Discovery Health Medical Scheme

FOR OUR MEMBERS

HIGHLIGHTS OF DISCOVERY HEALTH MEDICAL SCHEME'S RESULTS FOR 2017

This document contains highlights of the Scheme's performance for the year ended 31 December 2017, extracted from the 2017 Integrated Report. The financial information has been extracted from and is in agreement with the Annual Financial Statements, audited by PricewaterhouseCoopers Inc.

The full 2017 Integrated Report is available at **www.discovery.co.za/info/DHMSreports.**

Discovery Health Medical Scheme (DHMS or the Scheme) is a registered open medical scheme which any member of the public can join, subject to its Rules[1].

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

QUALITY OF CARE IS ONE OF OUR KEY MEMBERSHIP PROPOSITIONS

One of the Scheme's major longer-term strategies is to drive value-based healthcare, which is a delivery model in which providers are reimbursed based on health outcomes, and to promote member access to programmes and providers that are committed to continuous improvement in quality healthcare.

Through Discovery Health, the Scheme is deeply engaged in many quality of care initiatives and ongoing monitoring to ensure that our members have access to the safest, most efficient healthcare available in South Africa. The Scheme also empowers our members with information that is relevant to their needs.

WE MAKE SURE THAT YOUR INVESTMENT IN MEMBERSHIP TAKES CARE OF YOU

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

In pricing member contributions for each year, the Scheme's objective is to ensure sufficient contribution income to pay all claims, and to return a modest surplus to meet regulatory requirements as well as to maintain a cushion against unexpected cost increases. This is in accordance with the fundamental operating principles of a non-profit organisation.

The Scheme's income is used to fund activities to support and benefit its members, as well as ensure the sustainability of DHMS through activities such as innovation, administration, managed care, financial advisers and the daily operations of the Scheme.

Apart from the reserves and these activities, the Scheme's entire income is used to fund claims.

2017 DHMS EXPENSE BREAKDOWN

1 *The Scheme Rules are available to members on* ***www.discovery.co.za/medical-aid/scheme-rules****.*
The full Integrated Report for 2017 is available at ***www.discovery.co.za/info/DHMSreports.***

OUR PRINCIPAL OFFICER'S REVIEW OF THE YEAR

Discovery Health Medical Scheme continues to grow despite challenging economic conditions, and I am proud to report that the Scheme is financially stronger than it has ever been, with a record level of reserves.

We have been able to share that strength with our members through benefit amendments for 2018, in particular our increased maternity benefits, and through the lowest contribution increases in several years.

The Scheme (or DHMS) only has two sources of income: member contributions and the return on members' funds invested. With a limited source of funds, we are constantly focused on ensuring the sustainability of DHMS. This requires that members receive value from our benefit offering, and that we mitigate any adverse impact that the prevailing economic and other macroeconomic factors may have on members in terms of private healthcare funding.

The Board of Trustees (the Board or the Trustees) and the Scheme Office closely monitor metrics and other information to assess the financial wellbeing of our members. We continue to note with concern the rising cost of private healthcare, which continues to be above inflation and has been extensively discussed in interactions with the Competition Commission's Healthcare Market Inquiry (HMI). Also, with South Africa's low economic growth, stagnant employment growth and high household debt, and, as shown in DHMS's own data, increasing retrenchments at large corporates, it is evident that more members are finding private healthcare difficult to afford.

Also impacting financial wellbeing and the affordability of private healthcare is the low increase in rebates for medical aid tax credits, as detailed by the Minister of Finance in the Medium-term Budget Policy Statement 2017 and subsequent announcements in February 2018. Furthermore, the value-added tax (VAT) increase by 1 percentage point to 15%, effective 1 April 2018, adds further pressure on consumers.

In leveraging the Scheme's unmatched ability in the industry to absorb environmental shocks, DHMS will not be passing the VAT increase onto members during the remainder of 2018 and will absorb the increase from our operating surplus. As noted above, the Scheme's reserves are at record levels, and shielding members from unexpected additional contribution increases was deemed appropriate by the Trustees.

The Scheme supports the objectives of universal health coverage and participates in all forums regarding the National Health Insurance (NHI). As the private healthcare sector is undoubtedly a national asset, these discussions are an opportunity for the Scheme to collaborate with the Department of Health and all other stakeholders in determining how best the sector can achieve the objectives of quality and equitable healthcare.

