Minutes of the 27th Annual General Meeting of Discovery Health Medical Scheme ("DHMS"/"the Scheme") streamed live from The Forum, 1 Discovery Place, Sandton using the Lumi Global Platform on held on 23 June 2022 at 09:00

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1 Welcome and Quorum

The Chairperson of the Board of Trustees ("Board"), Adv John Butler SC, welcomed all present to the 27th Annual General Meeting ("AGM") of Discovery Health Medical Scheme ("DHMS"/"the Scheme").

The Chairperson confirmed that the Board appointed Deloitte & Touche ("Deloitte") as an independent third-party service provider to, among other things, oversee the voting and election processes at the AGM. He called upon Mr Leon Knoetze from Deloitte, to confirm the number of Principal Members ("Members") virtually present at the meeting.

Mr Knoetze addressed the meeting and indicated that, in terms of the Scheme Rules, at least 15 Members should be present in person or virtually at the meeting to declare the AGM quorate. He referenced the screen which displayed the number of participants in the meeting and pointed out that the reference to "Shareholder" represented and meant a Principal Member of the Scheme who registered to attend the meeting. Mr Knoetze confirmed that there were 152 Members virtually present at the meeting.

The Chairperson proceeded to confirm the meeting quorate and declared the meeting open. The Chairperson welcomed in particular the delegates from the Council for Medical Schemes ("CMS") to the meeting.

The Chairperson highlighted the following regarding navigating the virtual platform:

- The agenda and other relevant information could be found on the "Home" tab on the platform, which could be accessed by clicking on the "Home" icon.
- Questions would be dealt with via the chat functionality and should be posted timeously to be dealt with after each presentation. The platform did not make provision for questions to be posed verbally.
- Only questions related to the business of the AGM would be responded to.
- Should members wish to post a question in another official language in the chat functionality, interpreters would try as far as possible to interpret such questions or queries.
- All relevant documents were available on the "Documents" tab.
- The chat functionality was not to be used to report technical issues or queries such as sound or connection problems. Those were to be addressed via the Lumi support email address: supportza@lumiengage.com.

The Chairperson noted that, as the meeting was being conducted virtually, due accommodation for voting had been made by the Scheme.

In respect of the Agenda for this AGM, the Chairperson noted that the Members of the Scheme were required to vote on four resolutions, which included the election of three Trustees.

The Chairperson mentioned that, as provided for in the Scheme Rules, the Board appointed an independent Nomination Committee ("NomCo") to oversee the nomination and election process. The Board also appointed Deloitte as the Independent Electoral Body ("IEB") in terms of the Scheme Rules to assist the NomCo in carrying out its functions.

The Chairperson handed over to Mr Knoetze to explain the voting process.

Mr Knoetze elaborated on the role and activities of the IEB in the context of the AGM. In its capacity as the IEB, Deloitte was responsible for the following electoral processes and voting activities:

a. Call for nominations:
   - Call for nominations opened on 11 January 2022 and closed on 14 February 2022, 128 calendar days prior to the AGM.

b. Receiving of nomination forms and vetting of nominees for NomCo to determine their eligibility to stand for election to the Board:
   - Nominations received via email in a designated email inbox or in hard copy at designated Deloitte offices were independently vetted against the eligibility criteria as set out in the Scheme Rules.
   - A full set of the Scheme Rules was available on www.discovery.co.za for logged-in Principal Members to access.

c. Preparation of the candidate list for NomCo approval:
   - The vetting results for all nominees were presented to, discussed with, and approved by the NomCo. The distribution of the final approved candidate list together with the Notice convening the AGM was completed on 21 May 2022, 33 days prior to the AGM.
   - In respect of registration for the AGM, all Members were provided with a link to register from 23 May 2022 until 17 June 2022 to attend the virtual AGM as either a Member or a Guest.
   - Registrations were vetted by the IEB in terms of the Scheme Rules, which prescribe that only Members in good standing will be permitted to participate in the meeting on proof of identity. Access credentials were only provided to approved Members.
   - As at the closing of registration, the IEB had approved the registration of a total of 1 267 Members.

d. The receiving and vetting of proxies:
   - The Scheme Rules provide that every Member who is in good standing and who is present at the Scheme's AGM has the right to vote or may appoint another Member who is in good standing, as a Proxy to attend, speak or vote on their behalf. That Member may complete and sign a proxy appointment form in which he/she may nominate another Member of DHMS to attend, speak and vote in his/her stead.
   - Requests for proxy forms were received by the IEB via email in a dedicated email inbox or through the call centre. All proxies were vetted by the IEB to ensure compliance with the Scheme Rules prior to proxies being confirmed as valid.
   - Prior to the commencement of the AGM, Lumi allocated the valid number of proxy votes to proxy holders on the virtual platform. This was duly observed and verified by the IEB.

e. Overseeing the actual election at the AGM:
   - Members of the Scheme were required to vote on four resolutions.
   - Only Members and proxy holders in attendance virtually will be able to cast their vote.
   - The Chairperson will declare the voting open, after which the polling icon will appear as the third icon on the navigation bar on the screen. The matters to be voted on and the available voting options will then be displayed. Members and proxy holders may then commence with casting their vote.
   - Split voting is only available for proxy holders. Mr Knoetze explained the process to cast a split vote.
   - Members were informed that single votes were not permitted to be split.
   - Mr Knoetze advised that the IEB, in consultation with NomCo, had withdrawn the candidacy of the following candidates: Mr Tebogo Mabusela and Ms Sophia Venter. They were therefore no longer

available to be voted for. The updated candidate list could be viewed in the documents vault of the virtual meeting platform.

- Voting could be performed at any time during the meeting until voting closed at 16:00 that afternoon (23 June 2022). Members were reminded that their last choice would be submitted at that point. The polling icon would no longer be visible, and no further votes would be accepted.
- Members would still be able to send messages and view the webcast whilst the poll is open.

Mr Knoetze handed over to the Chairperson.

Point of order

The Chairperson noted that a point of order had been raised by Mr Raschid Vania and proceeded to read out the point of order, which was worded as follows:

"In terms of the current Rule 17.5, trustees appointed by incumbent trustees can only serve for a period of three years. Both you and Mr Johan Human as appointed trustees had your three year terms ended in June and August 2020, respectively. Accordingly, both you and Mr Human have no legal standing as trustees."

The Chairperson responded that the Rule referred to in that particular question was incorrect, the correct Rule Mr Vania was referring to was Rule 17.1, which governed the period under which Trustees may serve. In terms of Rule 17.1, Trustees could serve for two consecutive terms. It was correct that both Mr Human and the Chairperson's terms ended in 2020 but those were their first terms. Those terms were then extended for a second term, thus both of them were validly nominated and appointed.

The Chairperson confirmed that there were no further questions and declared voting open.

Confirmation of the Agenda

The Chairperson presented the agenda of the meeting.

The agenda for the meeting was as follows:

1. Welcome and quorum
2. Minutes of the 2021 Annual General Meeting – for approval
3. Tabling of the 2021 Integrated Report, including the Scheme's Annual Financial Statements for the financial year ended 31 December 2021
   - 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 and Managed Care Organisation of Discovery Health Medical Scheme
4. Governance
   - 4.1 Discovery Health Medical Scheme Trustee Remuneration Policy and approval of the 2022 Trustee Remuneration
   - 4.2 Appointment of Auditors
5. Motions
6. General
7. Voting and closure of the AGM
   - 7.1 2022 Trustee Remuneration
   - 7.2 Non-binding Advisory vote on the Trustee Remuneration Policy
   - 7.3 Appointment of Auditors
   - 7.4 Motions
   - 7.5 Election of Trustees

The Chairperson called upon Members to approve and second the agenda. Ms Esté Whyte proposed the approval of the agenda, and Ms Michelle Culverwell seconded the proposal. The agenda was duly confirmed.

2 Confirmation of the Minutes of the 2021 Annual General Meeting

The Chairperson referred Members to the copy of the minutes of the 2021 AGM, which were included in the documents tab on the virtual platform. He stated that the Board had considered the minutes and regarded them as an accurate reflection of the proceedings of the AGM held in August 2021.

The Chairperson pointed out that the minutes had been available to Members since 21 May 2022 and he moved that unless there were any objections of substance, the minutes of the 2021 AGM be approved.

