Minutes of the 23rd Annual General Meeting of the Discovery Health Medical Scheme ("DHMS"/Scheme") held on 22 June 2017, at The Hilton Conference Room, The Hilton Hotel, 138 Rivonia Road, Sandton at 09:00

1. Welcome and Quorum

The Chairman of the Board of Trustees, Mr Michael van der Nest SC, welcomed all present to the 23rd Annual General Meeting ("AGM") of the Discovery Health Medical Scheme ("DHMS"/"Scheme"). The Chair advised the meeting that the last page of the Highlights of the Discovery Health Medical Scheme's Results for 2016, as included in the member pack handed out at registration, included the agenda for the meeting.

The Chair called upon Mr Trevor White from PricewaterhouseCoopers Advisory Services (Pty) Ltd ("PwC") to declare the meeting quorate and to provide an overview of how the voting process would work.

Mr White addressed the meeting and indicated that, in order for a quorum to be present and for the meeting to be duly constituted in terms of Rule 25.1.4 of the Scheme Rules, at least 15 members present in person constitute a quorum. Mr White addressed the meeting and indicated that as names are called out people should indicate their presence by a show of hands. The following members indicated their presence in person:

- Riedwaan Wookay
- Phuzo Soko
- Karren Sanderson
- James Jones
- Amanda Leigh Bosch
- Natasha Roopa
- Navendrie Reddy
- David Gordon Webster
- Antoinette Caroline Nel
- John Stuart Gardner
- KR Ngobeni
- Andrew Ndlovu
- Jabulani Tshoke
- Phillip Short
- Gina Ally
- Vanitha Naidoo

Mr White confirmed that there was a quorum present and addressed the meeting as follows with regard to the voting processes:

- Mr White advised the members present that they are to use the marked exit doors located at the back of the room, should they wish to leave the meeting to vote and that they would be able to vote at any time after the meeting had been opened by the Chair. PwC electoral officers would be available to guide members in this regard. Members would be guided to the voter registration room where they would be handed the following ballots:
  - Election of Trustees;
  - 2017 Trustee Remuneration and
  - Non-binding Advisory vote on the Scheme's Trustee Remuneration Policy.
- After registration, members would be guided to the voting room in order to cast their votes. Mr White advised candidates that all three ballots that were handed to members in an envelope during voter registration, should be re-inserted into the envelope after the member had voted thereon and the envelope containing all three ballots should then be inserted into the ballot box.
- Mr White emphasised the following with regard to the voting:

- That members should only vote for a maximum of two candidates. Any submitted ballot booklets that have more than the two votes, would be deemed invalid. Members should indicate their vote for a specific candidate by placing their mark inside of the available space created therefore on the ballot form. Any marks made outside of the available space or not clearly marked, would render the member's submitted ballot booklet as being invalid.
- If an error was made or changes were required on one ballot paper, all three ballot papers would need to be replaced and if assistance in this regard is required, the PwC electoral officers would be available to assist. The first set of ballot forms would be cancelled and new ballot forms would be issued for all three ballots.

The Chair proceeded to declare the meeting and voting open.

Confirmation of the agenda:

The Chair presented the agenda for the meeting and requested confirmation thereof. The agenda was confirmed.

The agenda for the meeting was as follows:

1. Welcome and quorum
2. Minutes of the 2016 Annual General Meeting - for approval
3. Tabling of the 2016 Integrated Annual Report, including the Scheme's Annual Financial Statements for the financial year ended 31 December 2015
   - 3.1 Presentation by the Principal Officer of the Discovery Health Medical Scheme
   - 3.2 Presentation by the CEO of Discovery Health (Pty) Limited, the Administrator of the Discovery Health Medical Scheme
4. Governance
   - 4.1 Discovery Health Medical Scheme Trustee Remuneration Policy and approval of the 2017 Trustee Remuneration
   - 4.2 Appointment of Auditors
5. Motions
6. General
7. Voting and Closure of the AGM
   - 7.1 Election of Trustees
   - 7.2 2017 Trustee Remuneration
   - 7.3 Non-binding Advisory vote on the Trustee Remuneration Policy
   - 7.4 Motions
8. Member Engagement

