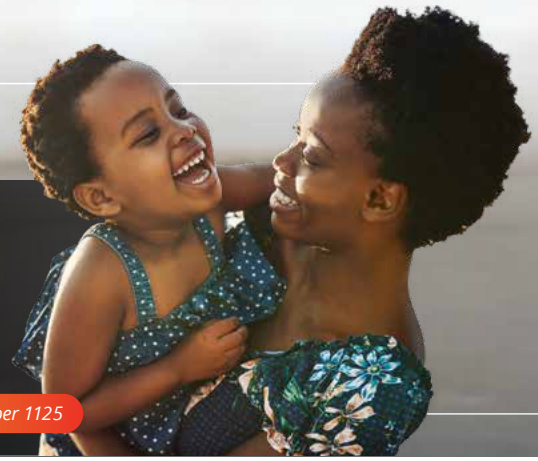

WE EXIST FOR OUR MEMBERS

Discovery Health Medical Scheme

HIGHLIGHTS OF DISCOVERY HEALTH MEDICAL SCHEME'S RESULTS 2021

Discovery Health Medical Scheme registration number 1125

This document contains highlights of the Scheme's performance for the year ended 31 December 2021, extracted from the 2021 Integrated Report. The financial information has been extracted from and is in agreement with the Annual Financial Statements, audited by PricewaterhouseCoopers Inc.

Who we are

Discovery Health Medical Scheme (DHMS or the Scheme) is a registered open medical scheme that any member of the public can join, subject to the Scheme Rules. Covering 2 784 793 beneficiaries at 31 December 2021, DHMS is the largest open medical scheme in South Africa, with an open medical scheme market share of 57.5%[1].

DHMS is a non-profit entity governed by the Medical Schemes Act (the Act)[2] and regulated by the Council for Medical Schemes (CMS). The Scheme belongs to its members and an independent Board of Trustees (the Trustees or the Board), of which the majority is member-elected, oversees its activities.

The Scheme outsources its administration and managed care functions to Discovery Health (Pty) Ltd through a formal contractual arrangement. Through our partnership with Discovery Health, and with healthcare professionals, we strive for seamless integration of services to provide quality care for our members, and the highest possible cost efficiency, in the context of severe socio-economic conditions and a fragmented and inflationary healthcare system.

Our aspirations and our goals in the work we do for our members, alongside our partners, are defined in our purpose: to meet our members' healthcare needs in an affordable, equitable and quality, value-based way now and into the future. Our approach to everything we do is strongly rooted in our 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 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 September 2021 (www.medicalschemes.co.za/wpfd_file/quarterly-report-for-30-september-2021/). At the end of 2020 there were 18 open schemes registered with the CMS, with approximately 55% of the total medical schemes market and 58 restricted schemes, with approximately 45% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately 1.9 million beneficiaries. Source: Annexures to the CMS Annual Report 2020/21.*

2 *Medical Schemes Act 131 of 1998, as amended.*

Why join DHMS?

QUALITY OF CARE IS KEY TO OUR MEMBERSHIP PROPOSITION

One of the Scheme's strategic priorities is to drive value-based healthcare, placing our members at the centre of care, an approach that reimburses healthcare professionals based on health outcomes and not only the volume of services they deliver. It gives our members access to programmes and professionals that are committed to continuous improvement in quality care.

The Scheme strives to ensure that our members have access to the safest, most efficient and effective healthcare available in South Africa. Our partnership with DH provides our members with many quality of care initiatives and innovations, which are closely monitored by the Scheme on an ongoing basis. We also empower our members with information 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'll be 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 full Integrated Report for 2021, including financial statements and related notes, is available at ***www.discovery.co.za/info/DHMSreports.***

WE MAKE SURE YOUR INVESTMENT IN MEMBERSHIP TAKES CARE OF YOU

The Scheme's income is derived only from member contributions and investment returns. The Scheme pools all contributions to fund members' claims, and any surplus funds are transferred to Scheme reserves for the security and benefit of members.

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 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.

1 *These may relate to various sources of healthcare inflation, and include uncertainty about the timing and severity of the disease burden that is expected to cause increased utilisation post-COVID-19.*

2021 EXPENSE BREAKDOWN

89.1% Claims *(2020: 76.5%)*

(1.4%) (Loss)/surplus to member reserves *(2020: 11.4%)*

9.9% Administration and managed care expenses *(2020: 9.8%)*

2.4% Financial adviser and Scheme expenses *(2020: 2.3%)*

2020 marked a radical shift in healthcare seeking behaviour, with stringent COVID-19 lockdown measures set in place by government and concerns about the risk of infection at places of care, resulting in 3.5 million fewer member claims than in 2019 and 76.5% of Scheme income funding claims (vs 87.3% in 2019). In 2021, members began utilising healthcare again, increasing the number of claims made to 54 556 179 (vs 47 675 525 in 2020) and the percentage of Scheme income spent on funding claims to 89.1%.

The Scheme's deferral of the 2021 contribution increase to 1 July 2021, providing relief to its members and passing on the benefit of excess reserves, resulted in the Scheme generating a planned negative net healthcare result for the year.

Our Principal Officer's review

In 2021, we led a concerted effort to give our members access to vaccinations as quickly as possible, in line with the Department of Health's guidelines and age-based progression. We were strongly supported by DH, who opened several mass vaccination sites, and mounted a comprehensive campaign to counter vaccine hesitancy.

At 28 February 2022, approximately 48% of our members have been fully vaccinated, with older and higher-risk members leading the way at around 80% for those over 60. I am deeply concerned, however, to see the drop off in vaccination rates and growing vaccine apathy, driven in part by misperceptions, including that infection with COVID-19 obviates the need to be vaccinated or to get a booster. Immunity from prior COVID-19 infection has a limited lifespan, and it has been comprehensively proven that vaccination decreases both asymptomatic and symptomatic infections; hospitalisation and death; and progression to Long COVID[1]. Beyond the benefits to individuals, transmission is reduced through lower and shorter infectiousness and so, the whole of society benefits[2]. Although the responsiveness to vaccines by COVID-19 variants differs, the benefits of vaccination are irrefutable.

As was the case last year, COVID-19 again created significant uncertainty for the Scheme, making planning and provisioning considerably more challenging. Utilisation continues to be lower than 2019, and reserves are therefore higher than expected. While total utilisation has reduced, there are some areas of specific concern where utilisation and costs related to the pandemic have increased materially.