Dr Max Price proposed the approval of the minutes, and Ms Nicky Lackay seconded the proposal. The minutes were thus duly approved.

3 Tabling of the 2021 Integrated Report, including the Scheme's Annual Financial Statements for the financial year ended 31 December 2021

The Chairperson referred to the financial statements for the year ending 31 December 2021. He noted that Scheme Rule 25.1.5 required the financial statements to be laid before this meeting.

The Chairperson noted the order in which the presentations would be made before any questions would be taken. A presentation would be made by the Principal Officer of DHMS, Ms Charlotte Mbewu, followed by a presentation by the CEO of Discovery Health (Pty) Ltd, Dr Ryan Noach.

The Chairperson advised that a video would be played, after which Ms Mbewu would commence with a presentation for the Scheme.

A video highlighting the impact of COVID-19 on the Scheme and its Members was shared.

3.1 Presentation by Principal Officer of Discovery Health Medical Scheme, Ms Charlotte Mbewu

Ms Mbewu commenced with providing an overview of the topics that she would be covering in her presentation.

The presentation highlighted the following aspects to Members:

Navigating COVID-19

- Ms Mbewu touched on the implications of COVID-19 and how the Scheme had supported its Members during the pandemic since the insurgence of COVID-19 in 2020 until 2022.
- The fourth wave was marked by the highly contagious Omicron variant. The South African environment had already started with the vaccination programme which meant there was some immunity within part of our population which resulted in lower morbidity and hospitalisation.
- The fifth wave brought a closer move to an endemic state and the Scheme waited to see what would unfold around an endemic state once this had been promulgated. Infection rates, however, persisted while lower levels of death and hospitalisation were being witnessed. Vaccination remained an

important mechanism of managing the COVID-19 pandemic, with booster shoots being seen to provide ongoing protection to the South African population and the Scheme's membership.

- The Scheme was pleased with the uptake of the vaccination programme in South Africa and within the Scheme. Some work was still required to ensure that the "at risk" population presented a better uptake of the booster shots.
- It was also pleasing that when looking at the Omicron variant period of December 2021 to January 2022, it could be seen that the vaccination uptake had a marked impact on lowering hospitalisation risk. Members who have had two doses of the Pfizer vaccine were 69% less likely to be hospitalised than those who were unvaccinated. There was a lower transmission risk and a lower mortality risk associated with those who had been fully vaccinated vis-à-vis those who had not been fully vaccinated.
- Ms Mbewu compared South Africa to other jurisdictions, and in particular Hong Kong, and noted that a higher number of Hong Kong's population had been vaccinated in comparison to South Africa. However, South Africa had a few indicators that put it at a better state than Hong Kong. Ms Mbewu elaborated on those indicators.
- The Scheme was aware and concerned about the second order effects of COVID-19 which have resulted in an increased overall disease burden and the health of Members of the Scheme worsening and requiring more initiatives and involvement in order to manage it.
- At the same time, there was a reduction in prevention and screening particularly for mammograms, pap smears, attendance at wellness events and HIV screenings, which together result in worsening population health. The Scheme saw a lower uptake of those benefits within the non-Vitality membership vis-à-vis the Vitality membership.

Caring for our Members

- The Scheme was concerned not only with COVID-19 but also with other general healthcare requirements of its Members. The Scheme implemented innovative solutions to better care for its Members.
- In relation to COVID-19, Scheme Members enjoyed comprehensive benefits and support. The Scheme assisted its Members to manage second order effects and any risks that may arise from being diagnosed with another condition or co-morbidity.
- Members had access to testing benefits, PCR and Antigen testing, and face-to-face or virtual consultations with physicians.
- Members have also been provided with much needed financial relief to ensure that the Scheme met them at their point of need, through a contribution increase deferral and accessing Members' Personal Medical Savings Account balances for contribution relief and assisting employers with additional COVID-19 support.
- The Scheme has provided relief in excess of R207 million through the deferred contribution for SMME's programme.
- In light of COVID-19, in excess of 1.4 million beneficiaries have received a COVID-19 vaccination which have been paid in full by benefits within the Scheme
- Some 851 000 Members tested for COVID-19, and some 36 000 members were admitted inside a healthcare facility as a consequence of having COVID-19 and the Scheme supported these Members in various ways.
- The Scheme acknowledged that there was a lag in Members seeking healthcare but that the utilisation had increased particularly in 2021.
- 745 000 Members benefited throughout the programmes in place from a chronic condition aspect. Some 34 000 babies were born to Members and beneficiaries of the Scheme. These were some of the ways the Scheme benefited its Members.
- The Scheme identified that one in two of its Members had more than one chronic condition. This meant there was an increase in prevalence of diabetes, cancer, hypertension and more. The benefits and

support programmes in place were being implemented to ensure support for Members as they navigated these chronic conditions, as well as mitigate or minimise downstream risks in an appropriate and proactive manner.

- The Scheme used innovative solutions as a mechanism to manage second order effects. One of these was the Connected Care platform that enabled Members to book virtual consultations and also book consultations either on a virtual basis or face-to-face basis with their treating doctors. Through Connected Care, some 408 000 appointments for COVID-19 vaccinations were booked and Members were able to hold at least 10 000 virtual consultations within the safety of their homes without having to enter treatment facilities.
- In 2022, the Scheme implemented hospital-acuity care provided to Members in the comfort of their homes. This was brought on by the requirements that the Scheme saw around COVID-19 where in 2021, the Scheme had to arrange for Members to receive treatment at home which enabled Members to receive quality care in their home environment similar to the levels of care they would have received in a hospital facility.
- The Scheme continued to provide mental healthcare support to Members. In 2021, 5 690 Members actively enrolled to participate in the mental health programme offered. Enrolments for this programme increased by 17 times from 2020 to 2022. This pointed to the rise of mental wellness conditions in the South African landscape.
- The Scheme continued to implement a multi-disciplinary approach in the treatment of its Members with the objective of improving recovery rates and Member experience. These included the arthroplasty same day discharge programme.
- Through 2021, the Scheme also launched the spinal surgery programme and quality network through which the Scheme received more than 7 000 admissions, and which the Scheme will continue to monitor and report on.

Ensuring the best value healthcare

- In 2020, claims were down due to a reduction in utilisation. Utilisation has now increased, and this has had a knock-on effect on the claims experience with 89.1% of the contribution income in 2021 having been utilised towards claims expenses.
- The Scheme experienced 6.9 million more claims in the 2021 financial year as opposed to 2020. This culminated in a loss being endured by the Scheme. The loss was anticipated given the contribution increase deferral.
- It is always a challenge for the Scheme to balance the short-term affordability constraints of its Members while ensuring long-term sustainability to ensure that Members are protected from any future price shocks. The Scheme was in a fortunate position in 2021 due to a better-than-expected surplus in 2020, which culminated in the 5.9% increase deferral to 01 July 2021. This deferral enabled the Scheme to announce a weighted average contribution increase of 2.9% for the 2021 financial year, which on average was better than that announced by the eight largest open schemes in the industry, which averaged at 5.1%.
- The contribution increase deferral was also being implemented for the 2022 financial year with the deferral being deferred to 01 October 2022 providing some R5 billion relief to Members during 2022.
- The Scheme was 14.9% better priced than the six largest open medical schemes. The Scheme was also better priced by plan type across all plan types when looking at the average contribution.
- Members were benefiting from a reduction in administration expenditure which continued to be on a downward trajectory year-on-year.
- In comparison to the eighteen open schemes, DHMS was ranked the fourth lowest in comparison to those schemes.

- In the 2020 financial year, for every R1 spent by the Scheme on managed care and administration fees, the Scheme derived a value of R1,88. While this value may have been lower than previous years, it could be appreciated that the decrease was a consequence of the decrease in utilisation emanating from the COVID-19 period.
- The Scheme aimed to reduce expenses within the Scheme in order to ensure Member contributions increases are low in order to make the Scheme more affordable.
- Forensic investigations and forensic efforts driven through the Scheme's administrator, Discovery Health (Pty) Ltd ("DH"), saved the Scheme R1 billion per annum, which resulted in a 1% lower contribution increase on an annual basis.