The Chair commented that there were two significant matters that he wished to address prior to proceeding with the agenda and other opening remarks:

- Firstly, Mr Milton Streak ended a significant term of 8 years as Principal Officer of the Scheme and after a rigorous search, Dr Nozipho Sangweni was appointed as Principal Officer of the Scheme on 01 January 2017.
- Prior to being appointed as Principal Officer, Dr Sangweni was the Chief Medical Officer of DHMS and before that also served as a Scheme Trustee and member of the Scheme's Clinical Governance Committee. She has an extensive knowledge of the healthcare and medical industries having worked as Chief Operations Officer at National Health Laboratory Service and as Chief Medical Officer at South African Airways and held other positions within healthcare and aviation medicine before joining DHMS.
- The second matter is that his term as Chair and Trustee ends in August 2017 and that this would be his last AGM. The Board of Trustees has, after discussion, appointed Mr Neil Morrison as Chairman. Neil has a Bachelor of Science in Physics and a Master's degree in Economics. Neil worked as an external consultant for McKinsey and

Company in Johannesburg for the past four years. Previously, he was Special Advisor to the Minister of Public Enterprises until 2004, CEO of Deutsche Bank, Johannesburg Branch and head of their Global Markets division.

The Chair proceeded with the following opening remarks:

- The unprecedented spike in the utilisation of benefits posed a significant challenge for the Scheme in 2016. However, the Scheme's well-established governance and risk management processes, combined with the capability of the Administrator and Managed Care provider, Discovery Health (Pty) Limited ("DH"), supported a strong and swift response. This allowed the Scheme to turn a mid-year forecasted operating loss to an operating surplus by year-end, which in addition to a good investment performance despite extraordinary volatility, returned the Scheme to a robust financial position for 2016 and also for the first half of 2017.
- All deliberations of the Scheme and the Board of Trustees are underpinned by the phrase "in the Interest of members". It is in the interest of members to have claims paid and provide full cover, however, it must be borne in mind that this is sometimes difficult to achieve due to the Rules of the Scheme and the construct of the different benefit plans offered by the Scheme.
- Two hundred and fifty thousand claims are processed each day, with the aim of each one being processed seamlessly, however, inevitably disputes arise which cannot be resolved internally alone, with some warranting referral to the Council for Medical Schemes ("CMS"). The disputes and complaint handling processes improve each year together with all service level metrics that are used to measure member perception, first call resolution and service levels.

The Chair commented that he would proceed to deal with the matters on the agenda. Mr Jonathan Egdes, a principal member of the Scheme, then requested the Chair if he could raise two matters and the Chair commented that these matters could be raised under General.

Confirmation of the Minutes of the 2016 Annual General Meeting (for the financial year ended 31 December 2015)

2. Confirmation of the Minutes of the 2016 Annual General Meeting (for the financial year ended 31 December 2015)

The Chair referred the members to the copy of the Minutes of the 2016 AGM, as included in the meeting pack given to principal members upon registration and which were also published on the Scheme's website.

The minutes were approved.

2016 Annual Financial Statements

3. 2016 Annual Financial Statements and Trustee Report

The Chair advised the members at the meeting that the 2016 Annual Financial Statements for the financial year ending 31 December 2016 were laid before the meeting in terms of Rule 25.1.4 of the Scheme Rules. This meant that no decision was required and that questions could be directed to the Principal Officer and/or the Scheme's Chief Financial Officer and DH's Chief Actuary.

The Chair called upon Mr Jan van Staden and Mr Emile Stipp to take a seat on the stage to answer any questions relating to the 2016 Annual Financial Statements for the financial year ending 31 December 2016.

The Chair enquired of members whether there were any questions on the 2016 Annual Financial Statements for the financial year ended 31 December 2016.

