



## HIGHLIGHTS OF DISCOVERY HEALTH MEDICAL SCHEME'S RESULTS 2025

Discovery Health Medical Scheme registration number 1125

***This document contains highlights of the Scheme's performance for the year ended 31 December 2025, extracted from the 2025 Integrated Report, and audited Annual Financial Statements as audited by Deloitte & Touche (Deloitte). Deloitte issued an unqualified audit opinion on 30 April 2026.***

## 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.

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)<sup>1</sup> 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%<sup>2</sup>.

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.

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](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.



### 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

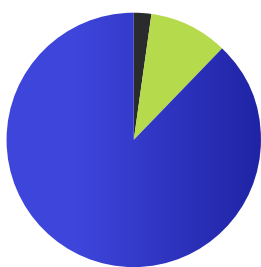
Financial strength and sustainability are key factors to consider when selecting a medical scheme. Sound financial control and risk management enable the Scheme to maintain its required solvency reserve levels which ensures its ability to pay claims even when they are unexpectedly high.

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<sup>1</sup>. 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 below) 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.

### 2025 EXPENSE BREAKDOWN



**88.4%**  
Claims paid  
(2024: 89.7%)

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

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

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

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

Average contributions for 2026 are **17.7% lower<sup>2</sup>** than the average of the average contributions of the next seven largest open medical schemes (2025: 12.7%).

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).

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

<sup>2</sup> 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.



# 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 MBEUW

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<sup>1</sup> 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.

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<sup>2</sup> 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.

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<sup>3</sup> 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.

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.

2. Cappuccio, F.P., et al. (2010) Sleep Duration and All-Cause Mortality: A Systemic Review and Meta-Analysis of Prospective Studies. *Sleep*, 33, 585.

3. 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.

## Our Principal Officer's Review *continued*

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.

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<sup>1</sup> 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.

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<sup>2</sup> 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<sup>3</sup>.

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<sup>4</sup>.

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.



**MS CHARLOTTE MBEWU**

Principal Officer

1. Prior to IFRS 17, known as member funds and renamed from "insurance liability to future members" in our previous Integrated Report.  
2. 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).  
3. 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.  
4. The use of a model which includes multiple private and public funders, designed to support cross-subsidisation for health and financial status.

# 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 below, 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<sup>1</sup>

**38.15**  
(2024: 37.56)

##### Pensioner ratio<sup>2</sup>

**13.65%**  
(2024: 13.00%)

##### Annualised lapse rate

**5.52%**  
(2024: 5.99%)

#### 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)

**57.7%<sup>3</sup>**

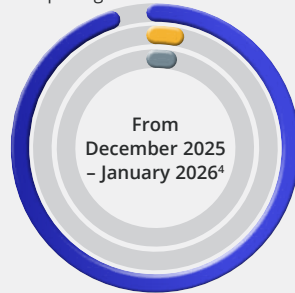
Share of open scheme market  
(2024: 58.0%)

**2 725 122**

Beneficiaries at 31 December 2025  
(2024: 2 735 204)

#### 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%**

#### 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<sup>5</sup>  
(2025: 12.7%)

- Based on beneficiaries' age as at 01 January of the report year. An increase of less than one year per annum is as this indicates that young people are joining the Scheme.
- Based on beneficiaries' age as at 01 January of the report year.
- 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](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.
- We monitor plan movements closely, especially when our contributions are increased and members are able to change their plans.
- 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.

### 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<sup>1</sup>  
(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)

#### 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<sup>2</sup>. 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%<sup>3</sup>**  
of gross contributions  
(2024: 2.52%)

- 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.
- As the assessment uses industry information reported by the CMS, results are only available for the preceding year.
- 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.

# Extracts from the audited Annual Financial Statements



## Statement of Financial Position

At 31 December 2025

	Notes <sup>1</sup>	2025 R'000	2024 R'000
<b>Assets</b>			
<b>NON-CURRENT ASSETS</b>			
		<b>31 964 284</b>	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
<b>CURRENT ASSETS</b>			
		<b>15 062 567</b>	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
<b>TOTAL ASSETS</b>		<b>47 026 851</b>	39 755 897
<b>Liabilities</b>			
<b>NON-CURRENT LIABILITIES</b>			
		<b>36 606 417</b>	30 489 597
Liability to members for future benefits <sup>2</sup>	10	36 604 016	30 485 863
Lease liability	2	2 401	3 734
<b>CURRENT LIABILITIES</b>			
		<b>10 420 434</b>	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
<b>TOTAL LIABILITIES</b>		<b>47 026 851</b>	39 755 897

1. See <http://www.discovery.co.za/info/dhmsreports> for the full Integrated Report, incorporating annual financial statements and notes.

