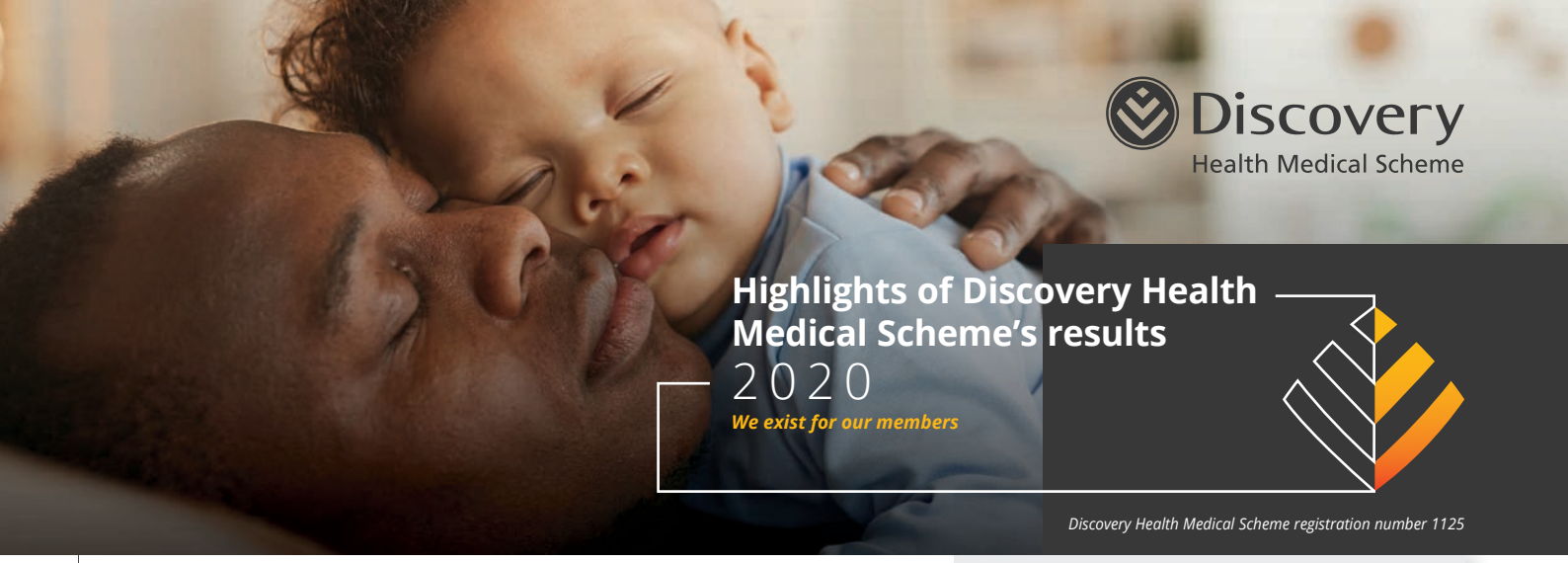


Discovery
Health Medical Scheme

# Highlights of Discovery Health Medical Scheme's results 2020

*We exist for our members*

*Discovery Health Medical Scheme registration number 1125*

***This document contains highlights of the Scheme's performance for the year ended 31 December 2020, extracted from the 2020 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 2 758 340 beneficiaries at 31 December 2020, DHMS is the largest open medical scheme in South Africa, with an open medical scheme market share of 57.0%[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) 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 providers, we strive for 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.

## 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, this approach reimburses providers based on health outcomes and not only the volume of services they deliver. It gives our members access to programmes and providers 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 Discovery Health 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

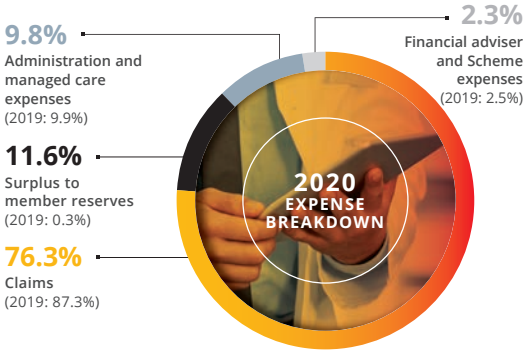
Financial strength and sustainability are key factors to consider when selecting a medical scheme. Sound financial control and risk management enable the Scheme to maintain its required solvency reserve levels, which ensures its ability to pay claims even when they are unexpectedly high.

### 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. 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 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.




In 2019, 87.3% of income funded claims. In 2020 this declined to 76.3%, reflecting less healthcare-seeking behaviour during the COVID-19 pandemic; DHMS received over 3.5 million fewer member claims in 2020. This unprecedented circumstance was also reflected in the increased surplus for 2020.