Mr Jim Jones enquired whether the contract with DH was put out to tender and whether the Trustees have the discretion to appoint an administrator:

- The Chair commented that the agreement with DH is a renewable one. The current three year agreement ends in December 2017 and negotiations are underway to renew the Agreement. Deloitte consulting has performed an in-depth analysis and developed a methodology for measuring the value added by DH to the Scheme. The methodology showed that in 2015 for every R1.00 the Scheme spent on administration and managed care services, R1.85 of value was added by DH. This is an increase from the R1.73 of value added in 2014.
- The Chair commented that the administration contract has not gone out to tender for the following reasons:
  - The Trustees of the Scheme do not find it tenable to have a position where different aspects of the Schemes' operations are managed by different providers. It is preferable to have a single provider to deal with all operations in order to ensure seamless delivery.
  - The Trustees are of the view that the value that is derived from the services provided by DH is the best of breed in the industry. The Scheme pays the 9th lowest administration fee when compared to all other open medical schemes.

Mr Egdes proceeded to provide his views on the administration agreement and commented that his view was that the administration fees being paid to DH are large and alluded to, in his view, a "state of capture". He further commented on the electoral processes employed by PwC, whom as part of their process, refused to divulge the number of votes cast for him after standing for election during the 2016 election and that he had proceeded to the CMS and the Minister of Health regarding this refusal with no success and lastly, that in his view, the fees paid to Trustees are excessive.

The Chair advised the members that the following presentations would be made:

- A presentation by Dr Nozipho Sangweni, the Principal Officer of the Scheme.
- A presentation by Dr Jonathan Broomberg, the CEO of DH, the Administrator of the Scheme.

3.1 Presentation by Dr Nozipho Sangweni

A video providing some positive member stories preceded the presentation and Dr Nozipho Sangweni in the context thereof commented that *"This is why we exist, this is our purpose. It is why we get up and work every day. For you, our members. We exist for our members to provide superior levels of care in a sustainable way."*

Dr Sangweni introduced herself as the new Principal Officer of the Scheme and acknowledged her predecessor Mr Milton Streak for his many years of dedicated and excellent service at the helm of the Scheme, under whom she served as the Chief Medical Officer.

Dr Sangweni commenced her presentation by indicating that the presentation would focus on the following:

a. We exist for our members.
b. Sustainability and financial security for member's peace of mind.
c. Extensive member support capabilities.

A. WE EXIST FOR OUR MEMBERS

Dr Sangweni provided an overview of the Scheme's strategic themes and how they were implemented to deliver on the Scheme's purpose:

- Lowest healthcare costs – The Scheme strives to deliver the lowest healthcare costs.
- The Scheme strives to achieve member centric servicing.
- Superior quality of care for members - The patient satisfaction score (PaSS) has increased from 56% in 2013 to 60% in 2016, post sharing results with hospitals.

- Through behavioural economics the Scheme can apply a personalised, predictive and preventative approach to care.
- Best practise outsourcing – An expert review of the Scheme's Vested® outsourcing business model was conducted, with positive results. Recommendations for improvements were made and are continuing to be implemented.
- Withstanding unpredictable market conditions – Despite the difficult market conditions, the Scheme has, through its financial strength, managed an overall investment return of 8.79% for 2016 and 6.01% for 2015.
- Excellent governance and regulatory response – The Scheme ensures that there is excellence in governance with robust structures in place to ensure effective governance.

Dr Sangweni commented that the Scheme is a non-profit organisation that exists for its members. A graphic overview was provided on how the Scheme's key stakeholders interact to create value for its members, described as follows:

- The Scheme: pools all members' contributions in order to fund member claims.
- DH has been appointed by the Trustees to provide administration and managed care services to the Scheme.
- The Scheme is regulated by the CMS, a statutory body responsible for regulating the medical schemes industry in South Africa.
- Financial advisers ("brokers") provide members with independent advice about their health plan options, based on individual medical and affordability needs.
- Healthcare providers are the health professionals that deliver healthcare services, and include, for example, doctors, nurses, dentists, specialists, hospitals and pharmacies.
- Dr Sangweni commented that what is not delineated in the diagram is the relationship that exists among members. The Scheme is not able to source funds from banks. It uses member contributions, and returns from investments to fund member claims. There exists, therefore, a social contract between members, where each member agrees to belong to this mutual fund, with the understanding that today I am well and able to fund you, and tomorrow, the reverse may apply.