Ensuring sustainability and membership growth

- The Scheme collected a net contribution income of R62.5 billion in the 2021 financial year. This took into account the contribution increase deferral of 2021. The gross healthcare results, which are contributions less claims, were R6.2 billion.
- After taking into account the expenses of the Scheme, the Scheme derived a net healthcare result of minus R1,2 billion. This was to be expected in light of the deferral of the contribution increase.
- The income derived from investments and other income of R3,2 billion ensured that the Scheme ended the financial year with a net surplus of R2 billion which assisted in bolstering the financial position and strength of the Scheme.
- The market share of the Scheme grew to 57.5% since the year 2017 and this was the result of the growth by some 40 692 new Members to the Scheme as at the end of May 2022.
- Most Members (96.8%) remained within their benefit plans.
- The Scheme paid out 96.7% of claims received from an in-hospital perspective.
- The Scheme had reserves of R30.4 billion which was equal to 38.01% from a solvency ratio perspective. The Scheme also received a AAA from its rating agency.
- The Scheme delivered value for the money for its Members and ensured the long-term sustainability of the Scheme.
- In terms of the 2021 financial year, the average age of a new joiner was 26.1 and the average chronic profile of a new joiner was 6.5%.

Regulatory and governance growth

- The Scheme is managed by a Board of Trustees to which the Scheme Office is accountable. The Board is accountable to the DHMS membership. The Scheme is regulated by the CMS which ensures that the Board acts in accordance with the Medical Schemes Act.
- In executing on its responsibilities and fiduciary duties, the Board is responsible for the strategic oversight and sound management of the Scheme. The Board is elected by the membership of the Scheme. The mechanisms the Board uses to execute on its duties include ensuring sustainability of the Scheme, ensuring that the Scheme has financial and other internal control systems, and also having oversight of the Scheme's investment strategy and returns.
- The Scheme has participated in ongoing engagements around the National Health Insurance ("NHI") and the Low-cost Benefit Options ("LCBO") framework.
- In relation to NHI, DHMS was in full support of universal health access for the citizens in South Africa as this would ensure affordable and equitable access to the entire population. The Scheme was, however, concerned with certain technical components enshrined within the Bill and continued to engage with the National Department of Health and other regulators to ensure that the Scheme's views were carried across into submissions and updates.

- From an LCBO framework perspective, engagements with the CMS are ongoing to ensure that there could be a further expansion of access to private healthcare through the relaxation of some of the regulatory components enshrined within the Medical Schemes Act to ensure that more South Africans, particularly in the lower LSM grouping, could have access to private healthcare insurance.

Ms Mbewu concluded her presentation and handed over to the Chairperson.

The Chairperson handed over to Mr Noach.

3.2 Presentation by the CEO of Discovery Health (Pty) Limited, Dr Ryan Noach

Dr Noach started his presentation with providing an overview of the topics that he would be covering.

The presentation highlighted the following aspects:

Review of past performance

- Dr Noach shared that at an industry level, medical schemes in South Africa have not grown since 2017. There was a contraction by more than 2% of membership for open medical Schemes like DHMS between 2019 and 2020 and that was as a direct result of COVID-19 and the impact it has had on the economy, employment and on the general population of South Africa. There has been some recovery in 2021.
- The large medical schemes like DHMS contracted much less than smaller medical schemes. In times of crises, smaller schemes experienced more volatility in their membership.
- The market share of DHMS increased while the market share of other open medical schemes decreased. DHMS has a 57,5% market share at the end of 2021.
- The period between December 2020 and May 2022 was one of the best growth periods that DHMS has ever seen. DHMS grew on a net basis by more than 40 000 lives during this period.
- The average age of a new joiner on DHMS was 26.1 which was a more than a year younger than the average age of other open medical schemes, which was 27.6. Young joiners were important as they protect the Scheme in that they ensured sustainability which was important for claims costs and keeping medical scheme contribution costs low.
- The chronic ratio of new joiners at DHMS was 6.5% which was substantially lower than the rest of the industry at 9.3%. This meant that not only were DHMS Members young joiners, but they were also healthier.
- Medical schemes have found pricing their membership contributions difficult due to the change in utilisation patterns that the whole world has experienced, including South Africa, due to COVID-19. Medical Schemes have seen a reduction in non-COVID19 related claims and this increased the reserves of medical schemes and reduced the cost of care.
- Over the years, DHMS has been very keenly priced. DHMS produced a surplus in 2017 and 2019, and a very large surplus in 2020. There would also have been a surplus in 2018 had it not been for the VAT change from 14% to 15% which led to a small operating loss. The rest of the industry in 2018 and 2019 experienced significant operating losses.
- During 2021, DHMS increased contributions in line with medical inflation but deferred those contribution increases to give Members the benefit of cash savings. This led to a planned operating loss of R1.1 billion, using the excess reserves of DHMS to protect its Members against the economic impact of a big increase in 2021.
- The DHMS pricing approach led to much more affordable contributions for Members and better price stability through the period. The deferment strategy resulted in 1.6% of additional reserves being used

to support Member affordability. Cash out of pocket for Members was less, relative to the rest of the market.

- Taking into account the contribution increase deferral strategy, Members paid 0.5% lower contributions than the rest of the industry.
- Contribution levels remained in line with anticipated future medical inflation, thus avoiding the need for future price shocks to Members.
- The outlook for DHMS was good because there has been excellent growth.

Key trends impacting health in 2022 and beyond

- Dr Noach shared the following healthcare trends that appeared during COVID-19:
  - Structural shift in the burden of disease
    - COVID-19 was the largest clinical driver of claims experience in 2021, leading to a structural shift in claims drivers
    - COVID-19 will add 11% to the cost of healthcare in 2022, if utilisation for other conditions settle at pre-COVID levels
    - The increase in disease burden, decrease in physical activity and mental health challenges requires a different healthcare approach
  - Equitable access to healthcare, especially in relation to the vaccination debate
  - Shift in the place of care: some Members received health care at home during COVID-19
  - Accelerated digitisation trend in healthcare
    - Major global medical insurance providers launched first virtual plans in 2021, which lowered costs by directing care to a virtual primary care provider as the first point of care
    - 2021 global healthcare corporate merger and acquisition activity also surged, with a focus on digital health
    - Digital health had a record year in 2021, with major investments in digital health ventures and high levels f activity from big tech
  - Acceleration in value-based care ("VBC")
    - DHMS has advanced VBC contracting substantially: 58% of hospital spend had moved to VBC arrangements as of 2022 and DH aims to shift 30-40% of all spend to VBC by 2023

COVID-19 | The next frontier

- COVID-19 has been a roller coaster ride for those in the healthcare system, thinking of it in three chapter headings, namely:
  - Odyssey: a long and eventful voyage marked by changes of fortune
    - DH funded 3 181 203 COVID-19 tests and 3 330 132 vaccines
    - 665 599 Members tested positive for COVID-19, af which 74 527 were admitted to hospital and 16 035 passed away
  - Recovery: the process of regaining or returning to a normal state of health
    - Clinical, health system and workplace recovery and returning to pre-COVID levels
    - Promising signs of COVID-19 nearing an endemic state
    - The evolution of COVID-19 infection fatality ratio in England is relative to seasonal flu
    - Waves were less severe since South Africa's Delta-led third wave
  - Hope: expectation that something desired will occur
    - Recovered COVID-19 patients experienced protracted and significant disruptions to daily living with side-effects present up to 18 months post-infection
    - There is a 2.75 times higher risk for developing diabetes post-COVID and a 5 times higher risk if hospitalised during COVID-19

        - There is a 1.5 times higher risk for developing a cardiac condition post-COVID and a 3.5 times higher risk if hospitalised during COVID-19
        - There is no evidence of increased mortality in the post-infection period, however, 1.4 times higher risk f hospital admission in the post-infection period
        - There was a 405 reduction in health insurance claims at the peak of South Africa's lockdown in March and April 2020 – utilisation and claims were starting to return to 2019 levels

