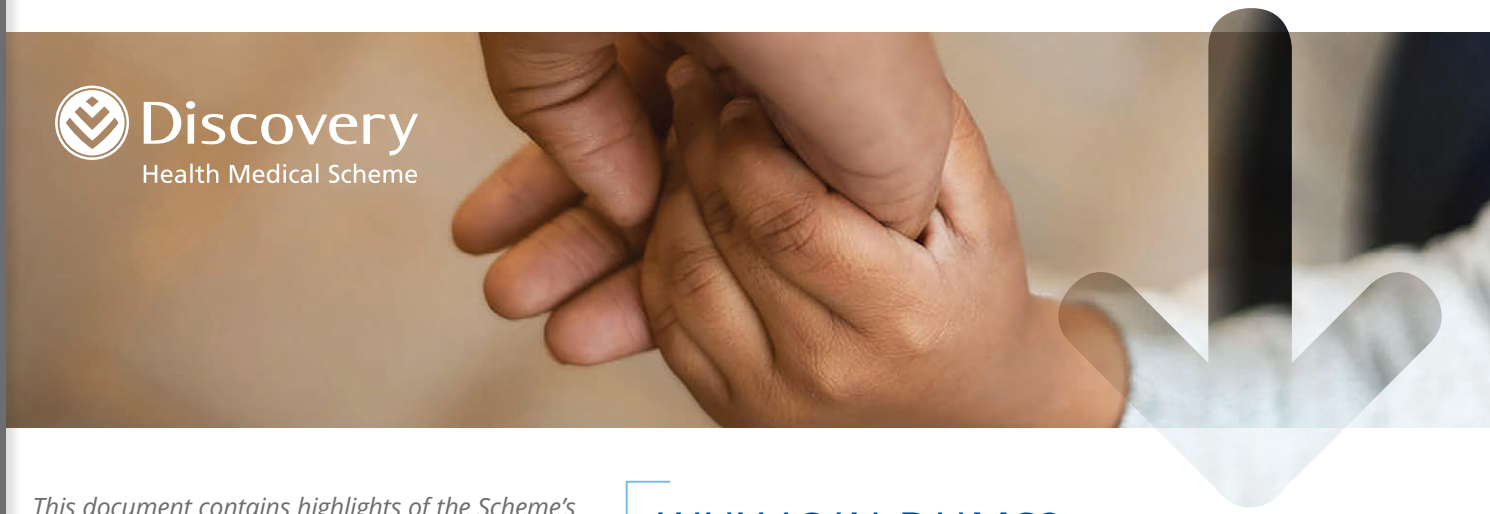
HIGHLIGHTS OF DISCOVERY HEALTH MEDICAL SCHEME'S RESULTS FOR 2018

Discovery
Health Medical Scheme



This document contains highlights of the Scheme's performance for the year ended 31 December 2018, extracted from the 2018 Integrated Report. The financial information has been extracted from and is in agreement with the Financial Statements, audited by PricewaterhouseCoopers Inc.

WHO WE ARE

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

The Scheme's purpose is 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.

COVERING
2 819 139
BENEFICIARIES
at 31 December 2018

DHMS IS THE
LARGEST OPEN MEDICAL SCHEME
in South Africa

WITH AN OPEN MEDICAL SCHEME
MARKET SHARE OF 56.6%[1]

DHMS is a non-profit entity governed by the Medical Schemes Act[2] (the Act) 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 activities.

The Scheme outsources its administration and managed care functions through a formal contractual arrangement with Discovery Health (Pty) Ltd (Discovery Health).

1 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Reports for the period ending 30 September 2018 (www.medicalschemes.com/Publications.aspx).*
2 *Medical Schemes Act 131 of 1998, as amended.*

WHY JOIN DHMS?

Quality of care is key to our membership proposition

One of the Scheme's key strategic priorities is to drive value-based healthcare. This delivery model places members at the centre of care and ensures that providers are reimbursed based on health outcomes, not inputs. This ensures that it is the health results that matter, not the volume of services delivered. This approach gives our members 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 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 your investment in membership takes care of you

