chosen plan, to substantial benefits including hospital cover, cover for approved chronic conditions and other major healthcare events.

Going concern

The Scheme ended 2025 in a strong financial position, with reserves exceeding statutory requirements. Based on the 2026 projected claims experience, the Trustees believe the Scheme remains able to pay claims as they arise.



Auditor independence

The Scheme appointed Deloitte & Touche as its external auditor. Deloitte & Touche has audited the Scheme's Financial Statements and the Audit Committee is satisfied that the external auditor is independent of the Scheme.

More about our auditors ***pg 5***

How Discovery Health supports the Scheme's value creation

We outsource administration and managed care services to Discovery Health (Pty) Ltd, as appointed by the Trustees in accordance with the Act and the Scheme Rules, to deliver approved services to the Scheme and its members. We utilise an integrated model with a single provider as the Trustees believe it is better suited to the Scheme's strategic intent, delivering best value for money and optimal efficiency.

Robust relational governance practices underpin the Scheme's relationship with Discovery Health. On occasion, the Trustees commission independent assessments of these practices, benchmarking them against local and international governance practice, contracting principles, independence requirements, and the ability to meet members' needs.

The Scheme's outsourced relationship with Discovery Health is operationalised using the Vested® model and through comprehensive contractual and service level agreements. The model defines and facilitates the Scheme's governance and oversight role, embedding its independence from Discovery Health while allowing us to leverage Discovery Health's expertise, systems, innovation, and value-added services in the best interests of the Scheme and our members. The relationship is overseen by our operational Relationship Management and Innovation Committees, which are mandated to monitor, review and improve the relationship and the innovation that the Vested model is designed to deliver.

In 2023, the agreements in place between DHMS and Discovery Health were renewed for the next five years after an extensive assessment of the services provided by Discovery Health. These services include the objectives that the Scheme agrees with Discovery Health each year, value added by Discovery Health, innovation, operational elements, marketing and distribution, compliance, the Health Market Inquiry's recommendations, and the CMS' requirements.

An independent review, which included publicly available information, was also conducted by Deloitte & Touche[1] to evaluate Discovery Health against global best practice for:

- Baseline criteria (including current administration and managed care capabilities, value-added services, third-party networks and scale to accommodate a scheme of DHMS' size);
- The performance of DHMS versus other top schemes, as an indicator of an effective administrator; and

Degree of innovation and competitive advantage.

As part of the agreements renewal process, a Vested Compatibility and Trust (CaT) assessment was carried out to assess the quality of the relationship against Vested criteria, the results of which, and related qualitative feedback, were discussed at a workshop. The DHMS-Discovery Health relationship scored as "very healthy", and no material problems affecting the relationship were identified.

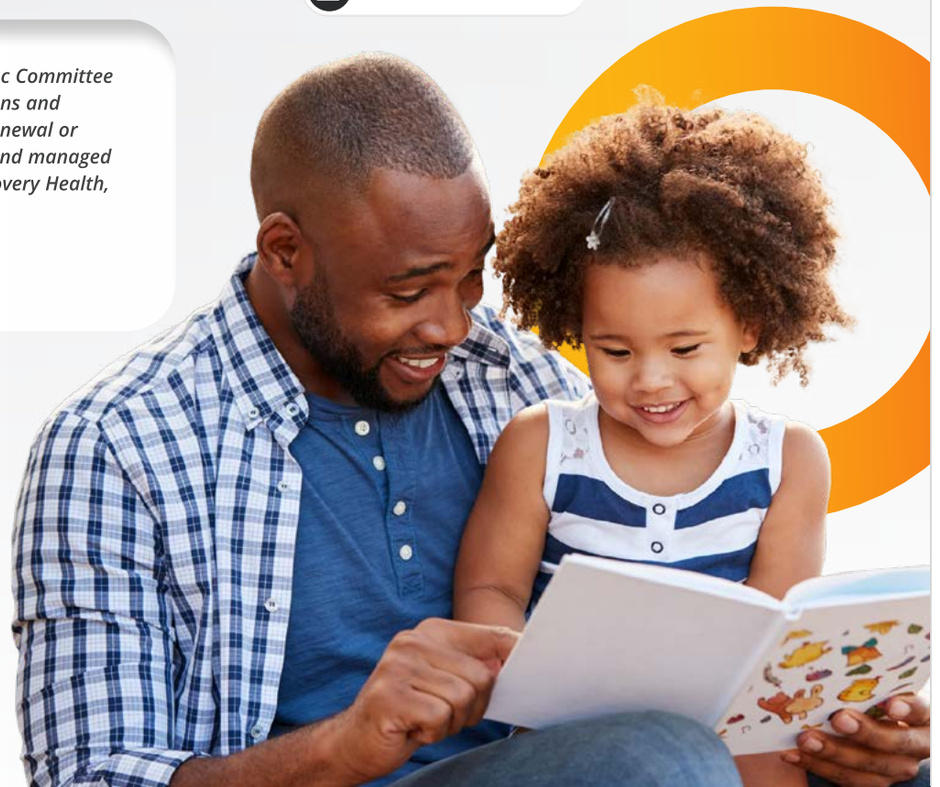
In 2024, the Scheme and Discovery Health engaged Professor Kate Vitasek[2] to analyse the strengths and weaknesses of the current relationship, and to examine opportunities for further improvement. The assessment indicated that the quality of the Scheme's relationship health with Discovery Health ranks among the top 1% of those measured internationally[3].

In 2025, Vested training was conducted for nine functional teams in Discovery Health, and ongoing training assessments are conducted annually across an expanding selection of operational teams.

More about Vested

The Board has established an ad hoc Committee to assist the Board in its deliberations and decisions related to the potential renewal or termination of the administration and managed care services agreements with Discovery Health, which expire at the end of 2027.

More about how we engage with Discovery Health ***pg 47***



1. *Prior to Deloitte & Touche's appointment as the Scheme's auditor.*
2. *Kate Vitasek is an international authority for her award-winning research and Vested® business model for highly collaborative and strategic relationships, and is a Distinguished Fellow at the University of Tennessee's Global Supply Chain Institute.*
3. *Based on a Combined Vested Deal Index, compared with 232 international organisations' relationships as measured by the University of Tennessee's Vested experts.*

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Value for money from Discovery Health

Our members benefit when our administration and managed care provider adds more value than the fees paid to it by the Scheme. The value that Discovery Health provides includes access to highly effective managed care programmes, innovative provider networks, a wide range of benefit plans, and a significantly lower average contribution paid by our members when compared with the next seven open schemes[1].

A pragmatic and replicable methodology for measuring the value added by Discovery Health has been applied since 2014, and the Trustees assess the results annually. The Scheme engaged NMG to perform an actuarial review on the reasonability of the data, methodology and results. NMG concluded that the methodology is appropriate, that the change in value added from 2023 to 2024 is reasonable, and that they did not encounter any significant anomalies in the data and calculations reviewed[2].

Discovery Health does extensive work to keep healthcare costs down, while driving improvements in quality health outcomes. This work includes negotiating for better medicine prices and hospital tariffs, recouping funds disbursed as a result of fraud, waste, abuse and errors, introducing managed care initiatives for members such as the Diabetes Care programme, and contracting using alternative fee reimbursement mechanisms instead of fee for service, which links healthcare professional fees paid to healthcare outcomes rather than just activities.

The results are expressed as the value added to DHMS by Discovery Health for each Rand paid to it:

2020	2021	2022	2023	2024
R1.90[3]	R2.02	R2.08	R2.06[4]	R2.10

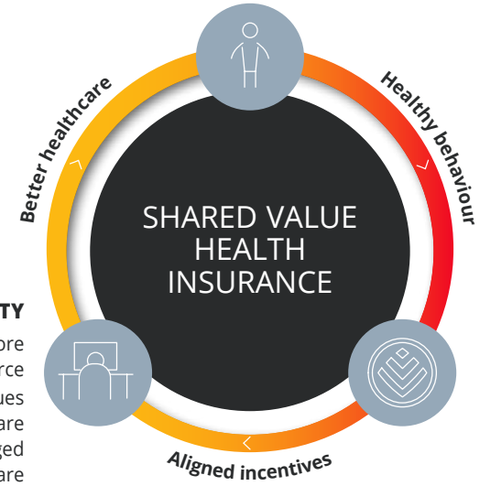
The assessment takes into account the value added from providing basic administration services, managing claims costs, making members healthier, attracting and retaining members, additional services offered, and innovation.

1. *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes. Contribution rates on individual plans of other schemes vary and may be cheaper or more expensive than DHMS's equivalent plans.*
2. *Value added of greater than one means that Scheme members receive more value than has been paid on their behalf. In 2023, for every R1.00 spent by DHMS on administration and managed care fees, members of DHMS received R2.08 (2022: R2.08) in value from the activities of Discovery Health. As the assessment uses industry information, results are only available for the preceding year.*
3. *The 2020 value added was restated from R1.88 to R1.90 using updated information from the CMS 2020/2021 Annual Report, changes in methodology and finalised settlement values for certain components.*
4. *The value added of R2.08 that was reported in the 2024 Integrated Report has been restated to R2.06, which reflects the inclusion of updated data published by the Council for Medical Schemes (CMS) on industry statistics for 2023.*

Discovery Health's business model: Shared Value Health Insurance

Discovery Health shares the Scheme's commitment to delivering an integrated value-driven healthcare system, centred on meeting the needs of our members and providing access to the best quality care at the best value for money. Discovery Health's pioneering shared value health insurance model incentivises people to be healthier, and utilises initiatives to slow down the progression of disease, reducing claims costs. It also incentivises healthcare providers through value-based contracting, with an emphasis on quality of care. This model supports the Scheme's sustainability, with shared value healthcare ultimately leading to a better healthcare system and a healthier society.

MEMBERS
- Better health and wellbeing
- Longer life expectancy
- Lower contributions



SOCIETY
- Healthier and more productive workforce
- Higher revenues for healthcare professionals engaged in high-quality care
- Less disease

SCHEME
- Growth and sustainability

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Discovery Health brings members better rest to transform physical and mental health

Sleep is one of the most powerful determinants of health and wellbeing. It influences every physiological system in the body – from cardiovascular regulation and metabolic control to cognition, immune function, and mental health. During sleep, the brain consolidates learning, regulates emotions, and clears metabolic waste, while the body repairs tissue, balances hormones, and restores immune integrity. Despite this, sleep remains one of the least measured and, often, the least prioritised components of preventive healthcare.

In October 2025, Discovery released *'The Sleep Factor: A Data-Led Blueprint for Better Health'*[1] – a landmark analysis exploring how sleep influences every dimension of wellbeing. Drawing on data from DHMS, Vitality, and Discovery Insure, the report integrates 47 million nights of sleep data from more than 105 000 Vitality[2] clients who have tracked their sleep through a smart watch or ring.

By linking these sleep data to clinical, behavioural, and claims information, Discovery Health has been able to derive one of the most comprehensive views yet of how sleep affects health outcomes – from chronic disease risk to mental resilience, and even our safety behind the wheel.

1. *See https://www.discovery.co.za/assets/template-resources/vitality/sleep-research-paper.pdf.*
2. *DHMS members may elect to join Vitality. Vitality is a separate wellness product, sold and administered by Discovery Vitality (Pty) Ltd, registration number 1999/007736/07. Limits, terms and conditions apply.*

THE ARCHITECTURE OF HEALTHY SLEEP CONSISTS OF THREE CORE ELEMENTS:

Duration: total number of hours slept – ideally seven to nine for most adults.

Regularity: consistency in bedtime and wake-up time each day stabilises the body's internal clock and supports every system, from metabolism to mood.

Quality: the restorative elements of sleep, measured by the time spent in deep sleep and Rapid Eye Movement (REM) sleep.

Deep sleep, which typically occurs during the first half of the night, is when the body repairs tissue, strengthens the immune system, and consolidates energy for the day ahead.

REM sleep dominates later in the night as the brain processes emotions and memories, and is essential for mental health, learning and resilience.

When any of these elements are disrupted over a short and extended period, the effects on health are significant. The impact of poor sleep can be experienced after even one night of inadequate sleep. However, consistent poor sleep over weeks, months or years can manifest in the long term through health impacts and safety risks.

THE CONSEQUENCE OF POOR SLEEP OVER TIME

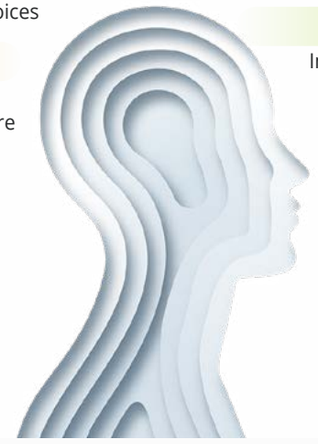
AFTER 1 NIGHT
Increased risk of motor accidents

AFTER 1 WEEK
Increased hunger hormones, risk of making unhealthy food choices

AFTER 1 MONTH
Increased anxiety and depression symptoms. Increased blood pressure and impaired glucose levels

AFTER 6 MONTHS
Impaired immunity, memory and focus

AFTER 1 YEAR
Chronic fatigue, increased risk of cancer, diabetes and psychosis



THE VALUE OF IMPROVED SLEEP OVER TIME

AFTER 2 NIGHTS
Reduced risk of motor accidents

AFTER 1 WEEK
Improved immune function

AFTER 2 WEEKS
Improved appetite regulation, enhanced mood and emotional stability

AFTER 1 MONTH
Reduced depression and anxiety symptoms

AFTER 2 MONTHS
Reduced blood pressure and insulin sensitivity

AFTER 6 MONTHS
Reduced risk of diabetes

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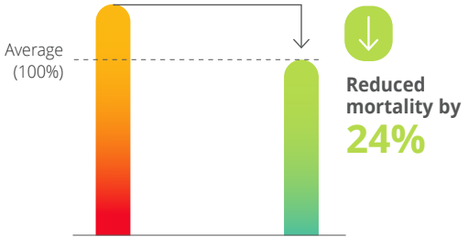
Discovery Health brings members better rest to transform physical and mental health *continued*

For most people, sleep quality is affected by modern lifestyles. Artificial light, late-night digital engagement, constant connectivity, and the use of alcohol, caffeine, and nicotine all disrupt the biological processes necessary for healthy sleep. This is evident in the Discovery Health Medical Scheme member base: compared with 2022, members sleep 12 minutes less and time spent in deep sleep has reduced by 36 minutes.

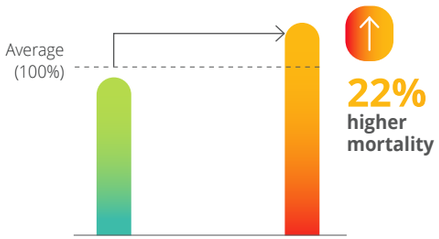
Discovery Health research reveals the negative impact of insufficient and irregular sleep on mortality risk – members who sleep less than seven hours per night and have irregular sleep patterns face a 22% higher mortality risk compared to the average population. Encouragingly, improving sleep regularity and duration can lower mortality risk by 24%, effectively normalising risk to average levels, illustrating the importance of improving sleep for Scheme members.

THE IMPACT OF IMPROVED SLEEP DURATION AND REGULARITY ON RELATIVE MORALITY RATES



In the analysis, regular sleep is defined as going to sleep inside the two-hour window of one's usual sleep time.

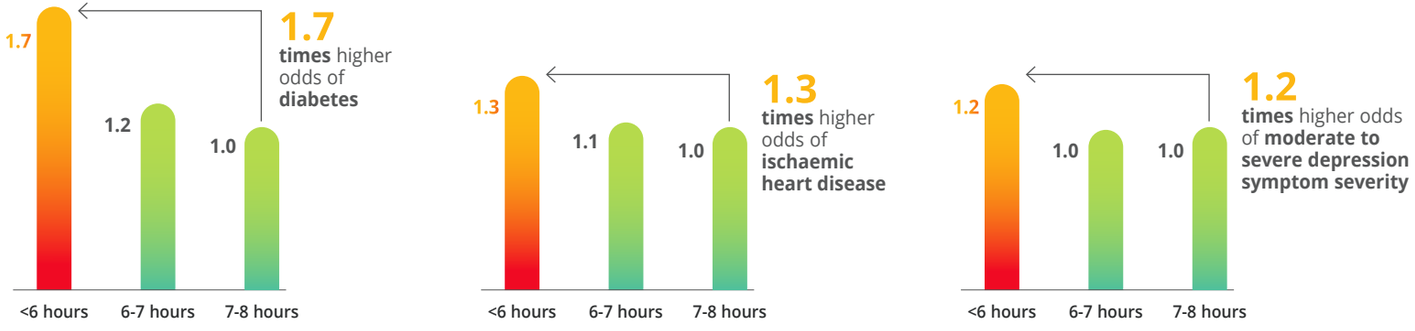
THE IMPACT OF INSUFFICIENT AND IRREGULAR SLEEP ON RELATIVE MORTALITY RATES



Irregular sleep is defined in the analysis as going to sleep outside the two-hour window of one's usual sleep time. Indicative mortality differential was calculated from analysis of 41 000 Vitality lives with wearable tracker over four years.

Looking at chronic condition risk, Discovery Health Medical Scheme members who sleep fewer than six hours per night face significantly higher health risk than those who sleep seven to eight hours. Those who sleep less than six hours per night have a 1.7 times higher likelihood of diabetes, 1.3 times higher likelihood of ischaemic heart disease (leading to potential heart attacks and strokes), and a 1.2 times higher likelihood of presenting with moderate to severe depression symptoms.

IMPACT OF INSUFFICIENT SLEEP ON PHYSICAL AND MENTAL HEALTH

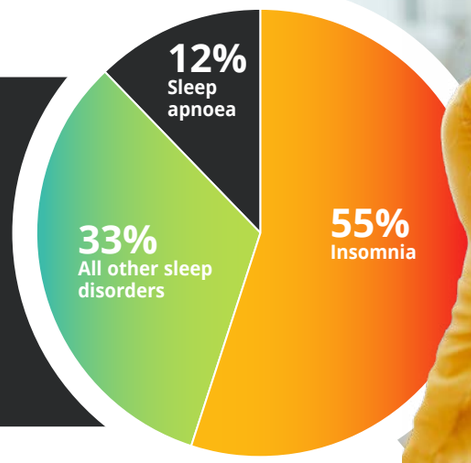


Insufficient sleep also results in a 41% higher risk of obesity, while sufficient sleep is associated with a healthy weight.

Discovery Health brings members better rest to transform physical and mental health *continued*

Furthermore, sleep disorders are rising among DHMS members, signalling a growing need for clinical screening and intervention, with claims almost tripling from 2008 to 2024. Insomnia is the most prevalent sleep disorder claimed for, comprising 55% of all primary sleep disorder claims in 2024 and growing by 4.7% per year. Obstructive sleep apnoea is the second most prevalent and fastest growing sleep disorder, comprising 12% of primary disorder claims in 2024 and growing at 9% per year.

INSOMNIA MADE UP MORE THAN HALF OF ALL PRIMARY SLEEP DISORDER DIAGNOSES IN 2024



Where members are diagnosed with both a chronic condition and a sleep disorder, risk-adjusted hospital admission rates and associated healthcare costs per life per month are significantly elevated. This suggests a compounding clinical and economic burden when sleep disorders co-exist with other chronic diseases.

When it comes to mental health, the relationship between sleep and wellbeing is bidirectional. Poor sleep contributes to irritability, anxiety, low mood, and impaired concentration; while depression, burnout, and chronic stress, in turn, disrupt sleep quality and rhythm. This creates a reinforcing cycle that gradually erodes emotional resilience and cognitive performance.

Even modest improvements in sleep regularity and duration lead to meaningful gains in mental health and functioning, as consistent, high-quality sleep supports:

- Emotional regulation and stress tolerance
- Faster recovery from psychological distress
- Better attention, working memory, and decision-making
- A lower risk of depressive and anxiety symptoms

Waking up after a good night of sleep improves mood, decision-making, and productivity, helping people feel more engaged in both their work and personal lives.

From 2026, Discovery Health Medical Scheme will become the first medical scheme globally to encourage members to improve their sleep, through Discovery Health's Personal Health Pathways (PHP) managed care programme. Through this initiative, members will receive personalised sleep goals, progress tracking and access to clinical screening for sleep disorders.

Healthcare professionals now also have opportunity to reframe sleep as a core health metric with the same focus we've long applied to other critical health behaviours such as healthy eating and exercise. Health professionals are encouraged to:

- Integrate healthy sleep into routine care
- Screen for sleep disorders, especially in patients with chronic conditions
- Educate patients on sleep hygiene and behavioural interventions
- Recognise sleep deprivation as a health risk, particularly in high-risk populations such as shift workers and drivers

Sleep is biology's innate regenerative process. Our focus on sleep reinforces our commitment to data-led innovation and the pursuit of better health for medical scheme members, with a ripple effect that benefits the societies in which we live and work.

More about PHP

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Glossary

Discovery Health's customer journeys[1] demonstrate its capabilities

At 31 December 2025, Discovery Health provided administration services to approximately 3.5 million scheme beneficiaries, including over 2.7 million for DHMS. Discovery Health services interact with millions of individuals during any given year, and the comprehensive and world-class service offerings, programmes and platforms they provide gives DHMS assurance that our members always have access to the best services and information available to suit their healthcare needs.

Discovery Health works to empower DHMS members by providing trusted thought leadership on topical healthcare matters such as mental health, women's health, oncology, and nutrition, available on the website through curated content hubs hosting articles, videos, podcasts and more. The Insight Hub's content is developed by a team consisting of actuaries, actuarial analysts, data scientists, data analysts, doctors, and computer programmers, with the objective of understanding the depth and breadth of what Discovery Health can do to enhance and protect lives, while providing stakeholders with clear, practical health insights.

Learn more about your health

On behalf of the Scheme, our administration and managed care provider proactively contacts members to inform them of benefits available to them at relevant life stages, as well as to welcome new members and assist them to best manage their health plans. A range of engagement options are available to our members, including virtual agent capability using artificial intelligence to respond to questions, and a highly responsive social media team that assists members on Facebook, X and Instagram. Members can also make contact via WhatsApp, the Discovery Health app, or the call centre.

On admission, members have access to benefit specialists in many hospitals throughout the country who provide support, facilitate their healthcare journeys, and advise them on their plan entitlements.

In 2025, Discovery Health won a gold iCXA[2] award for "Best CX for Vulnerable Customers" and a bronze award for "Best use of AI". It also won a "Best Health and Wellness Offering" award in the 2025 Global Insurance Innovation Awards[3].

1. *For members of all schemes administered by Discovery Health.*
2. *See https://internationalcxaward.com/hall-of-fame.*
3. *See https://thedigitalbanker.com/awards/global-insurance-innovation-awards/#2025.*

NEW BUSINESS

A new membership activated every

24 seconds

MEMBER PROFILES

Average principal member age	49
Oldest life	108
Members with chronic conditions	31%
Family memberships (single/family)	46%/54%
Average number of claims per member per year	24

SERVICE AND CLAIMS

Paid in claims per hour
R54.1mil

Claims received per day
339 835

Calls received per day
30 465

Billed in contributions per month
R10.8bil

Hospital admissions approved per day
2 753

BENEFIT MANAGEMENT

HIV Programme members
83 507

Diabetes Care Enrolled Lives
95 596

Member Care Programme Enrolled Lives
4 461

CIB Programme members
1 133 947

Cardio Care Enrolled Lives
267 878

Care Coordination Programme Enrolled Lives
3 928

Oncology Programme members
117 576

Mental Health Enrolled Lives
9 726

Advanced Illness Benefit Enrolled Lives
2 328

DIGITAL SUPPORT

Website users per month
271 923

Website logins per day
40 668

WhatsApp registered users
908 756

WhatsApp interactions per day
2 413

Mobile users per month
599 266

Mobile logins per day
26 214

Current HealthID users
6 772

Social Media followers
1.5mil

Virtual agent interactions per day
6 017

% calls IVR assisted
18%

Financials

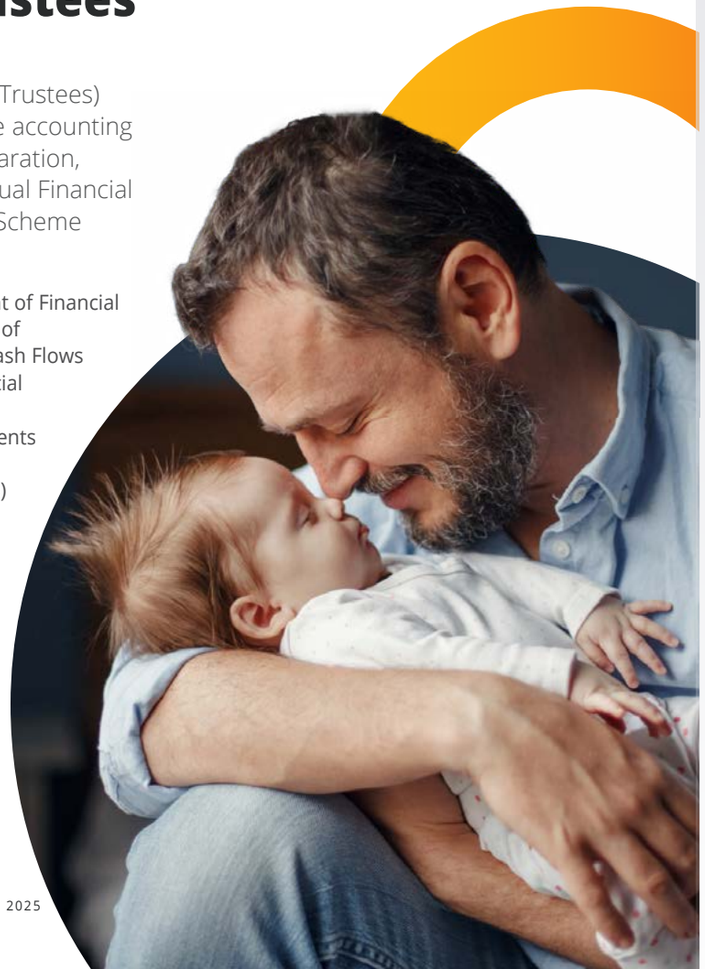
Statement of responsibility by the Board of Trustees

For the year ended 31 December 2025

The Board of Trustees (the Board or the Trustees) is responsible for ensuring that adequate accounting records are maintained and for the preparation, integrity and fair presentation of the annual Financial Statements of Discovery Health Medical Scheme (DHMS or the Scheme).

The Financial Statements comprise the Statement of Financial Position as at 31 December 2025, the Statement of Comprehensive Income, and the Statement of Cash Flows for the year then ended, and Notes to the Financial Statements, including a summary of significant accounting policies. The annual Financial Statements have been prepared in accordance with International Financial Reporting Standards (IFRS) as issued by the International Accounting Standards Board and the Medical Schemes Act, No. 131 of 1998, as amended, (the Act) and include amounts based on judgements and reasonable accounting estimates.

In preparing the annual Financial Statements, the Trustees consider that they have used the most appropriate accounting policies, consistently applied, and that all applicable International Financial Reporting Standards have been followed.



The Trustees are satisfied that the information contained in the annual Financial Statements fairly presents the results of operations of the Scheme for the year and its financial position of the Scheme at year-end. The Trustees have also reviewed the other information included in the Integrated Report and are responsible for both its accuracy and its consistency with the Financial Statements.

The Trustees are responsible for the Scheme's system of internal control and incorporate risk management and internal control procedures, which are designed to provide reasonable, but not absolute, assurance that assets are safeguarded and the risks facing the Scheme are being controlled. Reliance is placed on Discovery Health (Pty) Ltd's (Discovery Health's) system of internal controls.

Even an effective system of internal control, no matter how well designed, has inherent limitations, including the possibility of circumvention and the overriding of controls. An effective system of internal control therefore aims to provide reasonable assurance with respect to the reliability of financial information and particularly the presentation of the Financial Statements. The Trustees considered the system error that arose during the year that inadvertently altered the accumulation of medicine claims to the Above Threshold Benefit for some members on the Executive, Comprehensive and Priority plans and believe that it was isolated and did not constitute a material breakdown in the operation of the system of internal controls (refer to Note 27 for more details on the system error). To the best of their knowledge and belief, based on the above, the Trustees are satisfied that no material breakdown in the operation of the system of internal controls and procedures has occurred during the year under review.

The Board of Trustees have also reviewed the Scheme's budget for the year ending 31 December 2026, taking into consideration the impact of changing demographics on the utilisation of healthcare services.

The Scheme concluded 2025 in a strong financial and solvency position, providing the Scheme with the capacity to absorb potential increases in claims which may arise from higher-than-anticipated utilisation. Based on the expected claims experience for 2026, this is not expected to affect the Scheme's ability to meet its claims obligations as they arise.

Based on their review and in light of the Scheme's current financial position and available cash resources, at the end of the year and as projected in the 2026 budget, the Trustees have no reason to believe that the Scheme will not be a going concern for the foreseeable future, being at least 12 months from the date of issue of the annual Financial Statements. The going concern basis has therefore been adopted in preparing the Financial Statements and these Financial Statements support the viability of the Scheme.

The Scheme's External Auditor, Deloitte & Touche, has audited the Financial Statements and their unqualified report is presented on pages 109 – 112. The Financial Statements, which are presented on pages 113 – 204, were approved by the Board of Trustees on 30 April 2026 and are signed on its behalf by:

MICHELLE NORTON
Chairperson

DHESAN MOODLEY
Trustee

CHARLOTTE MBEWU
Principal Officer

Report of the Audit Committee

For the year ended 31 December 2025

We are pleased to present our report for the financial year ended 31 December 2025. The Audit Committee (the Committee) is an independent statutory committee. Duties are delegated to the Committee by the Board of Trustees.

AUDIT COMMITTEE TERMS OF REFERENCE AND ASSESSMENT

The Committee's role and responsibilities include specific statutory duties required by the Medical Schemes Act, as well as further responsibilities delegated to it by the Trustees. The Committee has adopted formal terms of reference that have been approved by the Trustees and are reviewed at least annually. The Committee executed its duties and conducted its affairs in accordance with its terms of reference and applicable laws and regulations in force during the financial year and has discharged the responsibilities contained therein.

Members of the Committee collectively keep up to date with key regulatory, accounting and other developments affecting their required skill set.

The performance of the Committee is assessed on an annual basis either through external independent parties, or through self-appraisals.

AUDIT COMMITTEE MEMBERS AND MEETING ATTENDANCE

Following the end of term of Eric Mackeown as Audit Committee Chairperson on 31 August 2025, Melanie Bosman was appointed to succeed him as Chairperson with effect from 01 September 2025. The membership and attendance of the Members of the Committee have been set out on page 62 of the Integrated Report.

EXTERNAL AUDITOR APPOINTMENT AND INDEPENDENCE

The Committee considered the matters set out in Section 36 of the Act and nominated Deloitte & Touche for appointment as External Auditor of the Scheme. Penny Binnie was approved by the Council for Medical Schemes (CMS) as the statutory auditor of the Scheme for the financial period 01 January 2025 to 31 December 2025 in accordance with section 36(2) of the Act on 17 December 2025.

The Committee has satisfied itself that the External Auditor is independent of the Scheme as required by Section 36(3) of the Act. The Auditor narrated the audit firm's internal governance processes that support and demonstrate its independence.

The Committee ensured that the appointment of the Auditor at the Annual General Meeting complied with the Act and Scheme Rules relating to the appointment of auditors.