The Scheme works hard with its Administrator and Managed Care Provider, Discovery Health (Pty) Ltd (Discovery Health), to contain the impact of healthcare inflation on our members. This is achieved through a number of initiatives that prioritise quality and cost efficiency measures. For instance, when contracting with service providers, we strive to shift reimbursement agreements towards value-based contracting, thus moving away from the traditional fee-for-service model. This clinical integration improves outcomes and fosters collaboration and innovation in multidisciplinary teams by ensuring the entire cycle of care is contracted for and monitored. We initiated some exciting pilots in this regard in 2017.

Also, to support the ongoing success of the Vested® outsourcing model (Vested model) that emphasises the role of innovation in providing value to our members, the Trustees have established two new operational committees in 2017: an Innovation Committee and a Relationship Management Committee. Respectively, these committees will monitor the work on innovation that Discovery Health engages in on behalf of the Scheme and work to optimise the relationship between the Scheme and Discovery Health.

On the Scheme's second source of income, the return on members' funds invested, we achieved excellent results for 2017, with investment income of R1 433 million (2016: R1 257 million). This contributed to the net surplus for the year of R2 450 million (2016: R1 305 million), thereby safeguarding member funds and Scheme sustainability. Investment income was supported by, among other strategies, the Scheme's offshore hedging strategy that provided effective protection from the strong appreciation of the Rand over the year.

During 2017, the Scheme introduced the Essential Smart plan. With this addition, DHMS has created the Smart Plan Series and changed the name of the Smart Plan, which has been available from the start of 2016, to Classic Smart. The Smart Plan Series shows ongoing excellent performance and growth, with both plans attracting young and healthy members to the Scheme.

The healthcare sector in South Africa continues to be a dynamic environment. DHMS is an active member of the Health Funders Association (HFA), an industry body that represents stakeholders in the private healthcare funding environment. The HFA represents 20 medical schemes, which combined, account for 76% of the open medical scheme environment and 53% of the total market.[1] It considers issues affecting all its members and engages with various bodies, institutions and structures to ensure a robust and viable private healthcare industry.

As of 1 January 2018, DHMS amalgamated with the University of the Witwatersrand Staff Medical Aid Fund (Witsmed). Initiated in August 2017, the amalgamation process was conducted in accordance with the requirements of the Medical Schemes Act 131 of 1998, as amended (the Act), its Regulations and the Scheme Rules. The Council for Medical Schemes (CMS) approved the amalgamation after receiving confirmation that the majority of voting members from both schemes were in favour of the amalgamation and any objection received was considered and addressed. The Competition Commission considered and approved the amalgamation as required by the Competition Act 89 of 1998.

1 Based on principal members of member schemes.

All amalgamation proposals are carefully and thoroughly assessed by the Scheme to ensure that the amalgamation would not result in an adverse impact on the member profile, the claims experience and reserves.

As reflected in our material matters detailed in our Integrated Report, the Scheme Office and Trustees are troubled by the recent governance and ethics failures in organisations across the public and private sectors. While the Scheme's financial exposure to Steinhoff was limited, as part of ongoing adherence to governance and ethical codes, in particular the King IV Report on Corporate Governance for South Africa 2016 (King IV), the Scheme is conducting an extensive review of its internal and external stakeholder environment and is optimising the structure that continually monitors and evaluates related risks.

The governance of the CMS vests in a board appointed by the Minister of Health, referred to as the Council. Dr Clarence Mini has been appointed as the new Chairperson of the Council and we congratulate him and wish him well in this position. The Scheme continues to interact constructively with the CMS and will continue to contribute through the various forums and structures where sector participation is required.

During 2017, the Scheme Office welcomed a new Chief Medical Officer, Dr Unati Mahlati, and bade farewell to its Chief Financial Officer (CFO), Jan van Staden. Mr van Staden departed to pursue his own interests and we wish him well in this. In the interim, the CFO portfolio is managed by our Chief Risk and Operations Officer, Mr Selwyn Kahlberg, who has previously managed the portfolio.

At the end of my first year as the Principal Officer of the Scheme, I extend my thanks to the Trustees, independent Committee members and to the Scheme Office team for their unwavering support during this time, which has been a period of great learning and personal development for me. I also welcome the Trustees appointed and elected to the Board during the course of 2017, and express my appreciation for the way in which they have integrated into the Scheme's governing bodies with great concern for their fiduciary duties and the wellbeing of the Scheme and its members.