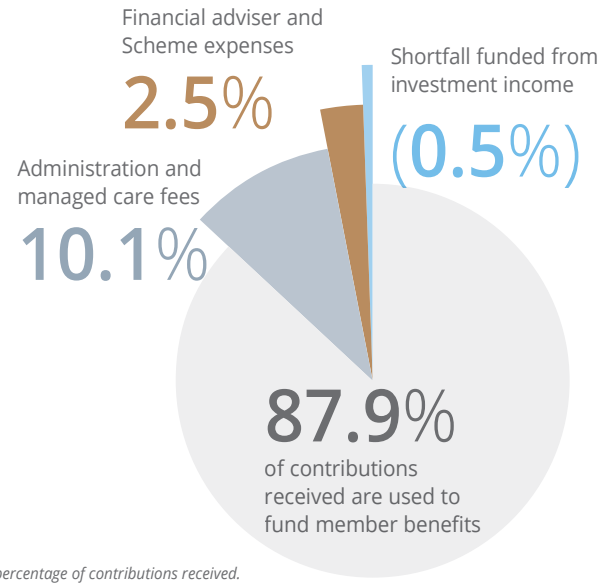
The Scheme's income is only derived from member contributions and investment returns. The Scheme pools all members' contributions to fund members' claims, and any surplus funds are transferred to Scheme reserves for the security and benefit of members.

In setting 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 accords with the fundamental operating principles of a non-profit organisation that must meet the claims needs of its members as well as maintaining a statutory level of reserves.

The Scheme's income is used to fund activities to support and benefit our 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.

2018 DHMS EXPENSE BREAKDOWN*



* *As a percentage of contributions received.*

The full 2018 Integrated Report is available at ***www.discovery.co.za/info/DHMSreports.***

OUR PRINCIPAL OFFICER'S REVIEW OF THE YEAR

Performance overview

Despite many challenges over the past year, DHMS has been able to fulfil our purpose of caring for our members' health and wellness while also safeguarding their funds. We ended the year in a very solid position across all key measures for the growth and sustainability of the Scheme.

Our final net healthcare result for the year was a negative R352 million (2017: positive healthcare result of R968 million). This operating result was affected by absorbing the impact of higher Value Added Tax (VAT) on behalf of our members, and supported by effective risk management interventions that mitigated the financial impact of higher utilisation during the year. The 1% point increase in VAT drove claims and other expenditure up unexpectedly by approximately R350 million, which shows that in the absence of the VAT increase, the Scheme's net healthcare result would have been at break-even.

Another year of satisfactory investment performance, despite volatile markets, bolstered the Scheme's financial position. Investment income of R1 465 million (2017: R1 433 million) contributed to a net surplus for the year of R816 million. While the net surplus was down substantially from R2 450 million in 2017, member funds therefore remained robust at R17.6 billion (2017: R16.7 billion) and the Scheme achieved a solvency level of 27.3% (2017: 27.44%), above the required minimum of 25%. With solvency at this level, the Scheme has an intended adequate buffer against unexpected poor claims experience or low investment returns. The Scheme is careful to balance the need for adequate solvency levels in the short and medium term against allowing solvency to grow too large as this could result in an inefficient use of members' financial resources.

Managing difficult trade-offs for sustainability

The affordability constraints our members are experiencing in relation to their medical cover are of deep concern to us. While current economic conditions are forcing our members to make difficult decisions about how they allocate their income, the absence of medical cover can result in devastating consequences for families should unforeseen life events occur. Also, gaps in cover may result in a longer-term negative financial impact as schemes may impose late joiner penalties in these instances, to protect their risk pools.

Our first consideration in delivering the best possible value to our members, notwithstanding affordability concerns, is to continue to enhance the benefits they pay for wherever and whenever we can. An example during the year was enhancing our maternity benefit to provide comprehensive maternity and post-birth benefits to families, with guidance and support specifically focused on young families delivered through the member app.

Healthcare inflation continues, stubbornly, to outpace the consumer price index (CPI). To manage this risk, we focus on containing healthcare costs in every way we can. Wherever possible, we push for value-based contracting to optimise access to quality care at the lowest possible cost. This migration from the traditional fee-for-service payment model is critical in delivering sustainable value to our members, with multidisciplinary healthcare teams delivering less fragmented and better health outcomes for our members.

In this regard we also monitor global healthcare trends, which inevitably affect our members more over time. Already a grave public health concern is the presence of antibiotic-resistant infections – so called "superbugs" – which are stimulated by the overuse of antibiotics, and result in escalating claims costs. We consider minimising the impact of such concerning trends to be core to our responsibility to our members, and to greater society.

A more specific intervention during the year, to ease the financial burden on our members, was the Board's decision not to implement an interim contribution increase during 2018 but rather to absorb the cost increase due to higher VAT. Mindful that medical scheme contributions already make up a high proportion of our members' monthly expenses, the Trustees decided that the Scheme's strong financial position made it possible to absorb the VAT impact for 2018.