These include far higher pathology costs mainly due to the volume of COVID-19 polymerase chain reaction (PCR) and antigen testing, and other tests associated with the management of the condition both in and out of hospital. Another area where utilisation and costs have risen is mental health, due to the prevalence of mental illness during the pandemic – a global phenomenon. The Scheme is paying close attention to improving access to mental health and wellbeing services, including exploring digital and self-care tools, and enhancing Scheme benefits where appropriate. Oncology programme registrations have also increased in the past year, as have the costs of novel high-cost oncology drugs, some of which the Scheme is able to partially fund on certain plans from 2022.

For the year ended 31 December 2021, DHMS delivered a negative net healthcare result of R1 165 million (2020: positive R7 451 million). This decline was mainly attributable to the delayed contribution increase for the 2021 benefit year, and the result was considerably better than expected. Worryingly, this indicated that our members continued to defer their healthcare needs during COVID-19 waves in 2021. We expect the reversal, as pent-up healthcare needs – likely exacerbated by worsened states of health due to postponing care – result in steep increases in utilisation.

The better-than-expected financial performance boosted members' funds to R30.4 billion (2020: R28.2 billion) with a solvency level of 38.01% (2020: 36.9%), exceeding the regulatory requirement of 25% by an atypically large margin. Adding to the net surplus of R2 044 million (2020: R9 006 million) for the year, was healthy investment income of R1 772 million (2020: R1 690 million), generated despite volatile and uncertain investment markets.

The latent effects of the pandemic mean that we cannot easily make reliable assumptions and must take a cautious approach in determining appropriate contribution increases to maintain the sustainability of the Scheme. We were able to delay our contribution increases to 1 October 2022, making the best use of our unusual solvency position. We were careful to do this in a way that eases the financial pressure on our members and preserves sufficient surplus in advance of the expected increase in utilisation. On balance of these imperatives, we contained the effective increase for members to 2.0% from a base of annualised rates at December 2021.

Uncertainty and challenges aside, the COVID-19 pandemic has also created opportunities to improve the healthcare system. To protect healthcare workers and patients, the adoption of virtual care increased dramatically during the year and, while finding the optimal balance of virtual versus physical care requires evolution, as does the appropriate platform, we believe that virtual care offers tremendous opportunities for access and ease of use for both patients and healthcare professionals.

We are excited to extend care at home capabilities for our members. It is entirely possible, and desirable, to deliver hospital-level care safely and effectively in a patient's home for numerous medical and surgical conditions that would otherwise require admission to hospital, subject to the recommendation of the treating physician. This eases the burden on the healthcare system, especially in times of significant disease burden, and gives comfort to members as they can remain in a familiar setting, with the support of their family, without compromising health outcomes. Qualifying members will have their care at home funded from their hospital benefit with access to relevant and appropriate care devices, medication and services, as well as a dedicated care team. This offering evolved from the home-based care provided to members, successfully treated for COVID-19 during 2021. In these cases, we saw similar or improved clinical outcomes and a better patient experience[3].

HEAR FROM OUR MEMBERS IN A VIDEO ON HOSPITAL AT HOME

In 2022, we will be launching an anaesthetic pre-operative management programme for out of hospital assessments and care for members undergoing major surgeries such as arthroplasty, colorectal surgery, coronary artery bypass graft, radical prostatectomy and mastectomy. This will promote improved health outcomes and reduce morbidity and downstream costs associated with elective surgery, where the patient was not sufficiently well and stable enough to do well with the procedure prior to the admission.

We have also been able to enhance several benefits to expand access to healthcare to more members. This includes the Assisted Reproductive Therapy Benefit, offering the Oncology Innovation Benefit on additional plans, and enhancing the Allied and Psychology Extender Benefit, the Trauma Recovery Extender Benefit and the palliative care offering.

OUR BENEFIT CHANGES FOR 2022

We continue to engage with our regulators, directly and in various industry initiatives. We await the outcome of the final report of the Section 59 Investigation into fraud, waste and abuse (FWA). The allegations made about our practices have not yet been conclusively laid to rest, despite the interim report finding no fault with them. In the interim, we have worked with DH on finding ways to further improve our processes for the management of FWA. This has included establishing a Health Professionals Reference Group to contribute to the review, development and redesign of DH's forensic investigation processes, which will be facilitated by independent professionals with healthcare management, legal and dispute resolution expertise. Improvements to the process will be based on the principle that any action taken to manage FWA by DH are fully lawful, but conducted with respect and fairness, and in a way that causes the least disruption to the majority of healthcare professionals whose practices are justifiably not subject to forensic investigation.

Our ongoing engagement alongside DH on key matters affecting the healthcare industry and its funding model continued in 2021. The Parliamentary Portfolio Committee on Health (PCH) heard presentations on the National Health Insurance (NHI) Bill during 2021, and these continued into 2022. DH presented our joint written submission to the PCH, which conveyed our full support of the principles of Universal Health Coverage and the need for structural reforms to

1 *Sources: "Duration of Protection against Mild and Severe Disease by Covid-19 Vaccines", https://www.nejm.org/doi/full/10.1056/NEJMoa2115481; "Risk factors and disease profile of post-vaccination SARS-CoV-2 infection in UK users of the COVID Symptom Study app: a prospective, community-based, nested, case-control study", https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00460-6/fulltext; "Reduced Incidence of Long-COVID Symptoms Related to Administration of COVID-19 Vaccines Both Before COVID-19 Diagnosis and Up to 12 Weeks After", https://www.medrxiv.org/content/10.1101/2021.11.17.21263608v1.*

2 *Sources: "Protection against SARS-CoV-2 after Covid-19 Vaccination and Previous Infection", https://www.nejm.org/doi/full/10.1056/NEJMoa2118691; "What is the vaccine effect on reducing transmission in the context of the SARS-CoV-2 delta variant?", https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8554481/.*

3 *For example, average length of stay was 4.1 days versus 7 days for an average COVID-19 ward admission, according to a comparison of DHMS care at home claims data versus hospital claims data. Patient-reported outcomes were also documented, and patient experience was assessed through surveys.*

improve social justice. Nonetheless, we believe there is a substantial amount of work required on the NHI Bill to avoid challenges to its Constitutionality, specifically in that it limits the right of access to healthcare and the role of medical schemes, among other potential weaknesses. We will continue to support constructive progress towards achievement of the principles expressed in our Constitution in respect of the right of access to healthcare services.