The following was illustrated in the slides forming part of the presentation:

- The independent governance structures that exist within the Scheme. At least 50% of Trustees are elected by members. The Board of Trustees is supported by various Board Committees with highly skilled members.
- The Scheme's income is derived from member contributions and investment returns. 87% of contributions received are used for members' direct benefit by funding claims and reserves. In pricing for contributions from members for each year, the Scheme's objective is to achieve a surplus to meet regulatory requirements as well as to have a cushion against unexpected cost increases. This is in accordance with the fundamental operating principles of a non-profit organisation.
- In 2016, R46.7 billion was paid in claims. This is broken down to 44.5% paid to professionals, 37.2% to hospitals, and 16.2% to medicine spend.
- The Scheme cares for every member of the Scheme but particularly cares for members with complex healthcare needs. The highest individual claim paid in 2016 amounted to R6.8 million. This was for a heart and lung transplant for a 37 year old member. This amounts to 199 years' worth of risk contributions to fund the claim. 6 036 individuals claimed over R500 000.00 and 1 378 members claimed over R1 million. *"I look after you today, and tomorrow you do the same for me".*
- A graphic overview was provided of cover ratios and the importance of networks within the Scheme plan ranges. The cover ratio indicates the extent to which members make use of extensive provider networks available to them, in all Scheme plans. Members enjoy exceptional levels of cover as a result, with cover ratios in excess of 92% throughout the plan ranges.

B. SUSTAINABILITY AND FINANCIAL SECURITY FOR MEMBERS' PEACE OF MIND

Dr Sangweni highlighted the key metrics for a sustainable scheme, which include:

- Membership size - Greater risk pooling means more predictable claims experience and accuracy in pricing, leading to stable performance.
- Membership growth - Continuous growth of young and healthy lives improves risk pooling and reflects attractiveness and competitiveness of the Scheme through cross-subsidisation principles.
- Plan movements - Indicates satisfaction, stability in benefit design and appropriate pricing.
- Contribution increases - Reflects effective risk management and value proposition to members.
- Absolute reserves - Demonstrates ability to meet large, unexpected claims variation.
- Pricing sufficiency - Surplus year-on-year reflects contribution levels that are in line with expected membership and claims.

In terms of membership size and growth:

- In 2016, DHMS continued to achieve strong membership growth. Principal members grew by 2.3%, which equates to more than 43 000 lives added in 2016. As of December 2016, the Scheme had 2.74 million lives covered.
- The Scheme's ability to attract young and healthy lives is important to ensure cross subsidisation and sustainability. For every year that the average age of a scheme increases, average claims increase by 3%. It is therefore important to note that the Scheme has aged by less than 1.5 years over a five year period. The new lives have an average age of 25.3 years, thus diluting the current average age of 34.2 years in the existing member base.
- The Scheme's market share in the Quarter 3 of 2016 was standing at 55.2% of open schemes.

In terms of plan movements and contribution increases

- The Scheme has a consistent pattern of stable plan distribution, which indicates member satisfaction with the Scheme's plan design and pricing. Since 2013, 94% of members remain within the same plans.
- When compared against the next 9 largest open medical schemes, the average contribution differential in 2017 was 15.1% for a family of 3. This is an improvement from the 2016 figure which was 14.6%. This means the Scheme is on average 15.1% cheaper than the next 9 open schemes.
- The Scheme has significant reserves to fund members' claims. Regulatory requirements state that the Scheme must maintain a solvency level of at least 25%. The Scheme's solvency level in 2016 was 26.3%, equating to R14.2 billion in reserves. The Scheme maintains an AA+ Global Credit Rating, the only scheme that has been awarded this highest possible rating, which provides assurance that member funds are safe with the Scheme.
- The Chair alluded to a difficult year in 2016 which resulted in a number of risk interventions being put in place. The Scheme's gross healthcare result in 2016 was R5.6 billion, with a net healthcare result of R100 million and a net surplus for the year of R1.3 billion.

Dr Sangweni commented that when combining all key metrics, the result is value generated for members and in terms of the value added assessment performed by DH and reviewed by Deloitte Consulting, for every R1 spent on managed care and administration fees, beneficiaries of the Scheme derived R1.85 in value. The Scheme has ensured a continued decrease in administration expenditure and fees. The administration expenditure as a percentage of gross contribution income, has decreased from 2011 to 2016 to a 10% differential between the Scheme and other third party administered open schemes.

