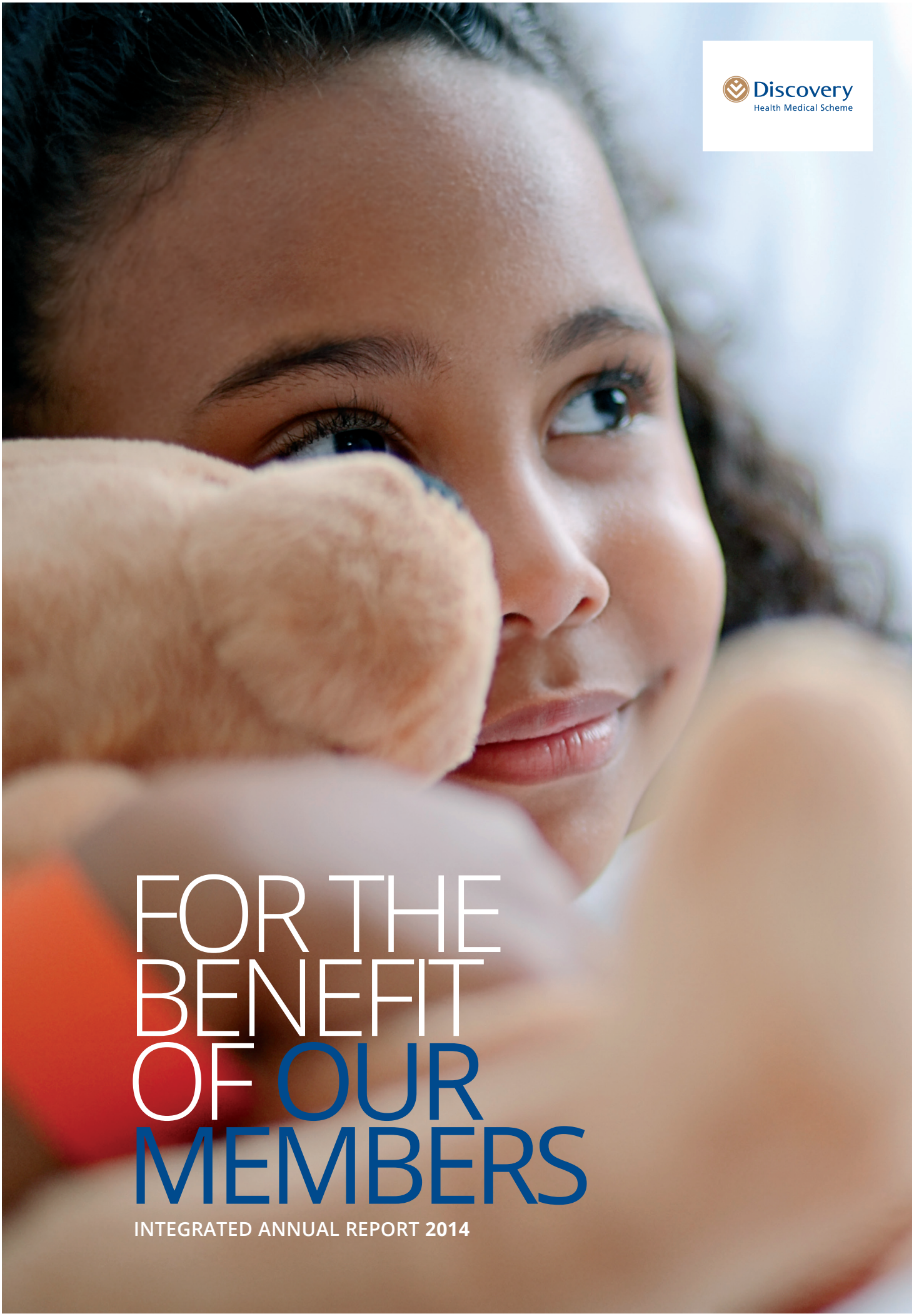
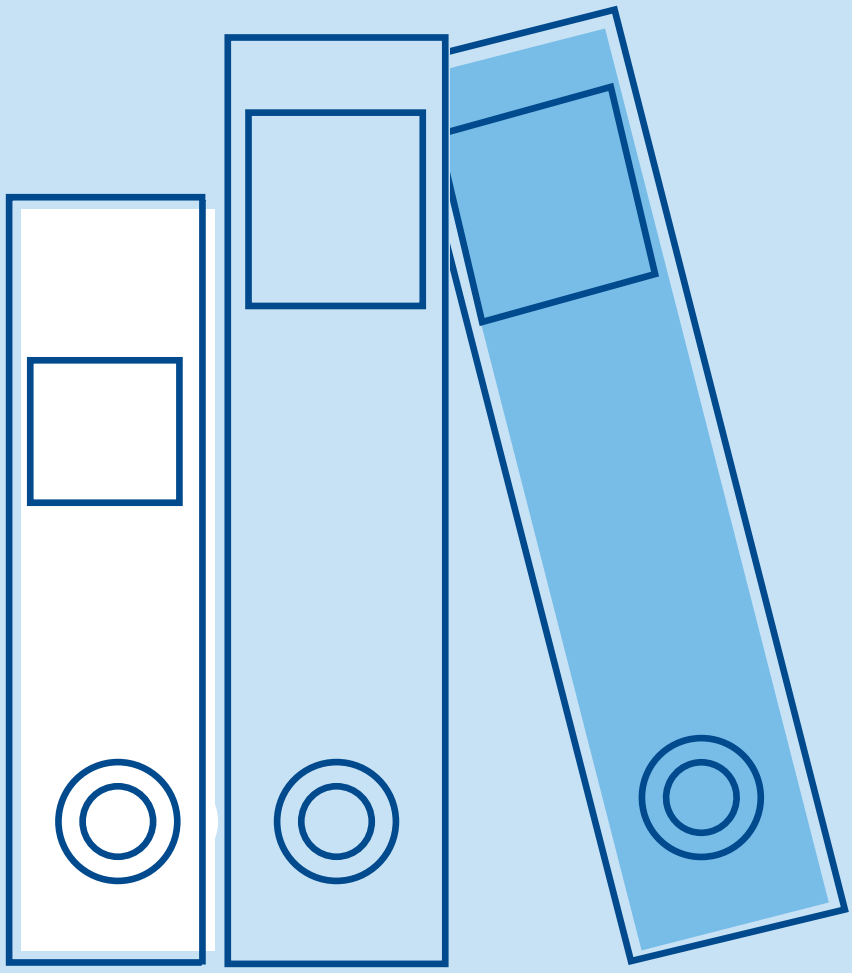

