2022 HIGHLIGHTS OF DISCOVERY HEALTH MEDICAL SCHEME'S RESULTS

Discovery Health Medical Scheme

Discovery Health Medical Scheme registration number 1125

This document contains highlights of the Scheme's performance for the year ended 31 December 2022, extracted from the 2022 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 non-profit entity governed by the Medical Schemes Act (the Act)[1] 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.

DHMS is a registered open medical scheme that any member of the public can join, subject to the Scheme Rules. Covering 2 810 992 beneficiaries at 31 December 2022, DHMS is the largest open medical scheme in South Africa, with an open medical scheme market share of 57.6%[2].

The Scheme outsources its administration and managed care functions to Discovery Health (Pty) Ltd (Discovery Health) through a formal contractual arrangement. In a context characterised by challenging socio-economic conditions and a fragmented and inflationary healthcare system, in partnering with Discovery Health and healthcare providers we work to provide access to high-quality care and ensure good health outcomes for our members by integrating services and achieving the highest possible cost efficiency.

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

2 *Based on beneficiaries, according to the CMS Annual Report for the year ended December 2021 (https://www.medicalschemes.co.za/publications/#2009-3631-wpfd-2021-22-annual-report/). At the end of 2021, there were 17 open schemes registered with the CMS, with approximately 54% of the total medical schemes market and 55 restricted schemes, with approximately 46% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately two million beneficiaries. Source: Annexures to the CMS Annual Report 2021-2022.*

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 providers based on health outcomes and not only the volume of services they deliver. This 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 ensure 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[1]. This accords with the fundamental operating principles of a non-profit organisation that must meet the claims needs of its members as well as maintain a minimum statutory level of reserves.

A small portion of income (shown 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.

2022 Expense breakdown

91.7%	10.2%	2.4%	(4.3%)
Claims *(2021: 89.1%)*	Administration and managed care expenses *(2021: 9.9%)*	Financial adviser and Scheme expenses *(2021: 2.4%)*	Loss to member reserves *(2021: (1.4%))*

COVID-19 lockdown measures and concerns about infection risks at places of care introduced radical shifts in healthcare seeking behaviour during 2020, resulting in 3.5 million fewer member claims than in 2019 and 76.5% of Scheme income funding claims (versus 87.3% in 2019). Members began to increase their healthcare utilisation again over the course of 2021, resulting in increased numbers of claims (54 556 179 in 2021 compared to 47 675 525 in 2020) and an increased percentage of Scheme income spent on funding claims (2021: 89.1%). In 2022, the number of claims continued to increase to 55 755 192[2], with 91.7% of the Scheme's income funding claims.

The Scheme's ability to defer contribution increases three times to 1 July 2021, 1 October 2022 and 1 April 2023, providing relief to its members and passing on the benefit of excess reserves, has given effective relief of approximately R8.6 billion to our members.

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.*

2 *Total claims made in 2022 extracted during February 2023; claims incurred during 2022 but not submitted by the date of extraction are not included.*

OUR PRINCIPAL OFFICER'S REVIEW

MS CHARLOTTE MBEWU

DHMS delivered against its 2022 objectives of caring for our members, managing the implications of COVID-19, ensuring Scheme sustainability and encouraging membership growth; all the while maintaining excellent governance and contributing to relevant policy and regulatory developments – despite a complex operating environment.

To protect our members, the Scheme's responses to the pandemic included funding 752 885 COVID-19 vaccinations and 447 085 COVID-19 tests during 2022. More broadly, we continued to enhance benefits in an effort to ensure that member healthcare needs can be met, and delivered on our mandate to ensure appropriate healthcare outcomes in balance with the financial stability and long-term sustainability of the Scheme.

During 2022, DHMS demonstrated its resilience by maintaining its strong financial position. This enabled us to delay our contribution increases for 2022 to October 2022 and to 1 April 2023 for the 2023 financial period. Further, with the prudent stewardship of our Trustees, this financial strength allowed us to expand our benefits in 2022, specifically to enhance the Assisted Reproductive Therapy Benefit by increasing funding and expanding access to certain treatments.

COVID-19 has had a significant impact on the world, and not least on healthcare. During the pandemic we adopted and adapted to new care delivery mechanisms including telemedicine to ensure continued access to healthcare services, while protecting patients and healthcare providers. We intend to maintain the many benefits of this shift, by facilitating the design of care pathways that optimise delivery mechanisms and ensure an appropriate mix of digital and remote care, and in-person care. To this end, DHMS continues to make Hospital at Home available to members; these home admissions enable the effective management of patients in a familiar environment, with 24-hour monitoring and oversight provided by their admitting doctors. Hospital-level care at home is a rapidly growing global trend. While uptake in South Africa has been slow, we believe there is potential for up to 30% of appropriate admission types to shift from in-hospital to a home-based care setting over time.

Hospital at Home is one example of how we are integrating new technology to enhance access, member experience and quality of care – without replacing the patient-doctor relationship. We are also exploring new opportunities in the mental health space, with some urgency. The prevalence of mental illness increased significantly during the pandemic; in February 2023, the World Health Organisation (WHO) reported a 25% increase in the prevalence of depression and anxiety globally[1]. Digital and self-care tools offer compelling possibilities in increasing access and we are excited to explore these opportunities in partnership with healthcare providers and our members.