With the objective of expanding access to private healthcare, we continue to advocate for the finalisation of a framework for low-cost benefit options. This would allow medical schemes to offer these to the sizeable proportion of the population that are not currently members of schemes but that could afford these scheme options.

Following extensive industry engagement since 2017, during which both DHMS and DH made written submissions, the Department of Health issued a declaration of undesirable practices relating to designated service provider (DSP) networks in April 2021. The declaration is concerning as it hinders schemes' ability to select healthcare professionals for these networks and to ensure that members benefit from savings when using these networks, which schemes have negotiated on their behalf. In response, the Health Funders Association (HFA) has lodged a Promotion of Administrative Justice Act request to the Registrar and Council at the Council for Medical Schemes (CMS) and Department of Health to understand the basis for the declaration.

The HFA has also lodged a Section 50 Appeal regarding the declaration of undesirable business practices in relation to DSP arrangements. Consistent with our submissions to the CMS, we hold a different view to the declaration, as DSP networks are of great benefit to members. Schemes have limited ability to control healthcare costs; we – and by extension our members – are largely at the mercy of service and product pricing. When schemes construct DSPs, they do so to be able to negotiate specific rates with the healthcare professionals concerned on behalf of members. Increasingly, such arrangements also include quality of care requirements. For these networks to be viable, schemes must be able to direct their members to utilise professionals in the network, and this is achieved by the imposition of co-payments as a penalty should members choose to go outside of the network applicable to their chosen plan.

An area where DH has done excellent work to benefit our members is in the accessibility and pricing of medication. In 2021, the DH medicines team worked with the Competition Commission on six cases including Trastuzumab (Herceptin), flu vaccines, anti-coagulants in haemophilia, pharmacy networks and fee structures, and industry mergers. In 2022, the team is working with the Competition Commission on the investigation into the pricing of therapeutics for the treatment of idiopathic pulmonary fibrosis.

After several years of persistent negotiations by DH, the price of the life-saving oncology medicine, Herceptin, was reduced substantially from approximately R23 000 per treatment cycle in 2018 to less than R5 000 in 2021, and we were pleased to note that the Commission has published a finding on Herceptin in 2022.

A highlight of 2021 was the price negotiation for biologics used in the management of rheumatoid arthritis and inflammatory bowel disease. Price reductions of 20% to 43% were negotiated with pharmaceutical organisations in addition to obtaining a price freeze until the end of 2023. The Scheme will save more than R52 million in 2022, without the need to switch to biosimilar alternatives and retaining full cover on the Specialty Medicine and Technology Benefit for rheumatoid arthritis, Crohn's disease and ulcerative colitis. Key opinion leaders and prescribers in rheumatology and gastroenterology were also engaged as part of our initiative to make biologics and biosimilars more accessible to our members.

In 2022, the focus is on price negotiation of biosimilar equivalents to affordably expand access to Priority, Saver, Core and Smart plans by 2023. The medicines team collectively saved DHMS approximately R310 million in Single Exit Price negotiations in 2021. This allowed richer benefits and lower co-payments for our members, but also benefitted the entire private healthcare industry with lower-priced medicines. The Discovery Health Centre for Clinical Excellence leadership team will continue to engage with and support the South African Health Regulatory Products Authority on affordable and prioritised access to biologics and biosimilars in addition to the Medicines Pricing Committee on high-cost novelty medicines, particularly where prevailing legislation precludes affordable access.

To protect and support our employees during this period, we instituted a work from home policy at the start of the pandemic. We now look forward to a time when, protected by vaccinations and with all precautions in place, we are able to move to a hybrid work environment to maintain our culture and optimise collaboration. We expect to implement a hybrid work strategy during the course of 2022, remaining agile in response to the developments in the pandemic as well as to treatments and guidelines.

As a small and highly efficient team, I thank my colleagues for their support and hard work on behalf of the Scheme and its members. My appreciation also goes to our Trustees and Independent Committee Members whose expert counsel and oversight has steered the Scheme safely through the COVID-19 storm. I also extend a word of gratitude to our stakeholders including our members, the Council for Medical Schemes, DH and healthcare professionals.

I am deeply proud of the balance we have achieved between competing imperatives and in making difficult trade-offs, amidst the turmoil that has characterised the last two years. Our duty of care has been strongly rooted in our unwavering focus on acting in the best interests of our members, now and into the future.

C Mbewu

MS CHARLOTTE MBEWU
Principal Officer

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, which reflects the attractiveness and competitiveness of the Scheme.

- **Net membership increase 1.69%** (2020: 1.57% decrease)
- **Net beneficiary increase 0.96%** (2020: 1.77% decrease)
- **Average age at year-end[1] 36.17** (2020: 35.86)
- **Pensioner ratio[2] 11.25%** (2020: 10.98%)
- **Annualised lapse rate 5.13%** (2020: 5.19%)

MEMBERSHIP SIZE

Greater risk pooling makes for more predictable claims experiences and pricing accuracy, leading to stable performance.

- **1 353 012 Principal members**
  at 31 December 2021
  (2020: 1 330 513)
- **2 784 793 Beneficiaries**
  at 31 December 2021
  (2020: 2 758 340)
- **57.5%[3] Share of open scheme market**
  at 31 December 2020
  (2019: 57.0%)

PLAN MOVEMENTS

Low movement between plans indicates member satisfaction, stability in benefit design and appropriate pricing. For 2022:

- **96.78% Plans did not change**
  (2021: 96.44%)
- **1.77% Plans were upgraded**
  (2021: 1.96%)
- **1.45% Plans were downgraded**
  (2021: 1.60%)

RELATIVE CONTRIBUTION LEVELS

Reflects value for money for members, effective risk management and value added by the administrator and managed care provider.

- **Average contributions for 2022 14.9%**
  lower than the next six largest open schemes[4]
  (2021: 16.1%[5])

1 *An increase of less than one year per annum is favourable as it indicates that young people are joining the Scheme.*
2 *Based on beneficiaries' dates of birth.*
3 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 September 2021 (https://www.medicalschemes.co.za/wpfd_file/quarterly-report-for-30-september-2021/).*
4 *Source: publicly available contribution information for DHMS and the next six largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a single member and for a family unit comprising one principal member, one adult dependant and one child dependant (i.e. a family of three). These average contributions are then weighted (for DHMS and the next six 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.*
5 *The 2021 contribution differential previously reported (17.3%) differs from this figure due to a change in methodology. The Scheme's contributions were compared to the next eight largest schemes, however, we have now amended the calculation to include the next six largest open schemes as the contribution information of the smaller two schemes was not available at the time of calculation.*

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.