C. EXTENSIVE MEMBER SUPPORT CAPABILITIES

The Scheme maintains high levels of member satisfaction and while the Scheme prides itself on its ability to provide excellent member service, with Member Perception Scores of 9.17/10 and Member Satisfaction Scores of 8.8 out of 10, it continues to strive to do better in delivering better services to members. In 2016, there were less than 800 member complaints submitted to the CMS out of 47.6 million claims processed.

The Scheme works hard to provide support to its members and each day:

- 117 babies are born to the Scheme;
- 250 900 claims are processed;
- 26 600 calls are handled;
- 2 900 hospital admissions are authorised;
- R142 million in claims are paid out;
- 1 350 new lives join the Scheme.

Dr Sangweni closed her presentation commenting that *"The Scheme invests significant resources to ensure that you have a seamless, quality healthcare experience and this is why we exist for you."*

3.2 Presentation by Dr Jonathan Broomberg

The Chair called upon Dr Jonathan Broomberg to present. Dr Broomberg began his presentation by thanking Mr Milton Streak for his superb contribution to a constructive working relationship with DH and also thanked the Chair for going beyond the call of duty and stewarding the Board of Trustees through many complex matters during his tenure.

Dr Broomberg commenced with his presentation and commented as follows:

- The Scheme has shown outstanding performance across all metrics in 2016 with a greater than 2.3% membership growth, a solvency level of 26.3% and R14.2 billion in reserves, the Scheme achieved a AA+ Global Credit Rating and a R103 million operating surplus with a R1.3 billion net surplus.

- DH's strategy for the Scheme focuses on the following :
  - Lower healthcare costs;
  - Improving quality of care for Scheme members;
  - Using digital technology to transform healthcare and member servicing;
  - Making members healthier.

- Dr Broomberg commented on the dramatic turnaround in the Scheme's loss ratio due to effective risk management interventions by DH. Dr Broomberg commented that efforts such as placing case managers in hospitals with high admission rates and implementing clinical reviews for outlier doctors and hospitals has resulted in a R700 million turnaround in projected Scheme claims (equivalent to 2% of total premiums).

A. LOWER HEALTHCARE COSTS

Dr Broomberg graphically illustrated that, as a result of DH's managed care interventions in 2016, the Scheme saved R4.3 billion and the graphic illustrated the buckets where the savings were realised, which include:

- R333 million realised by fraud and forensics initiatives;
- R209 million by implementing interventions in the surgical space;
- R2,017 million by implementing measures to control tariffs;

- R669 million by implementing interventions in the medicines space;
- R1,115 million by funding policy initiatives.

DH and Vitality interventions saved the Scheme R5.6 billion in 2016 and the combined effect of these interventions was a 13.1% effective reduction in the Scheme's risk claims.

There has been a sustained decrease in administration and managed care fees over the past 6 years and the Scheme pays the 5th lowest administration and managed care fees (when ranked against 23 open schemes based on 2015 CMS data) as a percentage of gross contribution income.

B. IMPROVING THE QUALITY OF CARE FOR SCHEME MEMBERS

Dr Broomberg commented that quality of care is a significant area of focus for DH and highlighted the following initiatives in this regard:

- Dr Broomberg provided a graphic overview of the impact the Advanced Illness Benefit has had on the quality of life and costs. The benefit realised estimated savings of R26 million for the Scheme in 2016, as patients that registered for this benefit spent less time in hospital.
- Discovery Homecare continues to remain a focus area and provides unique home-based healthcare services including post-natal care, palliative care, wound care, respite care and home-IV infusions.
- The establishment of an in-hospital psychiatry centre of excellence and the soon to be implemented centre of excellence for major joint replacements i.e. hip and knee.
- The new DiabetesCare programme for Scheme members has seen a high uptake with 5 681 members and 556 providers actively engaged on the programme.
- The Patient Satisfaction Score (PaSS) surveys as a hospital rating tool continue and it is anticipated that the infection and mortality rates survey results will be published for 2017, which are regarded as global measures of hospital performance.