During the early months of 2018, the Scheme continued to experience a high hospital admission rate. These appeared to be largely short length of stay medical admissions, linked in part to higher occurrences of seasonal viral infections in particular among our more vulnerable members, including children. Interventions were introduced to ensure clinically appropriate hospital admissions and to manage the claims risk to the Scheme. Health benefit specialists were placed in key hospitals to assist members and providers in understanding and accessing member benefits, to balance appropriate levels of care with the Scheme's financial stability.

We are conscious that certain of our risk management interventions may be disruptive for some of our stakeholders, and we do whatever we can to balance the needs of all of our stakeholders in implementing them. Our duty of care as a medical scheme, however, requires that we make use of evidence-based healthcare delivery models that continually improve the quality of care as cost-effectively as possible.

For example, going into 2019, we introduced the use of a day surgery network for certain procedures on certain plans. The South African private healthcare sector lags behind other developed healthcare systems in the use of same-day surgery. In the US, for example, over 85% of eligible hospital admissions occur on a same-day basis. In South Africa, the rate is below 20%, with the vast majority of procedures carried out in general acute hospitals. Shifting a higher proportion of suitable patients to same-day surgery centres is a well-proven approach to improving quality of care and patient convenience, and to reducing cost.

Fraud, waste and abuse are unfortunately all too common in healthcare. They drive inflationary pressure in the system, and the misappropriation of limited resources ultimately has an adverse effect on the members and the sustainability of schemes. The Council for Medical Schemes (CMS) estimates that up to 15% of all claims in our sector are fraudulent, which amounts to a negative impact of an estimated R25 billion. In effect, this staggering amount is stolen from honest scheme members, reducing their funds and ability to access healthcare. DHMS is determined to combat this scourge to the best of our ability.

In 2018, the Scheme's savings and recoveries totalled approximately R500 million. We estimate our fraud and waste prevention strategies have resulted in a 'halo effect' of benefit to the Scheme of an estimated R4 billion in the past five years. Our Administrator and Managed Care Provider, Discovery Health, has invested significantly in proprietary forensic skills and assets that enable continuous monitoring of claims and identification of unusual claims patterns. We also continue to work closely with all stakeholders in reaching a common understanding of the drivers of fraud and waste. We are grateful to our regulator, the Council for Medical Schemes (CMS) and our industry body, the Health Funders Association (HFA), for their leadership in this regard, specifically the initiatives resulting from the Fraud, Waste and Abuse Industry Charter recently signed by sector stakeholders.

Contributing to positive healthcare reform

As our Chairperson has noted[1], healthcare reform gathered pace in the year. Our approach at this critical juncture in the development of the South African healthcare environment is to be found in our vision, in which the Scheme commits to collaborating with all relevant stakeholders to shape an inclusive and complete healthcare system in South Africa. In particular, we fully support the objectives of universal health coverage, and will continue to work with all parties to achieve it.

While we agree with the Minister of Health, Dr Aaron Motsoaledi, that addressing the challenges in the public healthcare system is crucial, retaining the role of the private sector in building a truly equitable and inclusive healthcare system is an absolute imperative. As such, we continue to engage and submit comments and contributions to all health reform initiatives.

We note that the Medical Schemes Amendment Bill (MSAB) appears to be on hold pending the release of the final Health Market Inquiry (HMI) Report, due in September 2019. We support the many positive recommendations in the Provisional HMI Report, which we believe will improve the functioning of the private healthcare market, including reinforcing the need for rigorous and excellent governance of schemes by fit and proper and highly competent trustees.

In another development, the proposed amendments to the Competition Act will influence the nature of competition in the South African economy. The amendments promote further inclusion of small and medium enterprises and those with historically disadvantaged ownership. Similarly, while we support the principle of the amendments, care must be taken to ensure effective competition that will stimulate and grow the economy at the levels we need to achieve dramatically higher levels of employment and socioeconomic equity.

Closing and appreciation

The Scheme Office welcomes our new Chief Financial Officer, Ms Charlotte Mbewu-Sanqela, who joined DHMS on 1 March 2019. Ms Mbewu-Sanqela has extensive experience in the medical schemes environment. Our Chief Operations Officer, Mr Selwyn Kahlberg, ably held the position in the interim and I thank him for being a safe pair of hands in what has been a challenging period for the Scheme.

My gratitude to the Trustees, Independent Committee members and to the Scheme Office team for their thought leadership and hard work in protecting and growing the Scheme despite the operational constraints and financial pressures.

Our members can rest assured that their funds, and their Scheme, are secure and sustainable and will be able to provide for their healthcare needs into the future.