Discovery
Health Medical Scheme
FOR THE BENEFIT OF OUR MEMBERS
INTEGRATED ANNUAL REPORT 2014

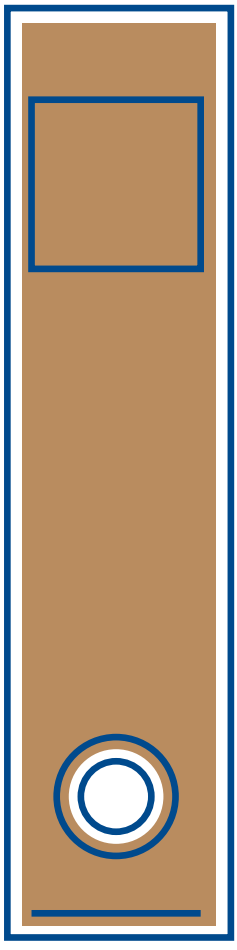
Discovery Health Medical Scheme has grown **from 720 000 to just over 2.6 million lives** in the past **14 years.**

It has indemnified many individuals and families from the devastating expenses associated with an extended stay in hospital or the treatment of a life-threatening disease. The Scheme has worked hard to ensure that its benefits match the clinical needs of its diverse members, and that health professionals are fairly compensated for the work they do. It has balanced its responsibilities so that it can continue to operate sustainably for many years to come.

Balancing the needs of its many stakeholders may not be easy, but it is fundamental to creating value for members, other stakeholders and, ultimately, South African society.



Integrated Annual Report 2014



Discovery Health Medical Scheme's Integrated Annual Report for 2014 covers the financial year from 1 January 2014 to 31 December 2014. This period is also referred to as a benefit year in the report.

REPORT SCOPE AND BOUNDARY

The report includes material information that is primarily of relevance to members of Discovery Health Medical Scheme. It provides an assessment of how Discovery Health (Pty) Ltd (the Scheme's Administrator) has managed its mandated administration and managed care responsibilities.

The report provides a holistic view of the Scheme's business model, strategy and performance, in relation to the key risks and opportunities that affect the private healthcare industry. The report also references other key stakeholders including regulatory authorities, health professionals, healthcare intermediaries and employer groups.

Sustainability has become integral to the way in which the Scheme conducts its business. In a time of increasing financial demands on Scheme members and above inflation increases in healthcare costs, the Scheme is determined to find sustainable ways of making a positive impact on society without adversely impacting the communities within which it operates. This report contains references to how the Scheme responsibly manages its available resources to create value for its members and greater society. It also monitors the progress of its Administrator and is confident that it meets its obligations in respect of sustainable business practice.

The Terms 'the Scheme', 'we', 'our', and 'us', all refer to Discovery Health Medical Scheme, unless otherwise specified. The terms 'the Administrator' and 'Discovery Health' all refer to Discovery Health (Pty) Ltd, unless stated otherwise. The term 'the Act' refers to the Medical Schemes Act No 131 of 1998, as amended.

MATERIALITY DETERMINATION

The Board of Trustees (the Board) is responsible for determining the matters that materially impact the Scheme's ability to create value for its members. Materiality determination is undertaken annually, and those issues established as material for the 1 January 2014 to 31 December 2014 benefit year are discussed in this report. The Board uses information from board and executive reports, business risks as contained in the Scheme's risk register, internal and external growth and benefit enhancement opportunities available to the Scheme and the Scheme's strategic objectives. It also uses stakeholder feedback as obtained through a range of formal (stakeholder activities and feedback sessions) and informal (emails and calls to the Scheme office) interactions.

The Board ensures that the Scheme's strategic objectives are adapted where appropriate, to ensure that all material matters are considered in the implementation of the Scheme's strategic priorities.

The Board identified the following material issues for the 2014 benefit year:

- Contribution affordability
- The regulatory environment and legislative compliance
- Value creation for members
- Stakeholder relations

*Read more about how the Scheme's strategic objectives align with addressing matters in **Business model, strategy and key risks** on page 24.*

BOARD RESPONSIBILITY

The Scheme is committed to ensuring that our members have access to accurate and reliable information. The Board of Trustees recognises its responsibility to assure the integrity of the integrated report, and is confident that the content of this report is material, complies with the Scheme's responsibility to provide detailed feedback on its operations and performance, and serves as a transparent, integrated source of information to all stakeholders.