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 38.01%** (2020: 36.9%) **exceeding the statutory solvency requirement of 25%**
- **AAA** **Independent credit rating for claims paying ability[1]** (2020: AAA)

PRICING SUFFICIENCY

Surplus year-on-year reflects contribution levels that are in line with expected membership and claims. In 2021, the Scheme deferred the contribution increase to 1 July, providing relief to its members and passing on the benefit of excess reserves. The deferral of the increase resulted in the Scheme generating a negative net healthcare result for the year.

- **Net healthcare result for the year of R1 165 million negative** (2020: R7 451 million positive)
- **Net surplus for the year of R2 044 million** (2020: R9 006 million surplus)[2]

PRUDENT INVESTMENT MANAGEMENT

Ensuring that investment returns, to bolster member funds, are maximised within an acceptable and conservative level of risk.

- **Gross return on investments 10.31%** (2020: 5.77%)

VALUE-ADDED ADMINISTRATION AND MANAGED CARE

- **For every R1.00 Spent by dhms on administration and managed care fees in 2020[3], our members received R1.88** (2019: R2.03) in value from the activities of Discovery Health. This is equivalent to nominal added value of R6.40 billion in 2020 (2019: R7.09 billion).
- **Administration fees 7.33%** of gross contributions (2020: 7.23%)
- **Managed care fees 2.56%** of gross contributions (2020: 2.54%)

1 *Rating affirmed in April 2021; this refers to how many times the Scheme is able to cover its monthly claims expense with its liquid investments.*
2 *Claims experience in 2020 was substantially reduced due to deferred healthcare seeking during the COVID-19 pandemic.*
3 *As the assessment uses industry information reported by the Council for Medical Schemes (CMS), results are only available for the preceding year.*

Extracts from the audited Annual Financial Statements

STATEMENT OF FINANCIAL POSITION

AT 31 DECEMBER 2021

R'000	2021	2020
Assets		
Non-current assets	**24 719 222**	16 270 481
Property and equipment	**9 658**	11 144
Long-term employee benefit plan asset	**7 998**	6 427
Financial assets at fair value through profit or loss	**24 701 566**	16 252 910
Current assets	**16 566 181**	22 004 691
Financial assets at fair value through profit or loss	**9 987 157**	15 177 582
Derivative financial instruments	**–**	193 030
Trade and other receivables	**2 729 850**	2 625 411
Cash and cash equivalents	**3 849 174**	4 008 668
– Personal Medical Savings Accounts trust assets arising from amalgamation	**10 860**	–
– Medical Scheme assets	**3 838 314**	4 008 668
TOTAL ASSETS	**41 285 403**	38 275 172
Funds and liabilities		
Members' funds	**30 418 845**	28 215 475
Accumulated funds	**30 418 845**	28 215 475
Liabilities		
Non-current liabilities	**8 671**	9 394
Leases	**8 671**	9 394
Current liabilities	**10 857 887**	10 050 303
Leases	**1 961**	1 832
Derivative financial instruments	**–**	34 723
Outstanding claims provision	**2 257 054**	1 769 008
Personal Medical Savings Account liabilities	**7 081 549**	6 675 945
Trade and other payables	**1 517 323**	1 568 795
TOTAL FUNDS AND LIABILITIES	**41 285 403**	38 275 172

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2021

R'000	2021	2020
Risk contribution income	**62 459 297**	61 242 728
Relevant healthcare expenditure	**(56 271 074)**	(46 656 654)
Net claims incurred	**(54 399 878)**	(44 815 954)
Risk claims incurred	**(54 467 338)**	(44 957 497)
Third party claim recoveries	**67 460**	141 543
Accredited managed healthcare services (no risk transfer)	**(1 960 416)**	(1 883 081)
Net income on risk transfer arrangements	**89 220**	42 381
Risk transfer arrangement fees paid	**(271 813)**	(260 068)
Recoveries from risk transfer arrangements	**361 033**	302 449
Gross healthcare result	**6 188 223**	14 586 074
Broker service fees	**(1 438 916)**	(1 489 823)
Expenses for administration	**(5 554 748)**	(5 389 056)
Other operating expenses	**(224 677)**	(177 363)
Net impairment losses on healthcare receivables	**(135 524)**	(79 096)
Net healthcare result	**(1 165 642)**	7 450 736
Other income	**3 638 788**	1 920 700
Investment income	**1 771 609**	1 690 370
Net gains on financial assets	**1 838 553**	212 981
Sundry income	**28 626**	17 349
Other expenditure	**(428 888)**	(365 316)
Asset management fees	**(93 213)**	(78 608)
Other expenses	**–**	(2 372)
Finance costs	**(1 242)**	(1 429)
Interest paid on savings accounts	**(334 433)**	(282 907)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**2 044 258**	9 006 120

STATEMENT OF CHANGES IN FUNDS AND RESERVES

FOR THE YEAR ENDED 31 DECEMBER 2021

	2021	2020
R'000	Accumulated funds	Accumulated funds
Balance at beginning of the year	**28 215 475**	19 209 355
Total comprehensive income for the year	**2 044 258**	9 006 120
Reserves transferred from other Medical Schemes	**159 112**	
TOTAL MEMBER FUNDS END OF THE YEAR	**30 418 845**	28 215 475

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2021

R'000	2021	Restated 2020
Cash flows from operating activities		
Cash receipts from members	**75 929 680**	74 514 512
Cash received from members – contributions	**75 929 680**	74 514 512
Cash paid to providers, employees and members	**(76 660 618)**	(65 979 695)
Cash paid to providers and members – claims	**(68 596 626)**	(58 199 219)
Cash paid to providers and employees – non-healthcare expenditure	**(7 570 583)**	(7 290 880)
Cash paid to members – savings plan refunds	**(493 409)**	(489 596)
Cash generated from operations	**(730 938)**	8 534 817
Purchase of financial assets	**(8 738 440)**	(11 887 221)
Proceeds from disposal of financial assets	**7 735 859**	3 763 349
Increase in long-term employee plan asset	**(5 360)**	(3 472)
Interest received	**1 345 637**	1 534 060
Dividend income	**322 814**	156 310
Interest paid	**(4)**	(136)
Asset manager fees paid	**(93 217)**	(78 608)
Net cash (outflow)/inflow from operating activities	**(163 649)**	2 019 099
Cash flows from financing activities		
Payment of lease liabilities	**(1 832)**	(1 713)
Net cash outflow from financing activities	**(1 832)**	(1 713)
Net increase in cash and cash equivalents	**(165 481)**	2 017 386
Cash and cash equivalents at beginning of the year	**4 008 668**	1 991 282
Transfer of cash and cash equivalents due to amalgamation	**5 987**	
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR	**3 849 174**	4 008 668
Cash and cash equivalents comprise		
Personal Medical Savings Account trust assets	**10 860**	–
Medical Scheme assets	**3 838 314**	4 008 668
	3 849 174	4 008 668

Solvency

The Medical Schemes Act 131 of 1998, as amended (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 2021, the Scheme's solvency level of 38.01% (2020: 36.9%) of gross annual contributions exceeded the 25% minimum statutory solvency requirement by R9.9 billion (2020: R8.9 billion).