The Committee, following consultation with the Scheme's Executive Officers, approved the engagement letter, audit plan, proposed audit fees and representation letter for the year ended 31 December 2025.

There is a formal policy in respect of the provision of non-audit services by the External Auditor of the Scheme and a formal procedure governs the process if the Scheme decides to appoint the auditor to provide any non-audit services. The Chairperson of the Committee and/or the Committee pre-approves the nature and extent of any non-audit services that the External Auditor provides in terms of the approved Policy, and a schedule of approved non-audit services is reviewed annually by the Committee. Fees in respect of audit and non-audit services, where applicable, are reflected in Note 14 to the Financial Statements.

During the year, the Committee met with the External Auditor without management being present. The Chairperson of the Committee also met separately with the External Auditor.

INTERNAL AUDITORS (IA)

The Committee is responsible for ensuring that the IA function is independent and has the necessary resources, standing and authority to enable it to discharge its duties. Furthermore, the Committee oversees co-operation between IA and the External Auditor, and serves as a link between the Board of Trustees and these functions.

The Committee considered and approved the IA charter.

The IA annual audit plan was approved by the Committee. The results of the work carried out by IA in terms of the audit plan were reviewed and the effect of any action plans to mitigate risks of any matters reported were considered by the Committee.

IA has responsibility for reviewing and providing assurance on the adequacy of the internal control environment across all Scheme operations. The Chief Audit Executive (CAE) is responsible for reporting the findings of the Internal Audit work against the agreed IA plan to the Committee on a regular basis.

The CAE has direct access to the Committee, primarily through its Chairperson.

The Committee has assessed and was satisfied with the performance of the CAE and the IA function.

During the year, the Committee met with the CAE without management being present. The Chairperson of the Committee also met separately with IA.

FINANCIAL STATEMENTS AND ACCOUNTING POLICIES

The Committee has reviewed the accounting policies and the Scheme's annual Financial Statements and is satisfied that they are appropriate and comply with International Financial Reporting Standards, the Act and circulars issued by the CMS.

INTERNAL FINANCIAL CONTROLS

The Committee is responsible for assessing the Scheme's system of internal financial and accounting control. In this regard the Committee has, among other things, evaluated the adequacy and effectiveness of the Scheme's system of internal controls and made appropriate recommendations to the Board of Trustees. In its evaluation of the adequacy and effectiveness of the Scheme's system of internal controls, the Committee assessed the Above Threshold Benefit claims system error that occurred during the year and were satisfied that this does not impact on the adequacy and effectiveness of the Scheme's system of internal controls (refer to Note 27 for more details on the system error). The Committee also considered the formal documented review by the IA function of the design, implementation and effectiveness of the administrator's system of internal financial controls pertaining to the Scheme. Based on the results of this review, it is the view of the Committee that a Reasonable Assurance* rating can be placed on the effectiveness of the system of internal control and a High Assurance** rating on risk management. Furthermore, a High Assurance** rating can be placed on the adequacy and effectiveness of the Scheme's internal financial controls, relative to the fair presentation of the Financial Statements.

* *Reasonable Assurance – The existing control framework provides reasonable assurance that material risks are identified and managed effectively.*

** *High Assurance – The existing control framework provides a high level of assurance that the annual Financial Statements are fairly presented.*

EVALUATION OF THE EXPERTISE AND EXPERIENCE OF THE CHIEF FINANCIAL OFFICER AND FINANCE FUNCTION

The Committee is satisfied with the expertise and experience of the Scheme's Chief Financial Officer. The Committee further reviewed and satisfied itself of the appropriateness of the expertise, resources and experience of the administrator's Finance function pertaining to the Scheme.

WHISTLEBLOWING

The Committee receives and deals with any concerns or complaints, whether from within or outside the Scheme, relating to the accounting practices and IA of the Scheme, the content or auditing of the Scheme's Financial Statements, the internal financial controls of the Scheme and related matters. The administrator's forensic department assists the Committee in discharging this responsibility. No such concerns or complaints were received during the year.

ETHICS AND COMPLIANCE

The Committee is responsible for reviewing any major breach of relevant legal and regulatory obligations. The Committee is satisfied that there has been no material non-compliance with laws and regulations, except for the matters of non-compliance with the Act as detailed in Note 31 to the Financial Statements. Certain members of the Audit Committee also serve as members of the Risk Committee.

RISK MANAGEMENT

The Committee monitors the risk management processes and systems of internal control of the Scheme through review of reports from, and discussions with, the Scheme's Internal and External Auditors and the risk management function.

The Audit Committee is responsible for ensuring that appropriate systems are in place for monitoring risk and compliance with laws, regulations and codes of conduct that may affect the integrity of the Financial Statements.

The Committee is satisfied that the system and the process of risk management is effective.

GOING CONCERN

The Committee has reviewed the going concern basis for the preparation of the Scheme's Financial Statements taking into consideration the Scheme's operating environment and financial position at 31 December 2025 as well as the Scheme's budget for the year ending 31 December 2026.

The Liability to members for future benefits exceeded R38.8 billion with a solvency level of 32.58% at 31 December 2025. Furthermore, the Scheme had sufficient financial resources (cash and cash equivalents and financial assets at fair value through profit or loss) at 31 December 2025 to cover monthly claims expenditure by up to 6.3 times.

Based on this review and taking note of the current net surplus of R7.2 billion, before taking into account the Liability to members for future benefits, the Committee considers that:

1. The Scheme's assets are currently equal to its liabilities; and
2. The Scheme in the ordinary course of its business, will be able to settle its liabilities as they arise for the foreseeable future.

The Committee also considered the enactment of the National Health Insurance Bill and concluded that this will not impact on the Scheme's ability to continue as a going concern in the foreseeable future, being at least 12 months from the date of issue of the annual Financial Statements.

The Committee agreed that, based on the assessment conducted, the Board of Trustees can be advised that there is no reason to believe that the Scheme will not be a going concern in the foreseeable future.

MS M BOSMAN
Chairperson: Audit Committee

30 April 2026

Independent Auditor's Report

TO THE MEMBERS OF DISCOVERY HEALTH MEDICAL SCHEME REPORT ON THE FINANCIAL STATEMENTS

OPINION

We have audited the financial statements of Discovery Health Medical Scheme (the Scheme), set out on pages 113 – 204, which comprise the statement of financial position as at 31 December 2025, and the statement of profit or loss and other comprehensive income, the statement of changes in members' funds and the statement of cash flows for the year then ended, and notes to the financial statements, including material accounting policy information.

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

BASIS FOR OPINION

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

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

Basis for determining materiality

R866 million

A key judgement in determining materiality is the appropriate benchmark to select, based on our perception of the needs of the users of the financial statements who are primarily the members of the Scheme and the regulator. Based on our professional judgement and the requirements of auditing standards, Insurance Revenue was the key benchmark for determining materiality applying a percentage factor of 1%.

KEY AUDIT MATTER (KAM)

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

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

KEY AUDIT MATTER

The valuation of the provision for outstanding claims – Incurred but not reported (IBNR) and the Risk Adjustment (RA) both of which are included in the insurance contract liability on the statement of financial position.

Refer to the following disclosures in the financial statements for details;

- Significant judgements and estimates section in the accounting policies section;
- Insurance contracts in the accounting policies; and
- Note 8: Insurance contract liability.

As at 31 December 2025, the Scheme recognised a provision for outstanding claims – Incurred but not reported (IBNR) included in note 8 amounting to R2 482 508 247 (2024: R2 383 659 239) and a Risk Adjustment (RA) amounting to R38 727 129 (2024: 45 766 257).

In determining the IBNR and RA, the Scheme applies significant judgement and estimation due to the Scheme having to determine claims from healthcare events that have occurred but have not yet been reported. In addition, the Scheme also needs to estimate a run-off period within which the incurred not reported claims will be submitted to the Scheme.

Themost significant assumptions in the determination of the IBNR are:

- The future cashflow projections; and
- The timing of the submission and payment and the level of future claims submitted.

The most significant assumptions in the determination of the RA are:

- The variability and level of claims; and
- The determination of the confidence level.

IBNR methodology and assumptions:

The methods used by the scheme to determine the best estimate of the IBNR are the following;

- Basic Chain Ladder techniques (BCL); and
- Cost per event method (CPE).

The BCL method is a common method used to calculate reserves for medical schemes. This method involves using run-off triangles constructed using treatment periods (typically months) as origin periods and analysing the development of payments per period.

Development factors that are weighted by the cumulative claims values from which they arise are used. The key assumption is that for each origin period, the expected amount of claims paid in each development period is a constant proportion of the total claims for that origin period. The development factors are then applied to claims which have already been observed to determine the amount of the reserve needed.

The CPE method makes use of an estimate for the cost per event combined with the known number of pre-authorisations (less the expected number of authorisations that do not lead to an event) and considers the expected case-mix of events to estimate the ultimate claims liability.

IFRS 17: Insurance Contracts, requires that the Scheme applies judgement when determining an appropriate estimation technique for the risk adjustment for non-financial risk.

Management has applied a Bootstrapping approach for the RA. This is in line with the Value at Risk (confidence level) technique for determining the risk adjustment for non-financial risk.

The risk adjustment reported for 2025 has been calculated as follows:

- Calculate the best estimate (mean) IBNR through bootstrapping using fully run-off data;
- Calculate the 75th percentile IBNR through bootstrapping using fully run-off data;
- The difference between these two items is the risk adjustment;
- Calculate the Risk Adjustment as a percentage of the 2024 IBNR; and
- Apply Risk Adjustment percentage to 2025 IBNR, which is the 2025 Risk Adjustment.

Back testing

The Scheme considers claims processed in 2026 in respect of services provided in 2025 to determine if there is a need to disclose that actual claims are materially different to forecast claims and the IBNR judgement.

How the matter was addressed in the audit

Our audit procedures to address the risks identified for the KAM were as follows:

- Obtained an understanding of and documented the process to determine the IBNR and RA and the actuarial processes; and
- Evaluated the design and implementation of the controls relating to the IBNR and RA calculations.

Data

We have considered the data used in determining the Incurred but not reported claims (IBNR) component of the LIC and RA.

We performed a reconciliation of the data used to calculate the 2025 Incurred but not reported claims (IBNR) component of the LIC and RA. The calculation is based on the claims data up to 31 December 2025.

Total claims presented in note 11of the financial statements for the period ended 31 December 2025 amount to R74.9bn. The claims input data used in the IBNR component of the LIC and RA calculation amounts to R74.7bn.

The full incurred claims balance includes items that are not taken into account in the determination of the IBNR. We performed a reconciliation of the claims data to the input data used in the calculation.

Claims data excluded related to claims covered under risk transfer arrangements as these are not settled by Discovery Health Medical Scheme. It is therefore appropriate that these are excluded.

Calculations

Engaged our internal actuarial specialists to perform an independent calculation of the IBNR and RA. The procedures performed by the actuarial specialists were:

- Considered the appropriateness of the methodology and assumptions applied in determining the IBNR provision and RA. Our actuarial specialists concur with the methodology and assumptions applied;
- Performed an independent calculation of the IBNR and RA using the same methodology and assumptions. The independently calculated IBNR and RA were agreed to the Scheme's actuaries' calculations with no material differences noted; and
- Considered the appropriateness of the confidence level applied for the RA and concluded that the confidence level at the 75th percentile is appropriate.

Disclosures

Considered the appropriateness of the disclosures relating to the determination of the IBNR and RA and concluded that these were appropriate.

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 concluded that the judgements and assumptions applied to determine the provision for outstanding claims are appropriate. The provision for outstanding claims – Incurred but not reported (IBNR) and the Risk Adjustment (RA) are reasonable. The disclosures of the related accounts are appropriate.

OTHER INFORMATION

The other information comprises the Integrated Report and the information included in the Statement of Responsibility by the Board of Trustees and the Report of the Audit Committee which we obtained prior to the date of this 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 Discovery Health Medical Scheme for two years.

The engagement partner, Penelope Binnie, has been responsible for Discovery Health Medical Scheme's audit for two years.

DELOITTE &TOUCHE
Registered Auditors
Per: Penelope Binnie
Partner

30 April 2026

5 Magwa Crescent
Waterfall
2090

Managing Partner: ML Tshabalala

A full list of partners and directors is available on request

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

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

Statement of Financial Position

At 31 December 2025

	Notes	2025 R'000	2024 R'000
Assets			
NON-CURRENT ASSETS		**31 964 284**	26 888 100
Property and equipment	*1*	**4 606**	6 024
Long-term employee benefit plan assets	*24*	**12 273**	11 334
Financial assets held at fair value through profit or loss	*3*	**31 947 405**	26 870 742
CURRENT ASSETS		**15 062 567**	12 867 797
Financial assets held at fair value through profit or loss	*3*	**9 638 228**	9 711 931
Derivative financial instruments	*6*	**68 478**	–
Trade and other receivables	*4*	**7 387**	11 583
Reinsurance contract assets	*9*	**3 130**	1 194
Cash and cash equivalents	*5*	**5 345 344**	3 143 089
TOTAL ASSETS		**47 026 851**	39 755 897
Liabilities			
NON-CURRENT LIABILITIES		**36 606 417**	30 489 597
Liability to members for future benefits[1]	*10*	**36 604 016**	30 485 863
Lease liability	*2*	**2 401**	3 734
CURRENT LIABILITIES		**10 420 434**	9 266 300
Lease liability	*2*	**1 894**	1 770
Derivative financial instruments	*6*	**–**	29 784
Insurance contract liability	*8*	**8 167 592**	8 034 282
Liability to members for future benefits	*10*	**2 157 078**	1 100 831
Trade and other payables	*7*	**93 870**	99 633
TOTAL LIABILITIES		**47 026 851**	39 755 897

1. *This line item was renamed from "Insurance liability to future members" in FY24 to "Liability to members for future benefits" in FY25. The revised wording more accurately reflects the nature of the balance, which represents the accumulated surplus held on behalf of members for future benefits.*

Statement of Comprehensive Income

FOR THE YEAR ENDED 31 December 2025

	Notes	2025 R'000	2024 R'000
Insurance revenue	11	**86 652 776**	80 673 076
Insurance service expense	11	**(86 227 264)**	(81 096 469)
Net income from risk transfer arrangements/reinsurance	11	**139 950**	73 068
INSURANCE SERVICE RESULT[1]		**565 462**	(350 325)
OTHER INCOME		**8 018 326**	4 577 188
Investment income	18	**2 985 313**	2 827 549
Net gain on financial assets	19	**4 989 582**	1 714 147
Sundry income	20	**43 431**	35 492
OTHER EXPENDITURE		**(1 409 388)**	(1 330 415)
Other administration fees	12	**(719 412)**	(686 987)
Other operating expenses	13	**(233 934)**	(210 659)
Asset management fees	21	**(111 795)**	(93 764)
Finance costs	22	**(561)**	(692)
Net finance expense from insurance contracts	23	**(343 686)**	(338 313)
NET SURPLUS FOR THE YEAR BEFORE MUTUALISATION		**7 174 400**	2 896 448
Transfer to Liability to members for future benefits	10	**(7 174 400)**	(2 896 448)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**–**	–

1. *Insurance service expense in accordance with IFRS 17 includes Liability to members for future benefits. Total insurance service result after adjusting for amounts transferred to Liability to members for future benefits amount to -6 608 938 (2024: -3 246 773).*

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		**101 218 737**	94 457 641
Cash received from members – contributions	8	**101 218 737**	94 457 641
CASH PAID TO PROVIDERS, EMPLOYEES AND MEMBERS		**(101 766 847)**	(96 475 258)
Cash paid to providers and members – claims and directly attributable expenses	8	**(100 027 282)**	(94 752 018)
Cash paid to risk transfer arrangement providers/reinsurers	9	**(315 846)**	(314 505)
Cash paid to providers and employees – other administration fees and operating expenses	26	**(903 194)**	(837 296)
Cash paid to members – savings plan refunds	8	**(520 525)**	(571 439)
CASH USED IN OPERATIONS		**(548 110)**	(2 017 617)
Purchase of financial assets	26	**(2 693 960)**	(6 419 310)
Proceeds from disposal of financial assets	26	**2 854 536**	4 800 757
Increase in long-term employee plan asset	24	**(7 510)**	(7 130)
Interest received	26	**2 186 465**	2 126 091
Dividend income	26	**524 743**	419 990
Interest paid	22	**–**	(10)
Asset management fees paid	21	**(111 795)**	(93 764)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES		**2 204 369**	(1 190 993)
Cash flows from investing activities			
Purchases of office equipment	1	**(347)**	–
NET CASH OUTFLOW FROM INVESTING ACTIVITIES		**(347)**	–
Cash flows from financing activities			
Payment of lease liabilities	2	**(1 770)**	(1 654)
NET CASH OUTFLOW FROM FINANCING ACTIVITIES		**(1 770)**	(1 654)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**2 202 255**	(1 192 647)
Cash and cash equivalents at the beginning of the year		**3 143 089**	4 335 736
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**5 345 344**	3 143 089

Accounting Policies

FOR THE YEAR ENDED 31 December 2025

GENERAL INFORMATION

DHMS offers the insurance of hospital, chronic illness and day-to-day benefits and is administered by Discovery Health, a wholly owned subsidiary of Discovery Ltd, listed in the insurance sector of the Johannesburg Stock Exchange (JSE).

The Scheme is an open medical scheme registered in terms of the Medical Schemes Act, as amended, and is domiciled in South Africa.

BASIS OF PREPARATION

The Financial Statements have been prepared in accordance with IFRS Accounting Standards, as issued by the International Accounting Standards Board (IASB), and interpretations provided by the IFRS Interpretations Committee. The Financial Statements are also prepared in accordance with the Act, which requires additional disclosures for registered medical schemes.

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

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

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

- Financial instruments held at fair value through profit or loss;
- Derivative financial instruments carried at fair value through profit or loss; and
- Insurance and reinsurance assets and liabilities – measured in terms of IFRS 17: *Insurance Contracts*.

All monetary information and figures presented in these Financial Statements are stated in thousands of Rand (R'000), unless otherwise indicated.

IMPLEMENTATION OF NEW STANDARDS

New standards, amendments and interpretations effective and relevant to the Scheme:

The following new standards, amendments and interpretations to the existing standards have been published and are effective for the current financial year.

Standard	Scope	Effective date
Amendments to IAS 21 – Lack of Exchangeability (Amendments to IAS 21)	An entity is impacted by the amendments when it has a transaction or an operation in a foreign currency that is not exchangeable into another currency at a measurement date for a specified purpose. A currency is exchangeable when there is an ability to obtain the other currency (with a normal administrative delay), and the transaction would take place through a market or exchange mechanism that creates enforceable rights and obligations. This amendment has no impact on the Scheme.	Annual periods beginning on or after 01 January 2025

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

The following new standards, amendments and interpretations to the existing standards have been published and are not yet effective for the current financial year.

Standard	Scope	Effective date
Amendments to the Classification and Measurement of Financial Instruments – amendments to IFRS 9 Financial Instruments and IFRS 7 Financial Instruments: Disclosures.	These amendments to IFRS 9 and IFRS 7 address feedback from the post-implementation review of classification and measurement requirements. They clarify the treatment of financial liabilities settled via electronic payment systems and refine the assessment of contractual cash flows, particularly for financial assets with ESG-linked features. Additionally, they enhance disclosure requirements for equity investments designated at fair value through other comprehensive income and introduce new disclosures for financial instruments with contingent features unrelated to basic lending risks and costs. This amendment has no impact on the Scheme.	Annual periods beginning on or after 01 January 2026
Annual improvements to IFRS Accounting Standards – Amendments to: **IFRS 1 First-time Adoption of International Financial Reporting Standards;** **IFRS 7 Financial Instruments: Disclosures and its accompanying Guidance on implementing IFRS 7;** **IFRS 9 Financial Instruments;** **IFRS 10 Consolidated Financial Statements;** **IAS 7 Statement of Cash Flows**	These amendments, published in Annual Improvements to IFRS Accounting Standards – Volume 11, introduce clarifications and minor revisions to five IFRS standards, effective for annual reporting periods beginning on or after 01 January 2026. The changes address inconsistencies and potential confusion in the application of IFRS 1, IFRS 7, IFRS 9, IFRS 10, and IAS 7. Key amendments include clarifications on hedge accounting for first-time adopters, derecognition of lease liabilities, disclosure of deferred differences in fair value, determination of a 'de facto agent' in consolidated financial statements, and the use of the term 'cost method' in cash flow statements. These updates ensure consistency and improve the usability of the standards without introducing major policy changes. This amendment has no impact on the Scheme.	Annual periods beginning on or after 01 January 2026

Standard	Scope	Effective date
IFRS 18 Presentation and Disclosure in Financial Statement	IFRS 18 was issued by the IASB in April 2024 and supersedes IAS 1 Presentation of Financial Statements. The standard introduces enhanced requirements for the presentation and disclosure of information in the primary financial statements and related notes, with the objective of improving transparency and comparability across entities. The standard is effective for annual periods beginning on or after 01 January 2027, with early application permitted. **Anticipated Impact on the Scheme:** The Scheme has commenced its impact assessment and notes the following expected implications: ▪ The statement of comprehensive income will require structural changes to reflect the new categories and subtotals, including reclassification of certain income and expenditure lines such as investment income, reinsurance results, and administration fees. ▪ Performance measures historically presented to stakeholders, such as net healthcare result and operating surplus, will need to be reviewed, defined as Management Performance Measures where applicable, and disclosed with reconciliations to IFRS-defined subtotals. ▪ The Scheme will be required to disclose operating expenses by nature in the notes to the Financial Statements, in addition to the current functional classifications. ▪ Comparative information for the 2026 financial year will need to be restated to conform with the new presentation requirements. ▪ The Scheme does not intend to early adopt IFRS 18 and plans to apply the standard for the financial year beginning 01 January 2027. The Scheme will continue to monitor guidance issued by SAICA, the CMS, and other relevant bodies to ensure full compliance.	Annual periods beginning on or after 01 January 2027

SIGNIFICANT JUDGEMENTS AND ESTIMATES

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

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

Significant judgements

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

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

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

Although the 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). Based on customary business practices in the medical scheme industry, the remaining assets of the Scheme should be distributed to the members on liquidation if there are any and if the Scheme does not amalgamate with another scheme. Even if the assets are distributed by a regulator or by the policyholders to an independent third party – e.g. another medical scheme, an administrator or a charity – the important aspect is that the choice resides with the members or the regulator acting on behalf of the members and 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, the Scheme meets the definition of a mutual entity in terms of IFRS.

The Scheme has 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 (which forms part of the insurance contract liabilities) on the face of the Statement of Financial Position.

As a result, the Statement of Comprehensive Income reflects total comprehensive income for the year as NIL.

Onerous contract assessment

When assessing whether facts and circumstances suggest that a group of insurance contracts is onerous, the Scheme, which is defined as a mutual entity evaluates whether the expected deficit for the following year exceeds the Liability to members for future benefits. In the rare scenario where the following year's expected deficit exceeds the Liability to members for future benefits – the contracts would be considered onerous and an onerous contract liability would be raised. Where the Liability to members for future benefits exceed the following year's expected deficit, the contracts would not be considered onerous, and no provision would be raised as the liability is already recognised within the Liability to members for future benefits.

Unit of account

The Scheme applies judgement in determining the unit of account for the measurement of its insurance contracts. Management has assessed the portfolio to be at a Scheme level 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 benefit option selected, the member will have access to the chronic condition management benefit.
- Risk transfer arrangements/reinsurance are based on conditions and not on benefit options.
- Pricing and benefit option changes are determined at a Scheme level to manage member migration between different benefit options to ensure each option is sustainable.
- Risk (utilisation and concentration) is managed holistically.

Risk adjustments – Liability for Incurred Claims

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

The risk adjustment was calculated at the portfolio level as the Scheme does not have groups due to laws that constrain the Scheme's ability to set a price for different members. The confidence level method was used to derive the overall risk adjustment for non-financial risk. In the confidence level method, the risk adjustment is determined by applying a confidence level to run-off triangles used to calculate the Liability for Incurred Claims. The confidence level is set at 75% in line with the Scheme's risk appetite.

The Scheme will present the changes in the risk adjustment for non-financial risk in the insurance service result.

The methods and assumptions used to determine the risk adjustment for non-financial risk are consistent with the prior year.

Classification of investments as current and non-current

The judgements relating to the classification of investments are set out in the Financial assets at fair value through profit or loss (Note 3) in the Financial Statements.

Classification of money market funds as cash and cash equivalents

The judgements relating to the classification of money market funds are set out in the Cash and cash equivalents (Note 5) in the Financial Statements.

Valuation of unlisted investments

The methodology relating to the valuation of level 2 investments is set out in the Financial Risk Management Report (Note 29) in the Financial Statements.

Significant estimates

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

In applying IFRS17 measurement requirements, the inputs and methods used include significant estimates. The present value of future cash flows is estimated using deterministic scenarios.

The sensitivities regarding the assumptions made that have the most significant impact on measurement under IFRS 17, are detailed in the Insurance Risk Management Report (Note 28) in the Financial Statements.

Estimates of future cash flows to fulfil insurance contracts

Included in the measurement of the portfolio are all the estimated future cash flows within the boundary of each group of contracts. The estimates of these future cash flows are based on probability weighted expected future cash flows. The Scheme estimates which cash flows are expected and the probability that they will occur as at the measurement date. In making these estimates, 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 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.

Methods used to measure the insurance contracts

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

The Scheme applies judgement in assessing the most appropriate technique to estimate insurance liabilities for the claims incurred. The actuarial methodology used in assessing the estimated claims outcome of insurance liabilities is the chain ladder method. For hospital claims in the latest service month, a blend of the chainladder method and another method, using the estimated cost per event and pre-authorised admissions, is followed.

The chain ladder method involves an analysis of historical claims development factors, and the selection of estimated

development factors based thereon. The selected development factors are then applied to cumulative claims data for each period (in the Scheme's case, for the four months post year-end) that is not yet fully developed to produce an estimated ultimate claims cost for each healthcare year. The chain ladder method is the most appropriate for this claim pattern.

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

The following is taken into account when estimating the Liability for Incurred Claims:

- The homogeneity of the data.
- Changes in pattern of claims.
- Changes in the composition of members and their beneficiaries.
- Changes in benefit limits.
- Changes in the Prescribed Minimum Benefits (PMBs).

FOREIGN CURRENCY TRANSLATION

Functional and presentation currency

Items included in the Financial Statements are measured using the currency of the primary economic environment in which the entity operates (functional currency). The functional and presentation currency of the Scheme is the South African Rand (R/ZAR).

Transactions and balances

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions, and from the translation at year-end exchange rates of monetary assets denominated in foreign currencies, are recognised in the Statement of Comprehensive Income.

CLASSIFICATION, RECOGNITION, PRESENTATION AND DERECOGNITION OF FINANCIAL INSTRUMENTS

The Scheme recognises a financial instrument when, and only when, it becomes a party to the contractual provisions of the instrument. The Scheme classifies its financial instruments into the following categories: financial assets or financial liabilities at fair value through profit or loss, derivatives, and other receivables. Other receivables are receivables other than those arising from insurance contracts and include sundry accounts receivable and interest receivable. Other receivables are disclosed under "Trade and other receivables".

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

Offsetting financial instruments

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

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

Derecognition of financial assets and liabilities

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

- The contractual right to the cash flows from the asset expires.
- The Scheme retains the contractual right to receive cash flows of the asset but assumes the obligation to pay one or more third parties the cash flow without material delay.

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

FINANCIAL LIABILITIES

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

PROVISIONS

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

- It has a present legal or constructive obligation resulting from past events.
- It is probable that an outflow of resources embodying economic benefits will be required to settle the obligation.
- A reliable estimate of the amount of the obligation can be made.

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

CONTINGENT LIABILITY

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

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

INSURANCE CONTRACTS

Insurance contracts

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

Separation of components

Before the Scheme accounts for an insurance contract, it analyses whether the contract contains components that require separation. There are three categories of components that must be accounted for separately:

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

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

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. While the cash flows are not recorded in the Statement of Comprehensive Income, they are considered in assessing onerous contracts.

Level of aggregation

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

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

CONTRACT BOUNDARY

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

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

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

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

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

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

Recognition and derecognition

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

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

An insurance contract is derecognised when it is:

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

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

Initial and subsequent measurement

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

For insurance contracts issued, on initial recognition, the Scheme measures the liability for remaining coverage at the amount of contributions received.

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

- The Liability for Remaining Coverage; and
- The Liability for Incurred Claims, comprising the fulfilment cashflows related to past service allocated to the group at the reporting date.

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

- Increased for amounts of expected contributions recognised as insurance revenue for the services provided for the period;
- Decreased for contributions received in the period;
- Increased for contributions received in advance; and
- Decreased by any investment component paid or transferred to the Liability for Incurred Claims.

The insurance contract liabilities consist of two components:

- The liability to current members; and
- The Liability to members for future benefits.

For insurance contracts issued at each of the subsequent reporting dates, the Liability for Incurred Claims included in the liability to current members is:

- The future cash flow projections; and
- The risk adjustment for non-financial risk.

Refer to Judgements and Estimates earlier in this note for the significant judgements and estimates used to determine the Liability for Incurred Claims and the estimates to determine the fulfilment cash flows.

The Liability to members for future benefits consists of accumulated profits or losses of the Scheme. The funds are mainly held as statutory reserves in lieu of the solvency requirement as required by the Act and they are:

- Increased by the net surplus for the period; and
- Decreased by the net deficit for the period.

Insurance revenue

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

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

Insurance service expenses

Insurance service expenses include:

- Incurred claims and benefits excluding investment components;
- Other incurred directly attributable insurance service expenses;
- Changes that relate to current and past service (i.e. changes in the fulfilment cashflows relating to the Liability for Incurred Claims); and
- 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.

Insurance interest income and expenses

The non-distinct investment component (the PMSA) accrues interest. This is disclosed within the net finance expenses from insurance contracts line item.

Reimbursements from the road accident fund

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

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

Other incurred insurance service expenses

Accredited managed healthcare services (no risk transfer)

Accredited managed healthcare services (no risk transfer) fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of healthcare services to the members of the Scheme and are expensed as incurred.

Accredited managed healthcare services are part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of the Scheme.

Managed healthcare services are recognised as an expense over the indemnity period on a straight-line basis.

Broker service fees

Broker service fees are costs directly attributable to individual contracts and the group of contracts. These fees are considered as insurance acquisition cash flows within the insurance contract boundary, arising from selling, underwriting and initiating a group of insurance contracts, and are also paid for the provision of ongoing services to members.

Broker service fees are expensed as incurred, and when contributions are received by the Scheme and the related broker is accredited in terms of the Act.

Expenses for administration – directly attributable costs

Expenses for administration are paid to the Scheme administrator and are expensed as incurred.

Other operating expenses – directly attributable costs

Other operating expenses charged to directly attributable costs include the following, and are charged as incurred:

- Actuarial services;
- Third-party claim recovery services; and
- Benefit management services.

RISK TRANSFER ARRANGEMENTS (REINSURANCE)

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 dependents.

Unit of account

Groups of reinsurance contracts held are assessed for aggregation separately from groups of insurance contracts issued. Applying the grouping requirements to reinsurance contracts held, the Scheme aggregates reinsurance contracts held concluded within a calendar year (annual cohorts) into groups of contracts for which there is a net gain at initial recognition.