Increasing access to healthcare is an ongoing priority for the Scheme. In 2022, we introduced the KeyCare Start Regional Plan. This plan is available in specified areas, where we have been able to negotiate with healthcare providers and create a supportive network, at an excellent contribution rate. Following positive engagements, the CMS approved the plan, demonstrating the significant value of designated provider networks in facilitating access at better cost. At the end of 2022 we also submitted LCBOs to the CMS; unfortunately, these have not been approved as yet, pending the finalisation of the LCBO framework by the CMS and Department of Health. We believe that making such options available to South Africans not in a position to access healthcare is an urgent priority, as the country moves towards universal health coverage, within which LCBOs have a much needed and appropriate place.

For the year ended 31 December 2022, DHMS delivered a planned negative net healthcare result of R3 281 million (2021: planned negative R1 165 million). This result is primarily attributable to the delay of the contribution increase to 1 April 2023; this is the third time the Scheme has been in a position to delay the increase, providing relief to members of approximately R8.6 billion over three years. Results are, however, significantly better than expected (likely due to members continuing to defer their healthcare needs during COVID-19 waves in 2022) and the Scheme generated investment income of R2 222 million (2021: R1 772 million), contributing to the net deficit of R1 489 million (2021: R2 044 million surplus) for the year.

We are proud to have grown our membership by 22 532 principal members in 2022, and 22 499 in 2021[2]. This was achieved despite the economic hardship that has seen much of the industry experiencing membership declines. We believe this is due to the extent of cover, the quality and comprehensive nature of our benefits, and the broad range of options tailored to meet our members' needs.

Members' funds decreased to R28.3 billion (2021: R30.4 billion) with a solvency level of 35.11% (2021: 38.01%), exceeding the regulatory requirement of 25%. Despite the challenging and unusual market conditions, DHMS ended 2022 in a strong financial position and we are well placed to meet members' needs, considering the anticipated increases in utilisation as healthcare seeking behaviour returns to normal, and as the postponement of care since 2020, with consequently worsened states of health of our members, impacts the healthcare system.

Our deep concern about the lower screening and healthcare access by members during the pandemic led to us launching the WELLTH Fund in 2023. This innovative, once-off benefit is made possible by our strong reserves, and we believe it to be the most important form of access we can provide to our members facing potentially undetected worsening health stemming from the pandemic. The WELLTH Fund is accessible to all members who have completed a health check from 1 January 2022 onwards.

Aligned with this concern for the health of our member population, in 2023 we are launching a programme to help members at high risk of diabetes or metabolic disease. Early identification and proactive management of these health conditions results in extended and healthier lifespan. The programme offers twelve months of support for these members, with comprehensive clinical management through GP visits and relevant medicine, healthcare coaching and nutritional assistance. At the end of the period, the member may either exit the programme, remain on relevant chronic medicine or register for our Chronic Illness Benefit for ongoing care.

In 2023, we were able to increase the threshold of the oncology benefit on all plans by 25%, to address the increasing costs of treatment. With the prevalence of cancer increasing over time, and the correlated increase in cost of care mainly due to introduction of new oncology

1 *Source: https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide.*
2 *Net principal member increase at 31 December 2021 vs 2020 and 2022 vs 2021.*

treatment protocols, we extended access to a defined list of novel and ultra-high-cost medicines for some cancers on additional plans within the Scheme.

We also look forward to the introduction of our Essential Dynamic Smart plan in 2023. This innovative, information-driven plan assists members to access the most efficient and appropriate facility for their care, depending on their location and condition. The pricing of this plan, again demonstrating the value of efficient designated provider networks, is affordable and supports increased access to healthcare with better health outcomes.

Last year, we reported on the Section 59 investigation into FWA management in the industry. We responded comprehensively to the interim report, which found no fault with the processes and practices operated by Discovery Health on our behalf, and we await the publication of the final report. Discovery Health established a Health Professionals Reference Group (HPRG) to contribute to the review, development and redesign of forensic investigation processes. The HPRG was independently facilitated and has been highly collaborative. Based on the outcomes of the HPRG, Discovery Health has subsequently engaged with a broadly representative group of doctors to collaborate on addressing the outdated coding system for medical procedures currently in use in South Africa. We look forward to the outcomes of this work and its benefit to healthcare providers and our members.

The CMS has announced its priorities for 2023, and we look forward to progress in these important areas, and to collaborating with the industry and our regulator in whatever ways we can on these. We appreciate the CMS' lead in the industry code of good practice for FWA management, and look forward to the establishment of a Tribunal to assist with the resolution of these matters. LCBOs, another priority area, is extremely important to extend access to healthcare.

I must thank my team in the Scheme Office for their dedication and hard work in supporting continued access to high-quality care for our members, through a wide benefit offering tailored to meet healthcare needs within individual financial constraints. The guidance and oversight of our Trustees and Independent Committee Members is also invaluable in steering the Scheme through challenging times with careful consideration, in-depth knowledge and in balancing the many difficult trade-offs between competing imperatives. I also thank our members, for whom we exist, and our other key stakeholders without whom we could not fulfil our duty of care as we do: the CMS; healthcare providers and facilities; financial advisers and our administration and managed care provider, Discovery Health.

We remain closely engaged with the development of national health policy and regulatory change, including supporting the move to UHC, for the benefit of all citizens. Despite the considerable challenges we face, we are excited to contribute to a dynamic era of change in healthcare and its regulation, and to build out new opportunities to benefit our members' wellbeing, and that of the South African healthcare system as a whole.

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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 and on the next page, together with an explanation of why we consider these important.

GROWTH AND SUSTAINABILITY

Membership growth

Growth in the number of young and healthy members improves risk pooling through cross-subsidisation principles and reflects the attractiveness and competitiveness of the Scheme.