Nozipho Sangweni

DR NOZIPHO SANGWENI
PRINCIPAL OFFICER

For more information refer to our Integrated Report at **www.discovery.co.za/info/DHMSreports**.

EXTRACTS FROM THE AUDITED

ANNUAL FINANCIAL STATEMENTS

STATEMENT OF FINANCIAL POSITION

as at 31 December 2017

R'000	2017	2016
ASSETS		
Non-current assets	**4 417**	5 614
Long term employee benefit plan asset	**4 417**	5 614
Current assets	**25 728 677**	20 864 905
Financial assets at fair value through profit or loss	**14 005 644**	12 211 677
Derivative financial instruments	**85 857**	54 760
Trade and other receivables	**1 147 665**	2 058 008
Cash and cash equivalents		
– Personal Medical Savings Account trust assets	**4 609 149**	4 142 672
– Medical Scheme assets	**5 880 362**	2 397 788
Total assets	**25 733 094**	20 870 519
FUNDS AND LIABILITIES		
Members' funds	**16 684 435**	14 234 461
Accumulated funds	**16 684 435**	14 234 461
Current liabilities	**9 048 659**	6 636 058
Outstanding claims provision	**1 240 063**	1 121 394
Derivative financial instruments	**86 445**	4 376
Personal Medical Savings Account trust liabilities	**4 656 633**	4 204 043
Trade and other payables	**3 065 518**	1 306 245
Total funds and liabilities	**25 733 094**	20 870 519

STATEMENT OF CHANGES IN FUNDS AND RESERVES

for the year ended 31 December 2017

R'000	2017 Accumulated funds	2016 Accumulated funds
Balance at beginning of the year	**14 234 461**	12 929 011
Total comprehensive income for the year	**2 449 974**	1 305 450
Total member funds at end of the year	**16 684 435**	14 234 461

The full Annual Financial Statements, including notes, are available in our Integrated Report at **www.discovery.co.za/info/DHMSreports**.

STATEMENT OF COMPREHENSIVE INCOME

for the year ended 31 December 2017

R'000	2017	2016
Risk contribution income	**48 702 024**	43 626 398
Relevant healthcare expenditure	**(41 747 808)**	(38 035 898)
Net claims incurred	**(40 228 057)**	(36 613 210)
Claims incurred	**(40 371 417)**	(36 772 332)
Third party claim recoveries	**143 360**	159 122
Accredited managed healthcare services (no risk transfer)	**(1 534 311)**	(1 407 267)
Net profit/(loss) on risk transfer arrangements	**14 560**	(15 421)
Risk transfer arrangement fees	**(392 023)**	(366 344)
Recoveries from risk transfer arrangements	**406 583**	350 923
Gross healthcare result	**6 954 216**	5 590 500
Broker service fees	**(1 214 205)**	(1 101 648)
Expenses for administration	**(4 511 596)**	(4 150 194)
Other operating expenses	**(260 461)**	(236 206)
Net healthcare result	**967 954**	102 452
Other income	**1 893 686**	1 524 116
Investment income	**1 433 187**	1 257 479
Net gains on financial assets at fair value through profit or loss	**458 753**	264 278
Sundry income	**1 746**	2 359
Other expenditure	**(411 666)**	(321 118)
Expenses for asset management services rendered	**(44 428)**	(31 076)
Interest paid	**(367 238)**	(290 042)
Net surplus for the year	**2 449 974**	1 305 450
Other comprehensive income	**–**	–
Total comprehensive income for the year	**2 449 974**	1 305 450