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

Recognition and derecognition

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

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

The Scheme does not recognise their reinsurance contract held until it has recognised at least one of the underlying insurance contracts.

Initial and subsequent measurement

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

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:

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

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

- Increased for ceding contributions paid in the period; and
- 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 coverage periods which are one year or less.

Contract boundary

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

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

Net income/(expense) from reinsurance contracts held

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 reinsurance provider).

Reinsurance expenses consist of:

- Reinsurance expenses;
- Other incurred directly attributable insurance service expenses; and
- 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 Premium Allocation Approach, the Scheme recognises reinsurance expenses based on the passage of time over the coverage period of a group of contracts.

INCOME TAX

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

ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT PLANS

The following items are directly allocated to benefit plans:

- Insurance revenue.
- Claims incurred.
- Risk transfer arrangement fees.
- Accredited managed healthcare service fees.
- Expenses for administration (directly attributable and non-directly attributable).
- Broker service fees.
- Finance expenses from insurance contracts.

The remaining items are allocated as detailed below:

- For insurance revenue that is not directly allocated to benefit plans these amounts are apportioned based on a percentage of net contribution income per plan.
- For claims that are not directly allocated to benefit plans these amounts are apportioned based on a percentage of net claims incurred per plan.
- Risk adjustment is determined at a Scheme level and is apportioned to the benefit plans based on a percentage of the estimate of the provision for Liability for Incurred Claims from healthcare events that have occurred but are not yet reported.
- The following items are apportioned based on the number of members per benefit plan:
  - Other operating expenditure (directly attributable and non-directly attributable);
  - Investment income;
  - Net fair value gains/ (losses) on financial assets at fair value through profit or loss;
  - Sundry income;
  - Expenses for asset management services rendered;
  - Interest paid, excluding finance expenses from insurance contracts; and
  - Changes in expected recoverability of member and service provider claims receivables.

STRUCTURED ENTITIES

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

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

The Scheme has determined that some of its investments in pooled funds and in collective investments (funds) are investments in unconsolidated structured entities. Disclosure of these investments has been made in Note 29. The objectives include achieving medium- to long-term capital growth. The investment strategy does not include the use of leverage.

These funds are managed by independent asset managers who apply various investment strategies to accomplish their respective investment objectives.

The change in fair value of each fund is included in the Statement of Comprehensive Income in "Net gains/(losses) on financial assets".

Notes to the Financial Statements

FOR THE YEAR ENDED 31 December 2025

1. PROPERTY AND EQUIPMENT

Accounting policy:

Property and equipment are stated at historical cost less accumulated depreciation and impairment. Historical cost includes expenditure that is directly attributable to the acquisition of the items.

Subsequent costs are included in the 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 are charged to the surplus or deficit during the financial period in which they are incurred.

Property and equipment are depreciated using the straight-line method to allocate their cost to their residual values over their estimated useful lives, as follows:

Right-of-use asset – Land and Buildings	Shorter of estimated life or period of lease
Leasehold improvements	Shorter of estimated life or period of lease
Office equipment	Six years

The term of the lease and the right-of-use asset has been determined as 10 years when assessing the term under IFRS 16 Leases.

The asset's residual values and useful lives are reviewed at each reporting date and adjusted if appropriate. An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount. The recoverable amount is the higher of the asset's fair value less costs to dispose and value-in-use.

Gains or losses on disposals are determined by comparing the proceeds with the carrying amount. These are recorded in the surplus or deficit.

Note:

Effective from 01 July 2023, the Scheme renewed its lease agreement for office space for an additional five year term at a decreased rate. This resulted in a modification of the lease according to IFRS 16 as the lease term remained unchanged while the lease rate decreased.

During the current financial year, the Scheme upgraded its boardroom facilities, acquiring office equipment including audiovisual systems, furniture, and fittings. These assets have been capitalised under Property and Equipment.

The total cost of the boardroom upgrades amounted to R347 000, and depreciation is applied over a six year period in line with the expected useful life of the office equipment.

R'000	Right-of-use asset Land and Buildings	Leasehold improvements	Office equipment	Total
Non-current				
Gross carrying amount	12 015	2 844	–	14 859
Additions	145	142	–	287
Lease modification	743	145	–	888
Accumulated depreciation	(8 075)	(1 935)	–	(10 010)
BALANCE AT 31 DECEMBER 2024	4 828	1 196	–	6 024
Gross carrying amount	12 015	2 844	–	14 859
Additions	145	142	347	634
Lease modification	743	145	–	888
Accumulated depreciation	(9 455)	(2 277)	(43)	(11 775)
BALANCE AT 31 DECEMBER 2025	**3 448**	**854**	**304**	**4 606**

1. PROPERTY AND EQUIPMENT *continued*

R'000	Right-of-use asset Land and Buildings	Leasehold improvements	Office equipment	Total
Non-current				
BALANCE AS AT 01 JANUARY 2024	**6 207**	**1 538**	**–**	**7 745**
Depreciation charge	**(1 379)**	**(342)**	**–**	**(1 721)**
BALANCE AT 31 DECEMBER 2024	**4 828**	**1 196**	**–**	**6 024**
Additions	**–**	**–**	**347**	**347**
Depreciation charge	**(1 380)**	**(342)**	**(43)**	**(1 765)**
BALANCE AT 31 DECEMBER 2025	**3 448**	**854**	**304**	**4 606**

Leased assets

The right-of-use asset arises from the lease agreement for the Scheme's offices. (Note 2)

2. LEASES

Accounting policy:

At inception of a contract, the Scheme assesses whether a contract is, or contains, a lease. A contract is, or contains, a lease if the contract conveys the right to control the use of an identified asset for a period of time, in exchange for consideration. To assess whether a contract conveys the right to control the use of an identified asset, the Scheme assesses whether:

- the contract involves the use of an identified asset – this may be specified explicitly or implicitly, and should be physically distinct or represent substantially all of the capacity of a physically distinct asset. If the supplier has a substantive substitution right, then the asset is not considered to be an identified asset;
- the Scheme has the right to obtain substantially all of the economic benefits from the use of the asset throughout the period of use;
- the Scheme has the right to direct the use of the asset. The Scheme has this right when it has the decision-making rights that are most relevant to changing how, and for what purpose the asset is used. In rare cases, where all the decisions about how and for what purpose the asset is used are predetermined, the Scheme has the right to direct the use of the asset if either:
  - the Scheme has the right to operate the asset; or
  - the Scheme designed the asset in a way that predetermines how and for what purpose it will be used.

At inception, or on reassessment of a contract that contains a lease component, the Scheme allocates the consideration in the contract to each lease component on the basis of their relative stand-alone prices.

The Scheme recognises a right-of-use asset and a lease liability at the lease commencement date.

Right-of-use asset

The right-of-use asset is initially measured at cost, which comprises the initial amount of the lease liability adjusted for any lease payments made at or before the commencement date, plus any initial direct costs incurred. An estimate of the costs to dismantle and remove the underlying asset or to restore the underlying asset or the site on which it is located are also included in the cost. The total cost is reduced by any lease incentives received.

The right-of-use asset is subsequently depreciated using the straight-line method from the commencement date to the earlier of the end of the useful life of the right-of-use asset or the end of the lease term. The estimated useful lives of right-of-use assets are determined on the same basis as those of property and equipment. In addition, the right-of-use asset is periodically reduced by impairment losses, if any, and adjusted for certain re-measurements of the lease liability.

2. LEASES *continued*

Lease liability

The lease liability is initially measured at the present value of the lease payments that are not paid at the commencement date, discounted using the interest rate implicit in the lease or, if that rate cannot be readily determined, the Scheme's incremental borrowing rate. Generally, the Scheme uses its incremental borrowing rate as the discount rate.

Lease payments included in the measurement of the lease liability comprise fixed payments, increasing annually at a rate set out in the lease agreement.

The lease liability is measured at amortised cost using the effective interest method. The lease liability is re-measured by discounting the revised lease payments using a revised discount rate if there is a change in the lease term, or if the Scheme changes its assessment of whether it will exercise an extension option.

When the lease liability is re-measured in this way, a corresponding adjustment is made to the carrying amount of the right-of-use asset or is recorded in the surplus or deficit if the carrying amount of the right-of-use asset has been reduced to zero.

Leases of low-value assets

The Scheme has elected not to recognise right-of-use assets and lease liabilities for leases of low-value assets, with a value of less than R100 000.

Disclosure

The Scheme represents right-of-use assets in "Property and equipment" and lease liabilities in "Lease liabilities" in the Statement of Financial Position. The Scheme recognises the lease payments associated with short-term leases, with a lease term not exceeding 12 months, and leases of low-value assets as an expense on a straight-line basis over the lease term.

Note:

Nature of leasing activities

The Scheme leases land and buildings for its office space. The lease for the office space is effective from 01 July 2018 with an initial period of five years and includes an option to renew the lease for an additional period of the same duration, after the end of the initial term. Effective from 01 July 2023, the Scheme renewed its lease agreement for office space for an additional 5-year term at a decreased rate. This resulted in a modification of the lease according to IFRS 16 as the lease term remained unchanged while the lease rate decreased. The lease payments are fixed and increase annually at a rate set out in the lease agreement.

Accounting under IFRS 16, the modification of the lease resulted in adjustments to the carrying amount of the right-of-use asset and lease liability for the modified lease. The revised lease payments were used to re-calculate the present value of future lease payments.

Consequently, the Scheme recognises a reduced lease liability, reflecting lower contractual payments over the remaining lease term. Simultaneously, the right-of-use asset is adjusted to reflect the updated present value of future cash flows associated with the lease.

The impact of the modification is reflected in the Statement of Financial Position, with the updated right-of-use asset and lease liability disclosed separately. Additionally, the updated lease expense will be recognised in the Statement of Comprehensive Income over the remaining lease term.

This lease includes non-lease components and provides for the payment by the Scheme of operational costs incurred by the lessor and rates and taxes levied on the lessor. These amounts are determined annually and are recognised as an expense in the period incurred. Detail of this lease is presented below.

The Scheme leases IT equipment and certain office equipment with contract terms of one to two years. These leases are leases of low-value items.

2. LEASES *continued*

R'000	Land and Buildings	Total
Right-of-use asset		
Gross carrying amount	12 015	12 015
Additions	145	145
Lease modification	743	743
Accumulated depreciation	(8 075)	(8 075)
BALANCE AT 31 DECEMBER 2024	4 828	4 828
Gross carrying amount	**12 015**	**12 015**
Additions	**145**	**145**
Lease modification	**743**	**743**
Accumulated depreciation	**(9 455)**	**(9 455)**
BALANCE AT 31 DECEMBER 2025	**3 448**	**3 448**
Lease Liability		
Gross carrying amount	12 015	12 015
Lease modification	(2 466)	(2 466)
Interest expense	7 305	7 305
Lease payments	(11 350)	(11 350)
BALANCE AT 31 DECEMBER 2024	5 504	5 504
Gross carrying amount	**12 015**	**12 015**
Lease modification	**(2 466)**	**(2 466)**
Interest expense	**7 866**	**7 866**
Lease payments	**(13 120)**	**(13 120)**
BALANCE AT 31 DECEMBER 2025	**4 295**	**4 295**

	2025 R'000	2024 R'000
Maturity analysis – contractual undiscounted cash flows		
Less than one year	**1 894**	1 770
One to five years	**3 073**	4 967
TOTAL UNDISCOUNTED LEASE LIABILITIES AT 31 DECEMBER	**4 967**	6 737
Lease liabilities included in the Statement of Financial Position at 31 December		
Non-current	**2 401**	3 737
Current	**1 894**	1 770
	4 295	5 504
Amounts recognised in the Statement of Comprehensive Income		
Depreciation	**1 380**	1 379
Interest on lease liabilities	**561**	682
Expenses relating to leases of low-value assets	**76**	68
	2 017	2 061
Amounts recognised in the Statement of Cash Flows		
Total cash outflow for leases	**1 770**	1654

3. FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS

Accounting policy:

The Scheme's investment strategy (business model objective) is determined by means of an allocation across different asset classes and grouping of financial assets into specific portfolios. Independent asset managers manage these portfolios under fully discretionary, active mandates with performance evaluated at the respective portfolio level on a fair value basis. All asset managers are remunerated based on the fair value of the portfolio under management.

The business model objective is achieved through the selling of assets per the documented and approved strategy for realisation of gains with the collection of contractual cash flows being incidental to the primary business model objective. The financial assets are managed together and grouped into specific portfolios. Based on the business model objective the financial assets are measured at fair value through profit and loss.

Financial assets at fair value through profit or loss are initially recognised at fair value and the transaction costs are expensed in the Statement of Comprehensive Income.

The fair value of the portfolios where the underlying financial instruments are traded in an active market is determined by using quoted market prices or dealer quotes of the underlying financial instruments.

The fair value of the portfolios where the underlying financial instruments are not traded in an active market is determined by using valuation techniques that maximise the use of observable market data and rely as little as possible on entity specific estimates.

Gains or losses arising from subsequent changes in fair value are recognised under "Other income" in the Statement of Comprehensive Income within the period in which they arise.

The methodology applied to assess assets as non-current or current is summarised below:

Measurement class	Methodology
Offshore cash and bonds	Offshore cash and bonds are in collective investment schemes. The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result, these portfolios have been included as open ended.
Equities	The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result these portfolios have been included as open ended.
Short duration bonds	The maturity date at instrument level is used to determine the expected settlement. If the maturity date is within 12 months from the reporting date, the instrument is considered to be settled within 12 months. All other instruments are considered open ended.
Flexible fixed income bonds	The maturity date at instrument level is used to determine the expected settlement. If the maturity date is within 12 months from the reporting date, the instrument is considered to be settled within 12 months. All other instruments are considered open ended.
Money market instruments	Assets that are expected to be realised to fund operating activities within 12 months from the reporting date are considered to be settled within 12 months. All other instruments are classified as open ended.
Property	The Scheme's intention is not to liquidate these portfolios; however, in the event that operational or strategic requirements require, these portfolios may be liquidated. As a result these portfolios have been included as open ended.

3. FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS *continued*

Note:

	2025 R'000	2024 R'000
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:		
− Offshore cash and bonds	**2 337 993**	2 450 096
− Equities	**12 711 639**	9 808 519
– Short duration bonds	**6 466 551**	5 895 290
– Flexible fixed income bonds	**12 012 723**	9 981 419
− Money market instruments	**7 029 647**	7 573 667
− Property	**1 027 080**	873 682
	41 585 633	36 582 673
Open ended, available on demand (Included as non-current)	**31 947 405**	26 870 742
Expected to settle within 12 months (Included as current)	**9 638 228**	9 711 931
	41 585 633	36 582 673
Reconciliation of the balance at the beginning of the year to the balance at the end of the year:		
At the beginning of the year	**36 582 673**	32 869 897
Acquisition and income earned	**2 966 176**	6 703 775
Disposals and expenses incurred	**(2 788 378)**	(4 676 533)
Net gains on revaluation of financial assets at fair value through profit or loss (Note 19)	**4 825 162**	1 685 534
AT THE END OF THE YEAR	**41 585 633**	36 582 673

A register of investment portfolios is available for inspection at the registered office of the Scheme.

4. TRADE AND OTHER RECEIVABLES

Accounting policy:

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market.

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

Impairment of other receivables – expected credit loss

The Scheme applies the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for other receivables. To measure the expected credit losses, other receivables are grouped based on shared credit risk characteristics and days past due. Note 29 sets out information about impairment of other receivables.

Note:

	2025 R'000	2024 R'000
Financial assets	**7 050**	7 976
Sundry accounts receivable	**112**	2 927
Interest receivable	**6 938**	5 049
Other receivables		
Prepaid expenses	**337**	3 607
TOTAL TRADE AND OTHER RECEIVABLES	**7 387**	11 583

At 31 December 2025, the carrying amounts of "Trade and other receivables" approximate their fair values due to the short-term maturities of these assets. Interest is not charged on overdue balances. The estimated future cash flow receipts have not been discounted as the effect would be immaterial.

5. CASH AND CASH EQUIVALENTS

Accounting policy:

Cash and cash equivalents are short-term, highly liquid instruments that are readily convertible to known amounts of cash and are subject to an insignificant risk of changes in value. These instruments are not held for investment purposes.

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

- Money on call and short notice.
- Balances with banks.
- Money market funds.

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

Note:

	2025 R'000	2024 R'000
Cash at bank	**3 901 592**	1 797 228
Short-term deposits	**917 480**	824 764
Money market funds	**526 272**	521 097
	5 345 344	3 143 089

The money market funds are held in an actively managed portfolio by an independent asset manager. The asset manager invests in line with its best investment view, subject to the investment mandate which includes investment in interest-bearing money market and/or interest-bearing short-term collective investment scheme portfolios, subject to the Collective Investment Schemes Control Act 2002. The targeted return is the Short-Term Fixed Interest (STeFI) Call Deposit Index, and the weighted average term to final maturity never exceeds 90 days. The portfolio is highly liquid with 100% of the portfolio being available within three working days. 60% of the portfolio must be available for same-day value with the balance available within two working days.

6. DERIVATIVE FINANCIAL INSTRUMENTS

Accounting policy:

Derivative financial instruments are not designated as effective hedging instruments and are carried at fair value through profit or loss.

The Scheme initially recognises derivative financial instruments in the Statement of Financial Position at fair value on the date which a derivative contract is entered into (the best evidence of fair value on day one is the transaction price) and subsequently re-measures these instruments to fair value. Fair values are obtained from quoted prices in active markets, including recent market transactions, and valuation techniques, including discounted cash flow models and options pricing models, as appropriate. All derivatives are carried as assets when the fair value is positive and as liabilities when the fair value is negative.

Derivative contracts with a remaining maturity of less than 12 months are classified as a current asset or liability.

Note:

	2025 R'000	2024 R'000
Financial asset/(liability) held at fair value through profit or loss		
Current asset/(liability)		
– Derivative financial instruments	**68 478**	(29 784)
DERIVATIVE FINANCIAL ASSET/(LIABILITY) AT THE END OF THE YEAR	**68 478**	(29 784)
DERIVATIVE FINANCIAL (LIABILITY)/ASSET AT THE BEGINNING OF THE YEAR	**(29 784)**	65 826
Net realised (loss)/gain on derivative financial instruments (Note 19)	**(66 158)**	(124 224)
Realised loss on derivative financial instruments	**(66 158)**	(124 224)
– Synthetic forward exchange contracts	**(66 158)**	(124 224)
Net fair value gain/(loss) on derivative financial instruments (Note 19)	**164 420**	28 614
Gains on revaluation of derivative financial instruments to fair value	**191 338**	28 614
– Synthetic forward exchange contracts	**191 338**	28 614
Losses on revaluation of derivative financial instruments to fair value	**(26 918)**	–
– Zero-cost collars	**(26 918)**	–
DERIVATIVE FINANCIAL ASSET/(LIABILITY) AT THE END OF THE YEAR	**68 478**	(29 784)

The Scheme enters into derivative contracts, including contracts facilitated by Khumo Capital, to manage the impact of the Rand appreciation against the US Dollar on the value of the Scheme's offshore investments, and changes in market prices for investments in the equity portfolios. Detail on these transactions have been included above.

Certain of the Scheme's independent asset managers utilise bond futures and other derivative instruments within their respective portfolios to manage duration risk, for risk mitigation and efficient portfolio construction. These derivatives are included in the financial assets managed together and grouped into specific portfolios. As a result, these transactions are not included above but included in the portfolio balances disclosed in Note 3.

Details of the Scheme's derivatives and the impact of these instruments on investment return are set out in the Financial Risk Management Report (Note 29).

7. TRADE AND OTHER PAYABLES

Accounting policy:

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Trade payables are classified as current liabilities if payment is due within one year or less. 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.

Unidentified deposits

Unidentified deposits arise when the Scheme receives unknown or unidentified deposits that cannot be immediately linked to a member or contribution payment. Amounts identified as relating to contributions are allocated by reducing the relevant debtor balance and are included within insurance contract liabilities, while deposits that remain unknown are presented within trade and other payables until identification and allocated accordingly.

Unidentified deposits that have legally prescribed, older than three years, are written back and recognised as "Sundry income" in the Statement of Comprehensive Income.

A liability for unidentified deposits that have not legally prescribed is recognised and disclosed under "Trade and other payables". The liability is measured at amortised cost using the effective interest rate method.

Note:

	2025 R'000	2024 R'000
Financial liabilities due to related parties (Note 24)	**62 317**	58 084
Discovery Health (Pty) Ltd	**60 275**	57 373
Discovery Central Services (Pty) Ltd	**2 042**	711
Financial liabilities	**31 175**	41 351
Unidentified deposits	**15 140**	21 158
General accruals	**16 035**	20 193
Other payables		
Leave pay provision	**378**	198
TOTAL TRADE AND OTHER PAYABLES	**93 870**	99 633

At 31 December 2025 the carrying amounts of trade and other payables approximate their fair values due to the short-term maturities of these liabilities.

8. INSURANCE CONTRACT LIABILITY

R'000 **INSURANCE CONTRACTS ISSUED**	2025 Liability for Incurred Claims Liability for remaining coverage	Present value of future cashflows	Risk adjustment	Total	2024 Liability for Incurred Claims Liability for remaining coverage	Present value of future cashflows	Risk adjustment	Total
Net balance as at 01 January	**(2 873 654)**	**10 862 172**	**45 766**	**8 034 284**	(2 674 170)	11 140 644	59 492	8 525 966
INSURANCE REVENUE								
New contracts and contracts measured under the full retrospective approach at transition	**(86 652 776)**			**(86 652 776)**	(80 673 076)			(80 673 076)
TOTAL INSURANCE REVENUE	**(86 652 776)**	**–**	**–**	**(86 652 776)**	(80 673 076)	–	–	(80 673 076)
INSURANCE SERVICE EXPENSES								
Incurred claims and other directly attributable expenses		**81 804 910**		**81 804 910**		76 976 790		76 976 790
Insurance acquisition cash flows (broker fees)		**1 816 835**		**1 816 835**		1 741 863		1 741 863
Changes in fulfilment cash flows relating to the Liability for Incurred Claims – past service		**130 050**	**(45 766)**	**84 284**		7 883	(59 492)	(51 609)
Changes in fulfilment cash flows relating to the Liability for Incurred Claims – current service		**2 482 508**	**38 727**	**2 521 235**		2 383 659	45 766	2 429 425
INSURANCE SERVICE EXPENSES	**–**	**86 234 303**	**(7 039)**	**86 227 264**		81 110 195	(13 726)	81 096 469
INSURANCE SERVICE RESULT	**(86 652 776)**	**86 234 303**	**(7 039)**	**(425 512)**	(80 673 076)	81 110 195	(13 726)	423 393
Finance expense from insurance contracts issued		**343 686**		**343 686**		338 313		338 313
Unclaimed PMSA written off		**(741)**		**(741)**		(813)		(813)
TOTAL AMOUNTS RECOGNISED IN COMPREHENSIVE INCOME	**(86 652 776)**	**86 577 248**	**(7 039)**	**(82 567)**	(80 673 076)	81 447 695	(13 726)	760 893
PMSA contributions and PMSA transferred from other schemes	**(14 877 202)**	**14 877 202**			(13 984 049)	13 984 049		–
CASH FLOWS								–
Contributions received (Note 8.2)	**101 218 737**			**101 218 737**	94 457 641			94 457 641
Incurred claims paid and other insurance service expenses paid (Note 8.2)		**(100 027 282)**		**(100 027 282)**		(94 752 018)		(94 752 018)
Recoveries from reinsurer[1] (Note 8.2)		**(455 796)**		**(455 796)**		(387 573)		(387 573)
Refunds on death or resignation – PMSA		**(519 784)**		**(519 784)**		(570 626)		(570 626)
TOTAL CASH FLOWS	**101 218 737**	**(101 002 862)**	**–**	**215 875**	94 457 641	(95 710 217)	–	(1 252 576)
INSURANCE CONTRACT LIABILITIES/(INSURANCE CONTRACT ASSETS) AS AT 31 DECEMBER	**(3 184 895)**	**11 313 760**	**38 727**	**8 167 592**	(2 873 654)	10 862 170	45 766	8 034 282

1 *Recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction.*

8. INSURANCE CONTRACT LIABILITY *continued*

8.1 Reconciliation of insurance contract liability

R'000 **NET INSURANCE CONTRACT LIABILITIES**	2025 Liability for Incurred Claims Liability for remaining coverage	Present value of future cashflows	Risk adjustment	Total	2024 Liability for Incurred Claims Liability for remaining coverage	Present value of future cashflows	Risk adjustment	Total
Contributions outstanding	**(3 494 544)**			**(3 494 544)**	(3 155 695)			(3 155 695)
Provision for impaired losses on contributions	**42 558**			**42 558**	42 467			42 467
Member and service provider claims receivables[2]		**(790 388)**		**(790 388)**		(633 621)		(633 621)
Provision for impaired losses on member and service provider claims receivables		**513 158**		**513 158**		465 668		465 668
Broker fee receivables		**(2 972)**		**(2 972)**		(2 455)		(2 455)
Provision for impaired losses on broker fees		**(878)**		**(878)**		1 687		1 687
Balance due to brokers		**4 566**		**4 566**		6 169		6 169
Forensic receivables		**(212 259)**		**(212 259)**		(228 889)		(228 889)
Provision for impaired losses on forensics receivables		**19 305**		**19 305**		18 325		18 325
Balance due to Discovery Third Party Recovery Services (Pty) Ltd		**3 236**		**3 236**		3 122		3 122
Hospital debtors		**(73 314)**		**(73 314)**		(52 268)		(52 268)
Balance due (from)/to Discovery Life Ltd		**(1 731)**		**(1 731)**		119		119
Balance due to Discovery Healthcare Services (Pty) Ltd		**521**		**521**		7 201		7 201
Contributions received in advance	**266 939**			**266 939**	228 604			228 604
Contribution refunds due to employers	**152**			**152**	10 970			10 970
Reported claims not yet paid		**604 000**		**604 000**		411 318		411 318
Administration fees payable		**551 151**		**551 151**		523 904		523 904
Managed Healthcare fees payable		**226 350**		**226 350**		200 386		200 386
Personal Medical Savings Accounts liability		**7 988 751**		**7 988 751**		7 757 845		7 757 845
Provision for outstanding claims – Incurred but not reported		**2 482 508**		**2 482 508**		2 383 659		2 383 659
Risk adjustment			**38 727**	**38 727**			45 766	45 766
TOTAL INSURANCE CONTRACT LIABILITIES/(ASSETS) AS AT 31 DECEMBER	**(3 184 895)**	**11 313 760**	**38 727**	**8 167 592**	(2 873 654)	10 862 170	45 766	8 034 282

2 Included in the member claims receivable is an amount of R126 million relating to the ATB claims system error. Further details are disclosed in the Events after the reporting period (Note 27) in the Financial Statements.

8. INSURANCE CONTRACT LIABILITY *continued*

8.2 Reconciliation of cashflows – contributions received and claims and other directly attributable expenses

	2025 R'000	2024 R'000
Contributions received	**101 218 737**	94 457 641
Risk contributions	**86 652 867**	80 671 170
Personal Medical Savings Accounts contributions	**14 855 392**	13 961 988
Transfers received from other medical schemes	**21 810**	22 061
Changes in the expected recoverability of contributions	**(91)**	1 906
Movement in contributions received in advance	**38 335**	5 894
Movement in contribution refunds due to employers	**(10 818)**	9 815
Movement in contributions receivable	**(338 758)**	(215 193)
INCURRED CLAIMS PAID AND OTHER INSURANCE SERVICE EXPENSES PAID	**(100 483 078)**	(95 139 591)
Risk claims	**(74 902 637)**	(70 445 687)
Personal Medical Savings Accounts claims	**(14 469 459)**	(13 978 095)
Directly attributable expenses	**(11 324 627)**	(10 650 782)
Changes in expected recoverability of member and service provider claims payables	**98 849**	464 547
Movement in risk adjustment	**(7 039)**	(13 726)
Movement in member and service provider claims	**(109 277)**	(30 166)
Movement in other insurance receivables	**(21 046)**	(13 085)
Movement in third-party receivables	**114**	22 059
Movement in forensic receivables	**17 610**	(30 387)
Movement in broker fees	**(2 929)**	(582)
Movement in balances due to related parties	**44 681**	48 221
Movement in reported claims not yet paid	**192 682**	(511 908)

8.3 Reconciliation of personal medical savings accounts

	2025 R'000	2024 R'000
Personal Medical Savings Account	**7 988 749**	7 757 845
Balance as at 01 January	**7 757 845**	7 985 017
Personal Medical Savings Accounts contributions received	**14 855 392**	13 961 988
Net finance expense from insurance contracts	**343 686**	338 313
Transfers received from other medical schemes	**21 810**	22 061
Claims paid to or on behalf of members	**(14 469 459)**	(13 978 095)
Refunds on death or resignation	**(519 784)**	(570 626)
Unclaimed Personal Medical Savings Accounts written off to scheme funds	**(741)**	(813)

9. REINSURANCE CONTRACT ASSETS

R'000 **HEALTHCARE RISK – REINSURANCE CONTRACTS HELD**	2025 Liability for Incurred Claims **Liability for remaining coverage**	**Present value of future cashflows**	**Risk adjustment**	**Total**	2024 Liability for Incurred Claims Liability for remaining coverage	Present value of future cashflows	Risk adjustment	Total
Insurance reinsurance contract liabilities as at 01 January	**(1 194)**	**–**	**–**	**(1 194)**	(1 406)	(1 588)	(49)	(3 043)
NET INCOME/(EXPENSES) FROM REINSURANCE CONTRACTS HELD								
An allocation of premiums paid	**(315 846)**			**(315 846)**	(314 505)			(314 505)
Amounts recovered from risk transfer arrangement/reinsurance		**455 796**		**455 796**		385 936		385 936
Changes in fulfilment cash flows relating to the Liability for Incurred Claims – past service		**–**	**–**	**–**		1 588	49	1 637
NET INCOME/(EXPENSES) FROM REINSURANCE CONTRACTS HELD	**(315 846)**	**455 796**	**–**	**139 950**	(314 505)	387 524	49	73 068
TOTAL AMOUNTS RECOGNISED IN COMPREHENSIVE INCOME	**(315 846)**	**455 796**	**–**	**139 950**	(314 505)	387 524	49	73 068
CASH FLOWS								
Premiums paid net of ceding commissions and other directly attributable expenses paid	**313 910**			**313 910**	314 717			314 717
Recoveries from reinsurance[3]		**(455 796)**		**(455 796)**		(385 936)		(385 936)
TOTAL CASH FLOWS	**313 910**	**(455 796)**	**–**	**(141 886)**	314 717	(385 936)	–	(71 219)
INSURANCE CONTRACT ASSETS AS AT 31 DECEMBER	**(3 130)**	**–**	**–**	**(3 130)**	(1 194)	–	–	(1 194)

3 *Recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction.*

10. LIABILITY TO MEMBERS FOR FUTURE BENEFITS

	2025 R'000	2024 R'000
Balance at beginning of the year	**31 586 694**	28 690 246
Liability to members for future benefits	**7 174 400**	2 896 448
BALANCE AT THE END OF THE YEAR	**38 761 094**	31 586 694
Non-current Liability to members for future benefits	**36 604 016**	30 485 863
Current Liability to members for future benefits*	**2 157 078**	1 100 831
BALANCE AT THE END OF THE YEAR	**38 761 094**	31 586 694

* *The Current Liability to members for future benefits represents the onerous contract liability projected to be incurred for the following financial year which will be funded from the Liability to members for future benefits.*

11. INSURANCE REVENUE AND SERVICE EXPENSES

	2025 R'000	2024 R'000
Insurance revenue		
Insurance revenue from contracts measured under the PAA		
Gross contributions	**101 508 259**	94 633 158
Personal Medical Savings Accounts contributions	**(14 855 392)**	(13 961 988)
Changes in the expected recoverability of contributions	**(91)**	1 906
TOTAL INSURANCE REVENUE	**86 652 776**	80 673 076
Insurance service expenses		
NET CLAIMS INCURRED*	**(74 902 637)**	(70 445 687)
Risk claims	**(74 932 717)**	(70 559 255)
Third-party claim recoveries	**30 080**	113 568
OTHER INCURRED INSURANCE SERVICE EXPENSES	**(11 324 627)**	(10 650 782)
Insurance acquisition cash flows (broker fees)	**(1 816 835)**	(1 741 862)
Accredited managed healthcare services (no risk transfer) (Note 11.1)*	**(2 699 701)**	(2 405 382)
Attributable expenses incurred – administration fees (Note 11.2)	**(6 572 479)**	(6 276 321)
Attributable expenses incurred – operating expenses (Note 11.3)	**(48 471)**	(41 602)
Changes in expected recoverability of member and service provider claims receivables	**(187 141)**	(185 615)
TOTAL INSURANCE EXPENSES	**(86 227 264)**	(81 096 469)
Net income from risk transfer arrangement/reinsurance		
An allocation of premiums paid (Note 11.4)	**(315 846)**	(314 505)
Amounts recovered from risk transfer arrangements/reinsurance and changes in fulfilment cash flows (Note 11.4)	**455 796**	387 573
TOTAL INCOME FROM REINSURANCE CONTRACTS HELD (NOTE 11.4)*	**139 950**	73 068
TOTAL INSURANCE SERVICE RESULT	**565 462**	(350 325)

* *Relevant healthcare expenditure consists of net claims incurred, accredited managed healthcare services (no transfer of risk) and reinsurance results, and amounted to R77 462 288 (2024: R72 778 001).*

11. INSURANCE REVENUE AND SERVICE EXPENSES *continued*

11.1 Accredited managed healthcare services

	2025 R'000	2024 R'000
Accredited managed healthcare services (no risk transfer)	**2 699 701**	2 405 382
Active Disease Risk Management Services and Disease Risk Management Support Services	**791 212**	762 178
Hospital Benefit Management Services	**748 273**	720 880
Managed Care Network Management Services and Risk Management	**911 433**	682 571
Pharmacy Benefit Management Services	**248 783**	239 753

11.2 Attributable expenses incurred – accredited administration fees

	2025 R'000	2024 R'000
Attributable expenses incurred – administration fees	**6 572 479**	6 276 321
Broker remuneration management	**94 928**	90 691
Claims management	**738 467**	705 140
Contribution management	**587 253**	560 784
Customer services	**3 262 341**	3 115 506
Financial management	**24 154**	23 011
Information management and data control	**1 197 760**	1 143 866
Member record management	**667 576**	637 323

11.3 Attributable expenses incurred – operating expenses

	2025 R'000	2024 R'000
Attributable expenses incurred – operating expenses	**48 471**	41 602
Actuarial services	**11 696**	11 137
Third-party claim recovery services	**36 776**	30 465

11. INSURANCE REVENUE AND SERVICE EXPENSES *continued*

11.4 Net income from risk transfer arrangements/reinsurance

Accounting policy:

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

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

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

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

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

Risk transfer arrangements/reinsurance contracts

Risk transfer arrangement providing optometry services to members on the KeyCare Plus and KeyCare Start plans

An analysis as to the expected costs of optometry benefits using the experience from other Scheme plans was conducted. These claim amounts are adjusted to include a provision for outstanding claims and converted to a Per Life Per Month (PLPM) rate. Generally the claims experience on KeyCare Plus and KeyCare Start is different to that of other Scheme plans as they are aimed at a specific target market and the benefits are restricted. To allow for this, the overall PLPM is adjusted by the ratio of KeyCare Plus and KeyCare Start claims experience to the other plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Start.