R'000	2021	2020
Total members' funds per Statement of Financial Position	**30 418 845**	28 215 475
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**(1 603 656)**	(686 683)
Accumulated funds per Regulation 29	**28 815 189**	27 528 792
Gross annual contribution income	**75 816 287**	74 537 501
Solvency margin = Accumulated funds/gross annual contribution income x 100	**38 01%**	36 93%

For the year ended 31 December 2021, the Net healthcare result generated a loss of R1.2 billion, a decrease of 116% compared to the year ended 31 December 2020, with total comprehensive income increasing to R2 billion after inclusion of investment and other income and expenditure. This performance increased accumulated funds by 8% to R30.4 billion with the statutory capital requirement increasing from 36.93% to 38.01%. The statutory solvency requirement exceeds the 25% minimum statutory requirement by R9.9 billion.

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 portfolio level on a fair value basis. All asset managers are remunerated based on the fair value of the portfolios under management.

The business model objective is achieved through the selling of assets per the documented 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 surplus or deficit section of the Statement of Comprehensive Income.

The fair value of the financial instruments traded in an active market is determined by using quoted market prices or dealer quotes. The fair value of financial instruments 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.

R'000	2021	2020
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:	**34 688 723**	31 430 492
− Offshore cash and bonds	**2 299 286**	1 975 533
− Equities	**7 578 533**	4 658 899
− Yield-enhanced bonds	**–**	8 871 310
– Short duration bonds	**10 604 304**	–
− Inflation-linked bonds	**–**	1 170 279
– Flexible fixed income bonds	**5 229 271**	–
− Money market instruments	**8 367 829**	14 323 269
− Property	**609 500**	431 202
	34 688 723	31 430 492
Open ended, available on demand (Included as non-current)	**24 701 566**	16 252 910
Expected to settle within 12 months (Included as current)	**9 987 157**	15 177 582
	34 688 723	31 430 492

Pursuant to the Scheme's financial position and excess solvency, the Scheme does not anticipate to liquidate the offshore, equities and properties portfolios.

Reconciliation of the balance at the beginning of the year to the balance at the end of the year:

R'000	2021	2020
At the beginning of the year	**31 430 492**	23 191 456
Acquisitions	**8 841 598**	11 887 221
Disposals	**(7 582 315)**	(3 470 050)
Transfer due to amalgamation	**155 632**	–
Net gains/(losses) on revaluation of financial assets at fair value through profit or loss (Note 24)	**1 843 316**	(178 135)
AT THE END OF THE YEAR	**34 688 723**	31 430 492

A register of investments is available for inspection at the registered office of the Scheme.

Personal Medical Savings Account liabilities

ACCOUNTING POLICY:

The Scheme Rules for PMSAs were amended, effective from 1 January 2018. The effect of the amendment is that a trust relationship is no longer established. Prior to the 2018 reporting period, PMSA's were disclosed as trust liabilities. From 1 January 2018 the Scheme rules have been amended to no longer establish a trust relationship, therefore no longer requiring the disclosure as a trust liability.

Members' PMSAs represent savings contributions (which are a deposit component of the insurance contracts), and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered Rules. The deposit component has been unbundled since the Scheme can measure the deposit component separately and the Scheme's accounting policies do not otherwise require recognition of all obligations and rights arising from the deposit component.

The savings accounts contain a demand feature and are initially measured at fair value plus transaction costs, which is the amount payable to a member on demand, discounted from the first date that the amount could be required to be paid. Subsequent to initial measurement, the liability is measured at amortised cost using the effective interest rate method.

Unspent savings at year-end are carried forward to meet future expenses for which the members are responsible. In terms of the Act, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

Advances on savings contributions are funded from the Scheme's funds and the risk of impairment is carried by the Scheme.

Interest payable on members' PMSAs is expensed when incurred.

Unclaimed PMSA balances that have prescribed, that is funds older than three years, are written back and included under "Sundry income" on the face of the Statement of Comprehensive Income.

Note:

R'000	2021	2020
Balance on Personal Medical Savings Accounts at the beginning of the year	**6 675 945**	5 522 613
Add:		
Personal Medical Savings Accounts contributions received or receivable (Note 11)	**13 356 990**	13 294 773
Interest on Personal Medical Savings Accounts (Note 26)	**334 433**	282 907
Transfers received from other medical schemes	**19 618**	16 479
Savings plan liabilities transferred to the scheme upon amalgamation	**11 165**	–
Less:		
Claims paid to or on behalf of members (Note 12)	**(12 823 100)**	(11 785 757)
Refunds on death or resignation	**(493 293)**	(487 217)
Unclaimed Personal Medical Savings Accounts written off to scheme funds (Note 25)	**(116)**	(2 379)
COVID-19 Support: Contributions funded from PMSA	**(93)**	(165 474)
BALANCE DUE TO MEMBERS ON PERSONAL MEDICAL SAVINGS ACCOUNTS AT THE END OF THE YEAR	**7 081 549**	6 675 945

It is estimated that claims to be paid out of members' PMSAs in respect of claims incurred in 2021 but not reported will amount to approximately R94m (2020: R124m) (Note 7).

PMSAs contain a demand feature and members can call on the funds at any time and these balances are categorised as "Available on demand". At 31 December 2021, the carrying amount of members' PMSAs were deemed to be equal to their fair values, which is the amount payable on demand.

Interest is determined from time to time by the Scheme at its discretion and added to the funds allocated to the member's PMSA in terms of the Scheme Rules. The Scheme does not charge interest on negative (overdrawn) PMSA balances.