STATEMENT OF CASH FLOWS

for the year ended 31 December 2017

R'000	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash flows generated from operations before working capital changes	**1 017 921**	151 902
Working capital changes:		
Decrease/(Increase) in trade and other receivables	**822 739**	(500 589)
Increase in outstanding claims provision	**118 669**	136 307
Increase in Personal Medical Savings Account trust liabilities	**452 590**	467 384
Increase in trade and other payables	**1 759 273**	123 640
Cash generated by operations	**4 171 192**	378 644
Purchases of financial instruments	**(2 953 775)**	(1 922 170)
Proceeds from sale of financial instruments	**1 669 533**	1 258 510
Increase in Long Term Employee Plan Asset	**(3 848)**	(7 544)
Interest received	**1 349 125**	1 206 486
Dividend income	**84 062**	50 993
Interest paid	**(367 238)**	(290 042)
Net cash flows from operating activities	**3 949 051**	674 877
NET INCREASE IN CASH AND CASH EQUIVALENTS	**3 949 051**	674 877
Cash and cash equivalents at beginning of year	**6 540 460**	5 865 583
CASH AND CASH EQUIVALENTS AT END OF YEAR	**10 489 511**	6 540 460
Cash and cash equivalents comprise		
Personal Medical Savings Account trust assets	**4 609 149**	4 142 672
Medical Scheme assets	**5 880 362**	2 397 788
	10 489 511	6 540 460

*The full Integrated Report for 2017 is available at **www.discovery.co.za/info/DHMSreports.***

SOLVENCY

The Medical Schemes Act No. 131 of 1998, as amended (the Act) requires the Scheme to maintain accumulated funds of 25% of gross annual contributions for the accounting period, in terms of Regulation 29 (2).

At 31 December 2017, the Scheme's solvency level of 27.44% (2016: 26.33%) of gross annual contributions was R1.5 billion (2016: R719 million) more than the statutory solvency requirement.

R'000	2017	2016
Total members' funds per Statement of Financial Position	**16 684 435**	14 234 461
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**(298 722)**	–
Accumulated funds per Regulation 29	**16 385 712**	14 234 461
Gross annual contribution income	**59 710 735**	54 056 212
Solvency margin = Accumulated funds/gross annual contribution income x 100	**27.44%**	**26.33%**

R'000	2017	2016
Financial assets at fair value through profit or loss		
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:		
Current assets	**14 005 644**	12 211 677
– Offshore bonds	**1 463 064**	1 245 709
– Equities	**3 378 331**	2 049 834
– Yield-enhanced bonds	**3 721 190**	3 413 740
– Inflation-linked bonds	**792 666**	610 476
– Money market instruments	**4 268 369**	4 891 918
– Listed property investments	**382 024**	–
	14 005 644	12 211 677
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	**12 211 677**	11 399 332
Acquisitions	**2 953 775**	1 922 170
Disposals	**(1 571 646)**	(1 127 159)
Net gains on revaluation of financial assets at fair value through profit or loss	**411 838**	17 334
At the end of the year	**14 005 644**	12 211 677
A register of investments is available for inspection at the registered office of the Scheme.		

R'000	2017	2016
Personal Medical Savings Account trust liabilities		
(Personal Medical Savings Account trust monies managed by the Scheme on behalf of its members)		
Balance on Personal Medical Savings Accounts at the beginning of the year	**4 204 043**	3 736 659
Add:		
Personal Medical Savings Accounts contributions received or receivable	**11 008 711**	10 429 814
For the current year	**11 008 711**	10 429 814
Interest on Personal Medical Savings Accounts	**367 238**	287 923
Transfers received from other medical schemes	**31 784**	13 691
Less:		
Claims paid to or on behalf of members	**(10 602 298)**	(9 942 225)
Refunds on death or resignation	**(352 845)**	(321 819)
Balance due to members on Personal Medical Savings Accounts held in trust at the end of the year	**4 656 633**	4 204 043
It is estimated that claims to be paid out of members' Personal Medical Savings Accounts in respect of claims incurred in 2017 but not reported will amount to approximately R83 200 000 (2016: R71 100 056).		
As at 31 December 2017 the carrying amount of the members' Personal Medical Savings Accounts were deemed to be equal to their fair values, which is the amount payable on demand. The amounts were not discounted, due to the demand feature.		
Interest is allocated on these Personal Medical Savings Account balances monthly in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes. The Scheme does not charge interest on negative (overdrawn) Personal Medical Savings Account balances.		