Risk transfer arrangement providing dentistry services to members on the KeyCare Plus and KeyCare Start plans

The methodology to estimate these recoveries has been enhanced in the current year to only use claims experience on benefit options where basic dentistry is paid from risk. This amendment is expected to provide a more comparable alignment of the nature of benefits available on these KeyCare options, and where experience is not influenced by competing needs from a limited savings account benefit. The cost of the group of dental procedure codes was isolated. Using claims data linked to this group, the overall PLPM cost of dental services on all plans excluding KeyCare Plus and KeyCare Start was estimated. These claim amounts are adjusted to include a provision for outstanding claims. Generally, the claims experience on KeyCare Plus and KeyCare Start is different to that of other Scheme plans as they are aimed at a specific target market and the benefits are restricted. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Start.

11.4 Net income from risk transfer arrangements/reinsurance *continued*

Risk transfer arrangement covering treatment for members diagnosed with diabetes (type I and II) on all plans excluding KeyCare plans

For their diabetes-related treatment, members have a choice of using the managed care organisation under this risk transfer arrangement or not. As the risk profile of the two groups of members are similar, the claims experience of the Executive and Comprehensive Plan members who have elected to not use this provider was used to estimate the members' fee-for-service cost for those who have elected to use this provider.

As no underlying fee-for-service data is available, the cost of providing the capitated services was estimated as follows:

- PLPM estimates were calculated for consultations, procedures, medication and hospital admissions to the extent that these services were covered under this risk transfer arrangement for the Executive and Comprehensive Plan members who have elected to not use this provider.
- The expected fee-for-service cost was calculated by multiplying the calculated PLPM costs by the number of members exposed for the period on this programme.

	2025				2024			
R'000	**Discovery Care Co-ordination Network**	**IsoLeso Limited**	**Dental Risk Company**	**Risk transfer arrangement/ Reinsurance**	Discovery Care Co-ordination Network	IsoLeso Limited	Dental Risk Company	Risk transfer arrangement/ Reinsurance
An allocation of premiums paid (Note 11.4)	**(111 350)**	**(65 538)**	**(138 958)**	**(315 846)**	(97 973)	(70 175)	(146 357)	(314 505)
Amounts recovered from risk transfer arrangements/reinsurance and changes in fulfilment cash flows	**127 620**	**147 896**	**180 280**	**455 796**	104 845	156 879	125 849	387 573
TOTAL INCOME/(EXPENSE) FROM REINSURANCE CONTRACTS HELD	**16 270**	**82 358**	**41 322**	**139 950**	6 872	86 704	(20 508)	73 068

12. OTHER ADMINISTRATION FEES

Accounting policy:

The Scheme pays an all-inclusive fee to the Administrator which has been allocated to Accredited administration services and Other administration services. Accredited administration services are directly attributable to the insurance contracts issued and are included in Insurance services expenses. Other administration services are not directly attributable and are included as other operating expenses. Fees paid to the Scheme administrator are expensed as incurred.

Note:

	2025 R'000	2024 R'000
Other administration services	**719 412**	686 987
Advanced data analytics	**78 156**	74 675
Digital service offering	**28 467**	27 131
Distribution services	**50 451**	48 164
Enhanced employer reporting	**2 168**	2 139
Enhanced service offering	**16 009**	15 394
Enterprise risk management services	**15 387**	14 635
Forensic investigations and recoveries	**41 684**	39 787
Governance compliance and human resources	**9 528**	8 998
Internal audit services	**19 700**	18 892
Legal services	**4 314**	4 120
Marketing and stakeholder relations services	**341 574**	326 367
Product innovation	**18 433**	17 375
Quality management and monitoring services	**93 541**	89 310

13. OTHER OPERATING EXPENSES

Accounting policy:

Other operating expenses include expenses, other than directly attributable expenses, and are expensed as incurred.

Note:

	2025 R'000	2024 R'000
Association fees	**7 386**	2 450
Audit fees	**8 844**	9 944
Financial statements audit	**7 921**	9 515
Regulatory related services-annual statutory return	**698**	325
Other assurance and related services- Medical Schemes Act compliance	**225**	105
Audit Committee fees (Note 14)	**2 228**	2 124
Annual general meeting costs	**9 490**	8 724
Bank charges	**9 898**	9 862
Clinical Governance Committee fees (Note 14)	**583**	1 036
Council for Medical Schemes	**70 051**	66 773
Credit rating expenses	**1 803**	1 666
Debt collecting fees	**4 318**	3 876
Depreciation	**1 764**	1 721
Dispute Committee fees	**3 115**	2 706
Fidelity Guarantee Insurance	**1 617**	1 617
Investment Committee fees (Note 14)	**694**	679
Investment reporting fees	**6 346**	5 612
IT infrastructure	**1 224**	1 129
Legal fees	**736**	794
Nomination Committee fees (Note 15)	**1 563**	1 842
Office operating costs	**5 962**	5 559
Practice Coding Numbering System fees	**3 942**	3 778
Principal Officer fees – Remuneration	**7 174**	6 924
Principal Officer fees – Unvested long-term employee benefit	**2 150**	2 112
Printing, postage and stationery	**37**	33
Professional fees	**22 343**	12 826
Remuneration Committee fees (Note 14)	**530**	665
Risk Committee fees (Note 14)	**471**	431
Scheme Office costs	**922**	1 456
Staff costs (Note 16)	**38 101**	34 862
Staff training	**291**	235
Stakeholder Relations and Ethics Committee fees (Note 14)	**114**	–
Sundry amounts written (back)/off	**2**	4
Telephone	**271**	270
Travel, accommodation and conferences	**997**	1 485
Trustee election costs	**5 616**	4 866
Trustees' remuneration and consideration expenses (Note 17)	**13 351**	12 598
	233 934	210 659

14. BOARD COMMITTEE FEES AND CONSIDERATIONS

Note:

2025 R'000	**Audit**	**Clinical Governance**	**Investment**	**Remuneration**	**Risk**	**Stakeholder Relations and Ethics**	**Total**
E Mackeown (Term ended 31 August 2025)	**967**		**242**		**141**		**1 350**
A Burger	**331**				**243**		**574**
H Van Deventer			**359**				**359**
B Hlophe (Term ended 30 June 2025)				**251**			**251**
L Baldwin-Ragaven		**280**					**280**
M Bosman (Chairperson effective 01 September 2025)	**646**		**93**		**87**		**826**
B Mathe (Term ended 30 June 2025)	**106**						**106**
D Tshabalala		**303**				**114**	**417**
T Sibisi				**279**			**279**
V Muguto	**116**						**116**
L Nopece	**62**						**62**
TOTAL	**2 228**	**583**	**694**	**530**	**471**	**114**	**4 620**

2024 R'000	Audit	Clinical Governance	Investment	Remuneration	Risk	Total
N Luthuli				22		22
N Mlaba		229				229
E Mackeown	1 062		291		216	1 569
A Burger	329				215	545
H Van Deventer			388			388
B Hlophe				582		582
L Baldwin-Ragaven		385				385
M Bosman	409					409
B Mathe	324					324
D Tshabalala		422				422
T Sibisi				61		61
TOTAL	2 124	1 036	679	665	431	4 936

For details of the Chairpersons of the respective Committees, refer to pages 58 – 59 and pages 73 – 74.

15. OTHER COMMITTEE FEES

Note:

	2025 R'000	2024 R'000
Nomination Committee fees		
A Bryce – Independent Member (Chairperson)	**659**	608
B Marais – Independent Member	**–**	508
A Muller – Independent Member	**478**	610
B Lekoko – Independent Member	**426**	116
	1 563	1 842

16. STAFF COSTS

Accounting policy:

Pension obligations

All employees of the Scheme are members of defined contribution plans. Defined contribution plans are plans under which the Scheme pays fixed contributions to separate legal entities.

The Scheme has no legal or constructive obligation to pay further contributions if the funds do not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The Scheme has no further payment obligations once the contributions have been paid. Contributions to the defined contribution funds are recognised in the net surplus or deficit for the year in which they are incurred.

Other post-employment obligations

The Scheme has no liability for the post-retirement medical benefits of employees.

Other long-term employee benefit

The long-term employee benefit plan refers to awards made to qualifying employees.

The amount recognised in the Statement of Financial Position in respect of the defined benefit plan is the present value of the defined benefit obligation at the end of the reporting period less the fair value of plan assets out of which the obligations are to be settled directly. The defined benefit obligation is calculated using the projected unit credit method.

Leave pay accrual

The Scheme recognises in full employees' rights to annual leave entitlement in respect of past service.

Bonuses

Management and staff bonuses are recognised as an expense in staff costs as incurred.

Note:

	2025 R'000	2024 R'000
Salaries and bonuses	**30 113**	27 419
Pension costs – defined contribution plans	**2 151**	2 012
Medical and other benefits	**1 295**	1 434
Long-term employee benefit service cost	**4 421**	3 890
Increase in leave pay accrual	**121**	107
	38 101	34 862
NUMBER OF EMPLOYEES AT 31 DECEMBER	**13**	13

17. TRUSTEES' REMUNERATION AND CONSIDERATIONS

Note:

The following table records the remuneration and consideration paid to Trustees during the year:

2025 R'000	Committee fees									
	Services as Trustee	Audit	Risk	Investment	Clinical Governance	Product	Remuneration	Stakeholder Relations and Ethics	Travel	Training	Total
M Norton	**1 401**					**289**	**320**	**196**	**133**		**2 339**
J Adams SC	**804**		**229**				**231**	**261**	**148**	**3**	**1 676**
L Harie	**855**		**425**		**348**			**196**	**21**	**38**	**1 883**
M Du Toit (Term ended 30 June 2025)	**504**	**111**		**160**		**110**			**101**		**986**
M Price (Term ended 30 June 2025)	**420**				**180**	**77**	**144**	**77**			**898**
D Moodley	**807**			**446**	**435**	**289**				**33**	**2 010**
R Mbuvha	**696**	**239**	**196**	**270**		**271**			**151**		**1 823**
C Schutte (Effective 01 July 2025)	**280**	**203**	**142**			**153**			**106**		**884**
D King (Effective 01 July 2025)	**288**			**188**			**183**	**116**	**77**		**852**
TOTAL	**6 055**	**553**	**992**	**1 064**	**963**	**1 189**	**878**	**846**	**737**	**74**	**13 351**

The following table records the remuneration and consideration paid to Trustees during the prior year:

2024 R'000		Committee fees									
	Services as Trustee	Audit	Risk	Investment	Clinical Governance	Product	Remuneration	Stakeholder Relations and Ethics	Travel	Training	Total
M Norton	1 487					230	346	187	71		2 321
J Adams SC	805		216				226	213	87		1 547
S Brynard	334					73	68	91	61		627
L Harie	779		245		332			187	92	1	1 636
M Du Toit	781	230		291		319			125	1	1 747
M Price	671				348	220	61	163		1	1 464
D Moodley	761			358	332	253				19	1 723
R Mbuvha	643	216	98	234		205			137		1 533
TOTAL	6 261	446	559	883	1 012	1 300	701	841	573	22	12 598

18. INVESTMENT INCOME

Accounting policy:

Investment income comprises dividends and interest received and accrued on investments at fair value through profit or loss and interest on cash and cash equivalents.

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

Dividend income from investments is recognised when the right to receive payment is established – this is on the "last day to trade" for listed shares and on the "date of declaration" for unlisted shares.

Note:

	2025 R'000	2024 R'000
Financial assets at fair value through profit or loss:	**2 615 526**	2 424 951
Dividend income	**604 118**	509 119
Interest income	**2 011 409**	1 915 832
Cash and cash equivalents interest income	**369 786**	402 598
INVESTMENT INCOME PER STATEMENT OF COMPREHENSIVE INCOME	**2 985 313**	2 827 549
The Scheme's total interest income is summarised below.		
Financial assets not at fair value through profit or loss:		
Cash and cash equivalents interest income	**369 786**	402 598
Financial assets at fair value through profit or loss:		
Interest income	**2 011 409**	1 915 832
TOTAL INTEREST INCOME	**2 381 195**	2 318 430

19. NET GAINS/(LOSSES) ON FINANCIAL ASSETS

Note:

	2025 R'000	2024 R'000
Net fair value gains/(losses) on financial assets at fair value through profit or loss (Note 3):	**4 825 162**	1 685 534
Fair value gains on financial assets at fair value through profit or loss:	**5 016 639**	1 839 567
– Equities	**3 379 575**	975 715
– Money market instruments	**17 133**	32 047
– Flexible fixed income bonds	**1 334 683**	522 410
– Offshore bonds	**–**	85 062
– Property	**206 635**	162 643
– Short duration bonds	**78 613**	61 690
Fair value losses on financial assets at fair value through profit or loss:	**(191 477)**	(154 033)
– Equities	**–**	(51 124)
– Money market instruments	**–**	(38 330)
– Offshore bonds	**(191 477)**	(64 579)
Net fair value (losses)/gains on derivative financial instruments (Note 6):	**164 420**	28 613
Fair value gains on derivative financial instruments:	**191 338**	28 613
Fair value losses on derivative financial instruments:	**(26 918)**	–
	4 989 582	1 714 147

20. SUNDRY INCOME

Note:

	2025 R'000	2024 R'000
Prescribed amounts written back	**41 980**	30 949
Unclaimed Personal Medical Savings Accounts written off to Scheme funds (Note 8)	**741**	813
Amounts received from administrator*	**–**	1 170
Amounts received from asset manager	**710**	2 560
	43 431	35 492

* *During the prior year, Discovery Health refunded an amount of R1.2 million to the Scheme related to the irregular processing of claims.*

21. ASSET MANAGEMENT FEES

Accounting policy:

Asset management fees are fees paid to the asset managers for their professional services incurred through the management of the portfolios. The fees are deducted in the individual asset portfolios.

Note:

	2025 R'000	2024 R'000
Asset management fees	**111 795**	93 764
	111 795	93 764

22. FINANCE COSTS

Note:

	2025 R'000	2024 R'000
	561	692
Interest paid – other	**–**	10
Interest on lease liability (Note 2)	**561**	682
	561	692

23. NET FINANCE EXPENSE FROM INSURANCE CONTRACTS

Accounting policy:

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

Note:

	2025 R'000	2024 R'000
Net finance expense from insurance contracts	**343 686**	338 313
	343 686	338 313

24. RELATED PARTY TRANSACTIONS

The Scheme is governed by the Board of Trustees, the majority of which are elected by the members of the Scheme.

Key management personnel and their close family members

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

Close family members include close family members of the Board of Trustees and Executive Officers of the Scheme.

Parties with significant influence over the Scheme

Administrator

Discovery Health has significant influence over the Scheme, as Discovery Health participates in the Scheme's Financial and Operating Policy decisions but does not control the Scheme. Discovery Health provides administration, managed care services and wellness programmes. As Discovery Health is a related party, its subsidiaries and fellow subsidiaries within the Discovery Ltd group are related parties to the Scheme. Discovery Ltd's Annual Report provides details of its group structure.

Transactions with related parties

The following provides the total amount in respect of transactions which have been entered into with related parties for the relevant financial year.

Transactions with key management personnel and their close family members which include Trustees and Executive Officers:

	2025 R'000	2024 R'000
Transactions with key management personnel and their close family members		
Statement of Comprehensive Income transactions		
COMPENSATION		
Short-term employee benefits	**(31 858)**	(30 188)
Trustee remuneration and consideration (Note 17)	**(13 351)**	(12 598)
Unvested long-term employee benefit	**(6 571)**	(6 022)
CONTRIBUTIONS AND CLAIMS		
Gross contributions received	**1 857**	1 783
Claims paid from the Scheme	**(782)**	(901)
Claims paid from the Personal Medical Savings Account	**(434)**	(359)
Interest paid on Personal Medical Savings Accounts	**(30)**	–
Statement of Financial Position transactions		
Long-term employee benefit plan asset	**12 273**	11 334
Plan asset	**23 566**	22 785
Plan liability	**(11 293)**	(11 451)
Long-term employee benefit plan asset	**12 273**	11 334
Balance at the beginning of the year	**11 334**	10 206
Additions	**7 510**	7 130
Unvested long-term employee benefit	**(6 571)**	(6 002)
Contribution debtors	**114**	121
Claims debtors	**11**	1
Personal Medical Savings Account balances	**(171)**	(3)

24. RELATED PARTY TRANSACTIONS *continued*

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

Transactions	Nature of transactions and their terms and conditions
Compensation	This constitutes remuneration and consideration paid to Trustees and Executive Officers, short-term employee benefits and unvested long-term employee benefits.
Contributions received	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms applicable to other members.
Claims incurred	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the Rules of the Scheme, as applicable to other members.
Contribution debtors	This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Personal Medical Savings Account balances	The amounts owing to the related parties relate to Personal Medical Savings Account balances to which the parties have a right. In line with the terms applied to other members, the balances earn monthly interest on an accrual basis, at interest rates determined by the Scheme from time to time at its discretion. The amounts are all current and would need to be payable on demand as applicable to other members.
Long-term employee benefits	The Restricted Equity Fund refers to an award of restricted equity instruments in the form of equity shares in companies other than Discovery Ltd or its subsidiaries, for the settlement of the obligation that will arise to DHMS on the fulfilment of the requisite vesting conditions by participating employees stipulated in the award letter.

24. RELATED PARTY TRANSACTIONS *continued*

Transactions with entities that have significant influence over the Scheme which includes subsidiaries and fellow subsidiaries of the group:

	2025 R'000	2024 R'000
Transactions with entities that have significant influence over the Scheme		
DISCOVERY HEALTH (PTY) LTD – ADMINISTRATOR		
Statement of Comprehensive Income transactions		
Administration fees paid	**(7 303 586)**	(6 974 445)
Attributable expenses incurred – administration fees (Note 11.2)	**(6 572 479)**	(6 276 633)
Attributable expenses incurred – operating expenses (Note 11.3)	**(11 696)**	(10 825)
Other administration services (Note 12)	**(719 412)**	(686 987)
Amounts received from administrator (Note 20)	**–**	1 170
New business underwriting costs	**(139)**	(60)
Employee assistance programme (Healthy Company)	**(6)**	(5)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd*	**(611 426)**	(581 277)
Attributable expenses incurred – administration fees	**(550 172)**	(522 976)
Attributable expenses incurred – operating expenses	**(979)**	(928)
Other administration services (Note 7)	**(60 275)**	(57 373)
DISCOVERY HEALTH (PTY) LTD – MANAGED CARE ORGANISATIONS		
Statement of Comprehensive Income transactions		
Managed healthcare services paid (Note 11.1)	**(2 699 701)**	(2 405 382)
Accredited managed healthcare services (no risk transfer)	**(2 471 055)**	(2 380 666)
Diabetes management services	**(28 533)**	(24 716)
Personal Health Pathways programme	**(200 113)**	–
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd*	**(226 350)**	(200 386)
Accredited managed healthcare services (no risk transfer)	**(207 055)**	(198 224)
Diabetes management services	**(2 489)**	(2 162)
Personal Health Pathways programme	**(16 806)**	–

* *Total amount due to Discovery Health (Pty) Ltd for the current financial year is R838 million (2024: R782 million).*

24. RELATED PARTY TRANSACTIONS *continued*

	2025 R'000	2024 R'000
Transactions with entities that have significant influence over the Scheme		
DISCOVERY THIRD PARTY RECOVERY SERVICES (PTY) LTD – THIRD-PARTY COLLECTION SERVICES		
Statement of Comprehensive Income transactions		
Third-party collection fees (Note 11.3)	**(36 776)**	(30 465)
Statement of Financial Position transactions		
Balance due to Discovery Third Party Recovery Services (Pty) Ltd	**(3 236)**	(3 122)
SOUTHERN RX DISTRIBUTORS (PTY) LTD – SPECIALIST PHARMACEUTICAL SERVICES		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(576 256)**	(530 919)
Statement of Financial Position transactions		
Claims due to Southern RX Distributors (Pty) Ltd	**(2 117)**	(894)
GROVE NURSING SERVICES (PTY) LTD – HOME-BASED NURSING SERVICES		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(65 258)**	(51 768)
Homecare services	**(64 828)**	(51 768)
Virtual Chronic Care	**(430)**	–
Statement of Financial Position transactions		
Balance due to Grove Nursing Services (Pty) Ltd	**–**	(17)
Homecare services	**–**	(17)
MEDICAL SERVICES ORGANISATION INTERNATIONAL (PTY) LTD – INTERNATIONAL TRAVEL SERVICES		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(165 361)**	(158 079)
Claims paid to unrelated providers for Africa Evacuation & International Travel Benefit	**(164 282)**	(158 079)
Fees paid for contracted additional services	**(1 079)**	–
Statement of Financial Position transactions		
Balance due (to)/from Medical Services Organisation International (Pty) Ltd	**(708)**	96
DISCOVERY LIFE LTD – BROKER SERVICES FEES		
Statement of Financial Position transactions		
Balance due from/(to) Discovery Life Ltd at year-end	**1 731**	(119)

24. RELATED PARTY TRANSACTIONS *continued*

	2025 R'000	2024 R'000
Transactions with entities that have significant influence over the Scheme		
DISCOVERY CONNECT DISTRIBUTION SERVICES (PTY) LTD – BROKER SERVICES FEES		
Statement of Comprehensive Income transactions		
Broker fees paid	**(172 738)**	(157 871)
Statement of Financial Position transactions		
Balance due to Discovery Connect Distribution Services (Pty) Ltd at year-end	**(371)**	(179)
DISCOVERY CENTRAL SERVICES (PTY) LTD – CONTRACTUAL LEASE PAYMENTS		
Statement of Comprehensive Income transactions		
Contractual lease and non-lease payments	**(11 124)**	(9 576)
Statement of Financial Position transactions		
Balance due to Discovery Central Services (Pty) Ltd at year-end (Note 7) – Non-lease	**(2 042)**	(711)
Balance due to Discovery Central Services (Pty) Ltd at year-end (Note 2) – Lease	**(4 295)**	(5 504)
DISCOVERY LTD – FLOATING RATE NOTES		
Statement of Financial Position transactions		
Floating Rate Notes	**51 773**	46 775
DISCOVERY HEALTHCARE SERVICES (PTY) LTD – HEALTH COACHING SERVICES		
Statement of Comprehensive Income transactions		
Health coaching service fees paid	**(19 908)**	(15 560)
Statement of Financial Position transactions		
Balance due to Discovery Healthcare Services (Pty) Ltd	**(571)**	(7 200)
DIGITAL THERAPEUTICS XPRESS (PTY) LTD		
Statement of Comprehensive Income transactions		
Internet-based cognitive behavioural therapy	**(21 764)**	–

24. RELATED PARTY TRANSACTIONS *continued*

Discovery Health (Pty) Ltd

Administration service

The administration agreement is in terms of the Rules of the Scheme and in accordance with instructions given by the Trustees. The agreement is for a five-year period effective from 01 January 2023. The Scheme and the administrator shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

The administration fees are an all-inclusive fee, calculated on a per member per month basis. The total expense for administration cost changes in line with membership growth and inflation.

The main categories of service provided can be broken down as follows:

- Actuarial services
- Accredited administration services
- Distribution services
- Forensic investigation and recoveries
- Governance compliance and human resources
- Internal audit services
- Marketing and stakeholder relations services

The value of transactions for the year ended 31 December 2025 amounted to R7.3 billion (2024: R7 billion) and the balance as at 31 December 2025 is R611 million (2024: R581 million).

New business underwriting services

The Scheme is billed by Discovery Health (Pty) Ltd for the costs relating to the new business joining journey and for the purposes of determining underwriting to evaluate the health status, medical history, and potential risk factors of individuals applying for medical aid coverage. This may involve the cost associated with medical examinations, laboratory tests, and review of medical records.

The value of transactions for the year ended 31 December 2025 amounted to R139 000 (2024: R60 000).

Employee assistance programme

The Scheme is billed by Discovery Health (Pty) Ltd for access to the Healthy Company digitally enabled employee assistance programme for DHMS Scheme Office employees. Healthy Company helps the Scheme's employees, their partners and anyone living in their household to deal with everyday situations and more serious concerns impacting their emotional, financial, physical or legal wellbeing.

The value of transactions for the year ended 31 December 2025 amounted to R6 000 (2024: R5 000).

Managed healthcare services

Managed healthcare means clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, using rules-based and clinical management-based programmes.

The Scheme has contracted with the administrator to provide accredited managed healthcare services (no risk transfer). These services include bill review, specialist and hospital referrals, case management, disease management (where healthcare benefits are not included in the contract), peer review, claims audits and statistical analysis.

This agreement is in accordance with instructions given by the Trustees. The agreement is for a five-year period and effective from 01 January 2023. The Scheme and Discovery Health (Pty) Ltd shall be entitled to terminate the agreement by giving the other party at least 12 calendar months' written notice.

The accredited services provided by the managed care organisation include:

- Active Disease Risk Management Services and Disease Risk Management Support Services
- Hospital Benefit Management Services
- Managed Care Network Management Services and Risk Managed Services
- Pharmacy Benefit Management Services

The value of transactions for the year ended 31 December 2025 amounted to R2.5 billion (2024: R2.4 billion) and the balance as at 31 December 2025 is R207 million (2024: R198 million).

24. RELATED PARTY TRANSACTIONS *continued*

Discovery Health (Pty) Ltd *continued*

Diabetes management services including Discovery Care Coordination Network

The Scheme has contracted with Discovery Health (Pty) Ltd to provide diabetes management services for diabetic patients. Managed care includes capitation network providers – diabetologist General Practitioners, physicians and endocrinologists.

The value of transactions for the year ended 31 December 2025 amounted to R28.5 million (2024: R24.7 million) and the balance as at 31 December 2025 is R2.5 million (2024: R2.2 million).

Personal Health Pathways programme (PHP)

The Scheme has contracted with Discovery Health (Pty) Ltd to provide a bespoke composite managed care programme which in an interconnected manner provides tailored, individualised and medically appropriate guidance to facilitate ongoing engagement in healthcare.

Initially, the PHP programme will utilise advanced data science to generate comprehensive series of personalised health and exercise actions and engagement facilitation mechanisms to help members better understand, manage and comply with healthy pathways and thereby improve their long-term health outcomes. Over time, the PHP programme will ultimately culminate in the use of Artificial Intelligence in a manner that would incorporate a reinforcement learning agent.

The value of transactions for the year ended 31 December 2025 amounted to R200 million and the balance as at 31 December 2025 is R16.8 million.

Discovery Third Party Recovery Services (Pty) Ltd

Third-party collection services

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

The Scheme has entered into an agreement with DTPRS to cede its rights, titles, interests and obligations in and to the RAF claims in return for which DTPRS pays an advance each year and earns a share in the successful recoveries thereof. Further to the legal action against the RAF – following its directive of rejecting the payment for past medical expenses of any claim paid for by a medical scheme and the subsequent Court process in progress – a decision has been taken to postpone the payment of an advance for the 2024 and 2025 RAF claims.

The value of transactions for the year ended 31 December 2025 amounted to R36.8 million (2024: R30.5 million) and the balance as at 31 December 2025 is R3.2 million (2024: R3.1 million). All transactions relate to the identification of claims relating to the Compensation Fund for occupational injuries and diseases.