1 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 September 2020 (www.medicalschemes.co.za/publications/#2009-2010-wpfd-annual-reports).*

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

*The full Integrated Report for 2020 is available at* ***www.discovery.co.za/info/DHMSreports****.*

# Our Principal Officer's review of the year

*Our unwavering focus on our purpose, and knowing that we exist for our members, held us in strong stead amid the devastation caused by the COVID-19 pandemic. This inspired us to find effective and innovative ways to support and care for our members in unprecedented circumstances.*

The Scheme, working closely with Discovery Health, introduced innovative initiatives and expanded benefits in response to COVID-19. We extended the WHO Global Outbreak Benefit, adding to this basket of care as new understanding and developments in diagnostic testing, treatment and care became available. For members who could not self-isolate at home, we provided dedicated facilities and services in an effort to reduce the spread of the disease. Healthcare workers were available to assist members with symptom management and monitoring in these facilities. We also made pulse oximeters (devices to track oxygen saturation levels) available to high-risk members, which decreased mortality rates. By leveraging digital platforms we were able to meet the needs of our members, while keeping them and their doctors as safe as possible.

The pandemic required a shift in care models. We rapidly facilitated the move to digital health and a shift from hospital to outpatient care settings, including home-based. Strong adoption of the virtual facilities we made available motivated the launch of Connected Care, an ecosystem of benefits, services and connected digital capabilities to help our members manage their health and wellness at home. While our members still have access to hospital facilities when needed, the success of our Day Surgery Network and the adoption of virtual consultations indicate the effectiveness of these new care models in meeting specific healthcare needs in a changing care environment. In assessing the value of these new services, we continue to ensure that they support optimal healthcare outcomes.

Heightened awareness of the criticality of managing chronic conditions, strongly implicated in morbidity and mortality related to COVID-19, have reinforced the importance of screening and promotion of health-seeking behaviour, which will support the expansion of our care programmes. The demographic profile of our members has gradually worsened over the last several years, exacerbating health risk for members as new diseases emerge. Ongoing health management through managed care will therefore remain a cornerstone of our approach.

Besides these specific benefits, the impact of the pandemic on the affordability of cover prompted the Scheme to assist members and employers in financial difficulty. Qualifying members with positive balances in their medical savings accounts could use these to cover their contributions, and qualifying SMMEs could defer employee contributions for a specified period.

More broadly, and also likely to be exacerbated by the longer-term socio-economic impact of the pandemic, mental wellbeing is a growing concern for the Scheme. This has been underlined as claims associated with mental health conditions continue to increase, consistent with the global trend. In 2020, the Scheme expanded the benefits for major depression, beyond the prescribed minimum, to include chronic medicines funded from the risk benefit. Recognising that certain people suffering from depression tend to require re-admission to care facilities, we have enhanced the mental health disease management programme to encompass more comprehensive and holistic care co-ordination.

Other benefits introduced in 2021 include a Spinal Care Programme and a colorectal surgery centre of excellence. Both of these aim to improve outcomes in these common and often devastating health events. We have also introduced a continuous glucose monitoring benefit, and enhanced access to coaching and management, for members registered on our Diabetes Care management programmes. Diabetes, if untreated, can result in blindness, kidney failure and heart attacks and our care programme aims to protect against these complications. The telemetric glucose monitoring devices can also monitor conditions like chronic obstructive pulmonary disease, congestive cardiac failure and pneumonia, so this benefit extends to members with these conditions. We have also launched an assisted reproductive therapy benefit in 2021, available to members depending on the plan they have chosen.

The Scheme engages frequently and constructively with our regulators and policymakers for positive change in our industry, and to co-create a stronger national healthcare system. We are grateful for the support we received from the CMS, especially during the pandemic, which enabled us to quickly introduce measures to support our members. We also note that the Minister of Health's performance scorecard includes specific targets and deadlines to achieve universal health coverage and to oversee the implementation of the Presidential Health Compact interventions, designed to strengthen the healthcare system. We applaud the drive by the Department of Health to achieve these imperatives, to the benefit of all South Africans.

We look forward to resuming our engagements on the NHI Bill, and hope to present to the Portfolio Committee on Health. We also note the Portfolio Committee's interest in the investigation into allegations of racial discrimination and unfair practices by medical schemes and administrators related to combatting fraud, waste and abuse in our industry.

Discovery Health submitted a response to the interim report on 5 April 2021, and we await the final report and recommendations. We welcome the Investigation Panel's findings that no evidence of any bias, racial or otherwise, was found in the processes and systems employed by Discovery Health on the Scheme's behalf, and its recommendation that no changes to the Medical Schemes Act are needed regarding the powers of schemes to recover member funds fraudulently disbursed. We also welcome the Panel's acknowledgement of the serious adverse consequences of FWA on medical scheme members' funds, the affordability of healthcare insurance cover and the broader South African health system.