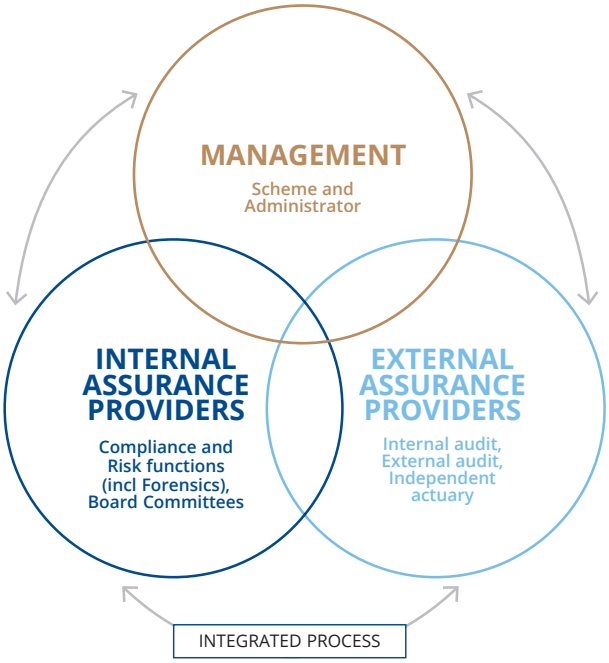
The Board is also satisfied that the Scheme has adequate resources to continue with its operations in the near future. The Scheme's Annual Financial Statements have therefore been prepared on the basis of the Scheme being a going concern.

*The Scheme's **Annual Financial Statements** are on page 49.*

COMBINED ASSURANCE

The Scheme uses a Combined Assurance Model based on three lines of defence and can be summarised as follows:

MANAGEMENT provides the Board of Trustees with assurance that the Scheme's risk management plan is integrated into the day-to-day running of the Scheme.



The **INTERNAL ASSURANCE PROVIDERS** (Compliance and Risk functions (incl Forensics), Board Committees) assess the effectiveness of the Scheme's internal control and risk management processes.

The Scheme and the Board receive **EXTERNAL ASSURANCE** on certain aspects of the Scheme's business, for example, external auditors, PricewaterhouseCoopers Inc, provide an opinion on the fair presentation of the Scheme's Annual Financial Statements.

The Scheme has decided to apply this model as it represents best practice in terms of corporate governance as contained in the King III Code.

AUDITOR INDEPENDENCE

The Scheme's Annual Financial Statements have been audited by PricewaterhouseCoopers Inc. The Scheme believes that the external auditors have observed the highest level of business and professional ethics. The Scheme has no reason to believe that the external auditors have not at all times acted with unimpaired independence and the Audit Committee is satisfied that the auditor is independent of the Scheme.

Details of fees paid to the external auditors for audit services are included in the Annual Financial Statements. The Scheme has adopted a policy governing non-audit services that are provided by the external auditor. The fees have also been disclosed to and agreed with the Audit Committee.

*Read more about the **Audit Committee** on page 19.*

REFERENCE ICONS FOUND IN THIS REPORT

To assist readers to connect related information, we have included cross-references to specific reviews and data found elsewhere in the report and in other sources of information. The following icons are used in the report:

In this report

Annual Financial Statements

On our website

IMPORTANT SOURCES OF INFORMATION

For more information about the benefits of your chosen health plan, you can refer to your benefit brochure or the Discovery Health Medical Scheme website at, **https://www.discovery.co.za/portal/individual/health-plan-guides**

A full version of the Scheme Rules is available on the website at, **https://www.discovery.co.za/portal/individual/dhms-rules** (You have to be a registered website user to access the Scheme Rules).

For more information on legislation that affects the business of a medical scheme, please refer to the Medical Schemes Act No 131 of 1998, as amended, available on the Council for Medical Schemes' website at, **https://www.medicalschemes.com/Content.aspx?130**

Chairperson's report: Discovery Health Medical Scheme

MEMBERSHIP GREW BY **2.7%**

TO **2 634 819 LIVES**

2013: **3.9%**

Discovery Health Medical Scheme has had another very successful year in respect of its membership growth and financial performance.

2014 was a challenging year for South Africans, with Statistics SA's Quarterly Employment Statistics report citing a national unemployment rate of 24.3% in the last quarter of 2014. The annual Consumer Price Inflation (CPI) rate peaked at 6.6% in June 2014, ending at 5.3% in December 2014*. All of these factors influence the Scheme's operations in some way. If individuals remain unemployed, they are likely unable to afford private healthcare cover, impacting the Scheme's ability to grow its membership. While CPI impacts healthcare costs, healthcare cost inflation has continued its upward trajectory, outstripping CPI by approximately 4% to 5% in 2014.

PERFORMANCE

Notwithstanding these challenges, the sound governance principles employed by the Scheme and efficient administration and managed healthcare services supplied by Discovery Health (Pty) Ltd, have led to another year of solid performance for the Scheme. Membership grew by 2.7% to 2 634 819 lives and lapse rates have remained low, at 4.5% (2013: 4.15%), proving once again that once members join Discovery Health Medical Scheme, they tend to stay. The Scheme's success during 2014 is a direct result of the successful implementation of its strategic priorities, which are discussed in more detail in this report. An effective business model is key to the continued implementation of these priorities and the Board of Trustees remains confident that the vested outsourcing business model employed by the Scheme works to the absolute advantage of its members.