Dr Nozipho Sangweni
PRINCIPAL OFFICER

1 *Chairperson's comments can be found in the Chairperson's Report in the 2018 Integrated Report.*

EXTRACTS FROM THE AUDITED ANNUAL FINANCIAL STATEMENTS

Statement of Financial Position

As at 31 December 2018

R'000	2018	2017
ASSETS		
Non-current assets	**22 377**	4 417
Property and equipment	**14 116**	–
Long Term Employee Benefit Plan asset	**8 261**	4 417
Current assets	**28 796 006**	25 728 677
Financial assets at fair value through profit or loss	**20 519 767**	14 005 644
Derivative financial instruments	**142 856**	85 857
Trade and other receivables	**2 357 902**	1 147 665
Cash and cash equivalents		
– Personal Medical Savings Account trust assets	**–**	4 609 149
– Medical Scheme assets	**5 775 481**	5 880 362
Total assets	**28 818 383**	25 733 094
FUNDS AND LIABILITIES		
Members' funds	**17 646 355**	16 684 435
Accumulated funds	**17 646 355**	16 684 435
LIABILITIES		
Non-current liabilities	**10 316**	–
Leases	**10 316**	–
Current liabilities	**11 161 712**	9 048 659
Leases	**1 600**	–
Outstanding claims provision	**1 499 227**	1 240 063
Derivative financial instruments	**–**	86 445
Personal Medical Savings Account liabilities	**5 040 832**	4 656 633
Trade and other payables	**4 620 053**	3 065 518
Total funds and liabilities	**28 818 383**	25 733 094

Statement of Comprehensive Income

for the year ended 31 December 2018

R'000	2018	2017
Risk contribution income	**52 828 931**	48 702 024
Relevant healthcare expenditure	**(46 718 953)**	(41 747 808)
Net claims incurred	**(45 099 436)**	(40 228 057)
Claims incurred	**(45 186 030)**	(40 371 417)
Third party claim recoveries	**86 594**	143 360
Accredited managed healthcare services (no risk transfer)	**(1 653 972)**	(1 534 311)
Net profit on risk transfer arrangements	**34 455**	14 560
Risk transfer arrangement fees	**(382 719)**	(392 023)
Recoveries from risk transfer arrangements	**417 174**	406 583
Gross healthcare result	**6 109 978**	6 954 216
Broker service fees	**(1 313 741)**	(1 214 205)
Expenses for administration	**(4 875 746)**	(4 511 596)
Other operating expenses	**(272 952)**	(260 461)
Net healthcare result	**(352 461)**	967 954
Other income	**1 457 721**	1 893 686
Investment income	**1 465 105**	1 433 187
Net (losses)/gains on financial assets	**(69 315)**	458 753
Sundry income	**61 931**	1 746
Other expenditure	**(289 456)**	(411 666)
Expenses for asset management services rendered	**(71 366)**	(44 428)
Finance costs	**(218 090)**	(367 238)
Net surplus for the year	**815 804**	2 449 974
Other comprehensive income	**–**	–
Total comprehensive income for the year	**815 804**	2 449 974

Statement of Changes in Funds and Reserves

for the year ended 31 December 2018

R'000	2018 Accumulated funds	2017 Accumulated funds
Balance at beginning of the year	**16 684 435**	14 234 461
Total comprehensive income for the year	**815 804**	2 449 974
Transfer of reserves from other medical schemes	**146 116**	–
Total member funds end of the year	**17 646 355**	16 684 435

Statement of Cash Flows

for the year ended 31 December 2018

R'000	2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash flows generated from operations before working capital changes	**(254 606)**	1 017 921
Working capital changes:		
(Increase)/decrease in trade and other receivables	**(1 313 257)**	822 739
Increase in outstanding claims provision	**259 164**	118 669
Increase in Personal Medical Savings Account liabilities	**384 199**	452 590
Increase in trade and other payables	**1 554 535**	1 759 273
Cash generated by operations	**630 035**	4 171 192
Payments for financial assets	**(9 618 505)**	(2 953 775)
Proceeds from sale of financial assets	**2 891 623**	1 669 533
Increase in Long Term Employee Plan asset	**(7 371)**	(3 848)
Cash transferred from other medical schemes	**146 116**	–
Interest received	**1 302 974**	1 349 125
Dividend income	**162 131**	84 062
Interest paid	**(217 415)**	(367 238)
Net cash (outflow)/inflow from operating activities	**(4 710 412)**	3 949 051
CASH FLOWS FROM INVESTING ACTIVITIES		
Payment for property and equipment	**(2 844)**	–
Net cash outflow from investing activities	**(2 844)**	–
CASH FLOWS FROM FINANCING ACTIVITIES		
Payment of lease liabilities	**(774)**	–
Net cash outflow from investing activities	**(774)**	–
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS	**(4 714 030)**	3 949 051
Cash and cash equivalents at beginning of the year	**10 489 511**	6 540 460
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR	**5 775 481**	10 489 511
Cash and cash equivalents compromise		
Personal Medical Savings Account trust assets	**–**	4 609 149
Medical Scheme assets	**5 775 481**	5 880 362
	5 775 481	10 489 511