The impact of the COVID-19 pandemic and related national lockdowns were, unsurprisingly, the most notable factors affecting the Scheme's financial performance in the year. The Scheme experienced a net decline in membership of 1.57% in 2020 and only marginal growth of 0.06% in 2019, reflecting the weak economic conditions and the contraction of the employment market even before the advent of the pandemic. In 2020, in line with the experience of other medical schemes, utilisation dropped substantially, as non-urgent hospitalisation was postponed or cancelled. This resulted in a net surplus for the year of R9 006 million (2019: R1 563 million), based on a positive net healthcare result of R7 451 million (2019: R136 million) and investment income of R1 690 million (2019: R1 698 million). The Scheme's solvency level remains healthy at 36.93%. This has allowed the Scheme to defer its annual increase to July 2021, but necessitates careful forecasting and planning for the next two to three years given that utilisation is expected to return to prior levels, and possibly with a mix of more severe cases.

In 2021, we look forward to an amalgamation with Quantum Medical Aid Society (QMAS). The CMS has approved the exposition of the amalgamation documents and Competition Commission approval is underway, following which members will be asked to approve the amalgamation at a Special General Meeting[1]. Amalgamating with QMAS bodes well for the Scheme in light of QMAS's demographic profile and reserves. This means that adding its approximately 3 200 members will not dilute DMHS's reserves.

Mrs Joy Malete was appointed as our Chief Financial Officer from 12 April 2021, and we are delighted to have a person of her calibre join the Scheme Office team.

The support of my team, the Trustees and our Independent Committee Members, and our administrator and managed care provider, Discovery Health, has been invaluable this year. Together, we have enabled the Scheme to assist our members in weathering the COVID-19 storm. This has tested our promise to our members, and our other stakeholders, to not only provide best practice governance but also thought leadership in our industry. We have demonstrated our ability to move quickly and innovatively to meet and exceed the healthcare needs of our members. We have also, I believe, supported the country's effective management of the pandemic and given credence to our commitment to assist in building a better healthcare system for all South Africans.

Challenges will no doubt continue into the future, but the Scheme is in robust health and our members can be assured of our unwavering dedication to fulfilling our purpose and working hard to realise our vision.

C Mbewu

MS CHARLOTTE MBEWU
**Principal Officer**

*1 At the time of publishing this report, approval for the amalgamation had been obtained from the Competition Commission and the CMS.*

## 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 to be 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.

**AVERAGE BENEFICIARY DECLINE**[1] **1.77%** (2019: 0.39% decline)

**AVERAGE NET MEMBERSHIP DECLINE**[1] **1.57%** (2019: 0.06% growth)

**AVERAGE AGE AT YEAR-END**[2] **35.86** (2019: 35.33)

**PENSIONER RATIO**[3] **10.98%** (2019: 10.35%)

**ANNUALISED LAPSE RATE** **5.19%** (2019: 5.41%)

#### MEMBERSHIP SIZE

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

**PRINCIPAL MEMBERS** **1 330 513** at 31 December 2020 (2019: 1 351 720)

**BENEFICIARIES** **2 758 340** at 31 December 2020 (2019: 2 808 106)

**SHARE OF OPEN SCHEME MARKET**[4] **57.0%** (2018: 56.7%)

#### PLAN MOVEMENTS

Low movement between plans indicates member satisfaction, stability in benefit design and appropriate pricing. For 2021:

**PLANS DID NOT CHANGE** **96.44%** (2020: 94.27%)

**PLANS WERE UPGRADED** **1.96%** (2020: 2.81%)

**PLANS WERE DOWNGRADED** **1.60%** (2020: 2.91%)

#### 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 2021** **17.3%** lower than the next eight largest open schemes[5] (2020: 16.7%)

*1 Membership growth across medical schemes is currently affected by affordability and a challenging economic climate, including job losses.*

*2 An increase of less than one year per annum is favourable as it indicates that young people are joining the Scheme.*

*3 Based on beneficiaries' dates of birth.*

*4 Based on beneficiaries, according to the Council for Medical Schemes Quarterly Report for the period ended 30 September 2020 (www.medicalschemes.co.za/publications/#2009-2010-wpfd-annual-reports).*

*5 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 eight 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. The data is sourced from published contributions for 2021 and uses a maximum average contribution increase of 2.95% for DHMS in 2021 (0% for the first six months of 2021, and a maximum of 5.9% for the second six months).*

## 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 financial strength and management outcomes metrics for the Scheme is presented below, together with an explanation of why we consider these to be 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 36.9%** (2019: 27.5%) 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.