Southern Rx Distributors (Pty) Ltd

Employer and Corporate wellness services

The Scheme is contracted with Southern RX Distributors, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to provide wellness experience (specialist pharmaceutical and screening) through lifestyle and health assessments to the members of the Scheme with the use of information technology and onsite medical evaluations of key health indicators. Corporate and Executive wellness screening includes health checks for diabetes, hypertension, cholesterol and HIV.

Courier Pharmacy services

Southern RX Distributors also provides for the procurement and dispensing of medicines and other items on a treatment plan and supplied by pharmacies. This includes the procurement and dispensing of non-registered medicine (Section 21) on a per patient basis.

The value of transactions for the year ended 31 December 2025 amounted to R576 million (2024: R531 million) and the balance as at 31 December 2025 is R2.1 million (2024: R894 000).

24. RELATED PARTY TRANSACTIONS *continued*

Grove Nursing Services (Pty) Ltd

Home-based nursing care services

The Scheme is contracted with Grove Nursing services also known as Discovery HomeCare, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to provide home-based nursing care to members of the Scheme in the comfort of their home. These healthcare programmes are designed to enhance and protect the lives of covered persons by providing high-quality healthcare solutions including support for activities of daily living and end-of-life care. The services include IV infusions, wound care, postnatal and palliative care.

Hospital at Home nursing

Discovery HomeCare provides a Hospital at Home programme which offers members of the Scheme the choice of treatment in the comfort of their home for various illnesses with the same quality and care standard as an acute hospital for admission types which are suitable for care at home.

The value of transactions for the year ended 31 December 2025 amounted to R64.8 million (2024: R51.9 million) and the balance as at 31 December 2025 is nil (2024: R17 000).

Virtual Chronic Care

Discovery HomeCare provides a Virtual Chronic Care programme which offers members remote support in managing chronic conditions through professional services, including programme enrolment, device connectivity to the Masimo platform, clinical needs assessments, health checks, and ongoing health coaching.

The value of transactions for the year ended 31 December 2025 amounted to R430 000 and the balance as at 31 December 2025 is nil.

Medical Services Organisation International (Pty) Ltd

International travel services agreement

The Scheme contracted with Medical Services Organisation International (Pty) Ltd, a subsidiary of Discovery Health (Pty) Ltd, to deliver the following benefit offered by DHMS to its members who are working or travelling outside the borders of the Republic of South Africa (RSA):

- **The International Travel Benefit**
  Members are covered for emergency medical assistance outside of the RSA for a period of 90 (ninety) days from date of departure from the RSA. This cover includes in-hospital treatment, repatriation and out-of-hospital treatment above a US$150 or €100 (one hundred and fifty US Dollars or one hundred Euros) excess payment by the member. This benefit is available to all members, except members on KeyCare plans.
- **The Africa Evacuation Benefit**
  Members are covered for emergency medical assistance with or without evacuation to the RSA and pre-authorised in-hospital elective procedures at the South African Rand equivalent in accordance with their respective health plans. Cover commences on the Member's date of departure from the RSA and continues for an unlimited period in those specified African countries. This benefit is available to all members, except members on KeyCare plans.

This agreement is in accordance with instructions given by the Trustees. The agreement is effective from 01 October 2020 and reviewed annually. The Scheme and Medical Services Organisation International (Pty) Ltd shall be entitled to terminate the agreement by giving the other party at least 90 days written notice.

The value of transactions for the year ended 31 December 2025 amounted to R165 million (2024: R158 million) and the balance as at 31 December 2025 is R708 000 (2024: R96 000).

Discovery Connect Distribution Services (Pty) Ltd

Insurance acquisition costs (broker service fees)

The Scheme is contracted with Discovery Connect Distribution Services (Pty) Ltd, a wholly owned subsidiary of Discovery Ltd, to provide broker services directly to the consumer. The amounts were determined and paid based on the same terms and conditions applicable to other brokers.

Broker service fees are fees paid as acquisition costs for the introduction and provision of ongoing services to members and are expensed as incurred when contributions are received by the Scheme. Discovery Connect is an accredited broker and has signed DHMS's standard broker agreement.

The value of transactions for the year ended 31 December 2025 amounted to R173 million (2024: R150 million) and the balance as at 31 December 2025 is R371 000 (2024: R179 000).

24. RELATED PARTY TRANSACTIONS *continued*

Discovery Life Ltd

Insurance acquisition costs (broker service fees)

Discovery Life Limited, a wholly owned subsidiary of Discovery Ltd, manages the deduction and payment of Pay As You Earn (PAYE) for Personal Service Providers—brokerages that conduct at least 80% of their business through Discovery and employ a minimum of four staff members. Upon designation as a Personal Service Provider, Discovery deducts PAYE from their earnings and pays it over to the South African Revenue Service.

Certain Brokers who owe monies to Discovery Life as part of their contractual agreements, have signed acknowledgements of debt, and have instructed the Scheme to pay the broker service fees due to them to Discovery Life.

The balance as at 31 December 2025 is R1.7 million due to the Scheme (2024: R119 000 due to the provider).

Discovery Central Services (Pty) Ltd

Contractual lease payments

The Scheme has contracted with Discovery Central Services (Pty) Ltd, a wholly owned subsidiary of Discovery Ltd, to lease land and buildings for its office space. The lease for the office space is effective from 01 July 2018 with an initial period of five years and an option to renew for a further five years. Subsequent to the expiry of the initial term on 30 June 2023, the Trustees decided to renew the lease for another five-year period resulting in a re-negotiation of the terms of the lease as well as the lease payments. The lease payments are fixed and will increase annually at a rate set out in the lease and variation agreements.

The lease includes non-lease components, such as rental of office furniture and equipment and provides for the payment by the Scheme of operational costs incurred by the lessor and rates and taxes levied on the lessor. These amounts are determined annually and are recognised as an expense in the period incurred.

The value of transactions for the year ended 31 December 2025 amounted to R11.1 million (2024: R9.6 million) and the balance as at 31 December 2025 is R2 million (2024: R711 000) for the non-lease components; and R4.3 million (2024: R5.5 million) for the lease component.

Payroll services agreement

The Scheme outsources its payroll services to Discovery Central Services, including the processing, reconciliation and provision of agreed payroll reports.

There is no direct financial reimbursement in respect of payroll services by DHMS.

Investments in Discovery Ltd

Negotiable Certificates of Deposits and Floating Rate Notes

As part of the Scheme's Investment Policy and investment diversification strategy, the Board of Trustees approved a Strategic Asset Allocation. The Scheme implements the investment strategy by appointing independent asset managers to manage the respective portfolios through discretionary mandates with no influence by the Scheme and its officers over the selection of underlying instruments in the respective portfolios.

The Scheme's cash and bond asset managers have included negotiable certificates of deposits issued by Discovery Bank Ltd and floating rate notes issued by Discovery Ltd in certain fixed income portfolios.

The balance as at 31 December 2025 is R51.8 million (2024: R46.8 million).

24. RELATED PARTY TRANSACTIONS *continued*

Discovery HealthCare Services (Pty) Ltd

Health Coaching services

The Scheme is billed by Discovery Healthcare Services (Pty) Ltd, a wholly owned subsidiary of Discovery Health, to provide health coaching services for identified members with diabetes, cardiovascular disease at risk of developing diabetes (Disease Prevention Programme) and at risk of a hospital readmission.

The value of transactions for the year ended 31 December 2025 amounted to R19.9 million (2024: R15.6 million) and the balance as at 31 December 2025 is R571 000 (2024: R7.2 million).

Digital Therapeutics Xpress (Pty) Ltd

Internet-based cognitive behavioural therapy

The Scheme funds an internet-based cognitive behavioural therapy programme for members diagnosed with depression. This is the first digital therapeutic programme to be funded by medical schemes in South Africa. The health service is provided in the form of a digital platform and registered as Software as Device with the South African Health Products Regulatory Authority.

Discovery Health (Pty) Ltd facilitated the provision and claiming of the service from inception to enable the launch of the benefit in January 2024. Effective 01 January 2025, a newly established Discovery Group owned entity, Digital Therapeutics Xpress (Pty) Ltd assumed responsibility for the provision, support and claiming for the service.

The value of transactions for the year ended 31 December 2025 amounted to R21.8 million and the balance as at 31 December 2025 is nil.

Nanolabs Health Services (Pty) Ltd

Pathology point-of-care services

The services provided by Nanolabs Health Services (Pty) Ltd (Nanolabs), a wholly owned subsidiary of Discovery Health, are not rendered directly to DHMS and no transactions have taken place between DHMS and Nanolabs. Nanolabs charges the contracted pathology lab based on the contractual terms for the software licensing and practice management services. No fees are paid to Nanolabs by DHMS. The contracted pathology labs claim directly from DHMS for pathology services to DHMS members.

This disclosure has been made due to Discovery Health's shareholding only in Nanolabs – there is no direct financial reimbursement to Nanolabs by DHMS.

Mediclinic Pathology (Pty) Ltd Joint Venture

Pathology management services

The services provided by Mediclinic Pathology, a joint venture between Mediclinic and Nanolabs, are not rendered directly to DHMS and no transactions have taken place between DHMS and the joint-venture entity. Clinical pathology services are delivered by the independent pathologist entity, Drs Hudson and Swart Inc t/a STATMed (STATMed). STATMed submits claims directly to DHMS for pathology services rendered to DHMS members and is reimbursed directly by DHMS. Mediclinic Pathology does not receive any fees from DHMS. STATMed pays a management fee to Mediclinic Pathology based on contractual terms for operational and management support services.

This disclosure has been made due to Discovery Health's indirect interest in Mediclinic Pathology through Nanolabs – there is no direct financial reimbursement to Mediclinic Pathology by DHMS.

25. SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN

2025	Executive Plan R'000	Classic Comprehensive R'000	Classic Smart Comprehensive R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Saver R'000	Essential Core R'000	Essential Priority R'000
Insurance revenue	1 233 040	10 916 294	329 953	3 098 523	24 467 843	5 855 655	9 830 006	3 180 984	355 180
Insurance service expense	(1 731 923)	(11 117 972)	(246 369)	(3 083 069)	(23 714 272)	(5 981 595)	(8 493 338)	(3 026 396)	(277 237)
Claims incurred	(1 666 840)	(10 400 171)	(222 492)	(2 722 337)	(20 573 765)	(5 399 806)	(6 952 145)	(2 556 931)	(238 027)
Risk claims	(1 667 566)	(10 404 138)	(222 573)	(2 723 482)	(20 581 095)	(5 402 116)	(6 955 082)	(2 558 172)	(238 141)
Third-party claim recoveries	726	3 966	82	1 145	7 330	2 309	2 936	1 242	114
Other incurred insurance service expenses	(65 083)	(717 800)	(23 877)	(360 733)	(3 140 506)	(581 789)	(1 541 193)	(469 465)	(39 210)
Insurance acquisition cash flows (broker fees)	(10 796)	(120 903)	(4 057)	(56 762)	(533 269)	(98 048)	(247 661)	(71 837)	(6 633)
Accredited managed healthcare services (no risk transfer)	(15 153)	(166 570)	(5 453)	(83 936)	(716 256)	(134 111)	(353 226)	(109 638)	(8 929)
Attributable expenses incurred – administration fees	(37 843)	(416 134)	(13 893)	(212 779)	(1 828 638)	(338 102)	(909 310)	(278 495)	(22 869)
Attributable expenses incurred – operating expenses	(268)	(2 949)	(98)	(1 508)	(12 958)	(2 396)	(6 444)	(1 974)	(162)
Net impairment losses on healthcare receivables	(1 023)	(11 244)	(375)	(5 748)	(49 385)	(9 132)	(24 553)	(7 521)	(618)
Net income from risk transfer arrangement/reinsurance	166	1 957	51	4 297	5 082	1 381	(1 912)	825	68
An allocation of premiums paid	(2 112)	(22 186)	(397)	(3 983)	(32 745)	(10 286)	(10 948)	(4 698)	(401)
Amounts recovered from risk transfer arrangements/reinsurance	2 278	24 143	449	8 281	37 827	11 667	9 037	5 523	469
INSURANCE SERVICE RESULT	(498 717)	(199 721)	83 635	19 751	758 653	(124 560)	1 334 757	155 414	78 010
Other income	43 474	477 165	15 960	245 546	2 114 360	389 680	1 054 145	323 039	26 386
Investment income	16 294	179 147	5 982	91 650	787 790	145 619	391 822	120 005	9 849
Net gain on financial assets	26 943	295 402	9 891	152 561	1 315 104	241 939	656 627	201 290	16 394
Sundry income	238	2 615	87	1 335	11 466	2 122	5 696	1 744	143
Other expenditure	(9 052)	(99 540)	(2 214)	(33 917)	(437 640)	(80 903)	(217 643)	(44 404)	(5 472)
Other administration fees	(4 142)	(45 550)	(1 521)	(23 291)	(200 162)	(37 008)	(99 533)	(30 484)	(2 503)
Other operating expenses	(1 274)	(14 010)	(468)	(7 177)	(61 737)	(11 405)	(30 717)	(9 406)	(771)
Asset management fees	(611)	(6 714)	(224)	(3 433)	(29 506)	(5 456)	(14 668)	(4 492)	(369)
Finance cost	(3)	(34)	(1)	(17)	(148)	(27)	(74)	(23)	(2)
Net finance expense from insurance contracts	(3 022)	(33 232)	–	–	(146 087)	(27 007)	(72 652)	–	(1 827)
NET SURPLUS/(DEFICIT) FOR THE YEAR BEFORE MUTUALISATION	(464 295)	177 904	97 382	231 379	2 435 374	184 217	2 171 259	434 049	98 924
Liability to members for future benefits*	464 295	(177 904)	(97 382)	(231 379)	(2 435 374)	(184 217)	(2 171 259)	(434 049)	(98 924)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	–	–	–	–	–	–	–	–	–

* *This item was previously referred to as "Amounts attributable to future members".*

25. SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN *continued*

2025	Coastal Saver R'000	Coastal Core R'000	KeyCare Plus R'000	KeyCare Core R'000	KeyCare Start R'000	Classic Smart R'000	Essential Smart R'000	Active Smart R'000	TOTAL R'000
Insurance revenue	9 632 711	4 021 336	6 396 466	517 810	159 014	4 320 093	2 054 153	283 714	86 652 776
Insurance service expense	(9 685 578)	(4 284 421)	(7 666 675)	(523 260)	(126 567)	(4 181 633)	(1 891 998)	(194 961)	(86 227 264)
Claims incurred	(8 400 557)	(3 757 941)	(6 579 166)	(432 044)	(86 180)	(3 511 370)	(1 296 300)	(106 565)	(74 902 637)
Risk claims	(8 403 695)	(3 759 586)	(6 582 024)	(432 281)	(86 223)	(3 512 831)	(1 297 000)	(106 713)	(74 932 717)
Third-party claim recoveries	3 139	1 645	2 858	237	43	1 460	700	148	30 080
Other incurred insurance service expenses	(1 285 022)	(526 480)	(1 087 509)	(91 216)	(40 387)	(670 263)	(595 698)	(88 396)	(11 324 627)
Insurance acquisition cash flows (broker fees)	(215 436)	(81 736)	(176 645)	(15 147)	(4 957)	(100 872)	(63 090)	(8 986)	(1 816 835)
Accredited managed healthcare services (no risk transfer)	(294 604)	(123 034)	(318 180)	(32 669)	(12 349)	(155 461)	(143 053)	(27 078)	(2 699 701)
Attributable expenses incurred – administration fees	(749 428)	(311 102)	(564 418)	(40 538)	(21 982)	(400 284)	(376 716)	(49 946)	(6 572 479)
Attributable expenses incurred – operating expenses	(5 311)	(2 205)	(5 481)	(531)	(213)	(2 837)	(2 670)	(467)	(48 471)
Net impairment losses on healthcare receivables	(20 243)	(8 403)	(22 784)	(2 331)	(886)	(10 809)	(10 169)	(1 918)	(187 141)
Expenses from reinsurance	2 408	932	121 250	–	2 430	677	315	22	139 950
An allocation of premiums paid	(13 651)	(5 535)	(198 561)	–	(5 935)	(3 038)	(1 268)	(102)	(315 846)
Amounts recovered from risk transfer arrangements/reinsurance	16 059	6 467	319 811	–	8 365	3 715	1 583	124	455 796
INSURANCE SERVICE RESULT	(50 459)	(262 153)	(1 148 958)	(5 450)	34 878	139 137	162 470	88 775	565 462
Other income	862 929	358 424	969 096	100 887	38 376	464 534	441 178	93 146	8 018 326
Investment income	322 753	133 987	363 021	37 240	14 161	172 497	162 449	31 047	2 985 313
Net gain on financial assets	535 470	222 484	600 782	63 109	24 010	289 530	276 377	61 670	4 989 582
Sundry income	4 706	1 953	5 293	539	205	2 507	2 352	429	43 431
Other expenditure	(179 318)	(49 589)	(103 839)	(8 761)	(4 051)	(63 833)	(60 101)	(9 107)	(1 409 387)
Other administration fees	(82 032)	(34 053)	(61 775)	(4 436)	(2 406)	(43 815)	(41 235)	(5 467)	(719 412)
Other operating expenses	(25 273)	(10 491)	(28 394)	(2 924)	(1 113)	(13 527)	(12 759)	(2 486)	(233 934)
Asset management fees	(12 093)	(5 020)	(13 602)	(1 394)	(530)	(6 458)	(6 076)	(1 149)	(111 795)
Finance cost	(61)	(25)	(68)	(7)	(2)	(32)	(30)	(6)	(560)
Net finance expense from insurance contracts	(59 860)	–	–	–	–	–	–	–	(343 686)
NET SURPLUS/(DEFICIT) FOR THE YEAR BEFORE MUTUALISATION	633 151	46 682	(283 701)	86 677	69 202	539 838	543 547	172 813	7 174 401
Liability to members for future benefits*	(633 151)	(46 682)	283 701	(86 677)	(69 202)	(539 838)	(543 547)	(172 813)	(7 174 401)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	–	–	–	–	–	–	–	–	–

* *This item was previously referred to as "Amounts attributable to future members".*

25. SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN *continued*

2024	Executive Plan R'000	Classic Comprehensive R'000	Classic Smart Comprehensive R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comprehensive R'000	Essential Saver R'000	Essential Core R'000
Insurance revenue	1 113 893	11 145 472	345 262	2 931 290	21 792 708	5 474 986	14 796	9 077 428	2 852 539
Insurance service expense	(1 464 337)	(11 960 145)	(271 236)	(2 946 410)	(21 240 638)	(5 508 574)	(2 371)	(7 861 186)	(2 746 752)
Claims incurred	(1 404 016)	(11 195 949)	(245 273)	(2 592 649)	(18 384 438)	(4 947 117)	(1 367)	(6 415 100)	(2 311 631)
Risk claims	(1 406 425)	(11 214 399)	(245 646)	(2 596 548)	(18 412 504)	(4 955 478)	(1 365)	(6 425 694)	(2 315 472)
Third-party claim recoveries	2 409	18 450	373	3 899	28 066	8 361	(2)	10 594	3 841
Other incurred insurance service expenses	(60 321)	(764 196)	(25 963)	(353 761)	(2 856 200)	(561 457)	(1 004)	(1 446 086)	(435 121)
Insurance acquisition cash flows (broker fees)	(10 003)	(130 603)	(4 203)	(55 797)	(491 426)	(96 360)	(1 004)	(231 652)	(65 832)
Accredited managed healthcare services (no risk transfer)	(13 225)	(166 734)	(5 631)	(77 103)	(611 854)	(120 955)	–	(313 280)	(95 518)
Attributable expenses incurred – administration fees	(35 870)	(451 461)	(15 597)	(213 571)	(1 695 055)	(332 790)	–	(871 403)	(264 728)
Attributable expenses incurred – operating expenses	(227)	(2 861)	(99)	(1 353)	(10 740)	(2 109)	–	(5 521)	(1 677)
Net impairment losses on healthcare receivables	(996)	(12 537)	(433)	(5 937)	(47 125)	(9 243)	–	(24 230)	(7 366)
Net income from risk transfer arrangement/reinsurance	17	230	28	2 402	2 034	418	4	(1 330)	381
An allocation of premiums paid	(1 765)	(23 405)	(243)	(3 512)	(27 079)	(8 727)	4	(8 785)	(3 993)
Amounts recovered from risk transfer arrangements/reinsurance	1 782	23 635	271	5 914	29 113	9 145	–	7 455	4 374
INSURANCE SERVICE RESULT	(350 427)	(814 443)	74 054	(12 718)	554 104	(33 170)	12 429	1 214 912	106 168
Other income	24 475	307 429	10 587	146 204	1 163 687	228 087	–	598 735	181 819
Investment income	15 204	191 465	6 614	90 469	717 826	140 999	–	368 933	112 039
Net gain on financial assets	9 080	113 564	3 890	54 600	436 849	85 319	–	225 169	68 373
Sundry income	191	2 400	83	1 135	9 012	1 769	–	4 633	1 407
Other expenditure	(8 469)	(106 605)	(2 420)	(33 138)	(400 140)	(78 567)	–	(205 697)	(41 076)
Other administration fees	(3 926)	(49 417)	(1 707)	(23 378)	(185 540)	(36 427)	–	(95 384)	(28 977)
Other operating expenses	(1 132)	(14 245)	(492)	(6 739)	(53 485)	(10 501)	–	(27 496)	(8 353)
Asset management fees	(503)	(6 337)	(219)	(2 999)	(23 810)	(4 674)	–	(12 240)	(3 719)
Finance cost	(4)	(47)	(2)	(22)	(176)	(35)	–	(90)	(27)
Net finance expense from insurance contracts	(2 904)	(36 559)	–	–	(137 129)	(26 930)	–	(70 487)	–
NET SURPLUS/(DEFICIT) FOR THE YEAR BEFORE MUTUALISATION	(334 421)	(613 619)	82 221	100 348	1 317 651	116 350	12 429	1 607 950	246 911
Liability to members for future benefits*	334 421	613 619	(82 221)	(100 348)	(1 317 651)	(116 350)	(12 429)	(1 607 950)	(246 911)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	–	–	–	–	–	–	–	–	–

* *This item was previously referred to as "Amounts attributable to future members".*

25. SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN *continued*

2024	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	KeyCare Plus R'000	KeyCare Core R'000	KeyCare Start R'000	Classic Smart R'000	Essential Smart R'000	TOTAL R'000
Insurance revenue	339 151	9 305 242	3 859 094	6 543 681	472 109	149 436	3 568 717	1 687 272	80 673 076
Insurance service expense	(277 149)	(9 505 832)	(4 171 953)	(7 654 564)	(470 273)	(107 751)	(3 409 290)	(1 498 008)	(81 096 469)
Claims incurred	(238 321)	(8 205 046)	(3 642 043)	(6 553 785)	(393 073)	(71 476)	(2 844 987)	(999 416)	(70 445 687)
Risk claims	(238 738)	(8 217 719)	(3 648 046)	(6 564 638)	(393 768)	(71 609)	(2 849 881)	(1 001 325)	(70 559 255)
Third-party claim recoveries	417	12 673	6 003	10 853	695	133	4 894	1 909	113 568
Other incurred insurance service expenses	(38 828)	(1 300 786)	(529 910)	(1 100 779)	(77 200)	(36 275)	(564 303)	(498 592)	(10 650 782)
Insurance acquisition cash flows (broker fees)	(6 650)	(224 223)	(83 772)	(185 937)	(13 781)	(4 609)	(84 712)	(51 298)	(1 741 862)
Accredited managed healthcare services (no risk transfer)	(8 332)	(278 708)	(115 436)	(320 642)	(28 550)	(11 098)	(123 408)	(114 908)	(2 405 382)
Attributable expenses incurred – administration fees	(23 058)	(771 531)	(319 790)	(563 945)	(32 202)	(19 520)	(344 416)	(321 384)	(6 276 321)
Attributable expenses incurred – operating expenses	(146)	(4 889)	(2 026)	(5 134)	(424)	(178)	(2 182)	(2 036)	(41 602)
Net impairment losses on healthcare receivables	(642)	(21 435)	(8 886)	(25 121)	(2 243)	(870)	(9 585)	(8 966)	(185 615)
Expenses from reinsurance	26	1 585	608	65 536	–	661	320	148	73 068
An allocation of premiums paid	(400)	(12 684)	(4 948)	(210 999)	–	(5 533)	(1 726)	(710)	(314 505)
Amounts recovered from risk transfer arrangements/reinsurance	426	14 269	5 556	276 535	–	6 194	2 046	858	387 573
INSURANCE SERVICE RESULT	62 028	(199 005)	(312 251)	(1 045 347)	1 836	42 346	159 747	189 412	(350 325)
Other income	15 808	528 251	218 853	616 701	55 359	21 563	236 390	223 240	4 577 188
Investment income	9 767	326 918	135 500	383 121	34 037	13 233	145 766	135 658	2 827 549
Net gain on financial assets	5 918	197 232	81 653	228 777	20 894	8 164	88 792	85 873	1 714 147
Sundry income	123	4 101	1 700	4 803	428	166	1 832	1 709	35 492
Other expenditure	(5 443)	(182 149)	(49 618)	(103 012)	(7 206)	(3 566)	(53 440)	(49 869)	(1 330 415)
Other administration fees	(2 524)	(84 452)	(35 004)	(61 709)	(3 528)	(2 136)	(37 700)	(35 178)	(686 987)
Other operating expenses	(727)	(24 344)	(10 090)	(28 521)	(2 539)	(987)	(10 867)	(10 141)	(210 659)
Asset management fees	(324)	(10 835)	(4 491)	(12 688)	(1 131)	(440)	(4 837)	(4 517)	(93 764)
Finance cost	(2)	(80)	(33)	(94)	(8)	(3)	(36)	(33)	(692)
Net finance expense from insurance contracts	(1 866)	(62 438)	–	–	–	–	–	–	(338 313)
NET SURPLUS/(DEFICIT) FOR THE YEAR BEFORE MUTUALISATION	72 393	147 097	(143 016)	(531 658)	49 989	60 343	342 697	362 783	2 896 448
Liability to members for future benefits*	(72 393)	(147 097)	143 016	531 658	(49 989)	(60 343)	(342 697)	(362 783)	(2 896 448)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	–	–	–	–	–	–	–	–	–

* *This item was previously referred to as "Amounts attributable to future members".*

26. RECONCILIATION OF MOVEMENTS IN THE STATEMENT OF CASH FLOWS

	2025 R'000	2024 R'000
Cash paid to provider and employees – other administration fees and operating expenses	**(903 194)**	(837 296)
Other administration fees (Note 12)	**(719 412)**	(686 988)
Other operating expenses (Note 13)	**(233 934)**	(210 659)
Add back: non-cash items included in these amounts		
Depreciation (Note 13)	**1 764**	1 721
Unvested Long-term employee benefit (Note 24)	**6 571**	6 002
Movement in accounts receivable (Note 4)	**6 085**	(2 613)
Movement in accounts payable (Note 7)	**(5 763)**	17 901
Sundry income (Note 20)	**43 431**	35 491
Movement in risk transfer arrangements/reinsurance contracts	**(1 936)**	1 849
Purchases of financial assets	**(2 693 960)**	(6 419 310)
Financial assets at fair value through profit or loss (Note 3)	**(2 966 176)**	(6 703 775)
Capitalised income	**272 216**	284 465
Proceeds from disposal of financial assets	**2 854 536**	4 800 757
Financial assets at fair value through profit or loss (Note 3)	**2 788 378**	4 676 533
Derivative financial instruments (Note 6)	**66 158**	124 224
Interest received	**2 186 465**	2 126 091
Interest income (Note 18)	**2 381 195**	2 318 430
Movement in interest receivable (Note 4)	**(1 889)**	2 997
Capitalised interest	**(192 841)**	(195 336)
Dividends received	**524 743**	419 990
Dividend income (Note 18)	**604 118**	509 119
Capitalised dividends	**(79 375)**	(89 129)

27. EVENTS AFTER THE REPORTING PERIOD

Above Threshold Benefit (ATB) claims processing error

In December 2025, the Scheme became aware of a claims processing error relating to the Above Threshold Benefit for certain medicine claims processed during the 2025 financial year. The error arose from a system configuration change implemented by Discovery Health in January 2025 in connection with the introduction of the Personal Health Fund. This change inadvertently impacted the accumulation and funding of ATB medicine claims for specific medicine categories, resulting in some claims being funded above the applicable ATB thresholds in terms of the Scheme Rules.

The error affected a subset of members on the Executive, Comprehensive and Priority plans to which the ATB applies and only those members who had activated the PHF during the year. The issue was confirmed by Discovery Health in December 2025 and was corrected through a system fix implemented on 19 December 2025. Claims were subsequently reprocessed during the period from late December 2025 to mid-April 2026. The reprocessing of claims in December resulted in the recognition of member claims receivables of R126 million.

The total financial impact of the overpaid benefits was determined after the reporting date and amounted to R148 million.

In consideration of its legal obligations and the need to protect the pooled funds of all members, the Scheme initially resolved to recover overpaid benefits from affected members. Subsequently, in January 2026, Discovery Health offered to reimburse the Scheme in full for the overpaid amounts arising from the claims processing error through a once off, non-precedent setting settlement. The Trustees accepted this offer, subject to the condition that members who had already repaid amounts would be reimbursed, thereby ensuring that no member would be disadvantaged. This settlement arrangement was finalised after the reporting date and, accordingly, no adjustment has been made to the amounts recognised in the annual financial statements for the year ended 31 December 2025. The matter is disclosed to provide users of the financial statements with relevant information regarding the nature of the event and its financial implications.

Increased volatility in local and global financial markets

Subsequent to the reporting date, financial markets both locally and globally have continued to experience volatility. This has been largely attributable to ongoing macroeconomic uncertainty, elevated geopolitical tensions, including the recent conflict in the Middle East, and persistent fluctuations in interest and inflation rates. Notably, the Middle East conflict has contributed to an increase in global fuel prices, resulting in heightened inflationary pressures and increased market volatility.

The Board of Trustees has carefully considered the effect of these developments on the Scheme's financial position, including the potential implications for the investment portfolio, claims experience, and the Scheme's solvency ratio. Following this review, the Board is satisfied that current market conditions, including the impact of higher fuel prices and the broader consequences of the Middle East conflict, do not have a material effect on the Scheme's financial position or solvency. Accordingly, the Board is of the view that these developments do not give rise to any events requiring adjustment to, or additional disclosure in, these annual financial statements. The Scheme continues to meet statutory solvency requirements, and no material adverse impact is anticipated for at least twelve months from the date of approval of these financial statements.