C. USING DIGITAL TECHNOLOGY TO TRANSFORM HEALTHCARE AND MEMBER SERVICING

Dr Broomberg commented that DH has a comprehensive digital strategy which includes the following:

- HealthTap which will significantly enhance the functionality of Health ID.
- HealthTap will provide access to a library of 6 billion curated medical questions and answers. The answers are provided by approximately 10 000 doctors worldwide and it is anticipated that South African doctors will be participants in this library from July 2017.
- Over 1.2 million members have consented to doctors accessing their medical and personal information using Health ID.
- Work will continue on the Smart plan which was introduced by the Scheme in 2015.
- DH has gone live with an Artificial Intelligence powered capability, where a member can ask a question and the engine produces an answer with a 90% accuracy rate.
- Pypestream is a system which will allow chat-based servicing by utilising WhatsApp as a way to communicate with service teams.
- According to the 2016 Independent Benchmarking McKinsey Service Comparison, DH far exceeds the best SLA benchmarks globally.

D. MAKE MEMBERS HEALTHIER

- Dr Broomberg, commented that 132 528 members were screened during wellness days in 2016.
- Vitality impacts positively on overall health engagement levels accounting for 255 000 Vitality health checks conducted, 26 million gym visits and 20 million healthy food baskets bought.

- An increasing number of Scheme members are engaging with Vitality Active rewards, with positive behaviour changes and members increasing their levels of physical activity by 25%.

Dr Broomberg thanked the Trustees and Dr Sangweni for another excellent year of collaboration and informed members that should they have any queries, a team is available outside the conference room to assist with these.

Governance

4. Governance

4.1 Discovery Health Medical Scheme Trustee Remuneration Policy and Trustee Remuneration

The Chair advised that in the absence of Don Eriksson, who is the Remuneration Committee Chairman, Dave King, a member of the DHMS Remuneration Committee, will present the DHMS Trustee Remuneration Policy and the proposed 2017 Trustee remuneration to the meeting.

Mr King commented that the presentation will cover the following aspects:

- Remuneration governance.
- The Trustee Remuneration Policy which includes:
  - Remuneration of the Board of Trustees;
  - Remuneration methodology;
  - Market benchmarking.
- The proposed 2017 Trustee remuneration.

Mr King commented that any questions that members may have, may be directed to himself or the Principal Officer of the Scheme after the presentation. In addition:

- To enable Scheme members to express their views on the DHMS Trustee Remuneration Policy, the Policy will be put to the meeting for a non-binding advisory vote as per King III.
- The 2017 Trustee remuneration will need to be approved by the meeting via ballot, which will take place as part of the voting process and which will be covered as part of the presentations.

A. REMUNERATION GOVERNANCE

- The Board of Trustees is responsible for the development and implementation of a Remuneration Policy for Scheme employees as well as the Board of Trustees and Board Committee members.
- The Board of Trustees has delegated the responsibility of Scheme remuneration oversight to a Remuneration Committee ("REMCO"). The REMCO consists of an Independent Chair and 2 Trustees.
- REMCO makes use of independent expert consultants and independent market benchmarking to assist the Committee in terms of best remuneration practices.
- Trustee remuneration disclosure occurs in 3 forums:
  - At the AGM;
  - To the regulator, being the CMS; and
  - In the Scheme's Integrated Annual Report.

B. REMUNERATION OF THE BOARD OF TRUSTEES

Mr King described how Trustees are remunerated and commented that:

- Annual Trustee fees are split into:
  - An annual base fee paid quarterly in arrears, which is 70% of total remuneration.

- A meeting fee, which is 30% of total remuneration. In the event of non-attendance of a meeting, the meeting fee is not paid.

- The above fees do not include:
  - Fees for Trustee training and Trustees are not paid for attending training or conferences over and above the training fees, travel costs, accommodation and subsistence costs.
  - Trustees are not paid any consulting fees.
  - In addition, Trustees do not participate in any incentive programmes and do not participate in any variable pay structures.
  - Trustees are, however, reimbursed for all reasonable expenses incurred by them in the performance of their duties as a Trustee.

C. REMUNERATION BENCHMARKING

- The CMS issued Circular 41 of 2015, in which it advised that it is not appropriate for schemes to benchmark Trustee remuneration against non-executive directors of listed companies. For this reason, the Scheme engaged PwC's Remuneration Advisory Practise in 2014 to assist in developing a new Trustee remuneration methodology.
- The methodology is based on a professional fee (hourly rate) discounted at an applicable rate and takes into account the number of meetings per year, preparation time for each meeting and duration of each meeting.
- The Chairman of the Board and the Chairs of sub-committees receive higher fees as they are required to be available and dedicate more time to meetings than other Committee members.