The Scheme introduced the payment of contributions from positive MSA balances to assist in the adverse impact of COVID-19 on its stakeholders. Individual member contributions that were offset against Personal Medical Savings Accounts amounted to R93k (2020: R165m). The Council for Medical Schemes (CMS) granted DHMS exemption on 9 April 2020 for a period of three months effective from 1 April 2020. An extension of the exemption was granted on 4 November 2020 for the period up to 31 December 2020.

OPERATIONAL STATISTICS PER BENEFIT PLAN

FOR THE YEAR ENDED 31 DECEMBER 2021

2021

	EXECUTIVE	CLASSIC				ESSENTIAL			
		COMP	CORE	SAVER	PRIORITY	COMP	SAVER	CORE	PRIORITY
Number of members at the end of the accounting period	7 927	105 496	46 937	316 368	74 947	12 235	154 565	50 719	5 075
Number of beneficiaries at the end of the accounting period	16 027	223 204	101 414	694 333	164 791	22 121	330 891	111 202	10 129
Average number of members for the accounting period	7 998	108 031	47 114	315 143	76 126	12 338	148 344	49 211	5 051
Average number of beneficiaries for the accounting period	16 306	229 611	102 019	692 010	167 543	22 400	317 558	107 799	10 151
Average risk contributions per member per month (R')	9 455.29	7 606.24	4 337.87	4 092.64	5 129.41	6 489.40	3 372.66	3 428.50	4 626.75
Average risk contributions per beneficiary per month (R')	4 638.05	3 578.70	2 003.31	1 863.80	2 330.63	3 574.32	1 575.51	1 565.12	2 302.38
Average net claims incurred per member per month (R')	11 106.92	7 726.02	3 497.81	3 386.06	4 631.16	6 062.97	2 371.16	2 646.87	3 289.29
Average net claims incurred per beneficiary per month (R')	5 448.22	3 635.06	1 615.35	1 542.02	2 104.24	3 339.45	1 107.67	1 208.30	1 636.83
Average administration costs per member per month (R')	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41	376.41
Average administration costs per beneficiary per month (R')	184.64	177.10	173.83	171.42	171.03	207.32	175.84	171.83	187.31
Average managed care: Management services per member per month (R')	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87	120.87
Average managed care: Management services per beneficiary per month (R')	59.29	56.87	55.82	55.05	54.92	66.58	56.47	55.18	60.15
Average family size	2.02	2.12	2.16	2.19	2.20	1.81	2.14	2.19	2.00
Loss ratio (%)	118.78%	103.22%	83.43%	85.71%	92.67%	95.34%	73.90%	80.74%	73.72%
Total non-healthcare expenses as a percentage of risk contributions (%)	5.20%	6.52%	11.03%	12.04%	9.66%	7.68%	14.29%	13.78%	10.65%
Average non-healthcare expenses per member per month	492.14	495.57	478.42	492.84	495.43	498.53	482.00	472.51	492.86
Average non-healthcare expenses per beneficiary per month	241.41	233.16	220.94	224.44	225.11	274.59	225.16	215.70	245.26
Average age of beneficiaries (years)	47.46	44.51	41.73	35.49	41.09	50.36	32.76	38.87	40.04
Pensioner ratio (beneficiaries over 65 years)	28.52%	22.41%	18.11%	9.94%	16.68%	34.28%	7.12%	14.16%	15.16%
Average relevant healthcare expenses per member per month	11 231.46	7 851.03	3 619.21	3 507.62	4 753.23	6 186.96	2 492.51	2 768.28	3 411.01
Average relevant healthcare expenses per beneficiary per month	5 509.31	3 693.88	1 671.42	1 597.38	2 159.71	3 407.74	1 164.36	1 263.72	1 697.40
Net surplus/(deficit) per benefit plan	(200 506)	(728 149)	255 589	1 025 293	54 328	(2 564)	1 027 975	236 171	54 669

2021

	COASTAL		KEYCARE			CLASSIC SMART COMP	SMART		TOTAL
	SAVER	CORE	PLUS	CORE	START		CLASSIC	ESSENTIAL	
Number of members at the end of the accounting period	169 966	73 193	211 492	16 903	6 026	454	55 372	45 337	**1 353 012**
Number of beneficiaries at the end of the accounting period	380 185	165 129	365 033	28 462	7 812	874	110 256	52 930	**2 784 793**
Average number of members for the accounting period	170 788	73 919	209 431	16 153	5 815	446	52 524	41 391	**1 339 822**
Average number of beneficiaries for the accounting period	382 386	166 860	362 434	26 949	7 527	883	104 546	48 119	**2 765 100**
Average risk contributions per member per month (R')	3 716.18	3 681.13	2 211.90	1 842.82	1 411.87	7 653.41	3 204.54	1 710.20	**3 884.80**
Average risk contributions per beneficiary per month (R')	1 659.78	1 630.74	1 278.14	1 104.59	1 090.74	3 863.53	1 609.95	1 471.07	**1 882.37**
Average net claims incurred per member per month (R')	3 219.97	3 259.92	2 196.63	1 471.40	843.38	4 314.71	2 439.80	1 021.70	**3 383.53**
Average net claims incurred per beneficiary per month (R')	1 438.16	1 444.15	1 269.31	881.96	651.55	2 178.12	1 225.75	878.84	**1 639.48**
Average administration costs per member per month (R')	376.41	376.41	203.98	109.47	203.98	376.41	376.41	376.41	**345.49**
Average administration costs per beneficiary per month (R')	168.12	166.75	117.87	65.62	157.58	190.02	189.11	323.78	**167.41**
Average managed care: Management services per member per month (R')	120.87	120.87	120.13	120.13	120.13	120.87	120.87	120.88	**120.75**
Average managed care: Management services per beneficiary per month (R')	53.99	53.55	69.42	72.01	92.81	61.02	60.73	103.97	**58.51**
Average family size	2.24	2.26	1.73	1.68	1.30	1.93	1.99	1.17	**2.06**
Loss ratio (%)	89.91%	91.85%	103.29%	86.36%	65.48%	58.00%	79.92%	66.82%	**90.09%**
Total non-healthcare expenses as a percentage of risk contributions (%)	13.14%	12.96%	12.70%	9.54%	18.45%	6.44%	14.70%	25.80%	**11.56%**
Average non-healthcare expenses per member per month	488.45	476.93	280.98	175.75	260.48	492.77	470.93	441.20	**457.39**
Average non-healthcare expenses per beneficiary per month	218.16	211.28	162.36	105.34	201.24	248.76	236.60	379.51	**221.63**
Average age of beneficiaries (years)	36.58	40.60	31.27	35.54	35.56	42.66	32.26	35.46	**36.17**
Pensioner ratio (beneficiaries over 65 years)	10.67%	16.02%	8.17%	13.18%	8.95%	18.13%	5.31%	4.72%	**11.25%**
Average relevant healthcare expenses per member per month	3 341.30	3 381.26	2 284.78	1 591.53	924.43	4 439.11	2 560.93	1 142.69	**3 499.91**
Average relevant healthcare expenses per beneficiary per month	1 492.35	1 497.90	1 320.25	953.96	714.17	2 240.92	1 286.61	982.91	**1 695.87**
Net surplus/(deficit) per benefit plan	133 761	30 779	(356 593)	55 758	30 648	15 697	242 855	168 544	**2 044 255**

MATTERS OF NON-COMPLIANCE
FOR THE YEAR ENDED 31 DECEMBER

Circular 11 of 2006 (the Circular) 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 2021, the Scheme did not comply with the following Sections and Regulations of the Act.