MITIGATING THE IMPACT OF ESCALATING HEALTHCARE COSTS

Healthcare Funders across the world continuously grapple with managing spiralling healthcare costs in societies that have become older and sicker. New medical technologies and other high-cost interventions enter the healthcare system at an increasingly rapid rate. Many of these technologies are life-changing and members and healthcare providers expect medical schemes and governments to fund these. The challenge for medical schemes in South Africa is finding a sustainable way to fund technologies that are cost-effective while adding clinical value, as opposed to funding new technology that is expensive, with little or no proven clinical benefit.

In many business sectors the introduction of new technologies leads to a decrease in costs. Healthcare technologies differ however, because the use of new technology still requires highly skilled labour, leading to an increase in costs, rather than a decrease. This is known as the "Baumol effect". The Scheme and its Administrator continue to engage with health professionals to find ways of countering ever-increasing healthcare inflation while also adopting the newest technologies that facilitate improvements in clinical quality and improved health outcomes.

Healthcare inflation is another major driver of healthcare costs. While tariffs charged by health professionals, hospitals and other service providers drive CPI-related increases, the key driver of inflation above CPI is the volume of services that medical scheme members consume. These increase significantly every year, because of a combination of demand- and supply-side factors, for example an ageing insured population and the rapid increase in chronic diseases of lifestyle. Discovery Health Medical Scheme supports the voluntary engagement of members in wellness interventions and programmes. Wellness interventions have had a significantly positive impact on Scheme members' claims experience. Members who are engaged in wellness programmes are generally healthier than their non-engaged counterparts, and spend less time in hospital if they are hospitalised. The combined efforts of the Scheme and Discovery Health (Pty) Ltd in the form of tariff negotiations, cost protection through provider networks, risk management savings and wellness interventions, have led to an estimated saving of 10% of claims costs for Discovery Health Medical Scheme, equivalent to R3.7 billion in 2014.

A lack of coordinated care and inefficient processes often lead to waste in the healthcare system. The efficient coordination of care, better information gathering and sharing, and optimised processes remain a core focus for the Scheme. Over the long term this results in freeing funds for richer benefits and increased remuneration for health professionals. To drive progress in this area, the Scheme and Discovery Health (Pty) Ltd have implemented a number of initiatives aimed at facilitating care coordination for patients and a better flow of information between health professionals. One such initiative is the Discovery Health KidneyCare programme, which uses comprehensive data analysis to provide detailed quality of care reports to participating specialists and dialysis centres in South Africa. The outcomes of this programme have yielded positive results: Discovery Health Medical Scheme members enrolled on the programme have a 4.2% lower mortality rate than the average chronic dialysis member – a significant result.

* *Source: http://www.statssa.gov.za*

Chairperson's report: Discovery Health Medical Scheme

FUTURE OUTLOOK

Private healthcare is an essential national asset that strives to serve society in a cost-effective manner. The country's private healthcare system can and must thrive, and it must expand its services beyond the 17% of South Africans it currently covers. Discovery Health Medical Scheme continues to engage with the Council for Medical Schemes, the National Department of Health and relevant industry bodies on issues impacting private healthcare funding in South Africa.

The Competition Commission has initiated its market inquiry into the private healthcare sector in South Africa. The Scheme remains committed to cooperating fully in this inquiry, and has made a comprehensive submission in this regard. We look forward to the outcome of the inquiry and trust that it will serve as a catalyst for positive change in the provision of private healthcare funding and delivery in South Africa.

The Board of Trustees evaluates trustee and committee remuneration annually. Following the publication of Circular 41 of 2014 by the Council for Medical Schemes, which deals with trustee remuneration, the Board requested PricewaterhouseCoopers' remuneration practice to assist with the development of a new trustee remuneration methodology, including best practice remuneration principles. This methodology takes into account the non-profit status of the Scheme. The revised trustee and committee remuneration methodology will be presented to members at the Scheme's 2015 Annual General Meeting for approval. Please visit www.discovery.co.za to view the revised remuneration policy.

DISCOVERY HEALTH MEDICAL SCHEME BOARD OF TRUSTEES

MICHAEL VAN DER NEST SC

BA (Law), LLB (Stellenbosch)
Chairperson

NOEL GRAVES SC

BA, LLB (UCT)

GILES WAUGH

MA (Cantab)
FIA (Fellow of the Institute of Actuaries UK), FASSA (Fellow of the Actuarial Society of South Africa)

The Board of Trustees ensures that the Scheme is operated in the most efficient manner possible, making full use of the wide range of skills and expertise represented by the members of the Board. The Board also determines and reviews the material issues affecting the Scheme's ability to create value on an annual basis, and ensures that the Scheme's strategy is adapted to enable the Board to effectively oversee the Scheme's affairs. The Board will focus on the following strategic priorities for 2015:

- Evaluating and enhancing the Scheme's outsourcing business model based on international outsourcing best practice principles
- Maintaining the Scheme's industry leadership position and competitive advantage through product development, contribution competitiveness and service experience
- Ensuring best practice governance and legislative compliance
- Making members healthier through increased wellness engagement at home and in the workplace
- Enhancing clinical risk management interventions and quality of healthcare delivery strategies.