NET MEMBERSHIP INCREASE
1.67%
(2021: 1.69%)

PENSIONER RATIO[2]
11.77%
(2021: 11.25%)

NET BENEFICIARY INCREASE
0.94%
(2021: 0.96%)

ANNUALISED LAPSE RATE
5.49%
(2021: 5.13%)

AVERAGE AGE AT YEAR-END[1]
36.57
(2021: 36.17)

Membership size

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

1 375 544
PRINCIPAL MEMBERS AT 31 DECEMBER 2022
(2021: 1 353 012)

2 810 992
BENEFICIARIES AT 31 DECEMBER 2022
(2021: 2 784 793)

57.6%[3]
SHARE OF OPEN SCHEME MARKET
(2019: 57.5%)

Plan movements

Low movement between plans indicates member satisfaction and appropriate benefit design and pricing. From December 2022 – January 2023:*

PLANS DID NOT CHANGE
97.15%
Sep-Oct 2022: 98.68%
Dec-Jan 2022: 96.53%

PLANS WERE UPGRADED
1.50%
Sep-Oct 2022: 0.75%
Dec-Jan 2022: 1.89%

PLANS WERE DOWNGRADED
1.35%
Sep-Oct 2022: 0.57%
Dec-Jan 2022: 1.58%

* *We monitor plan movements closely, especially when our contributions are increased and members are able to change their plans. Our next contribution increase will be in April 2023.*

Relative contribution levels

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

AVERAGE CONTRIBUTIONS FOR 2023 ARE
12.2%
lower than the next seven largest open medical schemes[4]
(2022: 14.6%)[5].

1 *An increase of less than one year per annum is favourable as this indicates that young people are joining the Scheme.*
2 *Based on beneficiaries' dates of birth.*
3 *Based on beneficiaries, according to the Council for Medical Schemes (CMS) Annual Report for the year ended December 2021 (https://www.medicalschemes.co.za/publications/#2009-3631-wpfd-2021-22-annual-report/). At the end of 2021 there were 17 open schemes registered with the CMS, with approximately 54% of the total medical schemes market, and 55 restricted schemes with approximately 46% of the market. The Government Employees Medical Scheme is the largest restricted scheme with approximately two million beneficiaries. Source: Annexures to the CMS Annual Report 2021-2022.*
4 *Source: publicly available contribution information for DHMS and the next seven largest open medical schemes. To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a principal member. These average contributions are then weighted (for DHMS and the next seven largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes.*
5 *The methodology for calculating the contribution differentials has been amended to reclassify a competitor plan and to correct a calculation error. The differential reported for 2022 was 14.9%, which has now been amended to 14.6%.*

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

35.11%
(2021: 38.01%)
exceeding the statutory solvency requirement of 25%.

AAA
Independent credit rating for claims paying ability[1]
(2021: AAA).

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

6.18%
(2021: 10.31%)

Pricing sufficiency

Surplus year-on-year reflects contribution levels that are in line with expected membership and claims. In 2022, the Scheme deferred the contribution increase to 1 October, providing relief to its members and passing on the benefit of excess reserves. The deferral of the increase resulted in the Scheme generating a planned negative net healthcare result for the year.

NET HEALTHCARE RESULT FOR THE YEAR OF

R3 281 million
negative
(2021: R1 165 million negative)

NET DEFICIT FOR THE YEAR OF

R1 489 million
(2021: R2 044 million surplus)

Value-added administration and managed care

FOR EVERY R1.00 SPENT BY DHMS ON ADMINISTRATION AND MANAGED CARE FEES IN 2021, OUR MEMBERS RECEIVED

R2.02
(2020: R1.90[2])
in value from the activities of Discovery Health. This is equivalent to nominal added value of R7.6 billion in 2021 (2020: R6.4 billion).

ADMINISTRATION FEES

7.56%
of gross contributions
(2021: 7.33%)

MANAGED CARE FEES

2.64%
of gross contributions
(2021: 2.56%)

1 *Rating affirmed in April 2023; this refers to how many times the Scheme is able to cover its monthly claims expense with its liquid investments.*
2 *The 2020 value added has been restated from R1.88 to R1.90 using updated information from the CMS 2020/2021 Annual Report, changes in methodology and finalised settlement values for certain components.*

Extracts from the audited Annual Financial Statements

STATEMENT OF FINANCIAL POSITION

AT 31 DECEMBER 2022

	NOTES	2022 R'000	2021 R'000
ASSETS			
Non-current assets		**24 348 071**	24 719 222
Property and equipment	1	**8 317**	9 658
Long term employee benefit plan asset	28	**8 314**	7 998
Financial assets at fair value through profit or loss	3	**24 331 440**	24 701 566
Current assets		**15 478 904**	16 566 181
Financial assets at fair value through profit or loss	3	**8 842 232**	9 987 157
Derivative financial instruments	8	**38 525**	–
Trade and other receivables	4	**2 974 013**	2 729 850
Cash and cash equivalents		**3 624 134**	3 849 174
– Personal Medical Savings Accounts trust assets arising from amalgamation	5	**–**	10 860
– Medical Scheme assets	6	**3 624 134**	3 838 314
TOTAL ASSETS		**39 826 975**	**41 285 403**
FUNDS AND LIABILITIES			
Members' funds		**28 930 015**	30 418 845
Accumulated funds		**28 930 015**	30 418 845
LIABILITIES			
Non-current liabilities		**7 735**	8 671
Leases	2	**7 735**	8 671
Current liabilities		**10 889 225**	10 857 887
Leases	2	**2 098**	1 961
Outstanding claims provision	7	**1 844 365**	2 257 054
Personal Medical Savings Account liabilities	9	**7 310 364**	7 081 549
Trade and other payables	10	**1 732 398**	1 517 323
TOTAL FUNDS AND LIABILITIES		**39 826 975**	**41 285 403**