**NET SURPLUS FOR THE YEAR OF**[2] **R9 006 million** (2019: R1 563 million)

#### 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 5.77%** (2019: 7.02%)

#### VALUE-ADDED ADMINISTRATION AND MANAGED CARE

**FOR EVERY R1.00 SPENT BY DHMS ON ADMINISTRATION AND MANAGED CARE FEES IN 2019**[3]**, OUR MEMBERS RECEIVED R2.03** (2018: R2.12) in value from the activities of Discovery Health. This is equivalent to nominal added value of R7.09 billion in 2019 (2018: R7.34 billion)

**ADMINISTRATION FEES**
**7.23%** of gross contributions (2019: 7.38%)

**MANAGED CARE FEES**
**2.54%** of gross contributions (2019: 2.53%)

1 *Rating affirmed in April 2021, and 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, results are only available for the preceding year.*

# Extracts from the audited Annual Financial Statements

## STATEMENT OF FINANCIAL POSITION

AT 31 DECEMBER 2020

| R'000 | 2020 | 2019 |
|---|---|---|
| **ASSETS** | | |
| *Non-current assets* | **16 270 481** | 18 426 |
| Property and equipment | **11 144** | 12 630 |
| Long-term employee benefit plan asset | **6 427** | 5 796 |
| Financial assets at fair value through profit or loss | **16 252 910** | – |
| *Current assets* | **22 004 691** | 27 818 342 |
| Financial assets at fair value through profit or loss | **15 177 582** | 23 191 456 |
| Derivative financial instruments | **193 030** | 75 179 |
| Trade and other receivables | **2 625 411** | 2 560 425 |
| Cash and cash equivalents | **4 008 668** | 1 991 282 |
| **Total assets** | **38 275 172** | 27 836 768 |
| **FUNDS AND LIABILITIES** | | |
| *Members' funds* | **28 215 475** | 19 209 355 |
| Accumulated funds | **28 215 475** | 19 209 355 |
| **LIABILITIES** | | |
| *Non-current liabilities* | **9 394** | 9 933 |
| Leases | **9 394** | 9 933 |
| *Current liabilities* | **10 050 303** | 8 617 480 |
| Leases | **1 832** | 1 713 |
| Derivative financial instruments | **34 723** | 14 689 |
| Outstanding claims provision | **1 769 008** | 1 526 497 |
| Personal Medical Savings Account liabilities | **6 675 945** | 5 522 613 |
| Trade and other payables | **1 568 795** | 1 551 968 |
| **Total funds and liabilities** | **38 275 172** | 27 836 768 |

# STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2020

| R'000 | 2020 | 2019 Restated |
|---|---|---|
| **Risk contribution income** | **61 242 728** | 57 222 228 |
| **Relevant healthcare expenditure** | **(46 656 654)** | (50 199 101) |
| Net claims incurred | **(44 815 954)** | (48 515 757) |
| Risk claims incurred | **(44 957 497)** | (48 672 460) |
| Third-party claim recoveries | **141 543** | 156 703 |
| Accredited managed healthcare services (no risk transfer) | **(1 883 081)** | (1 765 827) |
| Net income on risk transfer arrangements | **42 381** | 82 483 |
| Risk transfer arrangement fees paid | **(260 068)** | (299 464) |
| Recoveries from risk transfer arrangements | **302 449** | 381 947 |
| **Gross healthcare result** | **14 586 074** | 7 023 127 |
| Broker service fees | **(1 489 823)** | (1 444 563) |
| Expenses for administration | **(5 389 056)** | (5 156 926) |
| Other operating expenses | **(177 363)** | (179 943) |
| Net impairment losses on healthcare receivables | **(79 096)** | (106 108) |
| **Net healthcare result** | **7 450 736** | 135 587 |
| **Other income** | **1 920 700** | 1 757 601 |
| Investment income | **1 690 370** | 1 697 827 |
| Net gains on financial assets | **212 981** | 44 250 |
| Sundry income | **17 349** | 15 524 |
| **Other expenditure** | **(365 316)** | (330 188) |
| Asset management fees | **(78 608)** | (76 610) |
| Other expenses | **(2 372)** | (5 938) |
| Finance costs | **(1 429)** | (1 373) |
| Interest paid on savings accounts | **(282 907)** | (246 267) |
| **Total comprehensive income for the year** | **9 006 120** | 1 563 000 |

# STATEMENT OF CHANGES IN FUNDS AND RESERVES

FOR THE YEAR ENDED 31 DECEMBER 2020

| R'000 | 2020 Accumulated funds | 2019 Accumulated funds |
|---|---|---|
| Balance at beginning of the year | **19 209 355** | 17 646 355 |
| Total comprehensive income for the year | **9 006 120** | 1 563 000 |
| **Total member funds at the end of the year** | **28 215 475** | 19 209 355 |

# STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2020

| R'000 | 2020 | 2019 |
|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | |
| Cash flows generated from operations before working capital changes | 7 470 530 | 181 892 |
| Working capital changes: | | |
| Increase in trade and other receivables | (144 082) | (308 631) |
| Increase in outstanding claims provision | 242 511 | 27 270 |
| Increase in Personal Medical Savings Account liabilities | 1 153 332 | 481 781 |
| Increase/(decrease) in trade and other payables | 16 825 | (3 068 085) |
| **Cash generated/(utilised) by operations** | **8 739 116** | **(2 685 773)** |
| Payments for financial assets | (11 887 221) | (4 783 355) |
| Proceeds from sale of financial assets | 3 763 349 | 2 238 283 |
| Increase in long-term employee plan asset | (3 472) | (3 271) |
| Cash transferred from other medical schemes | – | – |
| Interest received | 1 534 060 | 1 513 838 |
| Dividend income | 156 310 | 183 989 |
| Interest paid | (283 043) | (246 309) |
| **Net cash inflow/(outflow) from operating activities** | **2 019 099** | **(3 782 598)** |
| **CASH FLOWS FROM INVESTING ACTIVITIES** | | |
| Payment for property and equipment | – | – |
| **Net cash outflow from investing activities** | **–** | **–** |
| **CASH FLOWS FROM FINANCING ACTIVITIES** | | |
| Payment of lease liabilities | (1 713) | (1 601) |
| **Net cash outflow from financing activities** | (1 713) | (1 601) |
| **NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS** | 2 017 386 | (3 784 199) |
| Cash and cash equivalents at beginning of the year | 1 991 282 | 5 775 481 |
| **CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR** | **4 008 668** | **1 991 282** |

# 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 292.

| R'000 | 2020 | 2019 |
|---|---|---|
| Total members funds | **28 215 476** | 19 209 355 |
| Less: cumulative unrealised net gain on re-measurement of investments | **-686 683** | – |
| Total net assets (Regulation 29) | **27 528 792** | 19 209 355 |
| Gross annual contributions | **74 537 501** | 69 855 135 |
| Solvency ratio | **36.93%** | 27.50% |
| Average accumulated funds per member at year-end | **20 690** | 14 211 |

For the year ended 31 December 2020, the Net healthcare result generated was R7.45 billion, an increase of 5 395% compared to the year ended 31 December 2019, with Total comprehensive income increasing to R9 billion after inclusion of investment and other income and expenditure. This performance increased accumulated funds by 47% to R28,22 billion with the statutory capital increasing from 27.50% to 36.93%. The statutory solvency exceeds the 25% minimum statutory requirement by R8.89 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.

**Note:**

| R'000 | 2020 | 2019 |
|---|---|---|
| **The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:** | | |
| | **31 430 492** | 23 191 456 |
| – Offshore bonds | **1 975 533** | 876 156 |
| – Equities | **4 658 899** | 4 182 545 |
| – Yield-enhanced bonds | **8 871 310** | 6 620 669 |
| – Inflation-linked bonds | **1 170 279** | 1 125 768 |
| – Money market instruments | **14 323 269** | 9 799 918 |
| – Listed property | **431 202** | 586 400 |
| | **31 430 492** | 23 191 456 |
| Open ended, available on demand (Included as non-current) | **16 252 910** | – |
| Expected to settle within twelve months (Included as current) | **15 177 582** | 23 191 456 |
| | **31 430 492** | 23 191 456 |

Pursuant to the improved financial position and excess solvency, there is a low expectation of the realisation of assets, with a maturity date longer than 12 months from the reporting date or with no defined maturity date, within 12 months of the reporting date of 31 December 2020.

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

| R'000 | 2020 | 2019 |
|---|---|---|
| At the beginning of the year | **23 191 456** | 20 519 767 |
| Acquisitions | **11 887 221** | 4 783 355 |
| Disposals | **(3 470 050)** | (2 215 835) |
| Net gains/(losses) on revaluation of financial assets at fair value through profit or loss | **(178 135)** | 104 169 |
| **At the end of the year** | **31 430 492** | 23 191 456 |

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 Personal Medical Savings Accounts (PMSAs) were amended, effective from 1 January 2018. The effect of the amendment is to reiterate that a trust relationship is not established. Prior to the 2018 reporting period, PMSAs 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 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 | 2020 | 2019 |
|---|---|---|
| Balance on Personal Medical Savings Accounts at the beginning of the year | **5 522 613** | 5 040 832 |
| **Add:** | | |
| Personal Medical Savings Accounts contributions received or receivable | **13 294 773** | 12 632 907 |
| Interest on Personal Medical Savings Accounts | **282 907** | 246 267 |
| Transfers received from other medical schemes | **16 479** | 22 456 |
| **Less:** | | |
| Claims paid to or on behalf of members | **(11 785 757)** | (12 004 885) |
| Refunds on death or resignation | **(487 217)** | (413 396) |
| Unclaimed Personal Medical Savings Accounts written off to Scheme funds | **(2 379)** | (1 568) |
| COVID-19 support: Contributions funded from PMSA | **(165 474)** | – |
| **Balance due to members on Personal Medical Savings Accounts at the end of the year** | **6 675 945** | 5 522 613 |

It is estimated that claims to be paid out of members' PMSAs in respect of claims incurred in 2020 but not reported will amount to approximately R124 404 720 (2019: R96 986 357).