APPRECIATION AND CONCLUSION

I extend my thanks to the members of Discovery Health Medical Scheme who are the reason for the Scheme's existence and the central focus of our continued efforts to create sustainable value. I thank my colleagues on the Board for their commitment and the strong diligence they display in fulfilling their duties. The Principal Officer and his management team in the Scheme office fulfil a very important operational and oversight role in ensuring that the Board's strategy is successfully executed. I wish to acknowledge their hard work and unwavering commitment to ensuring that the interests of the Scheme and its members remain the central focus of our operations.

MICHAEL VAN DER NEST SC
CHAIRPERSON

PUKE MASERUMULE

BA (Law), LLB (UCT),
Post Graduate
Diploma in Labour Law (UJ)

PROF ZEPHNE VAN DER SPUY

MBChB (Stellenbosch), MRCOG (Royal College of Obstetricians and Gynaecologists), PhD (University of London, UK), FRCOG 1991 (Royal College of Obstetricians and Gynaecologists), FCOG (SA) (South African College of Obstetricians and Gynaecologists)

DAISY NAIDOO

BCom (Post Graduate Diploma in Accounting)
CA(SA), Masters of Accounting (Taxation)

Principal Officer's report: Discovery Health Medical Scheme

The Discovery Health Medical Scheme continued its record of strong performance despite increasingly difficult economic conditions in South Africa.

The International Monetary Fund cut the country's growth prospects from 2.3% in April 2014 to 1.7% in June 2014. News of widespread industrial action and declining international demand for South African exports dominated news headlines for most of the year.

Some of the Scheme's members and employer groups were adversely affected by these economic conditions, but in testament to the Scheme's ability to meet the diverse needs of its members, it experienced another successful year of operation.

Lapse rates remained very low at 4.5%, despite the challenging economic conditions. Steady membership growth resulted in 2 634 819 (2013: 2 564 313) beneficiaries covered – an increase of 2.7% from an already high base.

Gross contribution income for 2014 exceeded R44 billion with a strong net healthcare result of R753 million (2013: R860 million) and a net surplus (including investment income) of R1.5 billion.

Claims for 2014 have exceeded R29 billion, with a net loss ratio of 97.51%. Legislation requires the Scheme to maintain 25% of gross annual contribution income as accumulated funds or member reserves. The Scheme's strong annual membership growth has historically created short-term solvency pressure, because although new members join the Scheme without reserves, the Scheme has to hold the full 25% solvency requirement from their date of joining. In 2011 the Scheme presented a business plan to the Council for Medical Schemes, outlining its plan to reach the required solvency level, with set targets for each year. During 2014 the Scheme reached a solvency level of 25.76% of gross annual contribution income, exceeding the statutory requirement and the business plan target level, one year earlier than the anticipated target date. Member reserves have increased to a considerable R11.7 billion.

The Board, with the support of the Non-healthcare Expenses Committee, has maintained its strong focus on ensuring that non-healthcare expenses, the only cost component that reduces annually in real terms, remain on a steady downward trajectory. Administration and managed healthcare fees have increased by 1.3% below the inflation rate for the period under review.

The Scheme focused strongly on its primary goal of securing the best possible value for money for its members in terms of the benefits, service levels, and quality of care they receive in return for the contributions they pay. During the 2014 financial year, the Scheme and Administrator invested significant time and resources in ensuring that members experience a simpler, more streamlined private healthcare experience. In this year's report you will read the stories of three members who have benefited from the Scheme's rich and innovative benefit design as well as the Administrator's ability to work closely with health professionals to coordinate the care members receive. This results in fewer consultations, tests and procedures and ensures that the best possible clinical outcomes are attained. The Scheme has also recognised, as good business practice, the six principles enshrined in the Financial Services Board's Treating Customers Fairly (TCF) regulatory framework. These principles serve as a guiding influence in the Scheme and Administrator's decision-making processes.

They are:

- Customers can be confident they are dealing with institutions where TCF is central to the corporate culture.
- Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly.
- Customers are provided with clear information and kept appropriately informed before, during and after point of sale.
- Where advice is given, it is suitable and takes account of customer circumstances.
- Products perform as institutions have led customers to expect, and service is of an acceptable standard and as customers have been led to expect.
- Customers do not face unreasonable post-sale barriers imposed by institutions when changing product, switching providers, submitting a claim or making a complaint.

In addition, ongoing market analysis has shown that Discovery Health Medical Scheme remains the most affordable medical scheme across the entire spectrum of healthcare plans available in the open medical schemes market on a like-for-like basis. On average, contributions are 14% lower than those of the next nine medical schemes competing in the open medical schemes market.