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.

For the year ended 2021 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net (deficit)/ surplus (R'000)
Executive	**(218 517)**	**(200 506)**
Classic Comprehensive	**(970 676)**	**(728 148)**
Classic Priority	**(116 613)**	**54 327**
Essential Comprehensive	**(30 278)**	**(2 564)**
Coastal Core	**(164 519)**	**30 778**
Coastal Saver	**(249 999)**	**133 760**
KeyCare Plus	**(910 471)**	**(356 593)**

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 on the sustainability of plans has to 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 the 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.

In addition, DHMS continually provides the CMS with updates on both the Scheme and individual benefit option performance through the 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. CMS has granted DHMS exemption for a period of three years effective from 1 December 2019.

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 period of three years effective from 1 December 2019.

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 the suspension of membership for non-payment.

BROKER FEES PAID

In terms of Regulation 28 (5) of the Act, broker fees shall be paid on a monthly basis on receipt by a medical scheme of the relevant monthly contribution in accordance with the maximum amount payable per Regulation 28 (2), limited to one broker as required by Regulation 28 (8).

In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible and represents less than 0.01% of the total broker fees paid for the year. The exceptions relate to transactions that do not occur frequently and the administrator has developed exception reporting to identify and correct these transactions, and has a well-established claw-back system to rectify commission overpayments.

PRESCRIBED MINIMUM BENEFITS

Section 29 (1) (o) and Regulation 8 provide the scope and level of minimum benefits that the Scheme must provide to members and dependants. During the year under review there were isolated instances where the Scheme did not pay claims in accordance with the scope and level of minimum benefits. The claims are being reprocessed to ensure that they are correctly paid.

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 were claims were not paid within 30 days. These represent less than 1% 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 the 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 inadvertently went into an overdrawn position due to the timing of inflows from the Scheme's investments not matching the timing of outflows. Additional processes have been implemented to mitigate the risk of this re-occurring.

COVID-19 INITIATIVES

The Scheme introduced specific initiatives to support stakeholders in managing the adverse impact of COVID-19. For the Scheme to offer these initiatives, exemption from the following provisions of the Act were obtained from the CMS:

PAYMENT OF CONTRIBUTIONS FROM POSITIVE PERSONAL MEDICAL SAVINGS ACCOUNT BALANCES

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. Regulation 10 (3) of the Act states that funds deposited in a member's personal medical savings account shall be available or the exclusive benefit of the member and his or her dependants but may not be used to offset contributions. Individual member contributions that were offset against Personal Medical Savings Accounts amounted to R93k resulting from late applications.

The CMS granted DHMS a three-month exemption on 9 April 2020 effective from 1 April 2020. An extension was granted on 4 November 2020 up to 31 December 2020.

MID-YEAR CONTRIBUTIONS COMMUNICATION ERROR AND FAILURE

The Medical Schemes Act, Section 57 (4) (d), requires that members must be informed of their rights, benefits, contributions, and duties in terms of the rules of the medical scheme. DHMS Rule 15.2 stipulates those members must be informed of changes in benefits or contributions at least 30 days before such change is affected.

DHMS mid-year contribution increase notifications were e-mailed on 28 May 2021. The link in the notification e-mail, to opening the increase letter, displayed an error message, resulting in some members not being able to view the content of the letter.

Apology notifications were sent to the affected members on 17 June 2021 with a new link.

The affected members received updated contribution letters and additional processes have been implemented to mitigate the risk of this re-occurring.

INCORRECT SUSPENSION OF DHMS MEMBERS

The Medical Schemes Act, Section 29 (2), states that a medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependents, except on certain grounds.

Electronic Funds Transfer (EFT) payments received in December 2021 did not reflect on the pay or transaction query, due to a system error, which resulted in 722 members being incorrectly suspended. Members who were incorrectly suspended were unsuspended. Apology calls were made to the affected members, and they were provided with confirmation that the allocation was corrected.

Our Trustees[1]

MR JOHN BUTLER SC (55)
B.Com, LLB, MA (Senior Counsel, Member of the Cape Bar)
Chairperson (from 1 January 2022)

MS JOAN ADAMS SC (58)[2]
B.IURIS LLB; (FP) SA[3]

DR SUSETTE BRYNARD (65)
BSc (Sciences); PhD (Education)

MRS LALITA (GITA) HARIE (63)
BA (Social Work), BA (Hons) Social Science (Psychology), Certified Director (IoDSA)

MR JOHAN HUMAN (51)
B.Bus.Sc; FIA[4]; FASSA[5]

MR DAVID KING (58)
BSc (Hons); MBA; Health Risk Management and Managed Care Certificate

DR DHESAN MOODLEY (59)
Masters in Metabolic, Functional and Anti-aging Medicine; MMed (Sports Science); MBChB; MBA; EDP Economics

MR NEIL MORRISON (65)
BSc (Hons) Physics; MA (Economics)
Chairperson (until 31 December 2021)

1 All ages are at 31 December 2021.
2 Ms Adams' term ended in August 2021.
3 Forensic Practitioner, South Africa.
4 Fellow of the Institute of Actuaries UK.
5 Fellow of the Actuarial Society of South Africa.

Discovery Health Medical Scheme
2022 Annual General Meeting Notice

Discovery Health Medical Scheme ("DHMS"/"the Scheme") will hold its Annual General Meeting ("AGM") virtually on 23 June 2022. Members are invited to attend the Scheme's AGM.