Maximising DHMS Member value

- DH aimed to maximise DHMS Member value by means of a value proposition framework which:
    - Addresses the reduction in screening and prevention
        - Reduction in prevention and screening was less for Vitality members
        - Hospital re-admission prevention using predictive analytics
        - Sophistication in identifying and monitoring Members living with diabetes
        - The Vitality cancer score allows for targeted screening campaigns with more predictive outcomes
    - Addresses the changing disease burden
        - Value-based care interventions were established
        - Arthroplasty: 7 000 patients benefitted from the network per year, with an 18% reduction in 30-day all-cause re-admission
        - Care Management Organisation for Type 1 and 2 diabetes: 16 500 patients benefitted from the network per year
        - For every R1 spent on new VBC incentives, R3 is saved in primary care costs compared to historic risk adjusted experience
    - Embraces the shift in the place of care
        - 64.4% of the spend on mental health care was for out of hospital treatment
        - Outpatient mental health care was made more accessible through a structured primary care programme, whereby there was a 6.7% reduction in total costs within the first six months of Members registering on the programme
- To maximise the value for Members requires product innovation, predictive servicing and stakeholder engagement.
- A video highlighting the digital health initiatives, trends, and opportunities that DH offered to Members of DHMS was shared.
- Following the video, Dr Noach presented a number of key initiatives that DHMS have launched, including the following:
    - The KeyCare Start Regional Option
    - The first Shari'ah Compliance medical scheme arrangement which is available on all health plans in DHMS
    - New digital tools to meet the shift in digital servicing demands
    - Enhanced communication platforms to support a seamless digital servicing experience for members
- DH's service to DHMS outperformed against leading global benchmarks, whether it be from a First Call Resolution ("FCR") or Net Promoter Score ("NPS") perspective.
- Dr Noach highlighted that DH was in support of all universal health access, where both public and private players provide equitable access to quality care including the South African government's initiative to provide a consistent structured and equitable National Health Insurance system. However, this needed to be done in collaboration with the private sector to ensure that there was a sustainable system for both private and public healthcare.

Dr Noach handed back to the Chairperson.

The Chairperson thanked Dr Noach for his presentation and proceeded to open the floor for questions on the 2021 financial statements.

The Chairperson noted that a number of questions had come in on the chat platform, not all of which related to the financial statements themselves. He clarified that if questions were not raised and answered at that stage, it did not mean they would not be dealt with in detail later when appropriate.

Questions and answers

a. The Chairperson noted that one of the questions related to amounts paid to brokers in 2020, and payments thereafter (Mr Raschid Vania).

   The Chairperson responded that there were four points that needed to be made in this regard. The first was that the Trustees identified and noted that there had been a contravention of the Act in relation to brokers in those years. The second point was to bear in mind that the Trustees performed an oversight role of the Scheme and therefore called on the Scheme to provide information and explanations to the Trustees as appropriate. The third to note was that the contravention to which this question related was a matter raised not by the Trustees, but by the Scheme as soon as it came to the Scheme's attention. In other words, the Scheme, in the opinion of the Board acted responsibly and promptly in raising this before the Board and the matter was taken seriously and dealt with at the time. Fourth, the Board was satisfied that what had occurred in this particular situation was not by design but an oversight. The matter was then promptly rectified. So this issue did not have an impact on the financial statements which have been placed before the Board at the moment.

b. The Chairperson indicated that one of the questions related to marketing and stakeholder expenses, and what the campaigns were that the Scheme sponsored in those years (Mr Raschid Vania). There was also a question relating to unpacking R32 million other operating expenses (Mr Raschid Vania). The Chairperson requested Ms Mbewu to respond to those two questions.

   Ms Mbewu responded that it was important to note that the Scheme did not make any sponsorships but that the Scheme did have certain marketing and stakeholder related expenditure through certain services that it procured in order to market itself so that it attracted new Members and retained the current Members that it does have. The Scheme engaged with service providers to provide them with marketing and stakeholder related services but those services were in no way a sponsorship by the Scheme. Sponsorships were frowned upon as these monies that we were talking about were monies that belonged to the Members through their membership in the Scheme.

   Ms Mbewu then dealt with the second question regarding the "other operating expenditure" by commenting that there were two key elements to note. The first one being in the region of some R24 to R25 million which were recoveries from third parties for motor vehicle accidents and Compensation for Occupational Injuries and Diseases. The second aspect related to amounts that the Scheme paid for the practice coding system which is applied by South Africa in the private sector to ensure that the Scheme could identify and recognise various healthcare service providers that service Members.

The Chairperson observed that there did not appear to be any further questions relating to the financial statements.

The Chairperson handed over to Mr Dave King, the Chairperson of the Scheme's Remuneration Committee to present the DHMS Trustee Remuneration and Associated Policy for 2022 to the meeting.

4 Governance

4.1 Discovery Health Medical Scheme Trustee Remuneration Policy and approval of the 2022 Trustee Remuneration

Mr King presented the following Agenda for his presentation:

1. Remuneration Governance
2. Trustee Remuneration Policy
    - Remuneration Methodology
    - Remuneration of the Board of Trustees
3. Proposed 2022 Trustee Remuneration
    - Trustees
    - Chairpersons

Remuneration Governance

Mr King explained that the Board of Trustees was responsible for the development and implementation of a remuneration policy for both Scheme employees, as well as Trustees and Board Committee members. The Board of Trustees delegated that responsibility of oversight to the Remuneration Committee ("RemCo").

RemCo comprised four Trustees, one of whom was the Chairperson of the Board, and one Independent Committee Member. With effect from 01 July 2022, RemCo would be appointing a second Independent Committee Member.

The adoption and approval of remuneration was presented to this AGM for majority vote by the Members. The Board of Trustees had already approved this provisionally on recommendation of RemCo.

In terms of the Remuneration Policy, the policy for Trustee and Board Committee remuneration for each prospective financial year is reviewed and recommended by RemCo to the Board for approval and thereafter tabled at this AGM for a non-binding advisory vote by Members.

In terms of disclosure, Trustee remuneration is disclosed through various channels:

- At this AGM to the Members of the Scheme
- In writing by submission to the CMS who is the Regulator for all medical schemes
- In the Integrated Report which is published annually in the annual financial statements.

Remuneration Methodology

In terms of methodology, the objective of the remuneration policy for the Board and Board Committees was to provide a legal and policy framework against which all remuneration decisions were made, validated, implemented, approved and reported by the Scheme.

In 2014, the RemCo engaged PricewaterhouseCoopers' Remuneration Practice to assist in developing a new remuneration methodology and system of benchmarking which has been in operation since then and was still deemed fit for the purpose that the Scheme required. This was approved at the time by the CMS and was submitted each year for ongoing approval.

The total remuneration paid to Trustees as part of this policy was determined by a number of elements and illustrative examples would be provided later in this presentation. The elements were:

- Number of meetings planned per year
- Preparation time for each of those meetings
- Anticipated duration of the meetings
- Estimated time required between meetings in some cases
- Number of actual meetings attended

In terms of the methodology, Trustee remuneration was paid on an hourly rate. These take into account the fact that the Scheme is a not-for-profit entity. The benchmark for 2022 signified an hourly rate of R3 992. That was in fact a discounted rate from a professional fee of R5 703 less 30%. This was the proposed amount, which represented a 4.5% increase on the approved 2021 rate. The increase proposed was exactly the inflation rate prevailing at the time.

The methodology when paying Trustees was to draft a schedule of the meetings that a Trustee would be required to attend in any given fund year. If it was assumed that that amounted to 100% of their anticipated remuneration, 70% of that total amount was deemed to be an annual base fee per Trustee. The annual base fee was split up into four quarterly annual base fees which were paid to each Trustee quarterly in arrears. The remaining 30% was attributable to meeting attendance and paid at the end of each month, also in arrears, aligned with the specific meetings that each Trustee was expected to attend. Those two elements together added up to 100% of the planned remuneration for each Trustee. In the event that there were ad-hoc meetings which were added, and these did occur from time to time, these were remunerated directly as meetings attended at the end of a particular month.

Mr King noted that the policy for 2022 remained unchanged from 2021, and the 2021 policy enjoyed an upwards of 95% advisory approval from the previous AGM.

Fees were exclusive of VAT and insofar as a Trustee may be registered for VAT, he/she was obliged to collect VAT and remit to the South African Revenue Services. The Scheme was obliged to pay VAT in the event of a VAT registered provider in any respect.

There were certain occurrences where Trustees were explicitly not remunerated for training. They were trained and they attended training, but such programmes were explicitly not paid for by way of remuneration.

No Trustee is ever paid for consulting to the Scheme. That would be at variance with the policy and the Medical Schemes Act. Trustee remuneration was purely based on their attendance as in the attendance plan or on the occasion of an ad-hoc meeting.