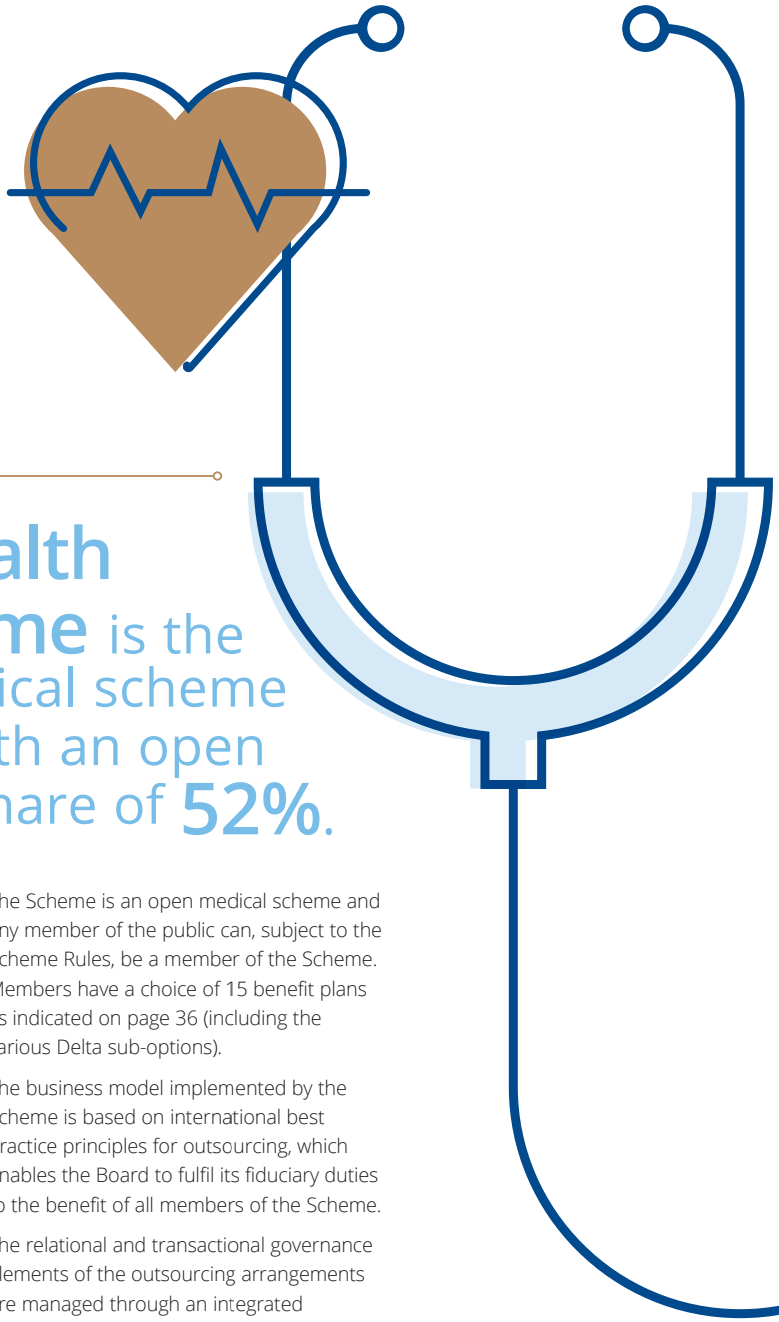
The Scheme has again retained its AA+ credit rating for its claims-paying ability from independent credit rating agency Global Credit Ratings Co. This is the highest rating a medical scheme is able to attain in South Africa and the Scheme has achieved this rating for the 14th consecutive year. Our members can therefore rest assured that the Scheme is able to fund their healthcare expenses reliably and sustainably for the foreseeable future.

The Scheme has continued to leverage the business model it has implemented with its Administrator and managed healthcare provider, Discovery Health (Pty) Ltd. This particular business model, based on the principles of vested outsourcing, has yielded tremendous value for the Scheme and its members. It is evident in the Scheme's record of innovation performance that the integrated operating model (one administrator) results in better performance compared to that of a scheme that adopts a fragmented operating model (multiple administrators). The Scheme office and Board of Trustees oversee the Administrator's performance as measured against a set of formalised service level metrics. This ensures that Discovery Health (Pty) Ltd works towards incentives that are strategically aligned to the Scheme's primary objective of creating value for its members.

The Scheme's Administrator implements a level of operations that remains unparalleled in the industry. With over 50 000 calls answered each day and just under 4 million claims processed every month, the Scheme and Discovery Health (Pty) Ltd have developed a range of technological and service innovations, including smartphone and tablet applications for members and health professionals. These applications have been enhanced to broaden their reach and the depth of information available to members and health professionals. More than 1 200 doctors use the HealthID application and over 550 000 members have given their consent, allowing their doctors to access their medical treatment history. This innovation plays an increasingly critical role in our ability to improve the quality of care that members receive. The link to telemetric diabetes monitoring that was introduced during the 2014 benefit year has proved effective in helping members with diabetes control their disease. Their doctors are able to electronically access a history of their blood glucose readings, add comments and notes to the patient's profile and view wellness data and a summary of any hospital events. This kind of proactive management results in a disease that is better managed, with members experiencing fewer or less intense clinical interventions.

Discovery Health Medical Scheme realises the important role of every contributor in the country's private healthcare system, but we acknowledge the challenge posed by trying to meet the needs of all the Scheme's stakeholders while ensuring long-term sustainability. This dynamic and complex operating environment however emphasises the need for medical schemes to implement transparent and responsible healthcare funding solutions. The Scheme, under the guidance of the Board of Trustees and with operational support from Discovery Health (Pty) Ltd, will continue to find ways of ensuring that our members benefit from access to the best quality healthcare at the most affordable rates and that society as a whole benefits from a stable private healthcare system.

MILTON STREAK
PRINCIPAL OFFICER



Who we are

Discovery Health Medical Scheme is the largest open medical scheme in South Africa with an open scheme market share of **52%**.

The Scheme is a non-profit entity governed by the Medical Schemes Act, No 131 of 1998, as amended (the Act), and is regulated by the Council for Medical Schemes.