Solvency

The Medical Schemes Act 131 of 1998, as amended (the Act) requires the Scheme to maintain accumulated funds of 25% of gross annual contributions for the accounting period, in terms of Regulation 29 (2).

At 31 December 2018, the Scheme's solvency level of 27.3% (2017: 27.44%) of gross annual contributions was R1.5 billion (2017: R1.5 billion) more than the statutory solvency requirement.

Calculation of regulatory capital requirement	**December 2018 R'000**	December 2017 R'000
Total members' funds	**17 646 355**	16 684 435
Less cumulative net gain on re-measurement of investments	**–**	(298 722)
Total net assets (Regulation 29)	**17 646 355**	16 385 713
Gross annual contributions	**64 649 012**	59 710 735
Solvency ratio	**27.30%**	**27.44%**
Average accumulated funds per member at year end	**13 063**	**12 859**

Financial assets at fair value through profit or loss

Accounting policy:

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

Financial assets at fair value through profit or loss are initially recognised at fair value and the transaction costs are expensed in the surplus or deficit section of the Statement of Comprehensive Income.

The fair value of the financial instruments traded in an active market is determined by using quoted market prices or dealer quotes. The fair value of financial instruments not traded in an active market is determined by using valuation techniques that maximise the use of observable market data and rely as little as possible on entity specific estimates.

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

Note:

R'000	**2018**	2017
The Scheme's financial assets at fair value through profit or loss are summarised by measurement classes as follows:		
Current assets	**20 519 767**	14 005 644
– Offshore bonds	**847 314**	1 463 064
– Equities	**4 038 399**	3 378 331
– Yield-enhanced bonds	**5 631 601**	3 721 190
– Inflation-linked bonds	**1 104 552**	792 666
– Money market instruments	**8 324 805**	4 268 369
– Listed property	**573 096**	382 024
	20 519 767	14 005 644
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	**14 005 644**	12 211 677
Acquisitions	**9 618 505**	2 953 775
Disposals	**(2 816 057)**	(1 571 646)
Net (losses)/gains on revaluation of financial assets at fair value through profit or loss	**(288 325)**	411 838
At the end of the year	**20 519 767**	14 005 644

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

Personal Medical Savings Account liabilities

Accounting policy:

The Scheme Rules for Personal Medical Savings Accounts (PMSAs) were amended, effective from 1 January 2018. The effect of the amendment is that a trust relationship is no longer established. In the prior reporting period, PMSAs were disclosed as trust liabilities. Following the Rule amendment these liabilities are no longer trust liabilities and no longer disclosed as trust liabilities. There were no other changes to the valuation or classification of PMSAs.

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.

Note:

R'000	2018	2017
Balance on Personal Medical Savings Accounts at the beginning of the year	**4 656 633**	4 204 043
Add:		
Personal Medical Savings Accounts contributions received or receivable	**11 820 081**	11 008 711
For the current year	**11 820 081**	11 008 711
Interest on Personal Medical Savings Accounts	**220 294**	367 238
Transfers received from other medical schemes	**24 393**	31 784
Less:		
Claims paid to or on behalf of members	**(11 279 740)**	(10 602 298)
Refunds on death or resignation	**(400 829)**	(352 845)
Balance due to members on Personal Medical Savings Accounts at the end of the year	**5 040 832**	4 656 633

It is estimated that claims to be paid out of members' PMSAs in respect of claims incurred in 2018 but not reported will amount to approximately R88 100 000 (2017: R83 200 000).

As at 31 December 2018 the carrying amount of the 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.