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 DECEMBER 2022

	NOTES	2022 R'000	2021 R'000
Risk contribution income	11	**65 630 927**	62 459 297
Relevant healthcare expenditure		**(60 971 703)**	(56 271 074)
Net claims incurred	12	**(58 921 666)**	(54 399 878)
Risk claims incurred	12	**(59 059 966)**	(54 467 338)
Third party claim recoveries	12	**138 300**	67 460
Accredited managed healthcare services (no risk transfer)	13	**(2 120 208)**	(1 960 416)
Net income on risk transfer arrangements	14	**70 171**	89 220
Risk transfer arrangement fees paid		**(312 221)**	(271 813)
Recoveries from risk transfer arrangements		**382 392**	361 033
Gross healthcare result		**4 659 224**	6 188 223
Broker service fees	15	**(1 612 455)**	(1 438 916)
Expenses for administration	16	**(6 010 611)**	(5 554 748)
Other operating expenses	17	**(208 627)**	(224 677)
Net impairment losses on healthcare receivables	19	**(108 215)**	(135 524)
Net healthcare result		**(3 280 684)**	(1 165 642)
Other income		**2 256 202**	3 638 788
Investment income	23	**2 221 987**	1 771 609
Net gains on financial assets	24	**3 117**	1 838 553
Sundry income	25	**31 098**	28 626
Other expenditure		**(464 348)**	(428 888)
Asset management fees	26	**(103 130)**	(93 213)
Finance costs	27	**(1 266)**	(1 242)
Interest paid on savings accounts	27	**(359 952)**	(334 433)
TOTAL COMPREHENSIVE (LOSS)/INCOME FOR THE YEAR		**(1 488 830)**	**2 044 258**

STATEMENT OF CHANGES IN FUNDS AND RESERVES
FOR THE YEAR ENDED 31 DECEMBER 2022

	NOTES	2022 R'000 Accumulated funds	2021 R'000 Accumulated funds
Balance at beginning of the year		**30 418 845**	28 215 475
Total comprehensive (loss)/income for the year		**(1 488 830)**	2 044 258
Reserves transferred from other Medical Schemes	32	**–**	159 112
TOTAL MEMBER FUNDS END OF THE YEAR		**28 930 015**	**30 418 845**

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 31 DECEMBER 2022

	NOTES	2022 R'000	2021 RESTATED* R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash receipts from members and providers		**79 523 558**	75 880 364
Cash received from members – contributions	30	**79 514 258**	75 876 638
Cash received from members and providers – other	30	**9 300**	3 726
Cash paid to providers, employees and members		**(83 334 508)**	(76 611 068)
Cash paid to providers and members – claims	30	**(74 920 971)**	(68 679 150)
Cash paid to providers and employees – non-healthcare expenditure	30	**(7 922 943)**	(7 438 509)
Cash paid to members – savings plan refunds		**(490 594)**	(493 409)
Cash used in operations		**(3 810 950)**	(730 704)
Purchase of financial assets	30	**(7 774 847)**	(8 738 440)
Proceeds from disposal of financial assets	30	**9 410 317**	7 735 859
Increase in long-term employee plan asset	28	**(5 770)**	(5 360)
Interest received	30	**1 588 234**	1 345 399
Dividend income	23	**473 318**	322 814
Interest paid	27	**(102)**	(4)
Asset manager fees paid	26	**(103 130)**	(93 213)
Net cash outflow from operating activities		**(222 930)**	(163 649)
CASH FLOWS FROM FINANCING ACTIVITIES			
Purchases of right-of-use asset	2	**(145)**	–
Payment of lease liabilities	2	**(1 965)**	(1 832)
Net cash outflow from financing activities		**(2 110)**	(1 832)
Net decrease in cash and cash equivalents		**(225 040)**	(165 481)
Cash and cash equivalents at beginning of the year		**3 849 174**	4 008 668
Transfer of cash and cash equivalents due to amalgamation		**–**	5 987
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**3 624 134**	**3 849 174**
Cash and cash equivalents comprise			
Personal Medical Savings Account trust assets		**–**	10 860
Medical Scheme assets		**3 624 134**	3 838 314
		3 624 134	**3 849 174**

* *The restatement of the specific line items has been included in Note 30.*

Solvency

The Act requires the Scheme to maintain accumulated funds of 25% of gross annual contributions for the accounting period, in terms of Regulation 29 (2).

At 31 December 2022, the Scheme's solvency level of 35.11% (2021: 38.01%) of gross annual contributions exceeded the 25% minimum statutory solvency requirement by R8 billion (2021: R9.9 billion).

R'000	2022	2021
Total Members Funds	**28 930 015**	30 418 845
Less: cumulative unrealised net gain on re-measurement of investments	**(1 002 934)**	(1 603 656)
Total net assets (Regulation 29)	**27 927 081**	28 815 189
Gross annual contributions	**79 542 906**	75 816 287
Solvency ratio	**35.11%**	38.01%

Financial assets at fair value through profit or loss

ACCOUNTING POLICY:

The Scheme's investment strategy (business model objective) is determined by means of an allocation across different asset classes and grouping of financial assets into specific portfolios. Independent asset managers manage these portfolios under fully discretionary, active mandates with performance evaluated at the respective portfolio level on a fair value basis. All asset managers are remunerated based on the fair value of the portfolio under management.