28. INSURANCE RISK MANAGEMENT REPORT

Nature and extent of risks arising from insurance contracts

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

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

Insurance risk

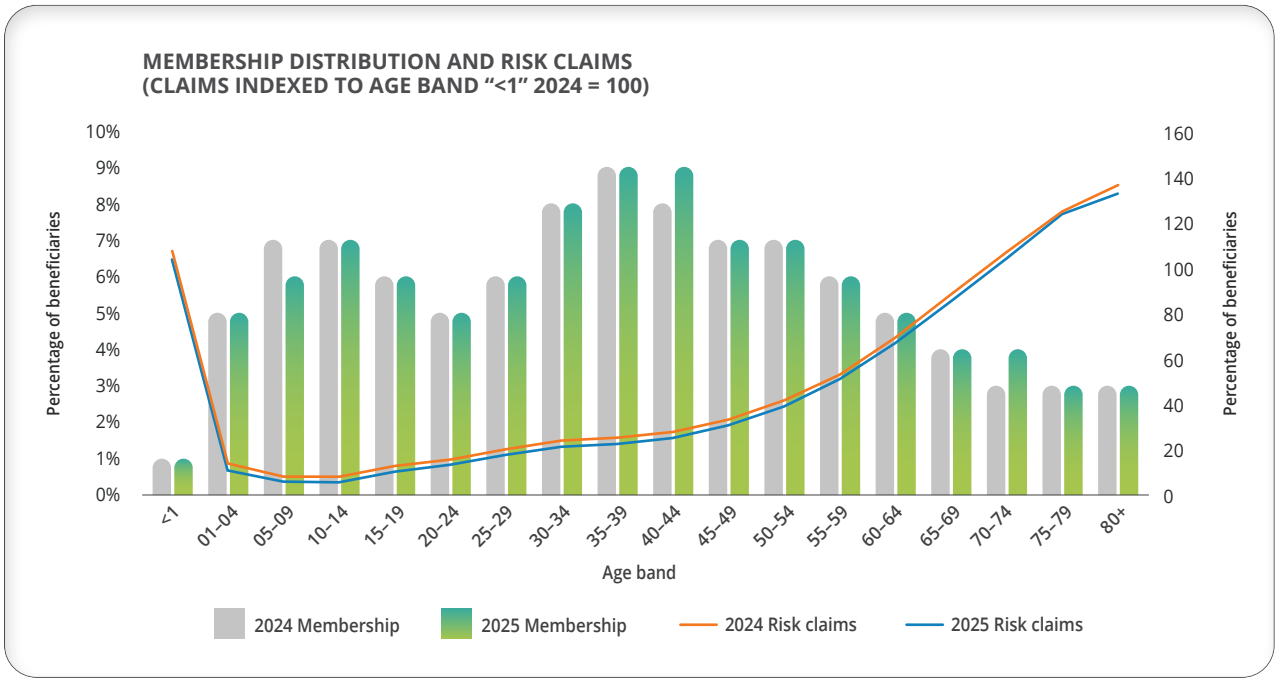
The risk under any insurance contract can be expressed as the probability that an insured event occurs multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The principal risk that the Scheme faces under its insurance contracts is that the actual claim payments exceed the projected amount of the insurance liabilities. This could occur because the frequency and severity of claims are greater than estimated.

A larger number of members will result in smaller variability of the actual claims experience relative to expected levels. This is because an adverse experience is diluted by a larger group of members whose claims are stable and thus predictable.

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

As the following graph illustrates, claims are expected to increase with age. In the absence of mandatory membership and a continuous inflow of young, healthy lives, the average age of lives covered by the medical scheme is expected to increase year-on-year. The increases expected from demographic changes are allowed for in the annual benefit and contribution reviews, but if this differs from the expected it may result in higher-than-expected inflationary increases in claims.

The following graph indicates the distribution of beneficiaries by age band for 2024 and 2025, as well as the risk claims paid. The risk claims are indexed to a value of 100 for the "<1" age band in 2024. There has been an increase in the proportion of beneficiaries older than 40 over the past year.



28. INSURANCE RISK MANAGEMENT REPORT *continued*

Insurance risk *continued*

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

Hospital benefits

The hospital benefit covers medical expenses incurred arising from admission to hospital. This includes accommodation, theatre, professional fees, medication, equipment and consumables.

Day-to-day benefits

Day-to-day benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines. The day-to-day benefits include both the PMSA and an insurance risk element. This includes the Day-to-day Extender Benefit, the Above Threshold Benefit (ATB) as well as the Personal Health Fund. The Scheme does not carry risk for PMSA benefits.

Chronic benefits

The Chronic Illness Benefit covers approved medication and treatment for up to 50 listed conditions, including the 27 PMB chronic conditions. These include conditions such as HIV/AIDS, high blood pressure, cholesterol and asthma.

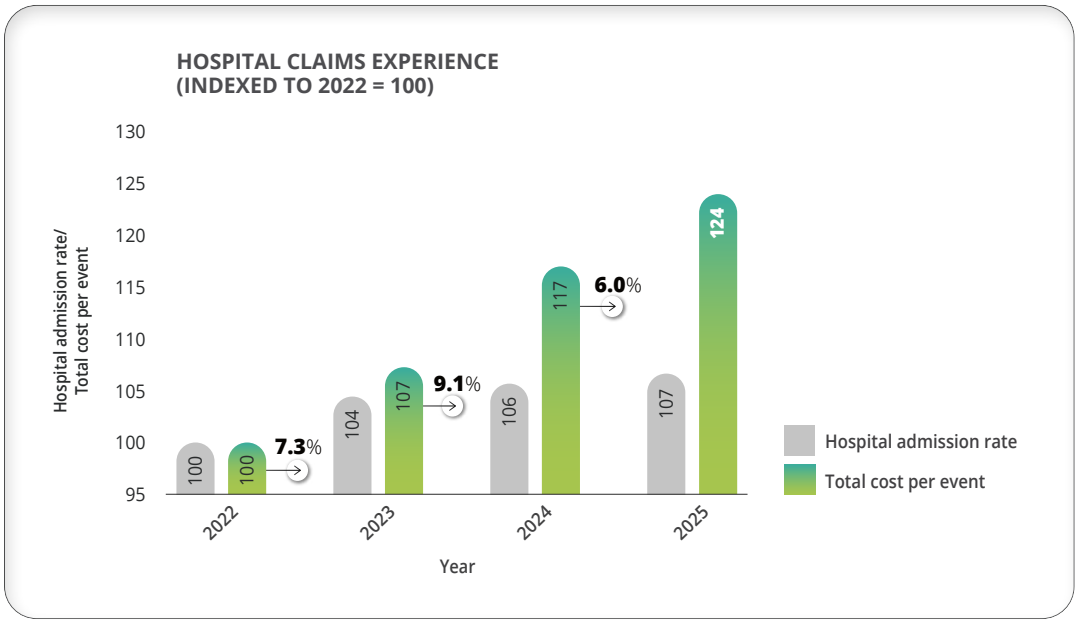
The risks associated to the Scheme with the types of benefits offered to members are addressed below:

Hospital benefit risk

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

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

The following graph indicates the change in the admission rate over the past four years as well as the impact on the costs per event (which have not been case-mix adjusted). This graph is indexed to a value of 100 as at 2022. The significant increase in admission rates after 2022 reflects a reversion to the long-term trend after lower admission rates during the COVID period.

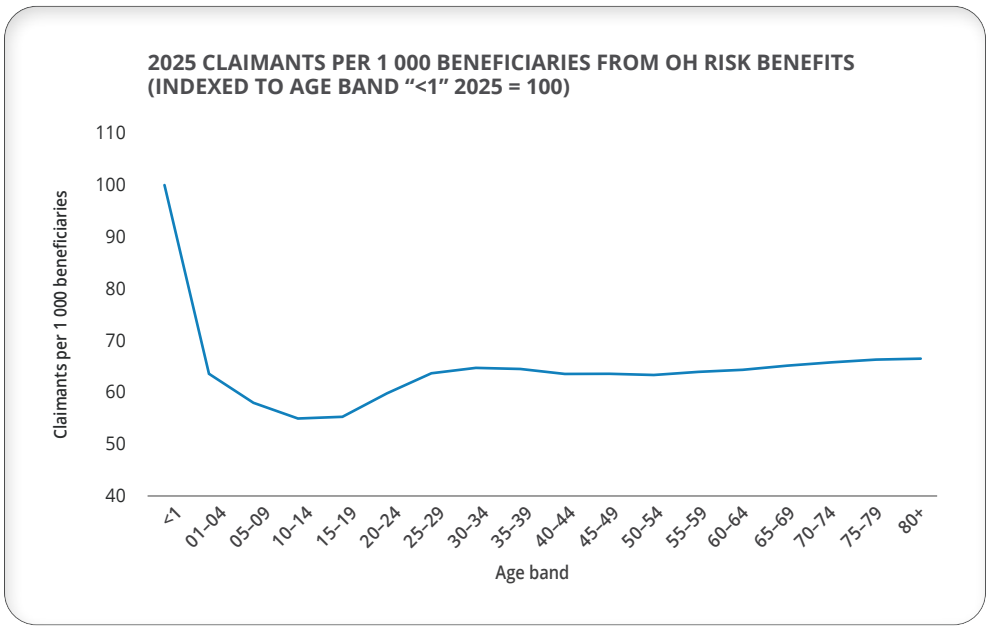


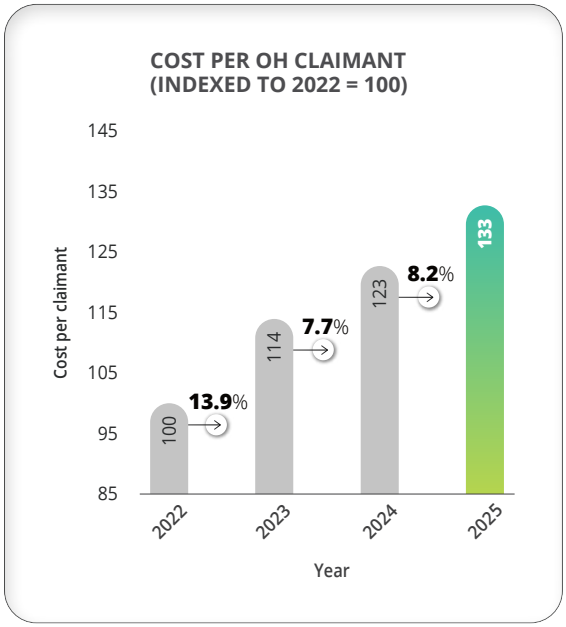
28. INSURANCE RISK MANAGEMENT REPORT *continued*

Insurance risk *continued*

Day-to-day benefits risk

The frequency and severity of claims are driven by the number and disease burden of claimants. The mix of members between the different benefit options, as well as an increase in the number of claims categorised as PMB claims, will also have an impact on the claims. The frequency of the ATB claims increases throughout the year as an increased number of members run out of their medical savings.





The out-of-hospital (OH) claims increased significantly from 2022 to 2023. This was predominantly due to the introduction of the WELLTH Fund as well as a significant increase in the limits of the oncology benefit. In 2024 OH claims increased in line with medical inflation. In 2025, the WELLTH Fund was re-purposed into the Personal Health Fund, and OH claims increased in line with medical inflation.

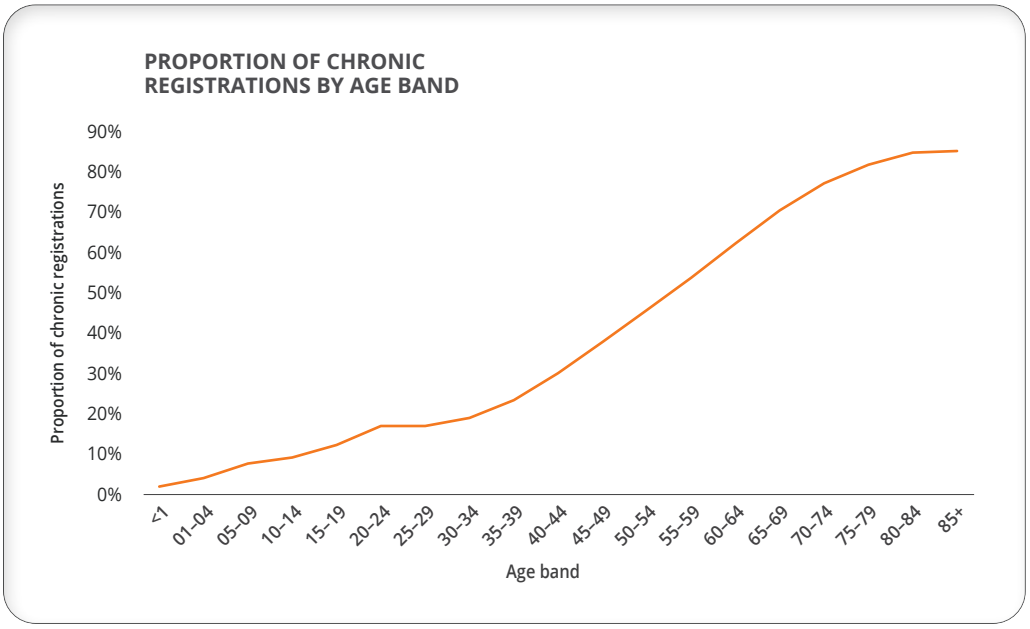
28. INSURANCE RISK MANAGEMENT REPORT *continued*

Chronic benefits risk

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

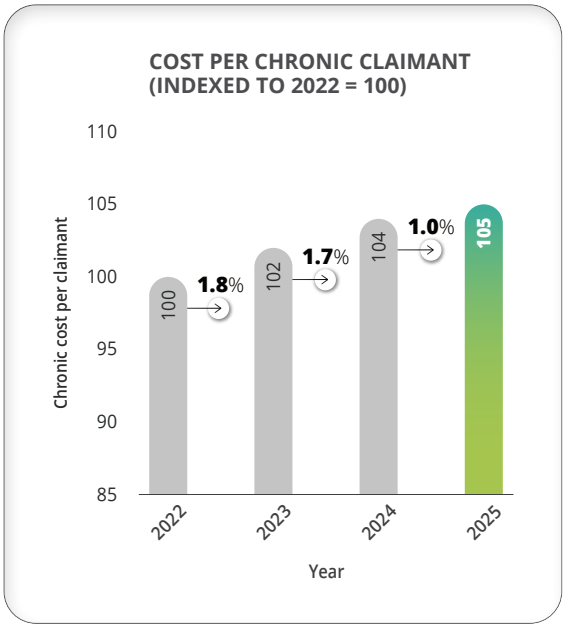
Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant.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

The following graphs indicate the percentage of chronic registrations by age band for 2025 as well as the change in the cost per claimant over the past four years. The cost per claimant graph is indexed to a value of 100 as at 2022.



28. INSURANCE RISK MANAGEMENT REPORT *continued*

Chronic benefits *continued*



The Scheme's extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, has assisted in keeping the increases in the chronic cost per claimant below the published Single Exit Price increases in medication year-on-year.

Sensitivity analysis

The following table shows the impact on the reported surplus or deficit caused by changes in key variables by the end of the reporting period. One of the main assumptions affecting the Liability for Incurred Claims (LIC) estimate is the claims development period used in calculating the run-off factors. The impact of using different claims development periods is shown in the table below.

Change in variable	Change in LIC 2025 R'000	Change in LIC 2024 R'000
Using 3-month development experience	**43 181**	(192 737)
Using 6-month development experience	**148 269**	(41 039)
Using 12-month development experience	**156 661**	9 274
Assuming 1% reduction in claims processing	**1 041 449**	967 152

This analysis is prepared for a change in a specified variable with other assumptions remaining constant. The change in liability also represents the absolute change in income/(expense) for the period.

28. INSURANCE RISK MANAGEMENT REPORT *continued*

Risk management

The Scheme has various initiatives that are used to manage the risk associated with claims experience. These include, but are not limited to:

- **Hospital admissions**
  - All hospital admissions are pre-authorised, to determine eligibility for benefits.
  - For elective admissions, members require a doctor referral.
  - Admissions for members that recently joined the Scheme are assessed to ensure that relevant waiting periods are correctly applied, including an assessment of non-disclosure by members to avoid waiting periods.
  - Active hospital admissions are managed by case managers to ensure that members are cared for in the appropriate ward and discharged at appropriate times.
  - Hospital admissions by doctors identified as efficiency outliers in relation to their peers are subject to enhanced pre-authorisation and case management.
  - Hospital Benefit Specialists review admissions by the casualty units of more than 50 hospitals to ensure eligibility for benefits.
  - Members identified as high risk for readmission are proactively identified and managed through a readmission risk reduction programme to avoid unnecessary readmissions.
  - Tariffs charged by hospitals are subject to negotiated tariff agreements, including network arrangements with discounted tariff agreements.
  - Alternative reimbursement agreements with doctors and hospitals incentivise greater efficiency and quality of care.
  - The cost of surgical items is managed through preferred supplier arrangements and reference pricing.
- **Healthcare technology**
  - All healthcare technology is subject to a health economic evaluation of the effectiveness of the technology, including medicines, with funding recommendations, benefit guidelines and clinical protocols.
  - Negotiated prices for new healthcare technology, including medicines.
  - Design and management of medicine formularies and baskets of care for chronic disease management.
  - The development of protocols around various high-cost conditions, such as lower back surgery.
- **High-cost healthcare events**
  - Dedicated unit for direct care co-ordination of high-risk beneficiaries that are exposed to conditions that would generate multiple admissions if not managed.
  - Advanced Illness Benefit Programme dedicated to managing care during the end-of-life stage for patients that are terminally ill.
  - Managed care programme for members on chronic dialysis to improve clinical outcomes and reduce hospital admissions.
- **Healthcare professionals**
  - Identification and active management of specialist doctors that are statistically significant outliers on admission rate and generated costs relative to their peers.
  - Governance programmes for specific procedures, including arthroplasty, interventional cardiology, and conservative back treatment, to enhance efficiency and quality of care.
  - Negotiated tariff agreements with radiology practices and pathology labs.
- **Disease management**
  - Managed care programmes for members diagnosed with cancer, HIV, diabetes, cardiovascular disease, chronic kidney disease, and depression.
  - Disease prevention programmes for members at risk of developing a diabetes, cardiovascular or depression diagnosis.
  - Medicine formularies to manage the cost of prescribed medication.
- **Designated Service Providers**
  - Comprehensive networks of healthcare professionals and facilities to ensure access to Prescribed Minimum Benefits at negotiated tariffs.
- **Fraud, waste, abuse and errors**
  - Dedicated resources for the proactive identification and recovery of fraudulent claims, wasteful healthcare expenditure, and benefit abuse.

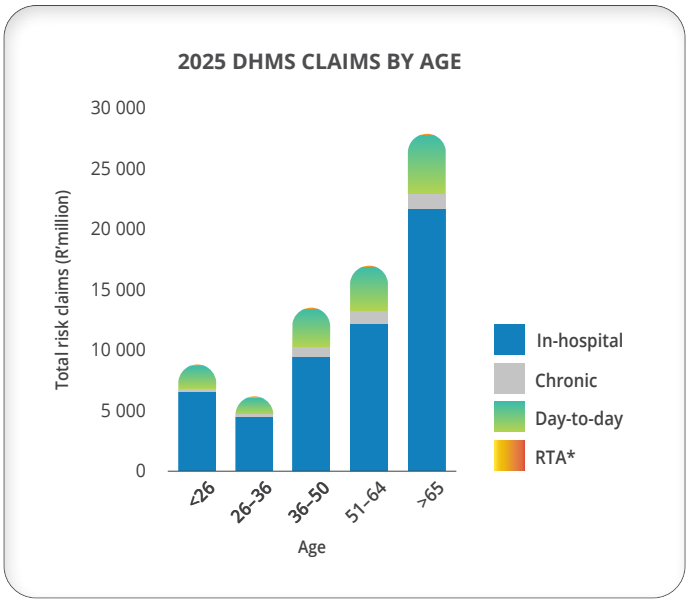
28. INSURANCE RISK MANAGEMENT REPORT *continued*

Concentration of insurance risk

As the largest open medical scheme by membership in South Africa, the Scheme is not subject to a significant degree of concentration risk. The Scheme also offers a wide range of benefit plans which meet a variety of members' needs. This results in the Scheme being representative of the medical scheme market and, as such, it experiences limited variability of the outcome.

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

The following graph summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred (before and after risk transfer arrangements (RTA)) by age group and in relation to the type of risk covered/ benefits provided.



Risk transfer arrangements

The Scheme has three risk transfer agreements in which suppliers are paid a capitation fee to provide certain minimum benefits to Scheme members, as and when they are required by the members. Capitation arrangements fix the cost to the Scheme of providing these benefits.

The Scheme cedes insurance risk to limit exposure to underwriting losses in terms of risk transfer arrangements where the third party agrees to reimburse the ceded amount in the event the claim is made. According to the terms of the capitation agreements, the suppliers provide certain minimum benefits to all Scheme members covered under the capitation arrangement, as and when required by the members.

The first two risk transfer arrangements cover out-of-hospital optometry and dentistry benefits for members on the KeyCare Plus and KeyCare Start plans. The third arrangement covers the treatment for members diagnosed with diabetes (type I and II) on all plans excluding KeyCare plans.

28. INSURANCE RISK MANAGEMENT REPORT *continued*

Concentration of insurance risk *continued*

Risk in terms of risk transfer arrangements

The Scheme does, however, remain liable to its members to provide these benefits. If any supplier fails to meet the obligations of the risk transfer arrangement, the Scheme will cover the costs of the benefit.

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

The following table summarises the concentration of insurance risk reinsured, with reference to the amount of the insurance claims incurred by option and in relation to the type of out-of-hospital risk covered/benefits provided:

	Medical practitioners	Dentistry	Optometry	Other
KeyCare options	0%	100%	100%	0%
Non-KeyCare options	5%	0%	0%	0%

Assessment of contribution increases

In 2024, the Scheme implemented a weighted average risk contribution increase of 10.5%, and a weighted average gross contribution increase of 7.5%, from 01 January. The lower gross contribution increase is due to a decrease in the PMSA portion on the Saver benefit options. The decision was also made to close the Essential Comprehensive, Classic Delta Comprehensive, and Essential Delta Comprehensive options since they were loss making. The remaining loss-making options were given higher increases to improve their financial position, thereby reducing the cross-subsidisation required from the other options on the Scheme, resulting in an improved overall financial position at a Scheme level. In addition to the consolidation of the Comprehensive options and the reduction of the PMSA portion on the Saver benefit options, a PMSA of 15% was added to the Classic Smart Comprehensive option.

In 2025, the Scheme implemented a weighted average risk contribution increase of 9.3% from 01 January. The increase was at the lower end of contribution increases in the open medical scheme market. The Scheme also registered a new benefit option called Active Smart, effective 01 January 2025. The introduction of Active Smart and the lower contribution increase was expected to lead to an increase in the number of young and healthy lives joining the Scheme in 2025. This did happen to a large extent, with more than 75% of members on Active Smart being younger than 40 years.

In 2026, the Scheme deferred the contribution increase to 01 April 2026 at which time it will implement a weighted average contribution increase of 7.2%. The increase is made up of 7.9% on the Executive plan, the Comprehensive series, Coastal plans and the KeyCare series; 0.0% on the Active Smart plan; and 6.9% on all other plans. The contribution increase is again lower relative to the contribution increases for the open medical scheme market. Similarly to 2025, new benefit options named Classic Smart Saver and Essential Smart Saver were introduced in an effort to attract young and healthy lives to the Scheme in 2026.

28. INSURANCE RISK MANAGEMENT REPORT *continued*

Concentration of insurance risk *continued*

Claims development

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

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

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

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

Based on the processing patterns and claims development up to the end of December 2025 in respect of treatment dates during the year, the recommended provision for outstanding claims as at December 2025 is R2 521 million (2024: R2 429 million). Note that any changes in case mix are automatically accounted for in the methodology. A sensitivity test is shown further below.

	2025 R'000	2024 R'000
The total claims incurred (including the provision for outstanding claims) for the most significant claims categories are as follows:		
Total estimate of incurred claims		
In-hospital claims incurred	**56 242 772**	52 393 799
Chronic claims incurred	**3 545 922**	3 460 656
Out-of-hospital risk claims incurred	**15 355 722**	14 522 383

The table below outlines the sensitivity of insured liability estimates to slower claims processing. If processing is slower than expected, a larger claims provision for unprocessed claims will be required. It should be noted that this is a deterministic approach with no correlations between the key variables.

	Change in variable %	**Impact on probability weighted best estimate of future cash flows for claims incurred but not yet reported 2025 R'000**	Impact on probability weighted best estimate of future cash flows for claims incurred but not yet reported 2024 R'000
In-hospital claims incurred	1% slower claims processing	**717 212**	666 531
Chronic claims incurred	1% slower claims processing	**12 006**	11 602
Out-of-hospital risk claims incurred	1% slower claims processing	**296 234**	275 773

28. INSURANCE RISK MANAGEMENT REPORT *continued*

Concentration of insurance risk *continued*

Claims development *continued*

The table below outlines the impact of different risk confidence levels on the risk adjustment.

Risk confidence level	Risk margin percentage of outstanding claims
75% Confidence level	1.6%
70% Confidence level	1.2%
80% Confidence level	2.0%

Liquidity risk

Members of the Scheme are required to submit their claims within four months of the service date. Therefore, the liability attributable to current members is expected to be settled within 12 months.

The members' PMSAs contain a demand feature. In terms of Regulation 10 of the Act, 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 plan and enrolls in another benefit plan or medical scheme without a savings account or does not enroll in another medical scheme. Therefore, the carrying values of the members' PMSA are deemed to be equal to their fair values, which is the amount payable on demand.

The remaining component of the Scheme's insurance liabilities is the outstanding claims provision. These are generally settled in a short period of time, approximately 98% of this provision is settled within three months after the claim was incurred and the balance is settled within six months. The remaining insurance liabilities are generally settled within 30 days.

The Scheme has budgeted a loss (before investment income) for the period ending 31 December 2026 of R2.2 billion. Future members would be expected to fully use these insurance contract liabilities within the next 12 months.

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

Assumption risk

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

Credit risk

Credit risk is the risk of financial loss resulting from a counterparty's failure to meet their contractual obligations. The Scheme does not have significant credit risk arising from reinsurance contract assets or insurance assets.

The capitation agreements are used to manage insurance risk. This does not, however, discharge the Scheme's liability as the primary insurer. If a reinsurer fails to pay a claim for any reason, the Scheme remains liable for the payment to the members.

Exposures to individual members are managed by adhering to the requirements of Section 26(7) of the PMSA i.e. actively pursuing all contributions not received within three days of becoming due, suspending benefits for all members where contributions have not been received for 30 days and terminating benefits for all members where contributions have not been received for 90 days. The credit risk is taken into account when the expected contribution is calculated.

29. FINANCIAL RISK MANAGEMENT REPORT

Overview

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

The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potential adverse effects on the Scheme's statutory solvency requirement.

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

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

The Scheme manages the financial risks as follows:

- The Investment Committee, a Committee of the Board of Trustees, recommends the Scheme's Investment Policy to the Trustees for approval. The Investment Committee meets at least quarterly and reports back to the Trustees on the matters included in its terms of reference.
- The Scheme has appointed reputable external asset managers to manage its investments, and their performance is monitored regularly.
- The Scheme has appointed an external asset consulting company, RisCura Solutions (Pty) Ltd, to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the external asset managers.
- Asset management agreements and mandates are concluded and reviewed by the Scheme's in-house legal counsel.
- An Independent assessment of the valuation of the Scheme's investments is performed by a third party.

Market risk

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

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

R'000	Total	Currency risk	Price risk	Interest rate risk
2025				
INVESTMENTS	**41 585 633**			
Offshore cash and bonds	**2 337 993**	✓		✓
Equities	**12 711 639**		✓	
Short duration bonds	**6 466 551**			✓
Flexible fixed income bonds	**12 012 723**			✓
Money market instruments	**7 029 647**			✓
Property	**1 027 080**		✓	
2024				
INVESTMENTS	36 582 673			
Offshore cash and bonds	2 450 096	✓		✓
Equities	9 808 519		✓	
Short duration bonds	5 895 290			✓
Flexible fixed income bonds	9 981 419			✓
Money market instruments	7 573 667			✓
Property	873 682		✓	

The Scheme's insurance contract liabilities to current members are settled within one year and the Scheme does not discount insurance contract liabilities. Consequently, changes in market interest rates would not affect the Scheme's surplus or deficit arising from changes in the insurance liability. The PMSA, that is included in the insurance contract liabilities, is not exposed to interest rate risk. Interest is allocated to positive PMSA balances greater than R5 000 based on a sliding scale. The interest rates used are fixed interest rates as per the approved Scheme Rules and the Policy for Interest on PMSA.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Currency risk

The majority of the Scheme's benefits are Rand-denominated and therefore the Scheme does not have significant net currency risk relating to benefits.

For the purpose of seeking investment diversification, the Scheme continued to invest in offshore bond portfolios (reference currency is the US Dollar (USD)). Derivative financial instruments are utilised by the independent bond managers within these portfolios for risk mitigation and efficient portfolio construction and grouped in the respective portfolio. At 31 December 2025, R2.3 billion (2024: R2.5 billion) (Note 3) was invested in these portfolios.

- **CURRENCY DERIVATIVES FINANCIAL INSTRUMENT (SYNTHETIC FORWARDS)**

  The Scheme entered into synthetic forward currency arrangements with South African banks to hedge exposure to changes in the ZAR/US Dollar exchange rate with respect to its offshore bond portfolios. The following table provides details of the open contracts at year-end.

		2025			
Contract	**Expiry date**	**Nominal USD value $'000**	**Spot at trade date**	**Strike price (Forward rate)**	**% above trade spot**
1	24/02/2026	$16 000	**R 18.35**	**R 18.93**	**3.17%**
2	20/08/2026	$32 000	**R 17.71**	**R 18.22**	**2.87%**
3	01/09/2026	$16 000	**R 17.57**	**R 18.08**	**2.89%**

		2024			
Contract	Expiry date	Nominal USD value $'000	Spot at trade date	Strike price (Forward rate)	% above trade spot
1	24/02/2025	$16 000	R 19.13	R 19.75	3.25%
2	20/08/2025	$32 000	R 17.82	R 18.40	3.25%
3	01/09/2025	$16 000	R 17.64	R 18.22	3.28%

The synthetic forwards are categorised as at fair value through profit or loss.

At the time of expiry of the synthetic forwards, the following transactions could occur depending on the rate at which the Rand is trading against the US Dollar:

- If the spot rate is higher than the strike price, the Scheme would be required to pay the difference between the strike price and the spot rate to the counterparty.
- If the spot rate is trading lower than the strike price, the counterparty would be required to pay the difference between the strike price and the spot rate to the Scheme.

Gains and losses on these arrangements are included in Net gains/(losses) on financial assets (Note 20).

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Currency risk *continued*

- **CURRENCY RISK SENSITIVITY ANALYSIS**

The sensitivity of the Rand appreciating and depreciating against the US Dollar is presented below. This impact would be recognised in the Statement of Comprehensive Income. The potential outcomes of the sensitivity are based on the assumption that the Rand has strengthened or weakened against the US Dollar by 5% (increase or decrease of R0.94) or 15% (increase or decrease of R2.83) from a spot level of R18.87 to the US Dollar, with all other variables held constant. The analysis is presented including and excluding the impact of the synthetic forwards, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the synthetic forwards would be based on the exchange rate at the date of expiry of the respective contracts.