Cash and cash equivalents – Personal Medical Savings Account trust assets

(Monies managed by the Scheme on behalf of members)

PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO (Managed by Aluwani Captial Partners (Pty) Ltd)		
Balance at beginning of the year	**2 071 391**	1 832 987
Net additional Investments	**55 608**	84 040
Interest Income	**177 819**	154 364
Balance at the end of the year	**2 304 818**	2 071 391
PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO (Managed by Taquanta Asset Managers (Pty) Ltd)		
Balance at beginning of the year	**2 071 281**	1 834 469
Net additional Investments	**61 143**	86 660
Interest Income	**171 907**	150 152
Balance at the end of the year	**2 304 331**	2 071 281
Total Personal Medical Savings Account trust assets	**4 609 149**	4 142 672

These funds represent members' Personal Medical Savings Account assets managed by the Scheme on behalf of its members. As required by Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes, these assets have been invested separately from the Scheme's assets. The difference between total Personal Medical Savings Account assets and Personal Medical Savings Account liabilities is reconciled monthly and arises from timing of cash flows to and from the portfolios. For the year under review the average rate earned on the Personal Medical Savings Account Trust assets was 8.33% (2016: 7.64%).

OPERATIONAL STATISTICS

2017	Executive	Classic Comp.	Classic Core	Classic Saver	Classic Priority	Essential Comp.
Number of members at the end of the accounting period	10 354	142 380	51 077	288 252	93 620	16 435
Number of beneficiaries at the end of the accounting period	22 602	320 053	110 099	631 879	212 763	31 609
Average number of members for the accounting period	10 587	145 839	50 577	285 821	94 585	16 870
Average number of beneficiaries for the accounting period	23 172	328 992	109 245	625 979	214 836	32 656
Average risk contributions per member per month (R')	7 285	5 787	3 295	3 117	3 938	4 981
Average risk contributions per beneficiary per month (R')	3 329	2 565	1 526	1 423	1 734	2 573
Average net claims incurred per member per month (R')	9 391	5 806	2 402	2 326	3 141	4 256
Average net claims incurred per beneficiary per month (R')	4 291	2 574	1 112	1 062	1 383	2 199
Average administration costs per member per month (R')	317	317	317	317	317	317
Average administration costs per beneficiary per month (R')	145	140	147	145	139	164
Average managed care: Management services per member per month (R')	98	98	98	98	98	98
Average managed care: Management services per beneficiary per month (R')	45	43	45	45	43	51
Average family size at 31 December	2.18	2.25	2.16	2.19	2.27	1.92
Loss ratio (%)	130%	102%	76%	78%	82%	88%
Total non-healthcare expenses as a percentage of risk contributions (%)	6%	7%	12%	13%	11%	9%
Average non-healthcare expenses per member per month (R')	424	426	410	421	426	426
Average non-healthcare expenses per beneficiary per month (R')	194	189	190	192	187	220
Average age of beneficiaries (years)	44.13	41.31	39.33	32.72	37.46	46.38
Pensioner ratio (beneficiaries over 65 years)	22%	17%	15%	7%	12%	27%
Average relevant healthcare expenses per member per month (R')	9 494	5 912	2 500	2 424	3 239	4 364
Average relevant healthcare expenses per beneficiary per month (R')	4 338	2 621	1 157	1 107	1 426	2 254
Net surplus/(deficit) per benefit plan (R'000)	(324 005)	(819 810)	305 748	1 217 116	403 748	55 224

Essential Core	Essential Saver	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Access	Classic Comp. Zero MSA	Classic Smart	Essential Smart	Total
39 949	118 499	6 896	183 647	83 749	234 680	14 598	4 887	871	21 422	12 111	**1 323 427**
85 100	248 249	14 343	417 520	186 693	410 463	23 251	7 008	1 910	40 178	14 226	**2 777 946**
38 260	113 549	6 930	183 872	83 455	228 064	13 981	4 687	884	19 021	8 239	**1 305 219**
81 367	237 985	14 473	417 544	186 164	399 119	22 172	6 664	1 931	35 880	9 720	**2 747 898**
2 598	2 565	3 568	2 785	2 707	1 688	1 427	1 096	5 707	2 314	1 295	**3 109**
1 222	1 224	1 708	1 226	1 214	965	900	770	2 612	1 227	1 098	**1 477**
1 708	1 583	2 249	2 198	2 188	1 559	895	455	5 427	1 304	448	**2 568**
803	755	1 077	968	981	891	565	320	2 484	691	380	**1 220**
317	317	317	317	317	171	92	110	316	317	316	**288**
149	151	152	139	142	98	58	78	145	168	268	**137**
98	98	98	98	98	98	98	98	98	98	98	**98**
46	47	47	43	44	56	62	69	45	52	83	**47**
2.13	2.09	2	2.27	2.23	1.75	1.59	1.43	2.19	1.88	1.17	**2.10**
70%	66%	1	82%	84%	97%	70%	51%	97%	61%	42%	**86%**
16%	16%	0	15%	15%	14%	11%	15%	7%	17%	29%	**12%**
403	410	420	417	406	239	152	162	423	399	374	**382**
190	196	201	184	182	137	96	114	194	211	317	**182**
35.91	30.36	36.82	34.12	38.10	29.30	35.07	31.98	39.41	30.48	33.82	**34.50**
10%	5%	12%	8%	12%	6%	11%	4%	13%	3%	6%	**9%**
1 806	1 681	2 347	2 296	2 286	1 645	993	558	5 544	1 412	546	**2 665**
849	802	1 124	1 011	1 025	940	626	392	2 537	749	463	**1 266**
232 822	758 899	73 366	340 919	133 352	(212 254)	67 094	27 815	(1 514)	142 146	49 308	**2 449 974**