Trustees were not eligible to earn incentive money or variable pay under any circumstances whatsoever. Trustees were reimbursed for reasonable expenses often incurred by way of travel, which were payable to Trustees on approval. Permissible expenses comprised a very small proportion of any remittances made to Trustees.
Mr King shared two examples of how Trustees' annual fees are calculated. This would be at the proposed 2022 rates.

Members were afforded the opportunity to pose questions relating to the above presentation.

Questions and answers

a. There was a question from Mr Raschid Vania regarding the annual remuneration of the Principal Officer.

   Mr King responded that the Principal Officer was an employee of the Scheme. She was not a Trustee or in any way remunerated in the way Trustees were, but as an employee.

   Mr King commented that Mr Vania noted that, according to page 239 of the integrated report, in 2020 the Principal Officer's earnings amounted to R4.6 million and in 2021 they amounted to R5.2 million which was an increase in quantum of 12.9%. Mr King responded that Mr Vania could be reassured that the Trustees were subject to moderate increases, which in this case, were in line with inflation. With the employees it was inflation plus 1%. In this case, the higher increase year-on-year was attributable to the fact that Ms Mbewu was only appointed during the preceding year. In other words, her weighted average earnings for that year actually included her previous role as Chief Financial Officer and her new role as Principal Officer, which gave rise to the 12.9% increase, effectively taking into account that she was promoted during the previous year.

Mr King noted that he did not see any further remuneration related questions at that point.

In conclusion, Mr King firstly proposed that the 2022 Trustee remuneration as recommended by RemCo and approved by the Board, be approved by this AGM for the 2022 financial year.

Secondly, Mr King proposed that the Scheme Members express their views on the Scheme's Remuneration Policy for Trustees as recommended by RemCo and approved by the Board. The Trustee Remuneration Policy was also put before this meeting, but for a non-binding advisory vote. Mr King noted that these two votes were covered under Resolutions 1 and 2 and voting would be done via the polling function on this platform.

Mr King handed over to the Chairperson.

The Chairperson advised that there was one further question related to remuneration from Mr Vania.

b. Question from Mr Raschid Vania: *"The policy makes provision for payment to trustees and independent board committee members, elected trustees but no mention is made of co-opted trustees. Why is this so?".*

   The Chairperson responded that the position of Trustees included both elected Trustees and appointed Trustees. There was also reference in the Rules to the possibility of co-opted individuals. The reason why no provision was made for co-opted Trustees was that there has not been any and currently was no co-opted Trustees.

The Chairperson noted that there appeared to be no further remuneration related questions and proposed moving on to agenda item 4.2.

4.2 Appointment of Auditors

The Chairperson advised that the Audit Committee of the Board had considered PricewaterhouseCoopers ("PwC") against the set legislative requirements to assess their suitability for re-appointment as the auditors of the Scheme. After careful consideration, the Audit Committee recommended the re-appointment of PwC to the Board, which recommendation the Board accepted.

The Chairperson proposed that PwC be appointed as the auditors for the 2022 financial year. This vote was covered under Resolution 3 and voting would take place via the polling function on this platform and any questions relating to this would be dealt with when the opportunity arose.

5 Motions

The Chairperson advised that there were no valid motions. In terms of Rules 25.1.6 and 25.1.7 of the Scheme Rules, the Principal Officer received no valid motions.

The Chairperson noted that in Mr Vania's contributions to the chat he made the allegation that certain of his motions were spuriously disallowed. The Chairperson assured the meeting that it was not the case. The Rules, particularly Rule 25.1, made provision for how motions were to be presented and also as to what was a legitimate matter for a motion at the general meeting.

The Chairperson made commented that the fact that any Member, including Mr Vania, raised an issue of concern, does not lead to it not being considered. It was considered as a question and matters that Members raise in the AGM and at any stage as stakeholders, were taken seriously by the Board, by the Scheme Office, and by DH. The mere fact that a matter which was presented as a motion does not qualify as a motion does not mean that the Trustees ignored it. In addition, there was a good reason why the Rules read as they do. Rules have been agreed to by all of the Members and approved by the CMS. The reasoning was that it was not appropriate for the general meeting by a majority to direct the Scheme as to how matters should be dealt with by the Scheme. Those are matters dealt with appropriately in other fora.

There being no valid motions, the Chairperson proposed moving on to agenda item 6.

6 General

The Chairperson asked whether there were any other issued that Members wished to raise under General and proposed dealing with the questions that had been asked earlier in the day and moving through them and responding to them.

The Chairperson advised that in case there were questions that were not posted timeously earlier, which would also be dealt with.

a. Mr Sikander Abdool Haq Kajee asked how many valid proxies were lodged.

   Mr Knoetze responded that having taken into consideration the Scheme Rules, as well as directives that have been issued by the CMS as far as the use of proxies was concerned, the IEB approved a total of 160 valid proxies.

b. A question was raised about the availability of information to Members in order to make informed decisions about the election of Trustees (Patricia Laurie Holburn, Stuart Drysdale, Boitumelo Lesego Mokgethwa, Tanya Coetzee, Sikhunjulwe Sithobekile Mbuya, Guy Harris). A second question related to concerns about transparency in the process (Stuart Drysdale, Nicole May Gardner, Guy Harris).

   The Chairperson dealt first with the question on the availability of information and the attempts to make sure that the Trustees were staffed with the requisite skills. The question that was raised earlier in the chat made the point that on the curricula vitae that were available, very little information was made

available to allow Members to assess independently and objectively which candidates were suitable. The Chairperson clarified that for some years the Board had been concerned by this very issue. The Board wished to make sure that the election was conducted fairly and in accordance with the Medical Schemes Act and the directives of the CMS. An issue that arose immediately as to how to provide information concerned a prohibition on the Trustees themselves guiding the election or in any way indicating a preference for any candidate or any group of candidates. Trustees could not in any way influence the voting in a particular direction or guide the Members to vote for any particular individual with particular skills. One could easily see how that could lead to a very perverse outcome, were the Trustees to do that. One example was that many Members may otherwise be worthy to be considered but immediately disregarded because superficially they may not have the appropriate skills.

The second point to make was that the Trustees do not lack the skills merely because some of the Members of the Board of Trustees are elected by the Members. Elections in the past have been conducted successfully and the Trustees have been well-staffed, representing both elected Members and sufficient Trustees with the requisite skills. Two years ago, the Board of Trustees voted to increase the nominated Trustees by one. The reason for doing so was that the nominated Trustees could then be appointed to fill any perceived skill shortage on the Board of Trustees. The Board of Trustees was completely compliant with the Medical Schemes Act and with the Scheme Rules and possessed the requisite skills.

Regarding the question around transparency, the Chairperson clarified that the individual Trustees and the Board of Trustees do not conduct the election. An independent NomCo, referred to earlier in the presentations, conducted the election and NomCo was not accountable to the Board. NomCo reported to the Board, but the Board had no ability or power to direct the operations of NomCo. NomCo was assisted in the process by an independent and reputable firm of auditors who conduct and assist NomCo in the election and conduct the election. The results of the election were made available to the CMS, who ultimately have the power to direct any concerns to the Scheme, to ensure that the elections were free and fair.

c. The Chairperson proposed to move to a set of questions relating to brokers. These were questions relating to:
   - Value for money from brokers
   - How brokers assisted Members
   - Whether this amounted to a cost to Members which is inappropriate and does not provide appropriate value for money

   The Chairperson asked Ms Mbewu to clarify the role of brokers because it appeared that some Members may operate under a slight misapprehension as to the position occupied by brokers.

   Ms Mbewu commented that brokers were important in the ecosystem.
   - Firstly, this was enshrined in the Medical Schemes Act as a broker firstly needed to be accredited with CMS in order to be able to facilitate a service within the medical schemes industry. Brokers assisted Members in navigating quite a complex and unique medical schemes industry along with the various benefit options that existed by understanding the medical needs of the Member and supporting them in making the right choice. Benefits and options might change on an annual basis, the brokers then assist with this process on an annual basis.
   - The second aspect which dealt with and addressed whether the medical scheme ought not to allow for brokers. Ms Mbewu commented that the Scheme could not make this decision as it would be in contravention of various statutes of law and the Scheme needed to provide Members with an

unfettered time and space in which to engage with a service provider or a broker where they feel there is a need to do this without the need for that Member to incur an expense directly out of their own pocket. Medical schemes, from a contribution perspective, cannot charge differentiated contributions by plan type based on whether a member had elected to seek the services of a broker or not because that was not permitted in terms of the Medical Schemes Act.