The business model objective is achieved through the selling of assets per the documented 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 portfolios where the underlying financial instruments are traded in an active market is determined by using quoted market prices or dealer quotes of the underlying financial instruments.

The fair value of the portfolios where the underlying financial instruments are not traded in an active market is determined by using valuation techniques that maximise the use of observable market data and rely as little as possible on entity specific estimates.

Gains or losses arising from subsequent changes in fair value are recognised under "Other Income" in the Statement of Comprehensive Income within the period in which they arise.

R'000	2022	2021
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:	**33 173 672**	34 688 723
– Offshore cash and bonds	**2 196 242**	2 299 286
– Equities	**8 937 682**	7 578 533
– Short duration bonds	**5 488 733**	10 604 304
– Flexible fixed income bonds	**8 639 881**	5 229 271
– Money market instruments	**7 313 485**	8 367 829
– Property	**597 649**	609 500
	33 173 672	34 688 723
Open ended, available on demand (Included as non-current)	**24 331 440**	24 701 566
Expected to settle within twelve months (Included as current)	**8 842 232**	9 987 157
	33 173 672	**34 688 723**
Reconciliation of the balance at the beginning of the year to the balance at the end of the year:		
At the beginning of the year	**34 688 723**	31 430 492
Acquisitions	**7 930 674**	8 841 598
Disposals	**(9 410 317)**	(7 582 315)
Transfer due to amalgamation	**–**	155 632
Net (losses)/gains on revaluation of financial assets at fair value through profit or loss (Note 24)	**(35 408)**	1 843 316
AT THE END OF THE YEAR	**33 173 672**	**34 688 723**

A register of investment portfolios 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 that a trust relationship is no longer established and no disclosure around the trust liability is required. Prior to the 2018 reporting period, PMSA's were disclosed as trust liabilities.

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	2022	2021
Balance on Personal Medical Savings Accounts at the beginning of the year	**7 081 549**	6 675 945
Add:		
Personal Medical Savings Accounts contributions received or receivable (Note 11)	**13 911 979**	13 356 990
Interest on Personal Medical Savings Accounts (Note 27)	**359 952**	334 433
Transfers received from other medical schemes	**39 558**	19 618
Savings plan liabilities transferred to the Scheme upon amalgamation	**–**	11 165
Less:		
Claims paid to or on behalf of members (Note 12)	**(13 592 080)**	(12 823 100)
Refunds on death or resignation	**(489 390)**	(493 293)
Unclaimed Personal Medical Savings Accounts written off to scheme funds (Note 25)	**(1 204)**	(116)
COVID-19 Support: Contributions funded from PMSA	**–**	(93)
BALANCE DUE TO MEMBERS ON PERSONAL MEDICAL SAVINGS ACCOUNTS AT THE END OF THE YEAR	**7 310 364**	**7 081 549**

It is estimated that claims to be paid out of members' PMSAs in respect of claims incurred in 2022 but not reported will amount to approximately R77m (2021: R94m) (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 2022, 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 in the prior financial year. The Council for Medical Schemes (CMS) granted DHMS exemption on 9 April 2021 for a period of three months effective from 1 April 2021. An extension of the exemption was granted on 4 November 2021 for the period up to 31 December 2021.

Operational statistics per benefit plan[1]

FOR THE YEAR ENDED 31 DECEMBER 2022

2022	EXECUTIVE	COMPREHENSIVE			PRIORITY		SAVER		
		CLASSIC COMP	ESSENTIAL COMP	CLASSIC SMART COMP	CLASSIC PRIORITY	ESSENTIAL PRIORITY	CLASSIC SAVER	ESSENTIAL SAVER	COASTAL SAVER
Number of members at the end of the accounting period	7 652	101 938	11 928	475	71 925	5 034	327 968	167 082	168 227
Number of beneficiaries at the end of the accounting period	15 300	212 524	21 330	904	157 136	9 917	714 939	354 867	373 336
Average number of members for the accounting period	7 685	103 157	12 023	473	72 922	5 048	324 581	160 867	168 433
Average number of beneficiaries for the accounting period	15 463	216 181	21 556	896	159 570	9 953	708 854	343 101	374 820
Average risk contributions per member per month (R')	9 831.78	7 916.48	6 733.78	7 677.23	5 363.65	4 771.11	4 268.31	3 508.02	3 883.15
Average risk contributions per beneficiary per month (R')	4 886.06	3 777.59	3 755.75	4 050.60	2 451.13	2 419.93	1 954.44	1 644.77	1 744.98
Average net claims incurred per member per month (R')	12 615.66	8 488.87	7 008.61	4 403.57	4 918.14	3 180.14	3 589.41	2 500.44	3 489.55
Average net claims incurred per beneficiary per month (R')	6 269.55	4 050.73	3 909.04	2 323.38	2 247.54	1 612.98	1 643.58	1 172.36	1 568.10
Average administration costs per member per month (R')	400.50	400.50	400.50	400.50	400.50	400.50	400.50	400.50	400.50
Average administration costs per beneficiary per month (R')	199.03	191.11	223.38	211.31	183.02	203.14	183.39	187.78	179.97
Average managed care: Management services per member per month (R')	128.64	128.64	128.64	128.64	128.64	128.64	128.64	128.64	128.64
Average managed care: Management services per beneficiary per month (R')	63.93	61.38	71.75	67.87	58.79	65.25	58.90	60.31	57.81
Average family size	2.00	2.08	1.79	1.90	2.18	1.97	2.18	2.12	2.22
Loss ratio (%)	129.70%	108.95%	106.08%	59.09%	94.14%	69.38%	87.15%	74.99%	93.22%
Total non-healthcare expenses as a percentage of risk contributions (%)	5.36%	6.68%	7.87%	6.80%	9.86%	11.02%	12.32%	14.65%	13.43%
Average non-healthcare expenses per member per month	527.13	528.88	530.02	521.85	528.79	525.90	526.07	513.95	521.39
Average non-healthcare expenses per beneficiary per month	261.97	252.37	295.62	275.33	241.65	266.74	240.88	240.97	234.30
Average age of beneficiaries (years)	48.35	45.18	50.61	41.35	41.75	40.08	36.09	33.21	37.22
Pensioner ratio (beneficiaries over 65 years)	30.38%	23.58%	34.35%	15.45%	17.59%	15.04%	10.73%	7.62%	11.54%
Average relevant healthcare expenses per member per month	12 751.42	8 625.31	7 143.15	4 536.12	5 049.58	3 310.42	3 719.68	2 630.65	3 619.83
Average relevant healthcare expenses per beneficiary per month	6 337.02	4 115.83	3 984.08	2 393.31	2 307.60	1 679.06	1 703.22	1 233.41	1 626.65
Net surplus/(deficit) per benefit plan	(309 560)	(1 421 736)	(122 659)	15 569	(110 263)	62 012	439 689	878 483	(340 773)