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 2020, 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 R165 474 325 affecting 15 202 policies. CMS granted DHMS an 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 2020

| 2020 | EXECUTIVE | CLASSIC | | | | ESSENTIAL |
|---|---|---|---|---|---|---|
| | | COMP | CORE | SAVER | PRIORITY | COMP |
| Number of members at the end of the accounting period | 8 237 | 111 632 | 48 210 | 308 970 | 78 484 | 12 738 |
| Number of beneficiaries at the end of the accounting period | 17 057 | 239 654 | 104 414 | 680 184 | 174 025 | 23 272 |
| Average number of members for the accounting period | 8 523 | 115 662 | 48 088 | 312 996 | 80 299 | 13 136 |
| Average number of beneficiaries for the accounting period | 17 769 | 249 252 | 104 137 | 686 963 | 177 914 | 24 101 |
| Average risk contributions per member per month (R') | 9 308.46 | 7 460.05 | 4 212.66 | 3 976.25 | 5 001.79 | 6 353.44 |
| Average risk contributions per beneficiary per month (R') | 4 464.68 | 3 461,73 | 1 945.31 | 1 811.67 | 2 257.50 | 3 462.90 |
| Average net claims incurred per member per month (R') | 9 713.36 | 6 365.06 | 2 817.39 | 2 733.99 | 3 655.11 | 4 985.35 |
| Average net claims incurred per beneficiary per month (R') | 4 658.88 | 2 953.62 | 1 301.01 | 1 245.67 | 1 649.69 | 2 717.23 |
| Average administration costs per member per month (R') | 366.87 | 366.87 | 366.87 | 366.87 | 366.87 | 366.87 |
| Average administration costs per beneficiary per month (R') | 175.96 | 170.24 | 169.41 | 167.15 | 165.58 | 199.96 |
| Average managed care: Management services per member per month (R') | 116.67 | 116.67 | 116.67 | 116.67 | 116.67 | 116.67 |
| Average managed care: Management services per beneficiary per month (R') | 55.96 | 54.14 | 53.88 | 53.16 | 52.66 | 63.59 |
| Average family size | 2.07 | 2.15 | 2.17 | 2.20 | 2.22 | 1.83 |
| Loss ratio (%) | 105.67% | 86.96% | 69.68% | 71.71% | 75.43% | 80.37% |
| Total non-healthcare expenses as a percentage of risk contributions (%) | 5.19% | 6.51% | 11.16% | 12.18% | 9.71% | 7.67% |
| Average non-healthcare expenses per member per month | 482.87 | 485.46 | 470.02 | 484.26 | 485.80 | 487.22 |
| Average non-healthcare expenses per beneficiary per month | 231.60 | 225.27 | 217.05 | 220.64 | 219.26 | 265.56 |
| Average age of beneficiaries (years) | 46.74 | 43.94 | 41.27 | 35.01 | 40.41 | 50.17 |
| Pensioner ratio (beneficiaries over 65 years) | 27.22% | 21.51% | 17.60% | 9.44% | 15.76% | 33.82% |
| Average relevant healthcare expenses per member per month | 9 836.17 | 6 487.21 | 2 935.17 | 2 851.39 | 3 773.07 | 5 106.09 |
| Average relevant healthcare expenses per beneficiary per month | 4 717.78 | 3 010.30 | 1 355.40 | 1 299.16 | 1 702.93 | 2 783.04 |
| Net surplus/(deficit) per benefit plan | (95 203) | 786 843 | 529 535 | 2 712 146 | 793 731 | 132 447 |