The Scheme belongs to its members and an independent non-executive Board of Trustees (the Board) oversees its business. Members of the Scheme elect more than half of the Trustees in a transparent election process.

The Board comprises independent, highly skilled professionals, each with distinctive expertise in legal, clinical, financial, business and actuarial disciplines. A committee structure tailored to the Scheme's specific governance needs supports the Board.

*Read more about the composition of the Board in **Governance** on page 16 and see who the **members of the Board** are on page 06.*

The Scheme is an open medical scheme and any member of the public can, subject to the Scheme Rules, be a member of the Scheme. Members have a choice of 15 benefit plans as indicated on page 36 (including the various Delta sub-options).

The business model implemented by the Scheme is based on international best practice principles for outsourcing, which enables the Board to fulfil its fiduciary duties to the benefit of all members of the Scheme.

The relational and transactional governance elements of the outsourcing arrangements are managed through an integrated operating model in which Discovery Health (Pty) Ltd, as the Scheme's Administrator, manages all mandated aspects of the Scheme's operating environment, including the contractual relationships with health professionals and other providers of healthcare services and products.

*Read more about the Scheme's vested outsourcing business model in **Business model** on page 24.*

OUR GOAL

The Scheme's primary goal is to achieve the **best possible value for its members,** where value can be defined in terms of benefits, contributions, service levels and the quality of care members can access.

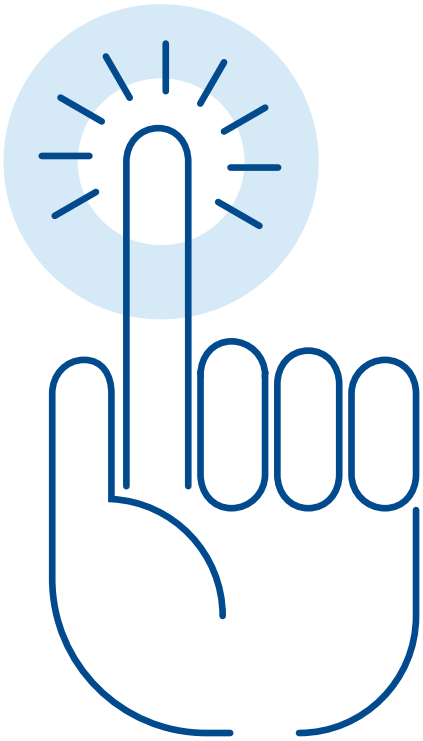
This provides the standard against which the Board measures the Scheme's performance. This definition of value is also at the heart of the Scheme's overall approach and, in particular, its relationship with its Administrator, Discovery Health (Pty) Ltd.

OUR UNDERSTANDING OF MEMBER VALUE

Creating value for its members is at the heart of the Scheme's strategy. It is essential that we understand what is of value to our members, what the drivers of this value are and how we measure the delivery thereof. The Scheme has a comprehensive view of member value, which includes the wellness of its members, the quality and appropriateness of healthcare services and administration, in relation to the overall contribution cost and the level of non-healthcare expenses (NHE), which includes the cost of administration and managed healthcare fees. The Scheme's central objective is to maximise overall value relative to overall cost and to deliver maximum benefit to members.

In 2012, the Scheme appointed Deloitte Consulting (Pty) Limited to conduct an independent assessment of the Scheme's operating model and governance structures, to ensure that the Scheme and its members were getting the best value for money in respect of administration and managed healthcare services provided by Discovery Health (Pty) Ltd. Deloitte developed a value formula, based on well-defined input criteria, using publicly available information to calculate the value received by Scheme members.

Deloitte's findings, based on the Scheme's 2011 data, indicated that every R1 spent on administration and managed healthcare fees created additional value for Scheme members of between R1.77 and R2.02. Using a similar methodology to Deloitte, the calculation of value received by the Scheme for 2013 indicated that the additional value was R2.20 for every R1 spent on administration and managed healthcare fees. To evaluate Discovery Health's performance in terms of providing value for money, the Board will perform this value calculation on an annual basis using publicly available information from the Council for Medical Schemes, in addition to the existing service level agreement (SLA) monitoring process. The 2014 calculation will be performed as soon as the Council for Medical Schemes has published its 2014/15 report.



How our members **derive value** from their Scheme membership

THE SCHEME WORKS CLOSELY WITH ITS ADMINISTRATOR, DISCOVERY HEALTH, **TO ENSURE THE BEST HEALTH OUTCOMES AND VALUE FOR MONEY FOR ITS MEMBERS.**

To illustrate this, we are extremely grateful to **Fawn Rogers, Thato Minyuku and Mr and Mrs Lyons,** who shared their stories with us. We hope that their stories will inspire you as they have us, and that the value they have gained from being members of Discovery Health Medical Scheme is evident.

Their experiences show the value of receiving clinically appropriate care that is provided in the right setting (in or out of hospital) and how important it is to coordinate care. This ensures that members don't have to repeat tests and treatments already performed when they use different healthcare providers. With coordinated care, every provider knows the member's medical history and latest treatments and interventions and can ensure that the most appropriate and effective care is given at all times. In addition, the service that Discovery Health provides to Scheme members is focused on alleviating their administrative burden in their time of need, making it easier to navigate a healthcare system which can at times be dauntingly complex.

FIGHTING FAWN

27-YEAR-OLD **FAWN ROGERS** HAS A LOT TO SMILE ABOUT. AFTER A LIFETIME BATTLING POOR HEALTH, SHE HAS NOW FINALLY REACHED THE PATH OF RECOVERY.