R'000	2018	2017

Cash and cash equivalents – Personal Medical Savings Account trust assets

(Monies managed by the Scheme on behalf of members)
Note:

PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO (Managed by Aluwani Capital Partners (Pty) Ltd)		
Balance at beginning of the year	**2 304 818**	2 071 391
Net (withdrawal)/additional Investments	**(2 395 237)**	55 608
Interest Income	**90 419**	177 819
Balance at the end of the year	**–**	2 304 818
PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO (Managed by Taquanta Asset Managers (Pty) Ltd)		
Balance at beginning of the year	**2 304 331**	2 071 281
Net (withdrawal)/additional Investments	**(2 381 615)**	61 143
Interest Income	**77 284**	171 907
Balance at the end of the year	**–**	2 304 331
Total Personal Medical Savings Account trust assets	**–**	4 609 149

Effective from 1 January 2018, the Scheme Rules were amended and Personal Medical Savings Account (PMSA) assets are no longer defined and treated as trust assets and these assets now form part of the Scheme assets and are included as part of the Scheme Cash and cash equivalents. In the prior year, these funds were treated as trust 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 were invested separately from the Scheme's assets. The difference between total Personal Medical Savings Account assets and Personal Medical Savings Account liabilities arose from timing of cash flows to and from the portfolios and was reconciled monthly. The average rate earned on the Personal Medical Savings Account Trust assets during 2017 was 8.33%.

OPERATIONAL STATISTICS PER BENEFIT PLAN

for the year ended 31 December 2018

December 2018	Executive	Classic Comp	Classic Core	Classic Saver	Classic Priority	Essential Comp
Number of members at the end of the accounting period	9 813	134 349	50 279	302 177	89 861	15 653
Number of beneficiaries at the end of the accounting period	21 082	297 212	108 239	663 032	203 166	29 249
Average number of members for the accounting period	10 086	137 597	49 812	301 250	91 394	15 995
Average number of beneficiaries for the accounting period	21 734	305 549	107 439	659 519	206 262	30 020
Average risk contributions per member per month (R')	7 745	6 212	3 546	3 354	4 257	5 309
Average risk contributions per beneficiary per month (R')	3 594	2 798	1 644	1 532	1 886	2 829
Average net claims incurred per member per month (R')	10 042	6 390	2 686	2 597	3 589	4 744
Average net claims incurred per beneficiary per month (R')	4 660	2 878	1 245	1 186	1 590	2 527
Average administration costs per member per month (R')	334	333	334	334	334	333
Average administration costs per beneficiary per month (R')	155	150	155	152	148	178
Average managed care: Management services per member per month (R')	103	103	103	103	103	103
Average managed care: Management services per beneficiary per month (R')	48	46	48	47	46	55
Average family size at 31 December	2.15	2.21	2.15	2.19	2.26	1.87
Loss ratio (%)	131%	105%	79%	81%	87%	91%
Total non-healthcare expenses as a percentage of risk contributions (%)	6%	7%	12%	13%	11%	9%
Average non-healthcare expenses per member per month	447	448	432	444	448	449
Average non-healthcare expenses per beneficiary per month	207	202	200	203	199	239
Average age of beneficiaries (years)	44.91	41.56	39.18	32.54	38.47	43.57
Pensioner ratio (beneficiaries over 65 years)	24%	18%	14%	7%	13%	22%
Average relevant healthcare expenses per member per month	10 151	6 503	2 789	2 700	3 692	4 856
Average relevant healthcare expenses per beneficiary per month	4 711	2 928	1 293	1 233	1 636	2 587
Net surplus/(deficit) per benefit plan	(337 379)	(1 110 523)	246 407	998 019	199 678	13 262

Essential Core	Essential Saver	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Access	Classic CompZero MSA	Classic Smart	Essential Smart	Total
42 305	128 611	6 384	184 540	81 100	232 791	14 561	4 599	915	30 607	22 309	**1 350 854**
91 012	270 854	13 017	417 639	181 951	406 661	23 309	6 573	1 990	58 281	25 872	**2 819 139**
40 343	124 268	6 426	184 229	80 846	227 771	13 644	4 507	929	27 947	18 049	**1 335 093**
86 838	261 327	13 121	417 251	181 288	397 742	21 800	6 403	2 015	53 406	20 870	**2 792 583**
2 818	2 760	3 808	2 994	2 931	1 807	1 529	1 195	6 158	2 524	1 374	**3 297**
1 309	1 313	1 865	1 322	1 307	1 035	957	841	2 841	1 321	1 188	**1 576**
1 954	1 783	2 224	2 509	2 493	1 760	1 075	535	5 400	1 607	649	**2 815**
908	848	1 089	1 108	1 112	1 008	673	376	2 491	841	561	**1 346**
334	334	334	334	334	181	97	116	334	333	334	**304**
155	159	163	147	149	104	61	82	154	174	289	**146**
103	103	103	103	103	103	103	103	103	103	103	**103**
48	49	51	46	46	59	65	73	48	54	89	**49**
2.15	2.11	2.04	2.26	2.24	1.75	1.60	1.43	2.17	1.90	1.16	**2.09**
73%	68%	61%	87%	89%	102%	77%	53%	90%	67%	56%	**88%**
15%	16%	12%	15%	15%	14%	11%	14%	7%	17%	29%	**12%**
426	433	443	439	429	252	160	171	447	420	392	**403**
198	206	217	194	191	144	100	120	206	220	339	**193**
35.96	30.37	37.76	34.65	38.68	29.64	35.53	33.10	40.05	30.80	33.81	**34.91**
10%	5%	13%	8%	13%	7%	12%	7%	13%	4%	4%	**10%**
2 057	1 886	2 327	2 612	2 596	1 845	1 178	635	5 520	1 689	767	**2 916**
956	897	1 140	1 153	1 158	1 057	738	447	2 546	884	663	**1 394**
204 151	756 292	85 085	17 494	(6 029)	(558 058)	45 394	25 719	3 104	168 028	65 139	**815 783**