Dr Noach added that, from Members' experience, the complexity of the medical schemes industry which involves many plans, many benefit options and a wide range of regulatory provisions, it is so complicated such that Members routinely require support from somebody who is knowledgeable and familiar with these plans and benefit options. The interactions between them fully provided the support about making choices about a plan, but also ensured that benefits were realised on a particular plan. Each family and individual circumstances were quite different. A family had certain financial needs and a family also had certain health needs and the role of the financial advisor in this high advice industry, in DH's view, was to find the intersection between financial needs and the health needs for any family or individual. The brokers must ensure that Members were supported in understanding that intersection, what the ideal choice plan for them and benefit entitlement would be. During the period of a claim when service was required and understanding was required, to also stand by those customers and ensure full understanding and full realisation of benefits. From the perspective of DH, financial advisers provided this type of advice all day, every day and DH thought it was essential to ensure that Members make the right choices and fully understand their claims.

d. One of the questions related to the Chairperson of the Audit Committee. Mr Drysdale asked whether there was not a conflict of interest in the appointment of an employee of PwC when PwC were the Scheme's auditors?

   The Chairperson responded that the Chairperson of the Audit Committee retired and left PwC in June 2018 and was appointed by the Scheme the following year (2019) in August. In addition to that, an independent third party was appointed and contracted to vet him and there were no actual or perceived conflicts of interest identified.

e. The Chairperson proposed dealing with a group of questions that fall under the broad category of the question of the appointment of DH as the Scheme's administrator, as well as questions relating to whether DH was not overpriced? A proposal was made by, among others, Mr Vania, that the Scheme should consider going onto self-administration.

   The Chairperson commented that since the DH administration agreement was up for review, the Trustees and the Scheme have, since 2021, established a specialist Committee to oversee and consider the renewal of the administration agreement, including the question whether to re-appoint DH or whether other options should be considered, which included going out to tender, going to other administrators, and self-administering. That sub-committee had taken advice from various consultants, all of whom were asked to assist in the analysis of the questions that were before the sub-committee. Detailed examinations were undertaken of all of the performance metrices against which DH was required to perform, and all of the terms of the existing arrangements and agreements between the Scheme and DH. All of the matters raised in the questions were considered repeatedly and in detail since last year. In addition, the sub-committee appointed Deloitte to conduct an independent review of the healthcare market and alternatives that were available and took into account all the matters raised as a response of that review. The Board was unanimously of the view that the retention of DH as the administrator was in the interests of Members. There were many reasons for this and all of those

reasons were impacted on by the detailed review that had been undertaken until now. The Board strongly disagreed with the suggestion that DH was overpriced.

Once all of the factors relevant to this consideration were taken into account, including what else was available in the market, the Board was of the view that an appropriate pricing mechanism needed to be put into place, has been in place, and that Members have indeed received value for money from the relationship with DH, including the pricing.

There was of course another practical consideration - if one were to notionally consider what would happen were the Scheme to terminate the agreement with DH and consider going to self-administration, what would the impact be practically? The Scheme would be distancing themselves from the entity that was without doubt the market leader and performer in South Africa and recognised internationally for its excellence. Its excellence included all aspects of administration, including innovation and being a responsible leader in the industry. In that scenario, the Scheme would then begin to make up their own internal administration and were the Scheme to do that, bearing in mind that the Scheme was the only open scheme administered by DH, DH would then be free to go into the market and start another open Scheme to compete with DHMS.

The proposal to self-administer had three very obvious disadvantages. The one was getting rid of what was undoubtedly an administrator who you wanted on your side. The second was the complete disadvantage created by a scenario where the Scheme would be trying to set up its own administration. The third is that DH would become the Scheme's competitor.

f. The Chairperson returned to a question from Ms Nicole May Gardner that related to the retention of Southern Rx as a service provider to perform certain services during COVID-19 and the continued retention of Southern Rx. The point was made that a sum of R780 million had been paid cumulatively for that service. The Chairperson referred this question to Ms Mbewu.

Ms Mbewu commented that the question from Ms Gardner attributed an accumulated amount of some R700 million to Southern Rx. It was important firstly to distinguish the fact that the R700 million was in relation to two years, the 2020 financial year and the 2021 financial year, with only some R400 million actually being attributable to the 2021 financial year. In respect of Southern Rx, there was an ongoing enquiry with the CMS in relation to wellness and screening benefits of the Scheme in relation to service providers that it had procured these from, which included Southern Rx. What was important to highlight was that Southern Rx did not only provide wellness and screening services to the Scheme, but also provided other services to the Scheme, including being an oncology Designated Service Provider for the Scheme. One of the objectives of Southern RX was to ensure that services it provided to the Scheme, was at a reduced rate in relation to the rest of the market to ensure that the Scheme benefited from preferential pricing and the benefit was then forwarded on to the Members of the Scheme in terms of how the claims were paid out.

g. The Chairperson referred to range of questions raised by Mr Drysdale concerning particular details of the financial statements.

The Chairperson dealt with certain factual backgrounds to the questions of detail asked by Mr Drysdale. The first was that, on 10 June 2022, Mr Drysdale raised a range of questions in correspondence to the Scheme Office. Significant resources were dedicated to considering all the questions, including engagement with the external auditors. The Scheme compiled a detailed and comprehensive response

to the questions in consultation with the auditors, PwC, and addressed each of the questions that Mr Drysdale raised.

The response was sent to Mr Drysdale on 21 June 2022 following proper governance process. The Chairperson assured the meeting that the questions raised by Mr Drysdale had been considered and responded to, including questions that was received on 22 June 2022, that required significant resources to deal with. Therefore, each of Mr Drysdale's detailed questions appeared to be questions that either were a repetition or a close repetition of matters that had already been raised and responded to. The Chairperson assured the meeting that the Scheme Office, including its chartered accountant, and the auditors were satisfied that the financial statements fairly reflected the affairs of the Scheme.

h. The Chairperson referred to one question to which more than one person had responded to in the chat function concerning what the implications for the Scheme were arising from the National Health Insurance ("NHI") legislation to be passed and the government's policy on NHI.

The Chairperson mentioned that Dr Noach had taken the meeting through a helpful and brief summary of the position of DH, a position on which the Scheme looked for guidance as to the appropriate response that the Scheme should articulate, given the likely progress of the NHI initiatives.

The programme relating to the NHI regularly received detailed attention from the Board of Trustees and advice was obtained from the administrator and others relating to the current situation and various scenarios. To a large extent, the views and positions adopted by the Scheme and by the Scheme's administrator had to be flexible and take into account all possible factors that may play a role in the implementation of NHI.

DHMS and its Trustees were keenly aware of the need for the Scheme to act as a responsible corporate citizen in responding to the NHI, to the challenges that the NHI presented, and to the undoubted benefits to South Africans of a better healthcare system. At the same time, the Trustees and the administrator were keenly aware of the responsibility owed to the interests of Members taking into account the Scheme's responsibility as corporate citizens. The Scheme agreed with its administrator that it was crucial in this process to have extensive stakeholder engagement with all role players in this process, including Members of the Scheme. It was also crucial that the Scheme skilfully and appropriately responded with the requisite flexibility to this issue as it developed.

The Chairperson gave the assurance that DHMS and its administrator took this matter very seriously and frequently considered and reconsidered the position of the Scheme in this context.

i. The Chairperson read out the following question relating to co-payments from Mr Daniel Govender: *"Could the medical scheme not review the following: remove co-payments especially for low-income and elderly members, negotiate with doctors to remove excess payments, especially for low-income earners and pensioners? Some or most pensioners are not online literate and do not have access to online portals. Can the Scheme consider innovative and creative ways to assist these categories of members? For those that are on hospital plans, could the Scheme not add a portion or limited medical aid for medication and doctor visits? Could the Scheme not consider payment for casualty trauma visits?"*

The Chairperson commented that other questions were raised by Members relating to the possible introduction of low-cost benefit options better suited to the vulnerable groups referred to by Mr Govender and requested Dr Noach to respond to this group of questions.