D. PROPOSED 2016 TRUSTEE REMUNERATION

- The multi-year fee implementation has been approved at the 2015 AGM by 94.57% of members in attendance during the 2015 AGM. The multi-year implementation is an ongoing staggered process and for 2017 the Trustee fee is based on a professional fee rate of R4 515 less a discount rate of 30%, based on the fact that the Scheme is a non-profit entity. This equates to an hourly fee of R3 160.
- An overview was provided of the practical application of the remuneration methodology indicating the:
  - Professional fee build up for 2017 for the Chairman of the Board - The total fee for the Chairman of the Board, based on the projections presented, amounts to R708 046.08. In addition, the Chair of the Board may also be a member of other sub-committees of the Board.
  - Professional fee build up for 2017 for a Trustee - The total fee for a Trustee based on the projections presented amounts to R404 597.76 per year.
  - Professional fee build up for 2017 for the Chair of a Board Committee - The total fee for a Chairman of a Board Committee based on the projections presented amounts to R237 069.00 per year.

4.2 Appointment of the Auditors

The Chair proposed that PricewaterhouseCoopers be appointed as auditors for the ensuing year on recommendation by the Audit Committee and as approved by the Board. Mr Selwyn Kahlberg seconded the approval of the appointment.

Motions

5. Motions

The Chair commented that two requests for motions were received and that both were assessed by the Board of Trustees and were not considered to be motions as per the guidelines for motions.

General and Closure

6. General

The Chair enquired whether there were any other issues that any member would like to raise under general. In this regard the following can be noted:

- Mr Ronny Silberman thanked Mr Milton Streak and the Chair for their service to the Scheme and also thanked Rishana Singh and her team from the Executive Office within DH for the courteous and efficient manner in which they have dealt and continue to deal with his queries. Mr Silbermann raised the following matter:
  - The video clip introducing Dr Sangweni's presentation is not representative of all race groups. Dr Sangweni commented that her view was that all race groups had been covered. It is also important to note that members share their stories voluntarily and therefore the scope of such a video is limited in terms of ensuring full racial representation.
  - That South African Universities should be consulted for their view on the Vested® relationship and not the University of Tennessee, as American institutions have different views to South African Universities. On this question Dr Sangweni commented that best practise outsourcing, namely Vested® outsourcing is pioneered by the University of Tennessee and the Scheme therefore undergoes the assessment, as developed by them, annually.
  - That he is a Vitality diamond status member and he has put a number of questions to the Head of Vitality with no response. Dr Broomberg committed to providing Mr Silbermann with assistance in this regard.

- Mr Samson Vilakazi commented that the presentation made by Dr Sangweni indicates that there are 1 250 daily member activations and queried how DH ensures that this is sustained, particularly with regard to retention of its own staff. He questioned whether member churn is attributable to economic downturn or service delivery. In addition, what are the three things that would keep DH up at night and if suggestions are proposed from members how these would be processed.
  - Dr Broomberg commented that churn and retention of members is a constant focus for both the Board of Trustees and DH. The Scheme has a churn rate of between 4% to 5% per annum, which is mainly attributable to change of employment by members. DH has a dedicated team in place to deal with members who wish to leave the Scheme and who engage members on their reasons for leaving. A very small percentage of member churn is attributable to benefits not being appropriate and an even smaller percentage to service.
  - Dr Broomberg commented that with regard to staff retention, the churn rate is akin to that of any call centre environment due to younger people being employed in these positions. The current DH churn rate is at 15%, which is below the industry average.
  - Dr Broomberg commented that the risk of technology and systems being up 99.9% of the time is something that would keep DH up at night e.g. power outages and telephone lines down have a significant impact on servicing members by increasing calls, with a resultant impact of increasing complaints. This risk is managed very carefully with focused teams dealing with these matters.