TRUSTEE ELECTIONS AND NOTICE OF THE AGM

Date: Thursday, 23 June 2022

Venue: Virtual Meeting (via the Lumi online platform)

Meeting time: 09:00

Registration: Online registration will open at 09:00 on 23 May 2022 and will close at 18:00 on 17 June 2022. Registrations will not be accepted after the closing date and time. Members who do not register will not be able to participate at the meeting.

THE AGENDA FOR THE MEETING IS AS FOLLOWS:

1. Welcome and quorum
2. Minutes of the 2021 Annual General Meeting – for approval
3. Tabling of the 2021 Integrated Report, including the Scheme's Financial Statements for the year ended 31 December 2021

3.1. Presentation by the Principal Officer of the Scheme

3.2. Presentation by the CEO of Discovery Health (Pty) Limited, the Administrator and Managed Care Organisation of the Scheme

4. Governance

4.1. The Scheme's Trustee Remuneration Policy and approval of the 2022 Trustee Remuneration

4.2. Appointment of Auditors

5. Motions
6. General
7. Voting and closure of the AGM

7.1. 2022 Trustee Remuneration

7.2. Non-binding Advisory vote on the Trustee Remuneration Policy

7.3. Appointment of Auditors

7.4. Motions

7.5. Election of Trustees

PLEASE REGISTER YOUR ATTENDANCE ONLINE

1. Please register **here** to attend, participate and vote at the AGM.
2. Principal Members attending the AGM will be required to provide the following information to be able to register their attendance and cast their vote:

2.1 full name(s) and surname (as per identity document)

2.2 identity (or passport) number

2.3 email address

2.4 mobile phone number

2.5 DHMS membership number

3. Principal Members whose registration requests have been successfully approved will receive an email from Lumi with a link to the live streaming facility and user credentials, including a link to an instructional video on how to navigate the virtual platform.

Please note: by registering your attendance on the Lumi system, you give Lumi Technologies SA Pty Ltd consent to process your personal information on behalf of the Scheme for purposes of ascertaining your membership status with the Scheme and establishing your eligibility to attend, participate and vote at the AGM.

PLEASE ATTEND THE AGM OR NOMINATE A PROXY

Every Principal Member who is in good standing and who is present virtually at the AGM has the right to vote. If you are unable to attend the Scheme's AGM, you may nominate a proxy (another Principal Member authorised to attend, speak and vote on your behalf) by completing a proxy form. Only Principal Members in good standing (contributions not in arrears) may appoint another Principal Member, who must also be in good standing, as a proxy.

SUBMIT YOUR PROXY ON TIME

A Principal Member wishing to appoint a proxy to attend the AGM and vote on their behalf must personally request a proxy form from Deloitte & Touche ("Deloitte"), the Independent Electoral Body ("IEB"), at **za_dhmselections2022@deloitte.co.za** or by calling **0800 362 555**.

Please note that each proxy form has unique security features and will be issued against the requesting Principal Member's (proxy giver's) name. A Principal Member who is in good standing and unable to attend the AGM may appoint **only one** proxy to attend, speak and vote on his/her behalf. A Principal Member in good standing attending the AGM may be appointed as proxy by more than one Principal Member, to attend, speak and vote on their behalf. Communication relating to the proxy appointment request will be directed to the proxy giver only.

Any deletions/corrections on the proxy form will not be accepted and will render the proxy form "spoilt". A photocopy of any original proxy form that has already been submitted will render the photocopied proxy form a duplicate form, and therefore an invalid proxy form. If you inadvertently spoil your proxy form, please contact the IEB to issue a replacement proxy form.

All information required on the proxy form must be completed. The proxy form must be signed by both parties (the Principal Member appointing the proxy and the Principal Member appointed as proxy). Failure to do so will invalidate the proxy form. Please also note that the IEB will not accept proxy forms with electronic signatures. The proxy giver will therefore have to print out the proxy form that he/she received from the IEB, complete the details required in the form by hand (in block letters), sign the proxy form, as well as obtain the proxy's signature on the form.

The IEB shall screen the completed proxy forms and shall determine their validity, prior to the AGM.

Proxy forms must reach the IEB by no later than **09:00 on 16 June 2022**. Any proxy forms received after this date and time will be invalid.

SUBMITTING A MOTION

The Rules of Discovery Health Medical Scheme require that notices of motions to be placed before the AGM, reach the Principal Officer no later than **14 clear days** prior to the date of the meeting. For purposes of the submission of a motion, reference to a clear day contemplates a 24 hour day beginning and ending at midnight. Below is a guideline that will help you construct your motion in line with Rules 25.1.6 and 25.1.7 of the Scheme Rules.

1. Only a Principal Member in good standing may submit a motion. The Principal Member should present his/her motion at the AGM either personally or by means of a valid proxy.
2. Motions must be framed in terms that are definite, concise and free from ambiguity. A detailed motivation shall accompany the motion. Without a detailed motivation the motion will not be valid.
3. The Principal Member concerned shall first be required to engage with the Scheme/Trustees in good faith on the subject of his/her intended motion.
4. A motion may not deal with matters affecting the operations of the Scheme, or matters that fall beyond the scope of the AGM, and include matters that affect how the Trustees may exercise their fiduciary or statutory duties, that fetter the Trustees' discretion or compel/instruct the Trustees to act (whether by commission or omission) in a predetermined manner, and where the proposed motion would be inconsistent with or in contravention of the Medical Schemes Act or these Rules.
5. A motion must be for the benefit of and/or in the best interest of the Scheme and its Members.
6. All motions received by the Principal Officer will be evaluated by the Board, based on the above guidelines and only valid motions will be put to the meeting.

MOTIONS CAN BE SUBMITTED AS FOLLOWS:

- emailed to **dhmsmotions2022@discovery.co.za** or
- posted to The Principal Officer, Discovery Health Medical Scheme, PO Box 786722, Sandton, 2146

Motions have to reach the Principal Officer by no later than **12:00 midnight on 08 June 2022**. Without a detailed motivation the motion will not be valid. Any motions received after this date and time will be invalid. Please consider potential delays you may experience using the South African postal services, which could result in your motion not reaching the Principal Officer before the closing date and time.

The minutes of the 2021 Annual General Meeting, the summary of the Scheme's Trustee Remuneration Policy and the 2022 proposed Trustee Remuneration are available on **https://www.discovery.co.za/medical-aid/notices.**

Discovery Health Medical Scheme

Contact Centre 0860 99 88 77 | healthinfo@discovery.co.za | www.discovery.co.za

Discovery
Health Medical Scheme