Dr Noach commented that the research and development teams of DH, who worked very hard to understand claims and benefits and match these with Member needs, aspired to provide a brilliant full benefit product that covered all Members' healthcare needs without co-payments. As pointed out in the questions, this was most relevant to those who had limited disposable income. Although pensioners, the elderly, lower income groups were spoken about, in all situations where there was not disposable income available, DH endeavoured to support the Scheme's products to ensure that they provided full benefit options.

It was important to note that the Medical Schemes Act in South Africa required absolute consistency in the application of every benefit on each registered plan of the medical scheme to all members who are on that plan. This was known as community rating and it was applied together with guaranteed enrolment and what it effectively meant, was that every Member on a particular plan option paid exactly the same contribution for receiving exactly the same benefits, irrespective of their underlying health status, their demographics, their age, their pensioner status, or their income status. By law, schemes in South Africa on each could not differentiate the benefits that were paid based on a member's individual profile. The Scheme must treat all Members on a particular benefit option equitably. The reason the Scheme had so many benefit options was an attempt to design plans that cater for the needs of different segments of the population. In these categories that Members have raised, there were lower income plans that offered this. The only way to sustain those income plans and to keep their contribution levels at a lower price point, was to apply network provisions through contracting and managed care approaches towards those plans to provide a particular pathway of care which offered a full benefit cover option relative to other plans where you may have a full choice higher up in the plan range. It was important for Members to understand their benefits and in this regard, it is worth a conversation with a financial advisor or to engage with DH, the digital material on the Scheme's website or the services offered for the multi-channel operations (digital or call centre) to fully understand these benefits so that the choices Members made in the healthcare system support a fully funded path.

In terms of the second part of the questions which was low-cost benefit options - over the past 10 years, there has been an ongoing discussion with the CMS by various parts of the industry to try and find solutions and amendments to the Medical Schemes Act that would cater for a lower price point in medical schemes. On the basis of the current Medical Schemes Act provisions, the entry point at which the lowest affordable medical scheme plan that could be offered and was compliant with the law, was at about R1 000 and that was very expensive. There was work under way, which was led and co-ordinated by the CMS, and involved stakeholders from across the industry to determine compliance requirements, the technical and benefit requirements and the price points that could be affordable and sustainable for the implementation of low-cost benefit options.

j. The Chairperson read out the following question from Ms Leonie Vorster: *"Who is the responsibility party when it comes to member's personal information? Is it Discovery Health, DHMS or the brokers?"*

The Chairperson explained that there was important legislation in South Africa which governed the protection of personal information. The Scheme took its obligations under the POPI Act very seriously.

The Scheme and the administrator have access to personal information, which was made available with the consent of Members, which is, subject to all the statutory and other obligations, owned by the Scheme and by the administrator. Brokers specifically would obtain information from the Member, in which instance the broker is then responsible for that information. The broker does not have an entitlement to request the Scheme or the administrator to provide information to which the broker was not otherwise entitled.

The Chairperson reminded Members that voting was open and would remain open until 16:00 that afternoon, even if the meeting closed earlier. The Chairperson requested Members to exercise their right to vote.

k. The Chairperson referred to a comment by Mr Daniel Govender that accessing voting has sometimes been difficult and asked whether it was, for example, not possible to have access to voting prior to the meeting.

The Chairperson responded that the difficulty was that under the Scheme Rules, certain matters had to be dealt with at the meeting and it would not be in accordance with the spirit of the Rules and the legislation to do so other than strictly in accordance with the Rules. He requested Members to be patient and use the portal which hopefully was the best solution to the difficulties faced with COVID-19 at the moment.

l. Ms Kwena Mabotja raised the following question: *"From the presentation it appears that one can do home testing for COVID. Please elaborate on this."*

The Chairperson responded that the short answer to the question was that the Scheme had already introduced a pre-approved benefit for home testing. However, the Scheme was awaiting approval for the product before it could be implemented and make tests available.

m. Ms Kwena Mabotja raised a subsequent question: *"Has Discovery started doing a comparative analysis looking into natural immunity versus vaccine boosters' immunity, if so, has the Scheme already shared the results? It appears that there is or are studies done on this topic in other parts of the world."*

Ms Mbewu commented that there was ongoing research through DH, particularly the data analytics team, relating to the vaccine and the immunity that is provided by the various vaccines available to the Scheme. The Scheme specifically looked at the Pfizer two-dose vaccine together with the third dose being the booster.

Dr Noach invited Ms Mabotja to look at the health intelligence hub available on the DHMS website or also on LinkedIn where the health intelligence hub could be found. There was a great deal of research that has been published around the effectiveness of vaccination. DH has provided leading research to the world in this regard. It has been identified by some developed healthcare economies and other developing healthcare economies as very helpful to countries' responses to COVID-19.

In terms of the question of counterposing natural immunity against vaccination-induced immunity, there was a paper published by DH on the aforementioned hub, which indicated that the strongest immunity or most effective immunity against severe disease and death, was in fact in those people who have had a prior COVID-19 infection and developed anti-bodies from the infection and then have been vaccinated. As one would see in the paper, the combination of a prior infection plus a fully dosed vaccination led to more than 90% protection against severe disease and death. There were some comparisons of "natural immunity" or immunity derived after an infection versus vaccination in people who have never had an infection. In most of those studies, vaccination has proven to be more effective in reducing severe disease. DH's own data revealed that there were a very high number of re-infections, some with severe illness in people who were unvaccinated but have had prior COVID. It appeared, based on the burden of evidence emerging around the world and DH's own data, that there was benefit in being vaccinated even after having contracted COVID-19 as it afforded the best protection.

n. The Chairperson referred to a number of questions that were raised and to be referred to under the heading of Vitality and BMI Index issue.

- Ms Marika Sboros raised the following question: *"DHMS execs should urgently apply their minds to rewarding members, doctors who use low-carb dietary therapies to manage Type 2 diabetes and to some extent Type 1. The therapies have become mainstream as they are evidence based and shown to reduce drug use with Type 2 diabetes and in some cases, reducing avoiding drug use altogether with Type 2 diabetes, and there is a savings to the Scheme that is noted."*
- Mr Marco Martins raised the following question: *"I find the BMI index used in the Vitality Assessment isn't accurate for most active people. How can this be corrected?"*
- Mr Jan Nel raised the following question: *"Why is the R780 chronic benefit of sensors for an insulin pump to better control blood sugar levels in 2021 taken away in 2022? This is for sure a way to control diabetes better for less complication in future."*

Dr Noach commented that he did not necessarily have the clinical skill, notwithstanding being a doctor, to answer the detail on the dietary questions relating to diabetes. However, it was very clear to DH, and an integral part of the diabetes management programme, that lifestyle factors and human behaviour played a very big part in firstly, the development of diabetes and secondly in glycaemic control, how well diabetes was controlled. That was a long-standing evidence-based view supported by evidence and global consensus. A big part of the preventative programme in Vitality was built around mitigating these behaviours, supporting healthy eating and supporting these dietary interventions, and many other behavioural interventions, in treating diabetes holistically. DHMS's benefits fully supported appropriate funding for the treatment of both Type 1 and Type 2 diabetes and for the mitigation of risks, including lifestyle related risks. It was not within the remit of the Scheme to fund dietary choices as that fell outside of the definition of what a medical scheme may fund, notwithstanding being highly important but clearly there was no funding for food decisions within the medical scheme, unless in exceptional cases where medicinal nutritional support was required.

On the question on sensors, Dr Noach responded that DHMS was the first mover in the market to introduce a benefit about 2 or 3 years ago to fund continuous glucose monitoring and insulin pumps for the ongoing care of diabetes. The Member's contention was supported that continuing glucose monitoring was the future of diabetic management and did lead to much tighter glycaemic control as supported by the evidence. There were many insulin pumps and continuous glucose monitoring devices in the market. The clinical policy unit at DH went about benchmarking excellence in the continuous glucose monitors and insulin pumps and identified the standard required of the market and had benchmarked a price for which a continuous glucose monitor was fully funded out of the external medical appliances benefit. The sensors were also funded from the external medical appliances benefit on an ongoing basis up to a reference rate. That reference rate was based on a chosen device in the market. If a Member chose to use a device that was more expensive than the reference price, there would be a co-payment involved. If the Member chose to use the device at which the reference price was created or any device that was cheaper, the funding would be available in full.