- Mr Jhavery queried the deficits on the KeyCare and Coastal Saver plans and what practical plans are in place to address this. Dr Broomberg commented that with regard to KeyCare, the main reason for the deficit is pensioners with very high utilisation. Initiatives to manage this include benefit design review, risk interventions, network

optimisation and fraud prevention. The deficits on the Coastal Saver plan are attributable to utilisation increasing faster than premiums and the opening of a number of new hospitals in coastal areas, which risk is being managed.

- Mr Songezo Mabele raised the following questions:
  - How does the Board of Trustees induct a new Trustee and how is non-performance of a Trustee addressed. The Chair commented that a Trustee is elected for a 3 year term where after the Trustee may be re-elected. This re-election is not automatic. The job of a Trustee is particularly rigorous and the level of involvement required by a Trustee is great. Trustees have a peer review mechanism which results are discussed at the Board meeting. With regard to performance of a Trustee, the self-correcting mechanism is for the Chair to deal with a non-performing Trustee. With regard to training there are a number of training courses available for Trustees including one offered by the CMS.
  - With regard to the constitutional court ruling regarding member Medical Savings Account Funds, would the funds be protected in the event of insolvency. The Chair commented that the Genesis ruling reverses the decision of a previous judgement which provided that Medical Savings Account ("MSA") funds were trust funds. The new position under the Genesis judgment implies that Scheme no longer has to create a separate trust account for the maintenance of MSA funds. The accounting treatment of MSA funds based on the judgement require clarification from the regulatory authorities and this is being awaited.
  - Mr Mabele raised a query regarding cover and the date at which cover is effective and an experience that he has had with his employer in terms of late physical notification of membership. Dr Broomberg undertook to address this matter with the member after the meeting.

- Pat Sidley requested the Scheme to comment on its views regarding NHI and what proposed measures would be taken to ensure the sustainability of the Scheme. The Chair commented that private healthcare is a national asset and access to private healthcare is a national right. Universal access to healthcare is a right of all individuals and is something we all aim to achieve. Dr Broomberg commented that it is difficult to provide a definitive view as there is no clarity on the NHI model being proposed. The current views are that medical schemes will still be able to cover benefits not provided by NHI. Medical schemes will be carriers of NHI benefits where members would join a medical scheme for minimum NHI benefits for the formally employed and an NHI fund would carry cover for those not formally employed.

- Mr Morton raised a matter regarding the refusal of healthcare practitioners to refer members to a hospital in Krugersdorp due to the risk of infection. This decision displaces a number of members in the Randfontein, Carltonville and surrounding areas who are forced to go to Honeydew in order to be treated. In this regard the member questioned whether hospital inspections were conducted by DH and if yes, the frequency of these inspections. Dr Broomberg commented that the Health Networks Standards Authority is the official body entrusted to conduct inspections. DH is however very aware of issues regarding quality of care around infection rates and nursing standards and if significant matters are raised, hospitals may be removed from networks. Dr Broomberg commented that they will make enquiries regarding what the issues are.

- Mr Zak requested that an individual from Vitality contact him in order to discuss the Vitality rewards partners. The Chair advised that Vitality is a separate entity to the Scheme and that they need to be contacted separately.

- Mr Zubrinic questioned the process with regard to approval of chronic medication and whether an assessment is conducted on what medication the member is currently on and whether the member's doctor is consulted prior to any cover being declined. In addition, he finds it very difficult to achieve 90 000 Vitality point this year and is being forced to buy advanced tech to monitor his heart rate, blood pressure, etc. Dr Broomberg commented that the Vitality question is to be answered by Vitality and that his details would be obtained in this regard. With regard to chronic medication, most plans have a formulary. In terms thereof, if members chose a non-formulary drug they

will have a co-payment. With regard to a doctor who has requested that a member use a non-formulary drug there is a clinical appeal mechanism to facilitate this and that he should provide his details so that he can be assisted.

- Dr Brynard commented that her experience throughout the nomination process has been a very positive one. PwC was professional in all respects. A manifesto is not something that she would take into account in selecting a candidate. Her measure of the quality of a candidate is the work being done on the Board once they are appointed. She is also the mother of a handicapped child and the Scheme has done nothing but support her and her child.

7. Closure

There being no further business, the Chair closed the meeting and thanked all for attending.