2. 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 <sup>1</sup>	2025 R'000	2024 R'000
<b>Insurance revenue</b>	11	86 652 776	80 673 076
<b>Insurance service expense</b>	11	(86 227 264)	(81 096 469)
<b>Net income from risk transfer arrangements/reinsurance</b>	11	139 950	73 068
<b>INSURANCE SERVICE RESULT<sup>2</sup></b>		565 462	(350 325)
<b>OTHER INCOME</b>		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
<b>OTHER EXPENDITURE</b>		(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)
<b>NET SURPLUS FOR THE YEAR BEFORE MUTUALISATION</b>		7 174 400	2 896 448
Transfer to Liability to members for future benefits	10	(7 174 400)	(2 896 448)
<b>TOTAL COMPREHENSIVE INCOME FOR THE YEAR</b>		-	-

# Statement of Cash Flows

FOR THE YEAR ENDED 31 December 2025

	Notes <sup>1</sup>	2025 R'000	2024 R'000
<b>Cash flows from operating activities</b>			
<b>CASH RECEIPTS FROM MEMBERS AND PROVIDERS</b>		101 218 737	94 457 641
Cash received from members – contributions	8	101 218 737	94 457 641
<b>CASH PAID TO PROVIDERS, EMPLOYEES AND MEMBERS</b>		(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)
<b>CASH USED IN OPERATIONS</b>		(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)
<b>NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES</b>		2 204 369	(1 190 993)
<b>Cash flows from investing activities</b>			
Purchases of office equipment	1	(347)	-
<b>NET CASH OUTFLOW FROM INVESTING ACTIVITIES</b>		(347)	-
<b>Cash flows from financing activities</b>			
Payment of lease liabilities	2	(1 770)	(1 654)
<b>NET CASH OUTFLOW FROM FINANCING ACTIVITIES</b>		(1 770)	(1 654)
<b>NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS</b>		2 202 255	(1 192 647)
Cash and cash equivalents at the beginning of the year		3 143 089	4 335 736
<b>CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR</b>		5 345 344	3 143 089

1. See <http://www.discovery.co.za/info/dhmsreports> for the full Integrated Report, incorporating annual financial statements and notes.

2. 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).

## 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

## 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.

# Operational statistics per benefit plan<sup>1</sup>

for the year ended 31 December 2025

2025	EXECUTIVE	COMPREHENSIVE		PRIORITY		SAVER		
	EXECUTIVE	CLASSIC COMP	CLASSIC SMART COMP	CLASSIC PRIORITY	ESSENTIAL PRIORITY	CLASSIC SAVER	ESSENTIAL SAVER	COASTAL SAVER
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
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
Average number of members for the accounting period	7 382	81 177	2 710	65 955	4 461	356 718	177 382	146 193
Average number of beneficiaries for the accounting period	14 656	161 158	4 817	139 969	8 659	768 537	367 991	316 959
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
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
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
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
Insurance service expenses ratio (%)	140.46%	101.85%	74.67%	102.15%	78.06%	96.92%	86.40%	100.55%
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
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
Relevant health care expenditure ratio (%)	136.40%	96.78%	69.07%	94.48%	69.51%	86.99%	74.34%	90.24%
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
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
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
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
Directly attributable insurance service expenses ratio (%)	5.20%	6.47%	7.12%	9.78%	10.87%	12.63%	15.43%	13.34%
Average administration costs per member per month (R')	473.95	473.95	473.95	473.95	473.95	473.95	473.95	473.95
Average administration costs per beneficiary per month (R')	238.72	238.73	266.66	223.33	244.19	219.99	228.46	218.60
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
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
Average non-healthcare expenses per member per month	61.15	61.14	61.15	61.17	61.16	61.18	61.19	61.17
Average non-healthcare expenses per beneficiary per month	30.80	30.80	34.40	28.82	31.51	28.40	29.50	28.21
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%
Average family size	1.99	1.99	1.78	2.12	1.94	2.15	2.07	2.17
Average age of beneficiaries (years)	48.43	48.00	49.80	44.20	41.73	37.85	35.23	39.52
Pensioner ratio (beneficiaries over 65 years)	32.05%	28.50%	32.04%	21.14%	17.03%	13.17%	9.63%	14.67%
Net surplus/(deficit) per benefit plan	(464 295)	177 904	97 382	184 217	98 924	2 435 374	2 171 259	633 151

2025	CORE			SMART			KEYCARE			TOTAL
	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	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	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	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	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')	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')	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')	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')	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 (%)	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	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	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 (%)	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')	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')	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')	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')	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 (%)	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	331.76	317.28	222.45	317.28	449.55
Average administration costs per beneficiary per month (R')	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')	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')	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	61.17	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	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 (%)	0.98%	1.25%	1.11%	1.33%	2.63%	2.80%	1.41%	1.42%	2.21%	1.10%
Average family size	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)	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)	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	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>.

# 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.

## 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 NAPP1 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<sup>1</sup> 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<sup>2</sup>, 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.

## Our Trustees<sup>1</sup>



Ms Michelle Norton SC 64

BA LLB; D Phil



Ms Joan Adams SC 62

Bluris LLB; MInstd



Mrs Lalita (Gita) Harie 67

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Dr Rendani Mbuva 35

BSc (Hons); MSc; PhD; FIA<sup>3</sup>; FASSA<sup>4</sup>; CERA<sup>5</sup>



Mr David King 62

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



Dr Dhesan Moodley 63

Masters in Metabolic, Functional and Anti-aging Medicine; MMed (Sports Science); MBChB; MBA; EDP Economics; Chartered Director (IoDSA<sup>2</sup>)



Prof Cornelius Schutte 62

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



Dr Max Price 70

MBBCh; BA; MSc; Postgraduate Diploma in Occupational Health Term ended in 2025.



Mr Marius Du Toit 63

BCom (Mathematics); FASSA<sup>4</sup> Term ended in 2025.

1. All ages are as 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.