On the BMI index question, Dr Noach responded that this was a question relating to Vitality and DHMS, and therefore was not really the business of the DHMS AGM. Notwithstanding, this was a point of common interest. The global evidence showed that the best way to track and measure BMI was to do so in conjunction with waist circumference. It was called a "waist circumference adjusted body mass index". If the BMI was adjusted based on the waist circumference, in general at population level, reliable body mass index measures were achieved that could be used as a proxy for a person's body health.

o. Mr Drysdale made a comment which suggested that there had been a failure to respond to his questions which he implied was a disgrace and a slap in the face of all Members.

The Chairperson responded to Mr Drysdale that it certainly was not the intention and that he did not think that was a fair comment. The numerous questions that he posed were very detailed and the Scheme Office did not take them lightly. Resources went into considering them carefully and responding to his questions. The second point was that the reason for engaging the external auditors was that the Scheme Office considered that they should not be the only decision-maker as to the materiality of any matter that Mr Drysdale raised and for that reason the auditors were engaged. The auditors have disagreed with his questions insofar as they have had time to consider them. Thirdly, the Chairperson emphasised the point that he made in the beginning. There were questions that were raised which the Trustees, The Scheme Office and the administrator remained willing to consider and to respond to, even after this meeting. The fact that a question was perhaps dealt with in not as much detail as it might be, or it came in after the meeting, was the same as any matter of concern relating to the Scheme's stakeholders, who were the Members. Therefore, insofar as Mr Drysdale perceived this to be a slap in the face, it most certainly was not one, it was not intended to be one, and the Chairperson repeated the willingness of the Scheme to continue to engage.

p. The second question that Mr Drysdale raised was whether Deloitte approved the appointment of a Trustee and his appointment as Chair of the Audit Committee.

The Chairperson explained that the Chair of the Audit Committee was not a Trustee. The Chair of the Audit Committee was independent and did not function as a Trustee. The second was that Deloitte was not asked to approve any appointment, but to undertake a review and vetting process to provide information to allow the Board to make its decision as to the appropriate person to be appointed.

Mr Knoetze added that Deloitte was not involved in that process and that it must have been another service provider.

q. The Chairperson noted a comment from Mr Raschid Vania that the audited financial statements could not be approved because a portion of the benefits were not compliant.

The Chairperson responded that, firstly, the financial statements were not presented for approval, they were presented for information and explanation. The Board took responsibility for the financial statements and the auditors took responsibility for the audit. On the suggestion that the financial statements were not compliant, the Scheme Office and the external auditors respectfully disagreed with that statement. The concerns were taken seriously, and appropriate resources were dedicated to considering them and responding to them.

r. There was a question relating to value-for-money from Mr Kgaile Mogoye, which the Chairperson would refer to Dr Noach. The questions read as follows: *"You seem to suggest that contributions are kept higher than other Schemes to mitigate against shock effects post the COVID economic slump. Shouldn't we allow for members to decide on this since members can do with some immediate savings? Also, the introduction of NHI might help to mitigate such shocks by driving the medical schemes costs down."*

Dr Noach explained that the Board of Trustees relied on complex and comprehensive advice from both external statutory actuaries and also an internal actuarial team who consider the claims and contributions of the Scheme in every cycle and also prospectively in the long term to ensure and

underpin its sustainability. Pricing of the Scheme was indeed highly complex and the primary dynamic that needed to be taken into account was medical inflation. In simple terms, this was the rate at which a basket of healthcare expenses that the Scheme funded tended to inflate in any period or over the longer term. If the rate of contributions by Members fell behind the rate of medical inflation, the Scheme was at risk of falling into an actuarial dead spiral where the gap between claims and contributions would continue to widen, reserves would be required to fund the claims and ultimately it could lead to the Scheme collapsing and being unsustainable. It was the responsibility of the Board of Trustees on the advice of these expert external and internal actuaries to price the Scheme correctly. This responsibility could certainly not be outsourced to the Members of the Scheme, considering the complexities, sophistication and understanding required. It was indeed precisely, the role of an appointed Board to make this very important sustainability decision, probably the most important for the Scheme.

It was a misunderstanding of the earlier point to say the Scheme was priced to be more expensive than other Schemes. On a scheme-to-scheme cost per benefit unit comparison, DHMS was 14.7% percent cheaper per benefit unit than the average of the next six largest competitors. The Scheme was brilliantly priced and provided an excellent value proposition for Members. The point made earlier was that the contribution increase during the COVID-19 period of 2020 and 2021 was a percentage point above some of the other large competitors in the market. In explaining that pricing decision, the decision to increase it at that rate was supported by a deferral of the date of increase of that contribution. The combination of the two meant that the Member paid less in rand terms. There was a saving in the pocket of the Member as asked in the question. However, in actuarial terms the contributions remained matched to the rate of medical inflation, to the rate at which claims are increasing. Going forward, the Scheme was in an ideal sustainability position. This was recognised in a circular by the CMS where, without naming DHMS specifically, CMS referred to innovative contribution strategies and recognised these as laudable in the market during the COVID period. This related to the strategy that the Board of Trustees took for DHMS' contribution increases.

s. The Chairperson asked Dr Noach to also respond to a related question from Mr Shaun Chinnasamy which read: *"This is not on point, but it needs to be mentioned that we have reserves of R30 billion. As a member I am inundated with co-payments. It is like being punished for being sick."*

Dr Noach invited the Mr Chinnasamy to engage with DH and the Scheme to help him understand how he could maximise his benefits to mitigate these co-payments. Dr Noach stated that, while he did not have a full understanding of his healthcare situation or specific claims, he was convinced that DH could give him guidance and a pathway that mitigated co-payments. Particularly, if the Member had a prescribed minimum benefit condition, then he would have full cover from DHMS. If the Member had a financial adviser, Dr Noach suggested that the Member engage them about this. These brokers were in the best position to give that type of advice. The accumulated reserves during COVID-19 were as a result of the utilisation discontinuities and the change in healthcare utilisation patterns that emerged globally and here also in South Africa through COVID-19.

Persons who had non-COVID-19 related issues tended to behave differently. They did not go to hospital, and they did not go to doctors as they typically do. They did much less prevention and screening and so the Scheme received fewer claims. As a result, the solvency increased. That solvency could not be deployed to reduce contributions or to enhance benefits on a once off basis. Unfortunately, contribution reductions and benefit changes persist into the future. It was critical that contributions and claims remained correctly matched for the actuarial sustainability of the Scheme. Those reserves could be returned to Members through initiatives like deferring a contribution increase in both 2021 and 2022. These deferrals have returned cash savings to Members exceeding R7 billion over the 2-year period. The

Scheme was running at an operating loss at the moment, using the reserves to fund that loss, although it was correctly priced with the price adjustment taking effect on 01 October 2022.

The Chairperson commented that he had earlier dealt with Mr Drysdale's question around the vetting of the Chairperson of the Audit Committee. The Chairperson advised that Mr Drysdale had asked whether PwC had approved him at that stage. The Chairperson advised that as he understood it, vetting was not undertaken by Deloitte but by PwC.

The Chairperson advised that where questions had been dealt with in groups, the intention was not to be disrespectful but rather to deal with the matters of the AGM as efficiently as possible.

The Chairperson advised that, while it cannot be said for certain that every question had been answered, approximately all the issues that were raised had been dealt with and stressed that if there was any issue overlooked, it was inadvertent. The Chairperson emphasised that the Scheme remained willing to engage on any matter any Member wished to raise, and assured Members that they would be taken seriously.

The Chairperson referred to a question from Ms Charissa Swart which seemed was a particular issue of importance to herself and not really the affair of an AGM. The Chairperson meant no disrespect but emphasised that questions of a personal and individual nature that were raised of this kind were probably best engaged on directly with the Scheme, the administrator and the Principal Officer of the Scheme. The Chairperson proposed that he would not read the question but assured the Member that their engagement with the Scheme would be taken seriously.

7 Voting and closure of the AGM

The Chairperson reminded Members that voting on all four resolutions, including the election of three Trustees, would remain open until 16:00 on 23 June 2022, after which the polling function will close and no further votes will be accepted.

In closing, the Chairperson thanked all the persons responsible for the arrangement of the AGM, including all the work preceding the AGM, and thanked the Members for engaging with the Scheme on the portal.

There being no further business, the Chairperson declared the AGM formally closed.

[Note: The use of sign language interpreters was used throughout the proceedings of the AGM]