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2017

The CMS issued Circular 11 of 2006 (the Circular) that deals with issues to be addressed in the audited financial statements of medical schemes. The Circular requires 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 the year, the Scheme did not comply with the following Sections and Regulations of the Act.

STATUTORY SCHEME SOLVENCY

Under the Act, medical schemes are required to hold a minimum of 25% of gross annual contribution income as a reserve or accumulated funds (also known as the solvency ratio). The solvency ratio is a measure of a scheme's ability to absorb unexpected changes in claims experience, demographics (e.g. average age, chronic profile, etc.) and legislative environments, and therefore reflects a scheme's financial strength.

During 2017, the Scheme's solvency level dropped below 25% during January. In January, the drop was attributable to the impact of annual contribution increases (schemes are required to hold reserves equal to annualised inflation-adjusted contributions from the first day of the financial year).

At 31 December 2017, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 27.44% (2016: 26.33%), exceeding the statutory solvency requirement of 25%.

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 31 December 2017 the following plans did not comply with Section 33 (2):

Benefit plan (R'000)	Net healthcare result	Net deficit
Executive	(334 418)	(324 005)
Classic Comprehensive	(963 232)	(819 810)
Classic Comprehensive Zero MSA	(2 763)	(1 514)
KeyCare Plus	(535 785)	(212 254)

The performance of all benefit options is monitored on an ongoing basis with a view to improving financial outcomes, and different strategies to address the deficit in these plans are continually evaluated.

When structuring benefit options, the financial sustainability of all the options is 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 balances 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 on individual benefit plans.

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

INVESTMENT IN EMPLOYER GROUPS AND MEDICAL SCHEME ADMINISTRATORS

Section 35 (8) (a) and (c) 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. DHMS has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs across the industry. The CMS granted DHMS an exemption from these sections of the Act up to 21 April 2018 and the Scheme will be applying for a further extension to this exemption.

The Scheme has no investments in Discovery Limited, the holding company of Discovery Health (Pty) Ltd.

INVESTMENTS IN OTHER ASSETS IN TERRITORIES OUTSIDE 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 Scheme was granted an exemption to invest in offshore derivatives, subject to certain conditions, up to 31 December 2018.

MINIMUM AMOUNT INVESTED IN CASH [CATEGORY 1 (A) (I) AND 1 (A) (II)]

Explanatory note 2 to Annexure B to the Regulations of the Act requires a medical scheme to have a minimum of 20% of its Regulation 30 assets invested in cash (Category 1 (a) (i) and 1 (a) (ii)). As at 31 March 2017, the Scheme did not meet this requirement as it held 19.79% in cash (Category 1 (a) (i) and 1 (a) (ii)). The non-compliance was due to a difference in interpretation between the CMS and DHMS of the relevant clauses of Regulation 30 of the Act. The Scheme has amended its calculation methodology to be aligned with the CMS interpretation.

Prior to Circular 2 of 2018: Personal Medical Savings Accounts and scheme rules, Personal Medical Savings Account (PMSA) assets were included as part of the Scheme's assets during the period July to December 2017. The PMSA assets were included in assessing compliance with the requirement for a minimum of 20% of Regulation 30 assets being invested in cash (Category 1 (a) (i) and 1 (a) (ii)). After excluding PMSA assets from Scheme assets, there were certain months where this requirement was not met.