| ESSENTIAL | | | COASTAL | | KEYCARE | | | CLASSIC SMART COMP | SMART | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| SAVER | CORE | PRIORITY | SAVER | CORE | PLUS | CORE | START | | CLASSIC | ESSENTIAL | |
| 141 708 | 49 036 | 5 203 | 172 053 | 76 359 | 208 859 | 15 950 | 6 151 | 467 | 47 602 | 38 854 | **1 330 513** |
| 302 754 | 107 039 | 10 653 | 386 250 | 172 129 | 365 712 | 26 389 | 8 007 | 958 | 94 353 | 45 490 | **2 758 340** |
| 140 056 | 46 523 | 5 272 | 174 589 | 76 506 | 209 314 | 14 803 | 5 999 | 482 | 45 855 | 35 136 | **1 333 237** |
| 297 985 | 101 650 | 10 771 | 391 360 | 172 318 | 366 263 | 24 422 | 7 776 | 1 000 | 90 658 | 40 654 | **2 764 994** |
| 3 263.98 | 3 334.08 | 4 541.26 | 3 603.93 | 3 562.39 | 2 170.62 | 1 781.75 | 1 333.03 | 7 854.32 | 3 077.32 | 1 639.59 | **3 827.95** |
| 1 534.10 | 1 525.93 | 2 222.50 | 1 607.74 | 1 581.64 | 1 240.47 | 1 080.01 | 1 028.34 | 3 781.86 | 1 556.52 | 1 417.02 | **1 845.78** |
| 1 922.66 | 2 093.59 | 2 661.56 | 2 608.98 | 2 636.55 | 1 875.14 | 1 127.20 | 637.11 | 2 606.71 | 1 869.42 | 785.08 | **2 801.20** |
| 903.67 | 958.19 | 1 302.57 | 1 163.89 | 1 170.58 | 1 071.61 | 683.26 | 491.49 | 1 255.13 | 945.56 | 678.51 | **1 350.69** |
| 366.87 | 366.87 | 366.87 | 366.87 | 366.87 | 198.81 | 106.70 | 198.81 | 366.87 | 366.87 | 366.87 | **336.84** |
| 172.43 | 167.91 | 179.55 | 163.66 | 162.88 | 113.62 | 64.68 | 153.37 | 176.65 | 185.56 | 317.07 | **162.42** |
| 116.68 | 116.68 | 116.67 | 116.67 | 116.67 | 116.53 | 116.54 | 116.54 | 116.67 | 116.68 | 116.69 | **116.65** |
| 54.84 | 53.40 | 57.10 | 52.05 | 51.80 | 66.60 | 70.64 | 89.90 | 56.18 | 59.02 | 100.85 | **56.25** |
| 2.14 | 2.18 | 2.05 | 2.24 | 2.25 | 1.75 | 1.65 | 1.30 | 2.05 | 1.98 | 1.17 | **2.07** |
| 62.49% | 66.31% | 61.20% | 75.64% | 77.30% | 91.00% | 69.80% | 56.19% | 36.08% | 64.52% | 55.01% | **76.18%** |
| 14.49% | 13.95% | 10.66% | 13.29% | 13.14% | 12.69% | 9.69% | 18.95% | 6.13% | 15.02% | 26.31% | **11.52%** |
| 473.07 | 464.98 | 484.02 | 479.02 | 468.06 | 275.35 | 172.57 | 252.59 | 481.65 | 462.31 | 431.34 | **441.05** |
| 222.35 | 212.81 | 236.88 | 213.69 | 207.81 | 157.36 | 104.60 | 194.86 | 231.92 | 233.84 | 372.79 | **212.67** |
| 32.33 | 38.35 | 39.60 | 36.07 | 39.98 | 30.68 | 35.68 | 34.94 | 42.84 | 31.76 | 34.92 | **35.86** |
| 6.81% | 13.36% | 15.43% | 10.02% | 15.12% | 7.85% | 13.10% | 8.74% | 18.50% | 4.97% | 4.55% | **10.98%** |
| 2039.65 | 2 210.82 | 2 779.20 | 2 726.14 | 2 753.66 | 1 975.21 | 1 243.74 | 749.07 | 2 833.51 | 1 985.36 | 901.90 | **2 916.25** |
| 958.65 | 1 011.84 | 1 360.14 | 1 216.15 | 1 222.58 | 1 128.81 | 753.90 | 577.86 | 1 364.34 | 1 004.20 | 779.47 | **1 406.17** |
| 1 402 896 | 431 492 | 86 019 | 1 005 732 | 413 710 | 74 377.83 | 85 515 | 31 894 | 26 841 | 408 686 | 179 457 | **9 006 120** |

# MATTERS OF NON-COMPLIANCE

FOR THE YEAR ENDED 31 DECEMBER 2020

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 external auditor considers them to be material or not.

During 2020, 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 2020 the following plans did not comply with Section 33 (2):

| R'000 | Net healthcare result | Net (deficit)/ surplus |
|---|---|---|
| **Benefit plan** | | |
| Executive | **(103 856)** | **(95 203)** |
| KeyCare Plus | **(213 255)** | **74 378** |

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.

## Annual General Meeting not held

In terms of Scheme Rule 25.1.1, the Scheme must convene an annual general meeting on or before 30 June each year. As a result of COVID-19 restrictions on gatherings, the Scheme applied for an exemption to deviate from its Rules as well as Section 32 of the Act and postpone the 2020 AGM. This exemption was granted by the CMS in line with Section 8 (h) of the Act on 14 May 2020.

## 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 an 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 an 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 they are correctly paid.

## Claims paid in excess of 30 days

Section 59 (2) of the Act states: "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 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.