R'000	15% appreciation of ZAR against USD	5% appreciation of ZAR against USD	5% depreciation of ZAR against USD	15% depreciation of ZAR against USD
2025				
(Loss)/gain arising from currency appreciation/ depreciation before synthetic forwards	**(350 699)**	**(116 900)**	**116 900**	**350 699**
(Loss)/gain arising from currency appreciation/ depreciation after synthetic forwards	**(212 361)**	**(30 925)**	**150 511**	**331 947**
2024				
(Loss)/gain arising from currency appreciation/ depreciation before synthetic forwards	(367 514)	(122 505)	122 505	367 514
(Loss)/gain arising from currency appreciation/ depreciation after synthetic forwards	(216 199)	(91 922)	32 354	156 630

Price risk

The Scheme is exposed to equity securities price risk due to equity investments held by the Scheme that are classified as at fair value through profit or loss. The value of the Scheme's equity and property investments amounted to R13.7 billion (2024: R10.7 billion) (Note 3).

The Scheme manages the price risk arising from investments in equity securities, through the diversification of its investment portfolios. Diversification of the portfolios is performed by independent asset managers in accordance with the mandate set by the Scheme. The strategy to manage price risk, by limiting exposure to any constituent of the benchmark to a maximum weight of 15%, remains in place.

The Scheme purchased derivative financial instruments to protect the solvency of the Scheme as a result of fluctuations in the equity market. The derivative strategy considers the impact of the decision to limit the maximum exposure to 15% of any constituent of the benchmark.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Price risk *continued*

EQUITY DERIVATIVES FINANCIAL INSTRUMENTS (ZERO-COST COLLARS)

The Scheme entered into zero-cost collar arrangements to hedge approximately 100% of the exposure to changes in marketprices for investments in the equity portfolios. The contracts provide downside protection of up to 15% after a reduction in equity prices of 5% (i.e. the Scheme is at risk for the first 5% drop in equity prices but protected for the next 15%). To achieve this, the Scheme agreed to forego upside benefit from an increase in equity prices above the predetermined level (the cap). The cap for these contracts range between 13% and 14% above the predetermined level.

Contract	Nominal R'000	Index	Index level at trade date	Long put level ("upper floor")	Call level ("cap")
1	280 000	JSE TOP40[1]	107 223	97.50%	115.10%
2	290 000	JSE TOP40[1]	107 777	97.50%	114.91%

The zero-cost collars are categorised as at fair value through profit or loss.

At the time of expiry, the following transactions could occur depending on the level at which the equity index trades:

- If the index level is higher than the cap, the Scheme would be required to pay the difference between the cap and the index level to the counterparty.
- If the index level is trading lower than the cap but higher than the upper floor, no action would take place.
- If the index level is trading between the upper floor and the lower floor, the counterparty would be required to pay the difference between the index level and the lower floor to the Scheme.
- If the index level is trading lower than lower floor, the Scheme would be required to pay the difference between the lower floor and the index level minus 15% to the counterparty.

Gains and losses on these arrangements are included in Net gains/(losses) on financial assets (Note 20).

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Price risk *continued*

EQUITY PRICE RISK SENSITIVITY ANALYSIS

The analysis reflecting the impact of increases or decreases in equity prices has been presented below. This impact would be recognised in the Statement of Comprehensive Income. The potential outcomes of the sensitivity are based on the assumption that equity prices had increased or decreased by 5% or 15%, spot reference levels of R116, 156 (JSE TOP40), with all other variables held constant. The analysis is presented including and excluding the impact of the zero-cost collars, valued at year-end, based on the underlying valuation variables. The actual outcome of the impact of the zero-cost collars would be based on the reference level at the date of expiry of the respective contracts.

The following table indicates the 5% or 15% change in the respective index.

Index	5% price increase or decrease in the index	15% price increase or decrease in the index
JSE TOP40	**5 808**	**17 423**

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
2025				
(Loss)/gain arising from price decrease/increase before zero-cost collars	**(1 910 521)**	**(636 840)**	**636 840**	**1 910 521**
(Loss)/gain arising from price decrease/increase after zero-cost collars	**(1 878 264)**	**(636 840)**	**636 840**	**1 857 786**
2024				
(Loss)/gain arising from price decrease/increase	(1 471 278)	(490 426)	490 426	1 471 278

The analysis reflecting the impact of increases or decreases in prices of the property portfolio has been presented below. This impact would be recognised in the Statement of Comprehensive Income. The potential outcomes of the sensitivity are based on the assumption that prices had increased or decreased by 5% or 15%, with all other variables held constant. The Scheme has not hedged this portfolio.

R'000	15% price decrease	5% price decrease	5% price increase	15% price increase
2025				
(Loss)/gain arising from price decrease/increase	**(154 062)**	**(51 354)**	**51 354**	**154 062**
2024				
(Loss)/gain arising from price decrease/increase	(131 052)	(43 684)	43 684	131 052

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Interest rate risk

The Scheme is exposed to interest rate risk as it places funds in short-dated investments, money market accounts and bonds. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolio as well as additional fixed and call deposit investments. The bond managers have made use of bond futures and other derivative instruments within these portfolios to manage duration risk with the contracts being grouped into the respective portfolio.

The table summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

R'000	0 – 3 Months	3 – 12 Months	>12 Months	Total
At 31 December 2025				
Cash and cash equivalents	**5 345 344**			**5 345 344**
Money market instruments carried at fair value through profit or loss		**7 029 647**		**7 029 647**
Short duration bonds carried at fair value through profit or loss		**1 470 951**	**4 995 600**	**6 466 551**
Flexible fixed income bonds carried at fair value through profit or loss		**1 319 139**	**10 693 584**	**12 012 723**
Offshore cash and bonds carried at fair value through profit or loss			**2 337 993**	**2 337 993**
At 31 December 2024				
Cash and cash equivalents	3 143 089			3 143 089
Money market instruments carried at fair value through profit or loss		7 573 667		7 573 667
Short duration bonds carried at fair value through profit or loss		1 332 370	4 562 919	5 895 289
Flexible fixed income bonds carried at fair value through profit or loss		805 894	9 175 525	9 981 419
Offshore cash and bonds carried at fair value through profit or loss			2 450 096	2 450 096

INTEREST RATE RISK SENSITIVITY ANALYSIS

A sensitivity analysis indicating results of increases/decreases in interest rates has been presented below. This impact would be recognised in the Statement of Comprehensive Income. The sensitivity is based on the assumption that local or foreign interest rates had increased or decreased by 1% or 2%, with all other variables held constant.

Gains/(losses) arising from change in:

R'000	2% interest rate decrease	1% interest rate decrease	1% interest rate increase	2% interest rate increase
2025				
Local portfolios	**1 912 746**	**956 373**	**(956 373)**	**(1 912 746)**
Foreign portfolios	**143 363**	**71 681**	**(71 681)**	**(143 363)**
2024				
Local portfolios	1 665 741	832 871	(832 871)	(1 665 741)
Foreign portfolios	181 031	90 516	(90 516)	(181 031)

The majority of the Scheme's assets are invested in variable interest rate instruments with a significant portion of the fixed rate instruments maturing in the short term. At 31 December 2025, 39% (2024: 37%) of the investments were invested in variable interest rate instruments, 16% (2024: 16%) in fixed rate instruments and the remaining 45% (2024: 47%) in non-interest bearing instruments. As a result, interest rate changes are not expected to have a material impact on the valuation of Scheme assets due to the short duration thereof.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Legal risk

Legal risk is the risk that the Scheme will be exposed to contractual obligations which have not been provided for. All Scheme agreements are reviewed by the legal team to ensure that the contractual obligations are clearly defined and not ambiguous. At 31 December 2025, the Scheme considered there to be no significant concentration of legal risk and no provision has been raised.

Investment risk

Investment risk is the risk that the investment returns on accumulated assets will be lower than anticipated, resulting in solvency reducing below 25%.

The Scheme's Investment Committee oversees that the funds are invested in line with the Act.

The investment philosophy is to hold a diversified pool of assets. The assets are selected as being most appropriate given the liquidity and solvency requirements of the Scheme. The Scheme's return goals, as well as the risk associated with each asset class, are considered. Diversification is across securities, issuers, asset classes and geographic regions, as well as managers within asset classes where practical. The Scheme investments in short-term deposits, and money market, bond, property and equity portfolios are managed by reputable asset managers.

The Scheme's investment objective statement is:

- Maximise targeted investment returns, which is dependent on the evaluation of the solvency level above the statutory minimum requirement from time to time.
- The return target will be reviewed at the end of every year taking into account the actual returns achieved and projected operating surplus.
- The return target is subject to a low-risk appetite for:
  - Solvency reducing below 25% due to poor investment returns; or
  - Achieving returns in any year that are lower than the return assumed by the actuary in the pricing budget.

The Investment Committee monitors the performance of the Scheme's asset managers to ensure performance in accordance with the agreed mandates.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Breakdown of investments

The investments are split between the following in the Financial Statements:

- Investments carried at fair value through profit and loss; and
- Cash and cash equivalents.

R'000	Segregated funds	Collective investment schemes	Policy of insurance	Total
2025				
INVESTMENTS	**37 190 888**	**2 337 993**	**2 056 752**	**41 585 633**
Offshore cash and bonds	**–**	**2 337 993**	**–**	**2 337 993**
Equities	**12 711 639**	**–**	**–**	**12 711 639**
Short duration bonds	**4 409 799**	**–**	**2 056 752**	**6 466 551**
Flexible fixed income bonds	**12 012 723**	**–**	**–**	**12 012 723**
Property	**1 027 080**	**–**	**–**	**1 027 080**
Money market instruments	**7 029 647**	**–**	**–**	**7 029 647**
CASH AND CASH EQUIVALENTS	**4 819 072**	**526 272**	**–**	**5 345 344**
	42 009 960	**2 864 265**	**2 056 752**	**46 930 977**
2024				
INVESTMENTS	32 260 914	2 450 096	1 871 663	36 582 673
Offshore cash and bonds	–	2 450 096	–	2 450 096
Equities	9 808 519	–	–	9 808 519
Short duration bonds	4 023 627	–	1 871 663	5 895 290
Flexible fixed income bonds	9 981 419	–	–	9 981 419
Property	873 682	–	–	873 682
Money market instruments	7 573 667	–	–	7 573 667
CASH AND CASH EQUIVALENTS	2 621 992	521 097	–	3 143 089
	34 882 906	2 971 193	1 871 663	39 725 763

Money market portfolios:

Local portfolios:

These money market portfolios are managed by independent asset managers. The investment mandates are for actively managed portfolios of financial instruments aimed at maximising return on the investments, on a long-term basis, with due regard to the relevant risks and the constraints imposed by the mandates.

For the first portfolio, the mandate stipulates liquidity requirements that 5% of the assets must be available within 24 hours and 15% within five working days. The weighted modified duration of the portfolio may not exceed 180 days. The weighted term to maturity of the portfolio shall not exceed three and a half years. The term of each individual instrument is also limited. The average weighted credit rating of this portfolio will not be less than A+.

The liquidity requirements of the second portfolio also stipulate that 5% of the assets must be available on 24 hours' notice and an additional 15% within five working days. The average portfolio duration is limited to 180 days and the weighted term to maturity to three and a half years. There are a number of additional liquidity requirements included in the mandate, such as requiring that all investments with a maturity longer than 18 months must be of a negotiable nature. The key feature of being of a negotiable nature is that the instrument can be sold by the holder of that instrument to another party without requiring explicit consent from the issuer of the instrument. The performance benchmark for these portfolios is measured against STeFI plus 130 basis points per annum over rolling one-year periods.

The local money market portfolios comprise approximately 17% (2024: 21%) of the Scheme's Financial assets at fair value through profit or loss.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Short duration bond portfolios:

Local portfolios:

The Scheme has three short duration bond portfolios, managed by independent asset managers.

The one portfolio uses a specialist fixed income strategy with South African exposure and invests in a broad spectrum of listed and unlisted fixed income instruments. The instruments are typically investment grade and include, but are not limited to, listed bonds, credit-linked notes, floating rate notes, interest rate swaps and bond futures. The benchmark for this portfolio is STeFI three-month index plus 150 basis points per annum. To manage liquidity, the asset manager endeavours to invest in securities such that the repayment of capital in relation to securities matches the Scheme's liabilities, as communicated to the asset manager from time to time.

The second portfolio is a specialist low interest rate yield enhanced portfolio with moderate risk limits that seeks diversity, reasonable yield enhancement, moderate liquidity and relatively low volatility due to constrained interest rate positions. This is achieved by investing in a broad spectrum of fixed interest and yield-enhanced debt instruments. The benchmark for this portfolio is the STeFI Composite Index. The weighted average credit quality is A+ with a weighted average term to maturity of less than five years. A minimum of 10% of the portfolio will be held in money market instruments with an expected term to maturity of less than 91 days. A minimum of 20% of the portfolio must be held in money market instruments.

The mandates set specific exposure limits depending on the credit rating of the individual counterparty and sets exposure limits to unrated investments.

The third portfolio is a duration constrained mandate that seeks yield enhancement through responsible credit allocation as well as harvesting a liquidity premium. The maximum term to maturity of any instrument may be no longer than seven years. Notice of three calendar months is required for a full withdrawal from the portfolio.

The benchmark for all three portfolios is the SteFI Composite Index plus 250 basis points, per annum.

These portfolios comprise approximately 16% (2024: 16%) of the Scheme's financial assets at fair value through profit or loss.

Offshore portfolios:

The Scheme has two offshore portfolios managed by independent asset managers.

The first portfolio is a multi-asset credit strategy invested in an open ended specialised investment fund on a non-discretionary basis. The fund is benchmarked against the Secured Overnight Funding Rate plus 400 basis points.

The second portfolio is actively managed on a discretionary basis investing in a portfolio of foreign offshore fixed income instruments. The primary objective is the long-term growth of capital and income. The benchmark for this portfolio is the FTSE World Government Bond Index (USD).

These portfolios comprise approximately 6% (2024: 7%) of the Scheme's financial assets at fair value through profit or loss.

Flexible fixed income portfolios:

The Scheme has two flexible fixed income portfolios, each managed by an independent asset manager.

Both portfolios have a composite benchmark of 50% FTSE/JSE All Bond Index and 50% FTSE/JSE Inflation Linked Bond Index. The mandates allow managers to switch between cash, nominal bonds and inflation linked bonds based on their investment view. The managers seek to outperform the benchmark through a combination of asset allocation as well as yield enhancement from security selection. The portfolios have no modified duration limits, but average weighted credit quality should be at least A+.

To limit concentration risk, limits are in place for both issuer and credit quality category.

These portfolios comprise approximately 29% (2024: 27%) of the Scheme's financial assets at fair value through profit or loss.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Short duration bond portfolios: *continued*

Equity portfolios:

The primary goal is to maximise long-term investment performance with due regard to the relevant risks, including volatility of returns, risk of capital loss and liquidity. These risks are mitigated by blending investment mandates across different manager styles and sectors.

The portfolios may only be invested in South African equities and are to be as fully invested as can practically be achieved at all times. The portfolios must comply with the Act and are prohibited from investing in British American Tobacco, Reinet Investments and Discovery Ltd.

The Scheme considers responsible investing in all its investments. Managers are required to exclude tobacco manufacturers and related exposures by utilising negative screening. This includes all direct investments and indirect investments greater than 5%.

The performance of the actively managed portfolios is measured against the benchmark, which is the FTSE/JSE Capped Shareholder weighted index adjusted to exclude tobacco (as per the Scheme's Responsible Investment Policy) and capping the combined exposure to Naspers and Prosus to a maximum of 15%. The performance of the passive portfolio is measured against the same benchmark.

These portfolios comprise approximately 31% (2024: 27%) of the Scheme's financial assets at fair value through profit or loss.

Property portfolios:

The primary objective of this mandate is to deliver consistent and incremental out-performance of the benchmark over a long-term period. The benchmark for this mandate is the FTSE/JSE SA All Property Index.

The mandate does not permit investment in foreign listed shares or direct property investments and requires that there will always be more than six holdings in the portfolio.

This portfolio comprises approximately 2% (2024: 2%) of the Scheme's financial assets at fair value through profit or loss.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Short duration bond portfolios: *continued*

Property portfolios: *continued*

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

	Financial assets and liabilities at fair value through profit and loss	Financial assets at amortised cost	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
2025					
INVESTMENTS					
– Offshore bond portfolio	**2 337 993**			**2 337 993**	**2 337 993**
– Equities	**12 711 639**			**12 711 639**	**12 711 639**
– Short duration bond portfolio	**6 466 551**			**6 466 551**	**6 466 551**
– Flexible fixed income bond portfolio	**12 012 723**			**12 012 723**	**12 012 723**
– Property	**1 027 080**			**1 027 080**	**1 027 080**
– Money market portfolios	**7 029 647**			**7 029 647**	**7 029 647**
CASH AND CASH EQUIVALENTS		**5 345 344**		**5 345 344**	**5 345 344**
DERIVATIVE FINANCIAL INSTRUMENTS	**68 478**			**68 478**	**68 478**
TRADE AND OTHER RECEIVABLES		**7 050**		**7 050**	**7 050**
TRADE AND OTHER PAYABLES			**(93 492)**	**(93 492)**	**(93 492)**
	41 654 111	**5 352 394**	**(93 492)**	**46 913 013**	**46 913 013**
2024					
INVESTMENTS					
– Offshore bond portfolio	2 450 096			2 450 096	2 450 096
– Equities	9 808 519			9 808 519	9 808 519
– Short duration bond portfolio	5 895 290			5 895 290	5 895 290
– Flexible fixed income bond portfolio	9 981 419			9 981 419	9 981 419
– Property	873 682			873 682	873 682
– Money market portfolios	7 573 667			7 573 667	7 573 667
CASH AND CASH EQUIVALENTS		3 143 089		3 143 089	3 143 089
DERIVATIVE FINANCIAL INSTRUMENTS	(29 784)			(29 784)	(29 784)
TRADE AND OTHER RECEIVABLES		7 976		7 976	7 976
TRADE AND OTHER PAYABLES			(99 435)	(99 435)	(99 435)
	36 552 889	3 151 065	(99 435)	39 604 519	39 604 519

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Credit risk

Credit risk is the risk of financial loss to the Scheme, if a counterparty to a financial instrument fails to meet its contractual obligations.

Key areas where the Scheme is exposed to credit risk are through its insurance contract receivables, investments and cash.

Exposure to credit risk

The carrying amount of insurance contract receivables represents the maximum credit exposure.

The Scheme ages and pursues unpaid accounts on a monthly basis, as set out in the approved Debt Management Policy.

The Scheme conducts a comprehensive assessment of credit risk for various debtor categories, drawing insights from historical data to estimate fulfilment of cash flows. For insurance revenue past due and outstanding for less than 90 days, the Scheme discerns no indication of non-recoverability, reflecting the accuracy of the premiums' expected collection.

Similarly, for member and service provider claims debtors, as well as broker fee debtors, past due and outstanding for less than 180 days, the Scheme recognises no non-recoverability indications based on the accuracy of the estimated fulfilment cash flows for claims.

Furthermore, for forensic debtors past due and outstanding for less than three years, the Scheme's estimation process indicates no evidence of non-recoverability.

It is crucial to highlight that the Scheme has not initiated any re-negotiation of receivables terms. Additionally, the absence of collateral or guarantees as security is considered in the estimation process, ensuring a thorough assessment of fulfilment cash flows. The Scheme remains committed to regular reassessment and adjustment of these estimates, thereby upholding the accuracy of its financial reporting.

Other receivables

The Scheme applies the IFRS 9 simplified approach to measure expected credit losses which uses a lifetime expected loss allowance for other receivables.

To measure the expected credit losses associated with other receivables, these have been grouped based on shared credit risk characteristics and the days past due. Other receivables comprise amounts due from related parties, sundry accounts receivable and interest receivable and are all current and not in a past due status. An immaterial expected loss rate is assigned to receivables that are not past due. Any loss associated with these receivables is negligible and no provision is raised. No further analysis is presented.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Cash and cash equivalents

For cash and cash equivalents, these amounts are short dated on demand deposits and money market funds with highly rated banks and money market funds, and as a result there is no expectation of any credit losses as the probability of default is remote. As a result the amount at risk would be immaterial and no further analysis presented.

R'000	Current	Total
2025		
Expected loss rate	**0%**	
GROSS CARRYING AMOUNT – OTHER RECEIVABLES	**7 050**	**7 050**
Sundry accounts receivable	**112**	**112**
Interest receivable	**6 938**	**6 938**
Gross carrying amount – cash and cash equivalents	**5 345 344**	**5 345 344**
2024		
Expected loss rate	0%	
GROSS CARRYING AMOUNT – OTHER RECEIVABLES	7 976	7 976
Sundry accounts receivable	2 927	2 927
Interest receivable	5 049	5 049
Gross carrying amount – cash and cash equivalents	3 143 089	3 143 089

Credit quality

The credit quality of insurance contract receivables can be assessed by reference to historical information about counterparty default.

Insurance revenue debtors

The Scheme collected 94% (2024: 95%) of outstanding insurance revenue in the month following their due date. This robust collection pattern signifies a high credit quality for insurance revenue. No further disclosure regarding the credit quality is deemed necessary, given the strong historical performance of insurance revenue collections.

Active member insurance service debtors

The Scheme estimates that 23% (2024: 54%) of the active member insurance service debtors will not be recovered. This has been taken into account in the fulfilment cash flows of the insurance contracts.

Withdrawn member insurance expense debtors

It is observed that these amounts are receivable from members who have withdrawn from the Scheme. The Scheme estimates that 81% (2024: 80%) of the withdrawn member insurance expense debtors will not be recovered. This has been taken into account in the fulfilment cash flows of the insurance contracts.

Service provider insurance expense debtors

The Scheme estimates that 72% (2024: 54%) of the service provider insurance expense debtors will not be recovered. This has been taken into account in the fulfilment cash flows of the insurance contracts.

Insurance acquisition cash flow (broker fee) debtors

The Scheme estimates that 30% (2024: 69%) of the insurance acquisition cash flow debtors will not be recovered. This has been taken into account in the fulfilment cash flows of the insurance contracts.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Credit quality *continued*

Forensic debtors

Forensic debt recovery mechanisms primarily include Acknowledgement of Debts, reversals, and cost adjustments. Acknowledgement of Debt amounts are recovered through various means such as debit orders, Electronic Fund Transfers, or direct deposits into the bank account, which undergo continuous monitoring. It's crucial to note that forensic debt is only written off in the event of the debtor's death or insolvency.

The Scheme estimates that 9% (2024: 8%) of the forensic debtors will not be recovered. This has been taken into account in the fulfilment cash flows of the insurance contracts. This estimate specifically applies to forensic debt instances where there have been no recoveries over a three-year period.

Other insurance receivables

These debtors mainly comprise of amounts due by hospitals, which are inherently of high quality. As agreed with the providers, the majority of these receivables are recovered by reducing future provider payments thereby providing a high certainty of recoverability, thus the Scheme estimates to recover 100% of these receivables.

Financial assets held at fair value through profit or loss, cash and cash equivalents and derivative financial instruments

The Scheme's credit risk exposures at 31 December for the respective years were as follows:

	2025 R'000	2024 R'000
– Offshore cash and bonds	**2 337 993**	2 450 096
– Short duration bonds	**6 466 551**	5 895 290
– Flexible fixed income bonds	**12 012 723**	9 981 419
– Money market instruments	**7 029 647**	7 573 667
– Cash and cash equivalents	**5 345 344**	3 143 089
– Derivative financial instruments	**68 478**	–
	33 260 736	29 043 561

The Scheme manages credit risk on its investment portfolios through the appointment of reputable and appropriate asset managers, extensive diversification and ongoing monitoring and management of credit risk exposures and portfolio holdings.

Cash and cash equivalents comprise cash deposits and money market funds with financial institutions. The risks associated with these deposits are managed by monitoring the Scheme's exposure to external financial institutions against approved deposit limits per institution. Information regarding the credit quality of cash and cash equivalents is provided on page 193.

Counterparties of derivatives disclosed in Note 6 are limited to high credit quality financial institutions.

The Scheme's Credit Risk Policy guides the Scheme with respect to credit risk identification, measurement, monitoring and management in its oversight capacity. The Policy provides for limits based on parameters such as:

- Instrument and counterparty exposure;
- Credit ratings;
- Geographical exposure (with over 90% of the credit risk exposure concentrated in South Africa);
- Industry exposure; and
- Expected loss.

Compliance with the limits is regularly monitored with a quarterly report back, presented to the Scheme's Investment Committee.

The Scheme has assessed whether the above financial assets are impaired. Based on the risk management measures undertaken by the Scheme, there is no objective evidence that any financial assets are impaired below the fair market values stated above.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Credit rating scales

Credit ratings provide an opinion on the relative ability of an entity to meet its financial commitments, such as interest, dividends or the repayment of capital invested. They are used as indicators of the likelihood of receiving the amounts owed in accordance with the terms on which they were invested.

Definitions of the symbols are presented below.

Long-term rating scales

AAA: Highest credit quality

AAA ratings denote the lowest expectation of default risk and are assigned only in cases of exceptionally strong capacity for payment of financial commitments. This capacity is highly unlikely to be adversely affected by foreseeable events.

AA: Very high credit quality

AA ratings denote expectations of very low default risk and indicate very strong capacity for payment of financial commitments. This capacity is not significantly vulnerable to foreseeable events.

A: High credit quality

A ratings denote expectations of low default risk. The capacity for payment of financial commitments is considered strong. This capacity may, nevertheless, be more vulnerable to adverse business or economic conditions than is the case for higher ratings.

BBB: Good credit quality

BBB ratings indicate that expectations of default risk are currently low. The capacity for payment of financial commitments is considered adequate but adverse business or economic conditions are more likely to impair this capacity.

BB: Speculative

BB ratings indicate an elevated vulnerability to default risk, particularly in the event of adverse changes in business or economic conditions over time, however business or financial flexibility exists, which supports the servicing of financial commitments.

B: Highly speculative

B ratings indicate that material default risk is present, but a limited margin of safety remains. Financial commitments are currently being met, however capacity for continued payment is vulnerable to deterioration in the business and economic environment.

CCC: Possibility of default

Obligations for which there is a current perceived possibility of default. Timely repayment of principal and interest is dependent on favourable business economic or financial conditions.

CC: Very high levels of credit risk

Default of some kind appears probable.

NR: Not rated

NR ratings indicate that the issuer has not been rated.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Exposure to credit risk

The following table discloses the Scheme's asset credit ratings using official credit ratings where available, or the asset manager's rating and is presented using a Fitch national scale rating. The Credit Risk Policy limits investments in non-investment grade instruments to a maximum of 10% after considering official credit ratings and asset manager assigned internal credit ratings where official ratings are not available. Less than 6% of the instruments are invested in non-investment grade instruments after consideration of internally assigned credit ratings.

		Long-term rating									
R'000	**Total**	**Govt**	**AAA**	**AA+ to AA-**	**A+ to A-**	**BBB- to BBB+**	**BB- to BB+**	**B- to B+**	**CCC+ to CCC-**	**C- to C+**	**Not rated**
2025											
AT FAIR VALUE THROUGH PROFIT OR LOSS:	**27 846 914**	**8 928 211**	**1 548 996**	**13 103 299**	**480 159**	**187 004**	**1 621 085**	**803**	**20 981**		**1 956 376**
Offshore bond portfolio	**2 337 993**	**–**	**–**	**741 379**	**–**	**–**	**1596614**	**–**	**–**	**–**	**–**
Short duration bond portfolio	**6 466 551**	**165 724**	**1 165 675**	**3 617 316**	**394 795**	**186 800**	**612**	**479**	**–**	**–**	**935 151**
Flexible fixed income bond portfolio	**12 012 723**	**8 647 888**	**354 437**	**1 885 814**	**81 843**	**204**	**23 859**	**325**	**2 426**	**–**	**1 015 927**
Money market portfolios	**7 029 647**	**114 598**	**28 884**	**6 858 790**	**3 521**	**–**	**–**	**–**	**18 555**	**–**	**5 298**
CASH AND CASH EQUIVALENTS	**5 345 344**	**–**	**–**	**5 345 344**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
DERIVATIVES	**68 478**			**68 478**							
TRADE AND OTHER TRADE RECEIVABLES	**7 050**										**7 050**
TOTAL	**33 267 786**	**8 928 211**	**1 548 996**	**18 517 121**	**480 159**	**187 004**	**1 621 085**	**803**	**20 981**	**0**	**1 963 426**
% PER RATING BAND		**26.84%**	**4.66%**	**55.66%**	**1.44%**	**0.56%**	**4.87%**	**0.00%**	**0.06%**		**5.90%**
2024											
AT FAIR VALUE THROUGH PROFIT OR LOSS:	25 900 472	7 782 542	1 139 809	13 257 390	331 588	1 742 067	–		28 045		1 619 031
Offshore bond portfolio	2 450 096	–	–	748 421	–	1 701 675			–		–
Short duration bond portfolio	5 895 290	234 563	765 784	3 747 236	254 626	39 851			–		853 230
Flexible fixed income bond portfolio	9 981 419	7 465 989	298 181	1 547 655	76 962	541			3 243		588 848
Money market portfolios	7 573 667	81 990	75 844	7 214 078	–	–			24 802		176 953
CASH AND CASH EQUIVALENTS	3 143 089	–	–	3 143 089	–	–	–		–		
DERIVATIVES	(29 784)			(29 784)			–				
TRADE AND OTHER TRADE RECEIVABLES	7 976	–	–	–	–	–	–		–		7 976
TOTAL	29 021 753	7 782 542	1 139 809	16 370 695	331 588	1 742 067	–		28 045		1 627 007
% PER RATING BAND		26.82%	3.93%	56.41%	1.14%	6.00%	0.0%		0.10%		5.61%

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Exposure to credit risk *continued*

The Scheme's investments in securitisations and collective investment schemes (funds) are subject to the terms and conditions of the respective funds' offering documentation and are susceptible to market price risk arising from uncertainties about future values of those funds. The investment manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying funds' managers. The Scheme does not control these funds as it has no voting rights, is not able to call meetings and, in addition, has no ability to direct the relevant activities of these funds. As the Scheme does not control these funds, its investments in these structured entities are not consolidated in the Scheme's Financial Statements.

All of the funds in the investment portfolio are managed by portfolio managers who are compensated by the respective funds for their services. Such compensation generally consists of an asset-based fee and a performance-based incentive fee, and is reflected in the valuation of the investment in each of the funds.

These investments are included in financial assets at fair value through profit or loss in the Statement of Financial Position and no other material risks relating to these investments have been identified other than those already disclosed in previous sections of this Report.