MATTERS OF NON-COMPLIANCE

for the year ended 31 December 2018

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

During 2018, the Scheme did not comply with the following Sections and Regulations of the Act:

Sustainability of benefit plans

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

For the year ended 31 December 2018 the following plans did not comply with Section 33(2):

R'000	Net healthcare result	Net (deficit)/ surplus
Benefit plan		
Executive	**(345 344)**	**(337 379)**
Classic Comprehensive	**(1 219 176)**	**(1 110 503)**
Coastal Saver	**(127 647)**	**17 494**
Coastal Core	**(90 170)**	**(6 029)**
KeyCare Plus	**(794 822)**	**(558 058)**

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

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

Investments in employer groups and medical scheme administrators

Section 35(8)(a) 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. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide. CMS has granted DHMS exemption for a period of 12 months effective from 1 April 2018.

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 Medical Schemes Act 131 of 1998. The Scheme was granted an exemption to invest in offshore derivatives, subject to certain conditions, which expired on to 31 December 2018. The Scheme submitted an exemption application to CMS on 6 November 2018, which at the date of publication of this report is still being considered.

Contributions received after due date

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

Broker fees paid

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

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

International travel cover

In Section 1 of the Act, the business of a medical scheme is defined as making provision for, granting assistance in defraying expenditure incurred in connection with or rendering a relevant health service in return for a contribution. As part of the Scheme's international cover benefit, amounts relating to the repatriation of mortal remains were funded up to April 2017. The repatriation of mortal remains is no longer offered by the Scheme and payments made by the Scheme related to repatriation have been recovered.

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 two instances during the year where the Scheme inadvertently went into an overdrawn position due to the timing of inflows from the Scheme's investments not matching the timing of outflows. Additional processes have been implemented to mitigate the risk of this re-occurring.

Matters of non-compliance *continued*

Amounts debited to scheme bank account

Section 26(4) of the Act provides that no amount may be debited to a scheme bank account other than

- payments by a medical scheme of any benefit, payable under the rules of a medical scheme;
- costs incurred by the medical scheme in the carrying on of the business as a medical scheme; or
- amounts invested by the Board of Trustees.

During the year under review a total of R4 614 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 has subsequently been refunded to the Scheme and additional controls implemented to mitigate this occurring again.

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 were reprocessed and correctly paid prior to the end of the benefit year.

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".

Due to a conflict in the payment run dates that were loaded on to the administration system for the generation of cheques to members and providers, 26 claims to the value of R22 280 were paid after 30 days. The value of exceptions should be considered in the context of approximately 50 million claims processed and net claims incurred of R45 billion in 2018. This error is not expected to re-occur as the Scheme no longer reimburses claims by means of cheque payments.

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 dependant and one child dependant (i.e. a family of three). These average contributions are then weighted (for DHMS and the next eight largest open schemes) according to the distribution of members across DHMS plans. This ensures that plans with similar benefits are being compared on a like-for-like basis, thereby providing a reasonable estimate of the lower contribution that a typical member of DHMS pays relative to members of similar options in competitor schemes.*

2 *Based on beneficiaries, according to the Council for Medical Schemes Quarterly Reports for the Period ending 30 September 2018 (www.medicalschemes.com/Publications.aspx).*

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

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

5 *How many times the Scheme is able to cover its monthly claims expense with its liquid investments.*

ENSURING THE SCHEME'S SUSTAINABILITY

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

GROWTH AND SUSTAINABILITY

RELATIVE CONTRIBUTION LEVELS

Reflects value for money for members, effective risk management and value added by the Administrator.