2022	CORE			SMART		KEYCARE			TOTAL
	CLASSIC CORE	ESSENTIAL CORE	COASTAL CORE	CLASSIC SMART	ESSENTIAL SMART	KEYCARE PLUS	KEYCARE CORE	KEYCARE START	
Number of members at the end of the accounting period	45 801	51 539	70 304	62 023	50 660	210 260	16 530	6 198	**1 375 544**
Number of beneficiaries at the end of the accounting period	98 089	112 852	158 280	124 136	58 985	362 594	27 784	8 019	**2 810 992**
Average number of members for the accounting period	45 965	50 440	71 023	59 667	47 837	207 799	16 207	5 893	**1 360 021**
Average number of beneficiaries for the accounting period	98 781	110 613	160 265	118 985	55 668	358 663	27 299	7 609	**2 788 276**
Average risk contributions per member per month (R')	4 522.24	3 587.23	3 867.11	3 374.54	1 796.07	2 321.78	1 937.13	1 505.21	**4 021.44**
Average risk contributions per beneficiary per month (R')	2 104.32	1 635.81	1 713.76	1 692.22	1 543.40	1 345.17	1 150.07	1 165.76	**1 961.51**
Average net claims incurred per member per month (R')	3 958.59	2 871.03	3 632.95	2 555.58	1 016.80	2 427.37	1 631.23	789.41	**3 610.34**
Average net claims incurred per beneficiary per month (R')	1 842.04	1 309.22	1 609.99	1 281.54	873.75	1 406.35	968.46	611.39	**1 760.99**
Average administration costs per member per month (R')	400.50	400.50	400.50	400.50	400.50	217.03	116.47	217.91	**368.29**
Average administration costs per beneficiary per month (R')	186.36	182.63	177.49	200.84	344.16	125.74	69.15	168.77	**179.64**
Average managed care: Management services per member per month (R')	128.64	128.64	128.64	128.64	128.64	127.85	127.85	127.85	**128.51**
Average managed care: Management services per beneficiary per month (R')	59.86	58.66	57.01	64.51	110.54	74.07	75.90	99.02	**62.68**
Average family size	2.14	2.19	2.25	2.00	1.16	1.72	1.68	1.29	**2.04**
Loss ratio (%)	90.38%	83.66%	97.31%	79.56%	63.79%	108.77%	90.81%	58.96%	**92.90%**
Total non-healthcare expenses as a percentage of risk contributions (%)	11.33%	14.13%	13.21%	14.93%	26.14%	12.92%	9.75%	18.52%	**11.93%**
Average non-healthcare expenses per member per month	512.51	506.70	510.91	503.69	469.51	299.95	188.81	278.79	**486.51**
Average non-healthcare expenses per beneficiary per month	238.49	231.06	226.42	252.58	403.46	173.78	112.09	215.92	**237.30**
Average age of beneficiaries (years)	42.50	39.41	41.34	32.79	35.80	31.64	35.90	35.87	**36.57**
Pensioner ratio (beneficiaries over 65 years)	19.13%	15.12%	17.14%	5.99%	5.10%	8.58%	13.81%	9.30%	**11.77%**
Average relevant healthcare expenses per member per month	4 087.21	3 001.00	3 763.25	2 684.92	1 145.71	2 525.37	1 759.08	887.51	**3 735.95**
Average relevant healthcare expenses per beneficiary per month	1 901.89	1 368.49	1 667.73	1 346.40	984.53	1 463.13	1 044.36	687.36	**1 822.26**
Net surplus/(deficit) per benefit plan	25 749	124 053	(241 399)	223 962	176 826	(943 906)	22 149	32 974	**(1 488 830)**

1 *Efficiency discount options (Delta, KeyCare Start Regional) are incorporated into their parent plans for operational statistics reporting purposes.*

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2022

Circular 11 of 2006 issued by the CMS deals with issues to be addressed in the audited financial statements of medical schemes. This includes the requirement that all instances of non-compliance be disclosed in the audited financial statements, irrespective of whether the auditor considers them to be material or not.