As at 31 December 2017, 32.51% of Scheme assets were invested in cash (Category 1 (a) (i) and 1 (a) (ii)) and therefore met the minimum 20% requirement. This requirement has been met using the amended calculation methodology and excluding PMSA assets.

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 days; 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 members or their employers to pay contributions within the prescribed period.

The Scheme applies robust credit control processes to deal 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.

WAITING PERIODS

Section 29A of the Act states the instances when medical schemes may impose waiting periods upon a person in respect of whom an application is made for membership or admission as a dependent. The waiting periods range from a three month general waiting period to a twelve month condition-specific waiting period. During the year under review, there were isolated instances where waiting periods were not applied in accordance with the Act. For the instances identified, the incorrect application of waiting periods has been rectified and a review conducted, which confirmed that no claims were rejected as a result of the waiting periods being incorrectly applied.

PRESCRIBED MINIMUM BENEFITS

Section 29 (1) (o) and Regulation 8 provides 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 were reprocessed and correctly paid prior to the end of the benefit year.

ENSURING THE SCHEME'S SUSTAINABILITY

The Scheme's ability to pay claims and it's sustainability over the long term are of critical importance to its members. A summary of key outcome metrics for the scheme's sustainability appears below:

GROWTH AND SUSTAINABILITY

MEMBERSHIP SIZE

Greater risk pooling means more predictable claims experience and accuracy in pricing, leading to stable performance.

- **2 777 946** beneficiaries as at 31 December 2017 (2016: 2 735 191)
- **56%** share of open scheme market (2016: 55%)

CONTRIBUTION INCREASES

Reflects value for money for members and effective risk management.

- Average contributions **16.4%** lower[1] than the next eight open schemes by size (for 2017: 14.6%)

MEMBERSHIP GROWTH

Continuous growth of young and healthy lives improves risk pooling through cross-subsidisation principles, which reflects the attractiveness and competitiveness of the Scheme.

- Average net membership and beneficiary growth of **2.08%** and **1.59%** respectively (2016: 2.45% and 1.71%)[2]
- Average age at year end of **34.50** (2016: 34.17)[3]
- **9.33%** pensioner ratio (2016: 8.92%)
- **5%** annualised lapse rate (2016: 5%)

PLAN MOVEMENTS

Indicates satisfaction, stability in benefit design and appropriate pricing.

- No change for 2018: **94.24%** (for 2017: 93.86%)
- Upgrades for 2018: **3.24%** (for 2017: 2.91%)
- Downgrades for 2018: **2.52%** (for 2017: 3.23%)

FINANCIAL STRENGTH AND MANAGEMENT

ABSOLUTE RESERVES

Demonstrates ability to meet large, unexpected claims variation.

- Accumulated funds expressed as a percentage of gross annual contributions of **27.44%** (2016: 26.33%), exceeding the statutory solvency requirement of **25%**
- **AAA independent credit rating** for claims paying ability (2016: AA+)

PRICING SUFFICIENCY

Surplus year-on-year reflects contribution levels that are in line with expected membership and claims.

- Net surplus for the year of **R2 450 million** (2016: R1 305 million)

PRUDENT INVESTMENT MANAGEMENT

Ensuring that investment returns are maximised within an acceptable and conservative level of risk.

- **10.00%** average return on investments (2016: 8.80%)

1 To ascertain the contribution differential between DHMS and competitors, we calculate an average contribution within each plan category for a family unit comprising one principal member, one adult and one child dependant (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 discount that a typical member of DHMS enjoys relative to members of similar options in competitor schemes. DHMS typically compares itself against our next nine largest competitors, but Sizwe's final contribution increases for 2018 were unconfirmed at the time of publishing and so this comparison excludes Sizwe.

2 Membership growth across medical schemes is currently constrained by affordability and a challenging economic climate, including stagnant job growth.

3 An increase of less than 1 year per annum is favourable as it indicates that young people are joining the Scheme.

DHMS is a non-profit entity governed by the Medical Schemes Act 131 of 1998, as amended, and regulated by the Council for Medical Schemes (CMS).

The Scheme belongs to its members and an independent Board of Trustees (the Board or the Trustees) oversees its business.