## Disclosure of personal information

Regulation 15J (2) (b) requires the Scheme to ensure that there are provisions for ensuring confidentiality of clinical and proprietary information, including the diagnosis and treatment pertaining to any beneficiary. POPIA Condition 7 requires that personal information should be kept secure against the risk of loss, unauthorised access, interference, modification, destruction or disclosure.

During the year under review, a dashboard meant for one employer was mistakenly sent to another employer contact. The dashboard contained information on COVID-19 risk assessments and contact tracing for 19 employees. The data included personal identification information. The data was only sent to a specific person who confirmed deletion of the information. The information was not shared for criminal or malicious intent.

## Contribution not billed for new dependants

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. Contributions must be received within a prescribed time when becoming due. The failure in not including dependants in the billing process constitutes non-compliance with the Act.

136 memberships were added through the online platform (new business system) and contributions since 2015 were not billed, resulting in a gross financial loss for the Scheme of R633 318, the majority of which has been written off.

The underwriting system has been enhanced to recognise active and historical additions, to ensure there are no duplicates. The data issues created by the addition of dependants through the online platform has been corrected, to ensure the system does not create historical records that cause data discrepancies.

## Commission paid to brokers with expired CMS accreditation

Section 65 (3) states that no broker shall be compensated for providing broker services unless the CMS has granted accreditation to such broker.

There was a total of 151 brokers over a two-year period where commission was paid to brokers whose accreditation had expired. The total value of these payments was R1.5 million. Commission paid to brokers with expired accreditation has been reversed and a process is underway to recover these amounts.

Enhancements to the commission system have been made to ensure this is not repeated.

## 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, exemptions 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. Individual member contributions that were offset against Personal Medical Savings Accounts amounted to R165 474 000 affecting 15 202 policies. 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.

### SME EMPLOYER CONTRIBUTION CONCESSIONS

Also relating to Section 26 (7) and Section 35 (8) (a) of the Act, financial relief to SMEs through contribution concessions amounted to R206 872 000 affecting 532 SMEs. The concession balance at 31 December 2020 was R86 172 000. Four SMEs with a balance of R71 000 defaulted on their repayments. The CMS granted DHMS a three-month exemption on 9 April 2020 effective from 1 April 2020.

### PAYMENT OF COMMISSIONS TO BROKERS PRIOR TO RECEIPT OF CONTRIBUTIONS

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. The CMS granted DHMS a three-month exemption on 11 June 2020 effective from 1 April 2020.

## Our Trustees

**MR NEIL MORRISON**
BSc (Hons) Physics; MA (Economics)
***Chairperson***

**MS JOAN ADAMS SC**
B.IURIS LLB; (FP) SA[1]

**MR JOHN BUTLER SC**
B.Comm, LLB, MA (Senior Counsel, Member of the Cape Bar)

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

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

**MR JOHAN HUMAN**
B.Bus.Sc; FIA[2]; FASSA[3]

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

*1 Forensic Practitioner, South Africa.*
*2 Fellow of the Institute of Actuaries UK.*
*3 Fellow of the Actuarial Society of South Africa.*

# Discovery Health Medical Scheme
# 2021 Annual General Meeting Notice

Discovery Health Medical Scheme ("DHMS/the Scheme") will hold its Annual General Meeting ("AGM") virtually on 31 August 2021. Members are invited to attend the Scheme's AGM.

## Trustee Elections and Notice of the AGM

**Date:** Tuesday, 31 August 2021

**Venue:** Virtual Meeting (via the Lumi online platform)

**Meeting time:** 09:00

**Registration:** Online registration will open at 10:00 on 30 July 2021 and will close at 18:00 on 27 August 2021. 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 2019 Annual General Meeting – for approval
3. Minutes of the 2021 Special General Meeting – for approval
4. Tabling of the 2019 and 2020 Integrated Reports, including the Scheme's Financial Statements for the years ended 31 December 2019 and 31 December 2020

4.1. Presentation by the Principal Officer of Discovery Health Medical Scheme

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

5. Governance

5.1. Discovery Health Medical Scheme Trustee Remuneration Policy and approval of the 2020 and 2021 Trustee Remuneration

5.2. Appointment of Auditors

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

8.1. 2020 and 2021 Trustee Remuneration

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

8.3. Appointment of Auditors

8.4. Motions

8.5. Election of Trustees

## Please register your attendance

1. Please register to attend, participate and vote at the AGM at **https://www.connectbylumi.com/A3vk50.**
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:
    a. full name(s) and surname (as per identity document)
    b. identity (or passport) number
    c. email address
    d. mobile phone number
    e. 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 are able to 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 form on time

Proxy forms must be requested from Deloitte & Touche ("Deloitte"), the Independent Electoral Body ("IEB"), at **za_dhmselections2021@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 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.

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

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 24 August 2021**. 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 **dhmsmotions2021@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 16 August 2021. 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 2019 Annual General Meeting, the summary of the Scheme's Trustee Remuneration Policy and the 2020 and 2021 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