During 2022, the Scheme did not comply with the following Sections and Regulations of the Act, and a directive issued by the CMS.

SUSTAINABILITY OF BENEFIT PLANS

In terms of Section 33 (2) of the Act, each benefit plan is required to be self-supporting in terms of membership and financial performance, and be financially sound.

For the year ended 2022 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net (deficit)/ surplus (R'000)
Executive	**(318 453)**	**(309 560)**
Classic Comprehensive	**(1 540 380)**	**(1 421 736)**
Classic Core	**(46 403)**	**25 749**
Classic Priority	**(193 709)**	**(110 263)**
Essential Comprehensive	**(136 488)**	**(122 659)**
Coastal Core	**(352 589)**	**(241 399)**
Coastal Saver	**(535 036)**	**(340 773)**
KeyCare Plus	**(1 272 181)**	**(943 906)**
KeyCare Core	**(3 385)**	**22 149**

The performance of all benefit options is monitored on a continuous basis with a view to improving their financial outcomes. Different strategies are continually evaluated to address the deficit in these plans while considering the overall financial stability of the Scheme.

When structuring benefit options, the financial sustainability of all the options and the requirements of the CMS are considered. The different financial positions reflect the different disease burdens in each option, among many other factors. The Scheme's strategy for plans' sustainability must balance short- and long-term financial considerations, fairness to both healthy and sick members, and continued affordability of cover for members with different levels of income and healthcare needs. While the Scheme is committed to complying wherever possible with applicable legislation, it also focuses intensively on the overall stability and financial position of the Scheme as a whole and not only individual benefit plans.

DHMS continually provides the CMS with updates on both the Scheme and individual benefit option performance through monthly management accounts and quarterly monitoring meetings.

INVESTMENTS IN EMPLOYER GROUPS AND MEDICAL SCHEME ADMINISTRATORS

Section 35 (8) (a), (c) and (d) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide and the CMS has granted DHMS exemption for a three-year period effective from 1 December 2022.

INVESTMENTS IN OTHER ASSETS IN TERRITORIES OUTSIDE THE REPUBLIC OF SOUTH AFRICA

The Scheme's offshore bond managers utilise derivative instruments to aid with efficient portfolio construction and management, and to reduce the overall risk within our portfolios. The derivatives used are highly liquid and are either exchange traded or governed by international swaps and derivatives association agreements. The derivative instruments are not used for speculation and there is no gearing or leverage applied.

Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7 (b) of Annexure B to the Regulations of the Act. The CMS has granted DHMS exemption for a three-year period effective from 1 December 2022.

CONTRIBUTIONS RECEIVED AFTER DUE DATE

Section 26 (7) of the Act states that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment becomes due. There are instances where the Scheme received contributions after the three-day period, however, there are no contracts in place agreeing to this practice. It is important to note that the Scheme has no control over the timely payment of contributions. The legal obligation resides with the members/employers to pay contributions within the prescribed period. The Scheme employs robust credit control processes dealing with the collection of outstanding contributions, including suspending membership for non-payment.

CLAIMS PAID IN EXCESS OF 30 DAYS

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

During the year, there were instances where claims were not paid within 30 days. These represent 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 these claims are paid expeditiously.

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. 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.

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 re-occurrence.

AMOUNTS DEBITED TO SCHEME BANK ACCOUNT

Section 26 (4) (b) provides that no amount may be debited to a scheme bank account other than costs incurred by the medical scheme in the carrying on of the business as a medical scheme. During the year under review, a total of R212 808 was debited to the Scheme's bank account that was not related to the Scheme. This debit arose from the incorrect allocation of bank accounts for certain payments. The amount and related interest have subsequently been refunded to the Scheme and additional quality assurance processes have been implemented to mitigate this occurring again.

NON-COMPLIANCE TO THE CMS DIRECTIVE ISSUED IN CIRCULAR 26 OF 2022 – BROKERS MAY NOT RECEIVE BROKER COMMISSION ON OWN POLICIES.

During 2022 CMS published Circular 26 of 2022: Brokers and Brokerages who earn commission in respect of their own health or medical scheme policies. The CMS directive stated that all arrangements in terms of which any broker is receiving broker commission, whether directly or indirectly, related to their own health or medical scheme policy, must be terminated by 30 June 2022.

During the year, there were two identified instances where brokers earned commission on their own health policies amounting to R840 after 30 June 2022. These represent less than 0.001% of total broker fees paid for the year. The identified policies have been moved to non-commissionable status.