The Scheme outsources its administration and managed care functions through a formal contractual arrangement with Discovery Health (Pty) Ltd, with its business model based on Vested® outsourcing.

DHMS RECEIVES EXCEPTIONAL VALUE FOR ITS ADMINISTRATION AND MANAGED CARE EXPENSES.

For every **R1.00 spent** by DHMS on administration and managed care fees in 2016, members of DHMS received **R2.00** (2015: R1.85) in value from the activities of Discovery Health.

Discovery Health Medical Scheme 2018 Annual General Meeting Notice

Discovery Health Medical Scheme (DHMS/the Scheme) is holding its Annual General Meeting (AGM) on 21 June 2018. Members are invited to attend the Scheme's AGM.

NOTICE OF THE AGM

Date:	Thursday, 21 June 2018
Venue:	The Grove Auditorium, 1 Discovery Place, Corner of Rivonia Road and Katherine Street, Sandton Parking will be available at the venue
Meeting time:	09:00
Registration:	07:00 to 09:00
Identification:	Members attending the AGM must bring their membership card and any of the following identification documents: A South African ID book or Smart ID card, South African driver's license or a passport
Live streaming:	If you are unable to attend the AGM, you can make use of the live streaming facility that will be available on www.discovery.co.za on 21 June 2018 at 09:00

THE AGENDA FOR THE MEETING IS AS FOLLOWS:

1. Welcome and quorum
2. Minutes of the 2017 Annual General Meeting - for approval
3. Tabling of the 2017 Integrated Report, including the Scheme's Annual Financial Statements for the financial year ended 31 December 2017
   - 3.1. Presentation by the Principal Officer of Discovery Health Medical Scheme
   - 3.2. Presentation by the CEO of Discovery Health (Pty) Limited, the Administrator of Discovery Health Medical Scheme
4. Governance
   - 4.1. Discovery Health Medical Scheme Trustee Remuneration Policy and approval of the 2018 Trustee Remuneration
   - 4.2. Appointment of Auditors
5. Motions
6. General
7. Voting and closure of the AGM
   - 7.1. 2018 Trustee Remuneration
   - 7.2. Non-binding advisory vote on the Trustee Remuneration Policy
   - 7.3. Motions
8. Member Engagement
   The Board of Trustees invites members to engage with the Principal Officer and the Board of Trustees on specific Scheme matters of their choice immediately after the closure of the AGM.

You can RSVP your attendance to the AGM on **www.discovery.co.za**.

PLEASE ATTEND THE AGM OR NOMINATE A PROXY

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.

SUBMIT YOUR PROXY FORM ON TIME

Proxy forms must be requested from PricewaterhouseCoopers Advisory Services (Pty) Ltd ("PwC"), at DHMSAGM2018@za.pwc.com or by calling 012 429 0150.

Please note that each proxy form has unique security features and a separate proxy form has to be requested for each proxy that a Principal Member wishes to appoint.

Any deletions/corrections on the proxy form will not be accepted and will render the form "spoilt".

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 may invalidate the proxy form.

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

Proxy forms must reach PwC by no later than **12:00 midday on 14 June 2018**. Any proxy forms received after this date and time will be invalid.

SUBMITTING A MOTION

The Rules of the Discovery Health Medical Scheme require that notices of motions to be placed before the AGM, must reach the Principal Officer not later than **14 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 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. A motion may not deal with matters affecting the operations of the Scheme, or matters that fall beyond the scope of the AGM and must be for the benefit of and/or in the best interest of the Scheme and its members.
4. 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:

- e-mailed to dhmsmotions2018@discovery.co.za or
- posted to The Principal Officer, Discovery Health Medical Scheme, PO Box 786722, Sandton 2146, or
- hand delivered to any of the reception desks at 1 Discovery Place, Ground Floor, Corner of Rivonia Road and Katherine Street, Sandton, 2146, in an envelope clearly marked for the attention of the Principal Officer of Discovery Health Medical Scheme.

Motions have to reach the Principal Officer by no later than **12:00 midnight on 06 June 2018**. Any motions received after this date and time will be invalid.

Discovery Health Medical Scheme

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

Discovery
Health Medical Scheme

The 2017 Integrated Report including the full set of audited Annual Financial Statements is available at **www.discovery.co.za/info/DHMSreports.**

Discovery Health Medical Scheme
1 Discovery Place
Sandton