The exposure to investments in unconsolidated structured entities is disclosed in the following table:

Name and description	2025 R'000	Authorised programme size	% of Authorised programme size	Fair value hierarchy Level	%	Debt Ranking	%	Credit Rating	%	Underlying assets	%
Asset-backed commercial paper	**144 605**	20 000 000	0.72%	Level 1	100%	Senior Secured	37%	AAA	37%	South Africa Government Bond	100%
						Secured	63%	AA- to AA+	63%		
Residential mortgage-backed securitisations	**457 969**	5 000 000	9.16%	Level 1	77%	Senior secured	80%	AAA	54%	Residential Mortgages	100%
				Level 2	23%	Secured	17%	AA- to AA+	20%		
						Subordinated	3%	A- to A+	9%		
								BBB- to BBB+	6%		
								F1+	6%		
								NR	5%		
Asset-backed securitisations	**676 870**	60 000 000	1.13%	Level 1	58%	Senior secured	60%	AAA	34%	Agriculture mortgage-backed loans	19%
				Level 2	42%	Secured	13%	AA- to AA+	15%	Building material finance	5%
						Senior Unsecured	23%	A- to A+	13%	Consumer loan receivables	24%
						Subordinated	4%	BBB- to BBB+	8%	Vehicle Asset Backed Loans	26%
								CCC- to CCC	2%	Trade receivables	4%
								F1+	1%	Unsecured loans	22%
								NR	27%		
Commercial mortgage-backed securitisations	**112 321**	825 000	13.61%	Level 1	43%	Senior Secured	100%	AAA	43%	Commercial mortgage loans	100%
				Level 2	57%			AA- to AA+	32%		
								A- to A+	19%		
								BBB- to BBB+	6%		

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Exposure to credit risk *continued*

Name and description	2025 R'000	Portfolio size R'000	% of Portfolio size	Fair value hierarchy	Credit rating	Fund
Collective investment schemes	**286 474**	21 364 876	1.34%	Level 2	AA+	Nedgroup Investments Money Market Class C2
	236 721	39 451 862	0.60%	Level 2	AA+	Nedgroup Investments Corporate Money Market F. C2
	2 013	62 705 678	0.00%	Level 1	AA	Nedgroup Investments Core Income Fund Class C2
	66	35 604 140	0.00%	Level 2	AA+	Ninety One Money Market Fund Class A
	226	64 561 255	0.00%	Level 2	AA+	STANLIB Corporate Money Market Fund Class B5
	741 414	250 500 000	0.30%	Level 2	AA+	FTGF Brandywine Global Opportunistic Fixed Income Prem USD Acc
	1 596 614	15 742 794	10.14%	Level 2	BB	Ninety One ga Multi-asset Credit

Name and description	2024 R'000	Authorised programme size	% of Authorised programme size	Fair value hierarchy Level	%	Debt Ranking	%	Credit Rating	%	Underlying assets	%
Asset-backed commercial paper	149 529	20 000 000	0.75%	Level 2	100%	Senior Secured	40%	AAA	100%	South Africa Government Bond	100%
						Secured	60%				
Residential mortgage-backed securitisations	530 363	20 000 000	2.65%	Level 1	83%	Senior secured	68%	AAA	65%	Residential Mortgages	100%
				Level 2	17%	Secured	26%	AA- to AA+	19%		
						Subordinated	5%	A- to A+	6%		
								BBB- to BBB+	5%		
								NR	5%		
Asset-backed securitisations	1 122 111	60 000 000	1.87%	Level 1	33%	Senior secured	77%	AAA	19%	Agriculture mortgage loans	7%
				Level 2	67%	Secured	10%	AA- to AA+	11%	Building material finance	3%
						Senior Unsecured	11%	A- to A+	7%	Consumer loan receivables	12%
						Subordinated	2%	BBB- to BBB+	6%	Vehicle Loans	17%
								CCC- to CCC	1%	Trade receivables	50%
								F1+	2%	Unsecured loans	11%
								NR	53%		
Commercial mortgage-backed securitisations	102 066	825 000	12.37%	Level 1	27%	Senior Secured	100%	AAA	27%	Commercial mortgage loans	100%
				Level 2	73%			AA- to AA+	31%		
								A- to A+	13%		
								BBB- to BBB+	29%		
	1 904 069										

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Exposure to credit risk *continued*

Name and description	2024 R'000	Portfolio size R'000	% of Portfolio size	Fair value hierarchy	Credit rating	Fund
Collective investment schemes	404 166	22 962 503	1.76%	Level 2	AA+	Nedgroup Investments Money Market Class C2
	111 936	42 892 214	0.26%	Level 2	AA+	Nedgroup Investments Corporate Money Market F. C2
	673	51 625 542	0.00%	Level 1	AA	Nedgroup Investments Core Income Fund Class C2
	793	22 348 700	0.00%	Level 2	AA+	Ninety One Corporate Money Market Class A
	1 195	37 059 723	0.00%	Level 2	AA+	Ninety One Money Market Fund Class A
	1 634	73 513 706	0.00%	Level 2	AA+	STANLIB Corporate Money Market Fund Class B5
	748 456	250 500 000	0.30%	Level 2	AA+	FTGF Brandywine Global Opportunistic Fixed Income Prem USD Acc
	1 701 675	16 277 449	10.45%	Level 2	BBB	Ninety One ga Multi-asset Credit

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Liquidity risk

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. In order to meet the conflicting objective of enhancing returns while also providing high liquidity, the combined Scheme portfolios have explicit constraints that guarantee liquidity of at least 20% of the Scheme assets within a period of one week.

The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Act.

Members of the Scheme are required to submit their claims within four months of the service date. Therefore the liability attributable to current members is expected to be settled within 12 months. The PMSA balances are payable on demand when a member exits the Scheme.

The Scheme expects to achieve a net deficit (before taking into account Liability to members for future benefits) for the period ending 31 December 2025 and therefore expects to utilise a portion of the liability attributable to future members within the next 12 months. The table below reflects the Scheme's liquidity requirements to meet its financial obligations.

At 31 December 2025

R'000	Less than 1 month	1–3 months	4 months–1 year	Over 1 year	Total
Financial assets at fair value through profit or loss	**4 596 665**	**34 932 216**	**2 056 752**	**–**	**41 585 633**
Cash and cash equivalents	**5 345 344**	**–**	**–**	**–**	**5 345 344**
Derivative financial instruments	**–**	**36 137**	**32 341**	**–**	**68 478**
Trade and other receivables	**7 387**	**–**	**–**	**–**	**7 387**
Reinsurance contract assets	**3 130**	**–**	**–**	**–**	**3 130**
Available cash and investments	**9 952 256**	**34 968 353**	**2 089 093**	**–**	**47 009 972**
Insurance contract liability	**(1 785 032)**	**2 439 202**	**8 012 017**	**(498 595)**	**8 167 592**
Trade and other payables	**84 987**	**4 569**	**1 165**	**3 149**	**93 870**
Lease liability	**152**	**305**	**1 436**	**2 401**	**4 295**
Total liabilities	**(1 699 892)**	**2 444 076**	**8 016 618**	**(493 045)**	**8 265 756**
EXCESS LIQUIDITY	**11 652 418**	**32 524 277**	**(5 925 525)**	**493 045**	**38 744 216**
LIABILITY TO MEMBERS FOR FUTURE BENEFITS	**196 718**	**1 561 803**	**398 556**	**36 604 016**	**38 761 094**

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Liquidity risk *continued*

At 31 December 2024

R'000	Less than 1 month	1–3 months	4 months–1 year	Over 1 year	Total
Financial assets at fair value through profit or loss	4 650 093	30 060 917	1 871 663	–	36 582 673
Cash and cash equivalents	3 143 089	–	–	–	3 143 089
Trade and other receivables	11 583	–	–	–	11 583
Reinsurance contract assets	1 194	–	–	–	1 194
Available cash and investments	7 805 959	30 060 917	1 871 663	–	39 738 539
Insurance contract liability	(1 572 741)	2 310 231	7 743 520	(446 727)	(8 034 283)
Trade and other payables	88 554	5 780	1 694	3 603	99 632
Derivative financial instruments	(12 438)	–	42 222	–	29 784
Lease liability	142	285	1 342	3 734	5 504
Total liabilities	(1 496 482)	2 316 295	7 788 779	(439 390)	8 169 202
EXCESS LIQUIDITY	9 302 441	27 744 621	(5 917 116)	439 390	31 569 337
LIABILITY TO MEMBERS FOR FUTURE BENEFITS	(145 919)	267 526	979 225	30 485 863	31 586 694

A maturity analysis for financial liabilities carried at amortised cost, excluding liabilities arising from insurance contracts is provided below:

R'000	Less than 1 year	Between 1 and 2 years	Between 2 and 5 years
At 2025			
Trade and other payables (Note 7)	**93 492**	**–**	**–**
Leases (Note 2)	**1 894**	**2 026**	**1 047**
	95 386	**2 026**	**1 047**
At 2024			
Trade and other payables (Note 7)	99 435	–	–
Leases (Note 2)	1 770	1 894	1 840
	101 205	1 894	1 840

Fair value estimation

Financial instruments

The fair value of financial instruments traded in active markets is based on quoted market prices at the reporting date. The quoted market price used for financial assets held by the Scheme is the current closing price.

The fair value of financial instruments that are not traded in an active market is determined by using valuation techniques. These valuation techniques maximise the use of observable market data where it is available and rely as little as possible on entity-specific estimates. Specific valuation techniques used to value financial instruments include quoted market prices or dealer quotes for similar instruments.

The carrying value less impairment provision of trade receivables and payables and cash and cash equivalents are assumed to approximate their fair values due to their short-term nature.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Fair value hierarchy for financial assets measured at fair value

Assets measured at fair value

	Total	Level 1	Level 2
2025			
Current assets			
– Offshore cash and bonds	**2 337 993**	**–**	**2 337 993**
– Equities	**12 711 639**	**12 711 594**	**45**
– Short duration bonds	**6 466 551**	**5 166 392**	**1 300 159**
– Flexible fixed income bonds	**12 012 723**	**11 201 742**	**810 981**
– Property	**1 027 079**	**1 027 080**	**–**
– Money market instruments	**7 029 647**	**6 996 488**	**33 159**
– Derivative financial instruments	**68 478**	**–**	**68 478**
	41 654 111	**37 103 296**	**4 550 815**
2024			
Current assets			
– Offshore cash and bonds	2 450 096	–	2 450 096
– Equities	9 808 519	9 803 424	5 095
– Short duration bonds	5 895 290	4 673 206	1 222 085
– Flexible fixed income bonds	9 981 419	9 539 856	441 563
– Property	873 682	873 682	–
– Money market instruments	7 573 667	7 114 838	458 828
– Derivative financial instruments	(29 784)	–	(29 784)
	36 552 889	32 005 006	4 547 883

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements.

The fair value hierarchy has the following levels:

Level 1 – These are assets measured using quoted prices in an active market.

Level 2 – These are assets measured using inputs other than quoted prices included within Level 1 that are either directly or indirectly observable.

Level 3 – These are assets measured using inputs that are not based on observable market data.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Fair value hierarchy for financial assets measured at fair value *continued*

The table below details the valuation techniques and observable inputs for financial instruments falling under Level 2:

R'000	Fair value at 2025	Fair value at 2024	Valuation techniques	Observable input
Financial assets at fair value through profit or loss:				
Unlisted:				
Debt securities	**4 449 133**	4 113 744	Reference to listed benchmark bond	Risk free yield to maturity curve, risk free zero curve
Money market securities	**33 159**	458 828	Discounted cash flow valuation, Black-Scholes model	Published exchange swap curve, published interest rate curve, published credit spread curve/implied credit spread curve, risk free yield to maturity curve, risk free zero curve, swap yield to maturity curve, swap zero curve
Equity	**45**	5 095	Discounted cash flow valuation	Risk free yield to maturity curve, risk free zero curve
Derivative financial instruments	**68 478**	(29 784)	Discounted cash flow valuation, Black-Scholes model	Published index levels, published exchange swap curve, published interest rate curve, published credit spread curve, implied volatilities
	4 550 814	4 547 882		

Capital management

The Scheme is subject to the capital requirement imposed by Regulation 29(2) of the Act, which requires a minimum solvency ratio of accumulated funds expressed as a percentage of gross annual contributions of 25%.

The Scheme's objectives when managing capital are to maintain the capital requirements of the Act, and to safeguard the Scheme's ability to continue as a going concern in order to provide benefits for its stakeholders. This note should be read in conjunction with Note 28 – Insurance Risk Management and Note 29 – Financial Risk Management.

29. FINANCIAL RISK MANAGEMENT REPORT *continued*

Statutory Capital Requirement

The calculation of the regulatory capital requirement is set out below. During the year under review, the Scheme has complied with externally imposed requirements as set out by the Council for Medical Schemes and the Medical Schemes Act 131 of 1998, as amended.

	2025 R'000	2024 R'000
Liability to members for future benefits per Statement of Financial Position	**38 761 094**	31 586 694
Less: cumulative unrealised net gain on re-measurement of investments to fair value	**(5 686 089)**	(2 236 225)
Accumulated funds per Regulation 29	**33 075 005**	29 350 469
Gross annual contribution income	**101 508 259**	94 633 158
Solvency margin		
= Accumulated funds/gross annual contribution income x 100	**32.58%**	31.01%

A medical scheme has limited sources of financial capital as this is derived only from member contributions and returns from investing member funds. The Board of Trustees is committed to complying with regulatory solvency requirements, maintaining a strong capital base to safeguard member interests and ensure Scheme stability and long-term sustainability. The Board regularly monitors capital adequacy and the performance of the Scheme's investment portfolio.

At year-end, the Scheme's solvency of 32.58% (2024: 30.01%) was R7.7 billion (2024: R5.7 billion) more than the minimum statutory solvency requirement of 25%. The Board of Trustees considers this solvency level appropriate for the Scheme's operational and regulatory requirements.

Capital Management Processes

The Scheme's approach to capital adequacy is guided by its Risk Appetite Statement, which sets forth principles for managing solvency risk. The Scheme maintains a risk appetite that targets a solvency level above 27.5%. This threshold is established through careful consideration of both pricing and investment risks.

To ensure that the probability of solvency falling below the statutory minimum of 25% in any given year is minimised, the Scheme has implemented capital management processes. These processes include:

- Regular review of solvency, liquidity and reserve levels to ensure financial stability and compliance with regulatory requirements.
- Scenario testing to assess the resilience of reserves to adverse claims or market conditions (Refer to Note 28 – Insurance risk Management and Note 29 – Financial Risk Management).
- Integration of capital considerations into pricing and benefit design processes.
- Management of investment risk through asset allocation processes.
- Monitoring non-healthcare expenditure to ensure alignment with CMS guidelines.
- Maintaining adequate liquidity to meet short-term claims obligations (refer to Note 29 – Financial Risk Management).

There were no changes to the Scheme's capital management objectives, processes or risk appetite during the year. Further details on the management of insurance related risks and financial related risks are provided in the Insurance Risk Management Note (Note 28) and the Financial Risk Management Note (Note 29).

30. NON-COMPLIANCE MATTERS

Circular 11 of 2006 issued by the CMS deals with issues to be addressed in the audited financial statements of medical schemes. This includes the requirement that all instances of non-compliance be disclosed in the audited financial statements, irrespective of whether the auditor considers them to be material or not.

During 2025, the Scheme did not comply with the following Sections and Regulations of the Act, and a directive issued by the CMS.

Sustainability of benefit plans

In terms of Section 33(2) of the Act, each benefit plan is required to be self-supporting in terms of membership and financial performance and be financially sound.

Section 33(2) of the Act pertains to specific financial requirements applicable to medical schemes and outlines the statutory reserves that medical schemes are required to maintain. However, IFRS 17 provides a comprehensive framework for accounting for insurance contracts, including the recognition, measurement, presentation, and disclosure of insurance contracts. In this context, Liability to members for future benefits, as determined under IFRS 17, are not subject to the specific provisions of Section 33(2) of the Act, and are excluded from the non-compliance testing related to Section 33(2) of the Medical Schemes Act.

For the year ended 2025 the following plans did not comply with Section 33(2):

Benefit plan	Net healthcare result (R'000)	Net deficit (R'000)
Executive	**(498 717)**	**(464 295)**
Classic Comprehensive	**(199 721)**	**177 904**
Classic Priority	**(124 560)**	**184 217**
Coastal Saver	**(50 459)**	**633 151**
Coastal Core	**(262 153)**	**46 682**
KeyCare Plus	**(1 148 958)**	**(283 701)**
KeyCare Core	**(5 450)**	**86 677**

The performance of all benefit options is monitored on a continuous basis with a view to improving their financial outcomes. Different strategies are continually evaluated to address the deficit in these plans while considering the overall financial stability of the Scheme.

When structuring benefit options, the financial sustainability of all the options and the requirements of the CMS are considered. The different financial positions reflect the different disease burdens in each option, among many other factors. The Scheme's strategy for plans' sustainability must balance short- and long-term financial considerations, fairness to both healthy and sick members, and continued affordability of cover for members with different levels of income and healthcare needs. While the Scheme is committed to complying wherever possible with applicable legislation, it also focuses intensively on the overall stability and financial position of the Scheme as a whole and not only individual benefit plans.

DHMS continually provides the CMS with updates on both the Scheme and individual benefit option performance through monthly management accounts and quarterly monitoring meetings.

Investments in employer groups and medical scheme administrators

Section 35(8)(a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide and the CMS has granted DHMS exemption for a three-year period effective from 01 December 2025.

30. NON-COMPLIANCE MATTERS *continued*

Investments in other assets in territories outside the Republic of South Africa

The Scheme's offshore bond managers utilise derivative instruments to aid with efficient portfolio construction and management, and to reduce the overall risk within our portfolios. The derivatives used are highly liquid and are either exchange traded or governed by International Swaps and Derivatives Association agreements. The derivative instruments are not used for speculation and there is no gearing or leverage applied.

Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7(b) of Annexure B to the Regulations of the Act. The CMS has granted DHMS exemption for a three-year period effective from 01 December 2025.

Contributions received after due date

Section 26(7) of the Act states that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment becomes due. There are instances where the Scheme received contributions after the three-day period, however, there are no contracts in place agreeing to this practice. It is important to note that the Scheme has no control over the timely payment of contributions. The legal obligation resides with the members/employers to pay contributions within the prescribed period. The Scheme employs robust credit control processes dealing with the collection of outstanding contributions, including suspending membership for non-payment.

Claims paid in excess of 30 days

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".

During the year, there were instances where claims were not paid within 30 days. These represent a negligible amount of total claims paid for the year. There is a defined process to identify claims that have not been paid within 30 days to ensure that these claims are paid expeditiously.

Direct or indirect borrowing of money

In terms of Section 35(6)(c) of the Act, a medical scheme shall not directly or indirectly borrow money without the prior approval of the CMS or may only do so subject to directives the CMS may issue. There were instances during the year where the Scheme's bank accounts, administered by some of its asset managers, inadvertently went into an overdrawn position due to the timing of investment related inflows and outflows. Additional processes have been implemented to mitigate the risk of re-occurrence.

Incorrect funding of intra-muscular injection claims from PMSA

The incorrect funding of intra-muscular injection claims from members' PMSAs constituted a breach in terms of Section 32 of the Medical Schemes Act, which provides that the rules of a medical scheme and any amendments thereof are binding on the scheme, its members, officers, and any person claiming benefits under those rules.

During the implementation of the benefit rule for Short Stay Arthroplasty, which allows for a two-day post-procedure stay, a defect in the system applied a forced OH rule to IM injection NAPPI codes. As a result, these codes were either rejected incorrectly or funded from day-to-day benefits, even in cases where members were hospitalised with a valid hospital authorisation.

The impact of this error affected, a total of 1 220 members and 295 providers experienced incorrect claim payments, with R107 165 mistakenly deducted from members' PMSAs instead of being funded from the appropriate OH risk benefits. In addition, 401 healthcare providers and 2 801 members experienced incorrect claim rejections, amounting to R294 250.

The cause of the failure was a system defect in the application of benefit rules.

Corrective action has since been taken, with all affected claims reversed and reprocessed to ensure proper risk benefit funding and prevent member liability.

30. NON-COMPLIANCE MATTERS *continued*

Incorrect payment of dental claims from risk benefit

The incorrect funding of a subset of dental claims from the risk benefit instead of from members' Personal Medical Savings Accounts (PMSA) constituted a breach in terms of Section 32 of the Medical Schemes Act, which provides that the rules of a medical scheme and any amendments thereof are binding on the scheme, its members, officers, and any person claiming benefits under those rules. This non-compliance further represents a failure to administer claims in accordance with Rule 15.1 of the Scheme Rules, read together with Regulation 18(2)(b) of the Medical Schemes Act, which requires that the administrator administer the business of the scheme in line with the Act and the Scheme's registered rules.

During the implementation of Active Smart Plans as part of the year-end 2025 programme, system configuration changes were applied to dental benefit rules. A defect in the system resulted in certain dental codes being incorrectly funded from the risk benefit instead of being allocated to members' PMSA balances, contrary to the Scheme's registered benefit rules.

The impact of this error affected 15 DHMS plan types and 17 499 members, resulting in incorrect claim payments amounting to R9 976 642, which were paid from risk instead of from PMSA.

The cause of the failure was a system configuration error arising from the implementation of benefit rule changes during the Active Smart Plans deployment.

Corrective action has since been taken, including the identification and quantification of all affected claims, reallocation of claim payments in accordance with Scheme rules, member and provider communication, and the implementation of system fixes to prevent recurrence.

Incorrect accumulation of tiered medicine claims towards ATB

The incorrect accumulation of tier 2, 3 and 7[1] medicine claims towards the Annual Threshold Benefit (ATB) constituted a breach in terms of Section 32 of the Medical Schemes Act, which provides that the rules of a medical scheme are binding on the scheme, its members, officers and any person claiming benefits under those rules. This non-compliance represents a failure to administer benefits in accordance with the Scheme's registered rules relating to tiered medicine reimbursement and accumulation towards the ATB.

A system defect introduced on 01 January 2025 resulted in tier 2, 3 and 7 medicine claims accumulating towards the ATB at 100% of the Discovery Health Rate[2], instead of at their designated tiered reimbursement rates. As a result, affected members reached their self-payment gap earlier than intended and obtained premature access to ATB risk funding, contrary to Scheme rules.

The impact of this error affected 16 658 members, representing 10.5% of Executive, Comprehensive and Priority members, and resulted in an overpayment of R148 million from the risk benefit.

The root cause of the non-compliance was a system defect introduced during system configuration changes, which incorrectly applied accumulation logic for tiered medicines.

Corrective action has been implemented, including the identification and correction of all affected claims. Discovery Health elected to absorb the full financial impact, ensuring that the Scheme was placed in the same financial position it would have been in had the error not occurred.

The system defect was remediated, and enhancements were implemented to ensure that tiered medicines now accumulate correctly towards the ATB in accordance with Scheme rules, thereby preventing recurrence.

Communication was issued to affected members, brokers, employers and staff, the Regulator was formally notified, and independent agreed-upon procedures reviews were performed to provide assurance that all impacted claims were fully reworked and completed. Furthermore, an independent review of the claims system will be undertaken.

Resources

Contact details

PRINCIPAL OFFICER

Email **principalofficer@discovery.co.za** or call +27 11 529 2888 and ask for the Principal Officer of Discovery Health Medical Scheme (DHMS or the Scheme).

COUNCIL FOR MEDICAL SCHEMES (CMS)

DHMS is regulated by the CMS. The CMS can be contacted by telephone on 0861 123 267/012 431 0500 or via email on **information@medicalschemes.co.za**. The CMS is located at Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157.

COMPLAINTS, COMPLIMENTS OR DISPUTES

DHMS is committed to providing you with the highest standard of service and your feedback is important to us. To submit a complaint, compliment or dispute:

- Please follow the process outlined on the website

Member support

- Need something? Here's how you can reach us
- Benefits and cover; understanding your plan
- Plan and benefit information
- Medical scheme terminology
- About DHMS and Scheme Rules
- Looking for something else?
- Choose the best plan for you and your family

Important sources of information

We include various useful links below. You may need to log into the website to view some information.

- The Medical Schemes Act
- The Council For Medical Schemes
- King Report on Corporate Governance for South Africa
- The International Integrated Reporting Framework

Feedback on the Scheme's Integrated Report

We welcome any comments you may have, and would value specific feedback on the following:

- Could you easily understand our Integrated Report, and if not, what did not make sense for you?
- Were you able to find the information you were looking for, and if not, what were you looking for?
- Did this Report cover all the information relevant to your relationship with the Scheme?
- Did it help in your understanding of the Scheme and its performance, and if not, how could we improve?

EMAIL YOUR FEEDBACK TO
dhms_stakeholders@discovery.co.za

Reporting fraud or unethical behaviour

We provide a fraud and whistleblowing hotline and investigate all reports. If you even slightly suspect someone of committing fraud or behaving unethically, please let us know on the contact details below. This facility is independently managed by Whistle Blowers (Pty) Ltd and you are able to remain anonymous if you prefer:

- Toll-free call: 0800 004 500
- Website: **https://www.whistleblowing.co.za**
- WhatsApp chatbot: +27 31 308 4664
- SMS short code (South Africa): 33490
- Email: **discoveryforensics@whistleblowing.co.za** or **discoveryethics@whistleblowing.co.za**
- Post: PO Box 51006, Musgrave, 4062

You can also email us directly at forensics@discovery.co.za to request that we investigate your concerns.

Registered addresses

Principal Officer

CHARLOTTE MBEWU

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Sandton, 2146

Registered office

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PO Box 786722, Sandton, 2146

Administrator and managed care provider

Discovery Health (Pty) Ltd 1 Discovery Place
Sandton, 2146
PO Box 786722, Sandton, 2146

AUDITORS

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South Africa

PRINCIPAL BANKERS

Rand Merchant Bank, a division of FirstRand Bank Ltd
1 Merchant Place, Corner of Fredman Drive
and Rivonia Road Sandton, 2196

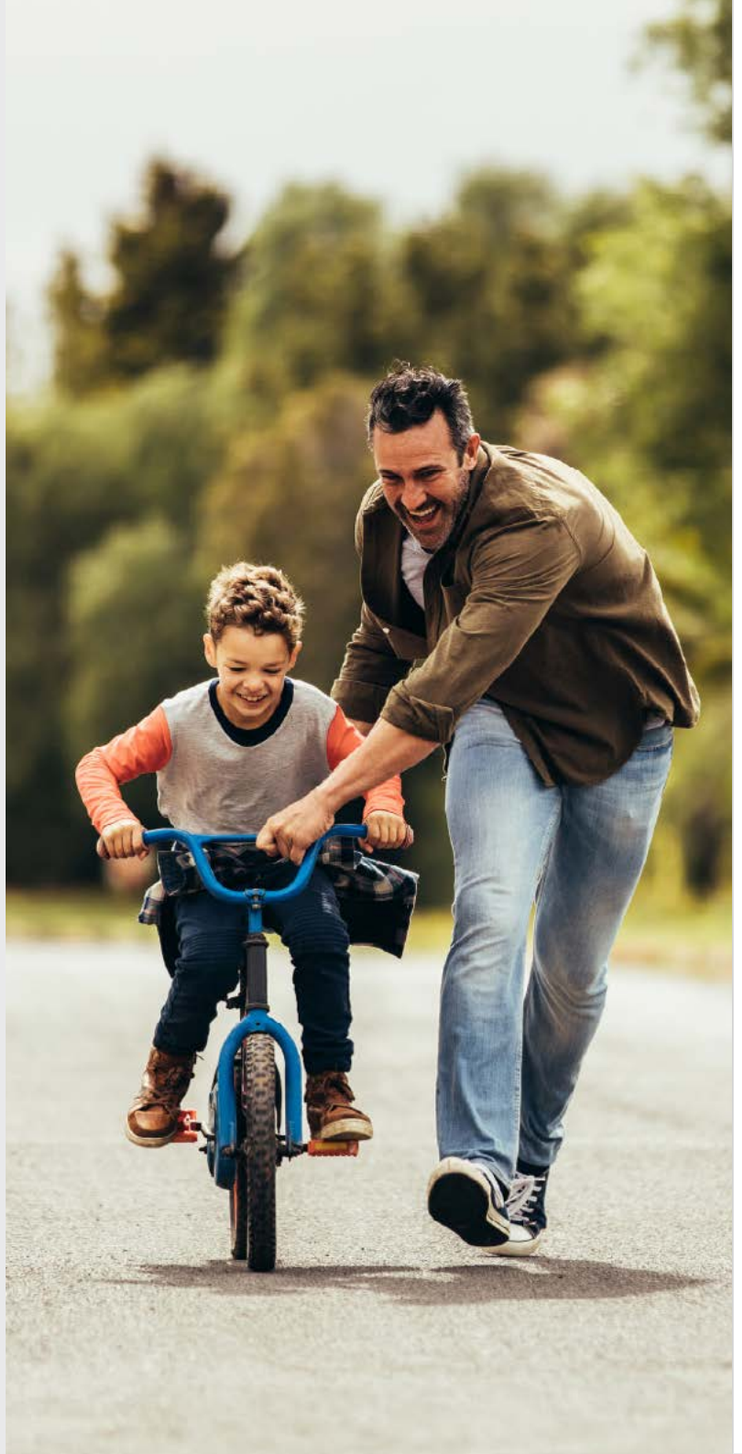
INVESTMENT MANAGERS

Investment managers for the Scheme in 2025 included the following:

- **ALLAN GRAY INVESTMENTS (PTY) LTD**
  1 Silo Square, V&A Waterfront, Cape Town, 8001
- **ALL WEATHER CAPITAL (PTY) LTD**
  9th Floor Katherine Towers, 1 Park Lane, Wierda Valley, Sandton, 2196
- **ALUWANI CAPITAL PARTNERS (PTY) LTD**
  EPPF Office Park, 24 Georgian Crescent East, Bryanston East, 2152
- **BRANDYWINE GLOBAL INVESTMENT MANAGEMENT LLC**
  Cannon Place, 78 Cannon Street, London, EC4N 6HL, United Kingdom
- **FAIRTREE CAPITAL (PTY) LTD**
  Willowbridge Place, Cnr Carl Cronje Dr & Old Oak Rd, Bellville, 7530
- **FUTUREGROWTH ASSET MANAGEMENT (PTY) LTD**
  3rd Floor, Great Westerford Building, 240 Main Road, Rondebosch, 7700
- **NINETY ONE SA (PTY) LTD**
  36 Hans Strijdom Avenue, Foreshore, Cape Town, 8001
- **SESFIKILE CAPITAL (PTY) LTD**
  2nd Floor, 18 The High Street, Melrose Arch, Johannesburg, 2076
- **STANLIB ASSET MANAGEMENT (PTY) LTD**
  17 Melrose Boulevard, Melrose Arch, Johannesburg, 2076
- **TAQUANTA ASSET MANAGERS (PTY) LTD**
  5th Floor, Draper on Main, 47 Main Road, Claremont, Cape Town, 7708
- **36ONE ASSET MANAGEMENT**
  140 West Street, Sandton, 2196
  The Citadel, 15 Cavendish Street, Claremont 7700

Glossary of acronyms and abbreviations used in this Report

AGM	Annual General Meeting
CMS	The Council for Medical Schemes
CPI	Consumer price index
DHMS/the Scheme	Discovery Health Medical Scheme
Discovery Health	Discovery Health (Pty) Ltd
DoH	National Department of Health
DSP	Designated service provider
FWAE	Fraud, waste, abuse and errors
GCI	Gross contribution income
HFA	Health Funders Association
HPCSA	Health Professions Council of South Africa
ICM	Independent Committee Member
IFRS	International Financial Reporting Standards
King IV/V	The King IV™ Report on Corporate Governance for South Africa 2016 / The King V™ Report on Corporate Governance for South Africa 2025
LCBOs	Low-Cost Benefit Options
NHI	National Health Insurance
NHI Act	National Health Insurance Act
NMG	NMG Consultants and Actuaries (Pty) Ltd
PCR	Polymerase Chain Reaction
PHF	Personal Health Fund
PHP	Personal Health Pathways
PMBs	Prescribed Minimum Benefits
PMSA	Personal Medical Savings Account
RAF	Road Accident Fund
SDGs	Sustainable Development Goals
STeFI	Short-Term Fixed Interest
TCF	Treating Customers Fairly
The Act	The Medical Schemes Act
The year	The financial year
The Trustees/Board	The DHMS Board of Trustees



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