Our Trustees[1]

MR JOHN BUTLER SC

CHAIRPERSON (from 1 January 2022)

BCom LLB; MA (Senior Counsel, Member of the Cape Bar)

MS JOAN ADAMS SC

BIuris LLB; MInstD

DR SUSETTE BRYNARD

BSc (Sciences); PhD (Education); Trustee Development Programme

MRS LALITA (GITA) HARIE

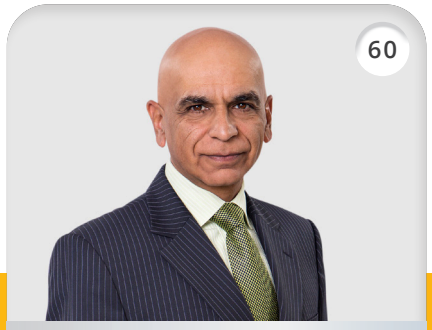
BA (Social Work); BA (Hons) Social Science (Psychology); Certified Director (IoDSA)

MR JOHAN HUMAN

BBusSc; FIA[2]; FASSA[3]

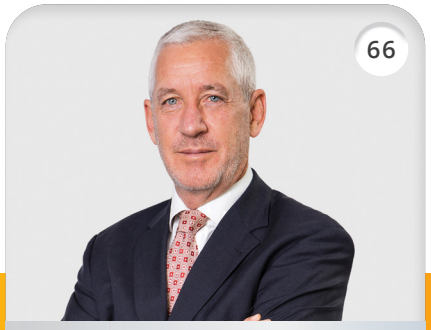
MR DAVID KING[4]

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



DR DHESAN MOODLEY[5]

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

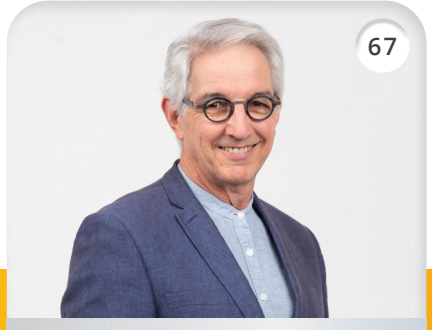


MR NEIL MORRISON[6]

BSc (Hons) Physics; MA (Economics)

MS MICHELLE NORTON SC

BA LLB; D Phil



DR MAX PRICE

MBBCh; BA; MSc; Postgraduate Diploma in Occupational Health

MR MARIUS DU TOIT

BCom (Mathematics); FASSA[3]

1 All ages are at 31 December 2022.
2 Fellow of the Institute of Actuaries UK.
3 Fellow of the Actuarial Society of South Africa.
4 Term ended on 22 June 2022.
5 Term ended on 22 June 2022.
6 Term ended on 22 June 2022.

DISCOVERY HEALTH MEDICAL SCHEME

2023 Annual General Meeting Notice

Discovery Health Medical Scheme ("DHMS"/"the Scheme") will hold its Annual General Meeting ("AGM") on 08 June 2023. Members are invited to attend the Scheme's AGM. Voting on all matters will take place at the AGM venue only and will be open from 09:00 – 16:00 on the day of the AGM.

NOTICE OF THE AGM

Date:	Thursday, 08 June 2023
Venue:	Auditorium 1, 1 Discovery Place, corner of Katherine Street and Rivonia Road, Sandton, Gauteng Parking will be available at the venue
Meeting time:	09:00
Registration:	07:00 – 09:00
Identification:	Members attending the AGM must bring their membership card and any of the following identification documents: South African ID book or Smart ID card, South African Driver's License or a Passport. In this regard, in conjunction with the above-mentioned identification documents, either a physical DHMS membership card or a digital membership card (available to DHMS members logged into the Discovery mobile app, under the medical aid tab) is acceptable.
Live streaming:	If you are unable to attend the AGM, you can view the AGM through the live streaming facility that will be available on **www.discovery.co.za** on 08 June 2023 at 09:00. In this regard, voting on matters presented at the AGM must take place in person, or by means of a proxy.

THE AGENDA FOR THE MEETING IS AS FOLLOWS:

1. Welcome and quorum
2. Minutes of the 2022 Annual General Meeting – for approval
3. Tabling of the 2022 Integrated Report, including the Scheme's Financial Statements for the year ended 31 December 2022

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 2023 Trustee Remuneration

4.2. Appointment of Auditors

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

7.1. 2023 Trustee Remuneration

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

7.3. Appointment of Auditors

7.3.1 For 2023

7.3.2 For 2024

7.4. Motions

7.5. Extension of Trustee Tenure from three to four years

PLEASE ATTEND THE AGM OR NOMINATE A PROXY

Every Principal Member who is in good standing and who is present at the AGM has the right to vote. If you are unable to attend the Scheme's AGM in person, you may nominate a proxy (another Principal Member authorised to attend, speak and vote on your behalf) by completing an electronic proxy appointment 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 ("proxy giver") wishing to appoint a proxy to attend the AGM and vote on their behalf can do so on the Lumi platform at **https://reg.lumiengage.com/discovery-health-medical-scheme-agm-2023/proxy.**

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.

All information required on the Lumi platform must be provided. Once all information has been submitted by the proxy giver, both the proxy giver and nominated proxy will receive an email notification, confirming the submission. The nominated proxy will then receive an automated email from the Lumi platform to request confirmation of the appointment as a proxy. Once the nominated proxy accepts the proxy appointment, another email will be received by the proxy giver and nominated proxy to confirm the appointment as proxy.

The Independent Electoral Body ("IEB") shall screen the proxy appointment submission and shall determine its validity, prior to the AGM. The IEB's decision as to the validity of a proxy appointment will be final and binding.

Proxy appointments can only be submitted online via the Lumi platform and as such, no written proxy appointments will be accepted. Proxy submissions must reach the IEB by no later than **09:00 on 01 June 2023.**

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 emailed to the Independent Electoral Body ("IEB") at **DHMS2023AGM@mazars.co.za.**

Motions have to reach the IEB by no later than **12:00 midnight on 24 May 2023.** Without a detailed motivation the motion will not be valid. Any motions received after this date and time will be invalid.

The minutes of the 2022 Annual General Meeting, the summary of the Scheme's Trustee Remuneration Policy and the 2023 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