Average contributions 16.5%[1] lower than the next eight largest open schemes (2017: 16.4%)

MEMBERSHIP SIZE

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

2 819 139 beneficiaries as at 31 December 2018 (2017: 2 777 946)

56.6%[2] share of open scheme market (2017: 55%)

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 growth 2.07% (2017: 2.08%)[3]

Average beneficiary growth 1.48% (2017: 1.59%)[3]

Average age at year end 34.91 (2017: 34.50)[4]

9.83% pensioner ratio (2017: 9.33%)

5% annualised lapse rate (2017: 5%)

PLAN MOVEMENTS

Indicates member satisfaction, stability in benefit design and appropriate pricing.

94.24% plans did not change in 2018 (2017: 93.86%)

3.24% plans were upgraded (2017: 2.91%)

2.52% plans were downgraded (2017: 3.23%)

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 27.3% (2017: 27.44%) exceeding the statutory solvency requirement of 25%

AAA independent credit rating for claims paying ability[5] (2017: AAA)

PRICING SUFFICIENCY

Surplus year-on-year reflects contribution levels that are in line with expected membership and claims, notwithstanding the impact of the increase in VAT from 14% to 15% during the year.

Net surplus for the year of R816 million (2017: R2 450 million)

PRUDENT INVESTMENT MANAGEMENT

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

5.85% gross return on investments (2017: 10.00%)

VALUE-ADDED ADMINISTRATION AND MANAGED CARE

For every R1.00 spent by DHMS on administration and managed care fees in 2017, members of DHMS received R2.02 (2016: R2.00) in value from the activities of Discovery Health (Pty) Ltd.

This is equivalent to nominal added value of R6.24 billion in 2017 (2016: R5.56 billion).

Administration fees 7.54% of gross contributions (2017: 7.56%)

Managed care fees 2.56% of gross contributions (2017: 2.57%)

DISCOVERY HEALTH MEDICAL SCHEME 2019 ANNUAL GENERAL MEETING NOTICE

Discovery Health Medical Scheme ("DHMS/the Scheme") is holding its Annual General Meeting ("AGM") on 20 June 2019. Members are invited to attend the Scheme's AGM.

Notice of the AGM

Date: Thursday, 20 June 2019

Venue: The Hilton Hotel, 138 Rivonia Road, Sandton, Gauteng. 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

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) would be accepted

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 20 June 2019 at 09:00

The agenda for the meeting is as follows:

1. Welcome and quorum
2. Minutes of the 2018 Annual General Meeting – for approval
3. Tabling of the 2018 Integrated Report, including the Scheme's Annual Financial Statements for the financial year ended 31 December 2018
   - 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 2019 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 2019 Trustee Remuneration
   - 7.3 Non-binding advisory vote on the Trustee Remuneration Policy
   - 7.4 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.

RSVP your attendance

To RSVP your attendance to the AGM, please visit **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. Only Principal Members in good standing (contributions not in arrears) may appoint other Principal Members, who must also be in good standing, as proxies.

Submit your proxy form on time

Proxy forms must be requested from PricewaterhouseCoopers Advisory Services (Pty) Ltd ("PwC"), the Independent Electoral Body ("IEB"), at **DHMSelection2019@za.pwc.com** or by calling 012 429 0150.

Please note that each proxy form has unique security features and a separate proxy form must 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 proxy form "spoilt". If you inadvertently spoil your proxy form, please contact the IEB to issue a replacement proxy form.

All information required on the proxy form must be completed. The proxy form must be signed by both parties (the Principal Member appointing the proxy and the Principal Member appointed as proxy). Failure to do so may invalidate the proxy form.

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

Proxy forms must reach PwC by **no later than 12:00 midday on 13 June 2019**. Any proxy forms received after this date and time will be invalid.

Submitting a Motion

The Rules of Discovery Health Medical Scheme require that notices of motions to be placed before the AGM reach the Principal Officer no later than 14 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 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 **dhmsmotions2019@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, Discovery Health Medical Scheme.

Motions have to reach the Principal Officer by **no later than 12:00 midnight on 05 June 2019**. Any motions received after this date and time will be invalid.

The minutes of the 2018 Annual General Meeting, the summary of the Scheme's Trustee Remuneration Policy and the 2019 proposed Trustee Remuneration are available on **www.discovery.co.za.**

Discovery Health Medical Scheme

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

Discovery
Health Medical Scheme

The 2018 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