Diagnosed at the early age of one with Cystic Fibrosis, a genetic disorder that most commonly affects the lungs, Fawn has only ever known a life of hospitals, doctors, and cautious living. *"It affected my life hugely. Daily pills, physiotherapy, and special diets made me stand out at school and I wasn't able to participate in much, which isolated me further. I had to be hospitalised every three months for two weeks of treatment which also meant I missed out on a lot of school and social events."*

In 2011, Fawn had just started a part-time job when she fell very ill and was forced to resign. *"I spent about six weeks fighting an infection in hospital and by the time I had gotten over the infection, my lung function had dropped drastically and I started to need oxygen 24 hours a day."*

Twelve months later, Fawn received her life-changing call: an organ donor had been found and she was ready for the transplant operation.

During a lengthy 8-hour procedure, Fawn's medical team removed one lung at a time and replaced each with what she now jokingly refers to as her "shiny new working lungs". Fawn then spent a week in the Intensive Care Unit before being stable enough to be transferred to a normal isolation ward at Milpark Hospital in Johannesburg.

For Fawn, the support of friends and family played a crucial role in her recovery. That, and not having to worry about the financial implications of her surgery. *"While I was in hospital recovering for three months, I did not see a single bill. Everything was taken care of by Discovery Health Medical Scheme and I am truly thankful that I had chosen them as my medical scheme. I am not sure how much the whole procedure cost but I estimate in the millions – not having to worry about this took a huge weight off my family and my shoulders."*

Hopeful and excited about her future, Fawn is still aware of the magnitude of having been through the transplant process and the responsibility she has, to look after her health. *"I still have to go for regular checkups which are every three months. I take daily pills which consist of my Cystic Fibrosis pills as well as anti-rejection and transplant medication. I am also a diabetic and need insulin to control this. I know that a transplant is not a cure, but I got my second chance at life, and I'm taking it!"*

The Scheme covered the cost of Fawn's organ transplant from the Hospital Benefit, based on the plan type she had chosen. All follow-up medication and treatments are covered in accordance with legislated Prescribed Minimum Benefits where applicable, and/or the Scheme's Chronic Illness Benefit, and/or Fawn's available plan benefits.

FROM LAWYER TO RE-LEARNING LANGUAGE

THATO MINYUKU WAS BASKING IN THE GLOW OF NEWLYWED-BLISS AFTER MARRYING HER HUSBAND, KARL, IN APRIL 2012. WITH THE HONEYMOON FRESH IN HER MEMORY, SHE RETURNED TO WORK AS A LAWYER.

The ever-elusive work-life balance seemed harder and harder to achieve with a hectic job and a family life that took an emotional toll on her.

One Sunday Thato started feeling nauseous and unwell. She assumed that it was something she ate while out with Karl. By the next Wednesday she was still not feeling any better, so she decided to take a sick day and stay home to recover. Thato's symptoms worsened considerably though and on 13 June 2012 she suffered a massive stroke that left her completely mute.

The most challenging aspect of Thato's journey to recovery is the aphasia that resulted from the stroke. Aphasia is a communication disorder that prevents a person from being able to speak and to understand others, but it does not affect intelligence. Reading, writing and speaking are difficult, but the condition can improve with intensive therapy.

Thato still undergoes gruelling sessions of speech, occupational and neuro-occupational therapy. The goal is to help her return to a level of function as close to what she had before the stroke. *"I really love the progress I am making with speech therapy. At the beginning I could hardly pronounce letters, let alone words, sentences or paragraphs. Now, while it is a bit slow, I can do all of those things."*

Another difficult adjustment was the knowledge that she couldn't immediately go back to practising law. *"I thought I'd be able to go back to work in a month, but by December 2012 I started to realise that this wouldn't happen and by mid-2013 I made peace with the fact that being well enough to work again was still far in the future. I am so grateful to my husband Karl, who did everything for me – I was like a child, but he took care of me so beautifully."*

Karl is grateful that he and Thato had the benefit of medical cover. "I am conscious that we pay for medical cover and this is Discovery Health Medical Scheme's business, so in some respects this is just 'what you do'. However, from my perspective, the Scheme and Discovery Health have helped make an incredibly hard journey easier. You have helped Thato get to a point in her life where she can drive again, where she can hold conversations again and where she is able to lead her life and have hope for the future."

Thato hopes to return to be a lawyer again and finish the thesis she started before the stroke. There's very little doubt that this determined young woman will achieve the goals she has set for herself.

The cost of Thato's in-hospital treatment was covered from the Hospital Benefit on her chosen plan and all follow-up treatment and medication are paid from the legislated Prescribed Minimum Benefits where applicable, the Scheme's Chronic Illness Benefit, or Thato's available plan benefits.

A LIFE WORTH LIVING

MR ARCHIE LYONS IS A WORLD WAR 2 SURVIVOR WHO IS **102 YEARS OLD.**

Mr Lyons is also a cancer survivor and suffers from a few age-related chronic illnesses. Despite his medical problems, Mr Lyons and his 90-year-old wife, Fanny, live in an apartment on the third floor of a block of flats which he built. They have a daughter who lives in the United States of America, with whom they have regular contact. She visits them here in South Africa every three months.

Mrs Lyons used to be her husband's primary caretaker, but with the onset of muscular degeneration in them both, as well as age-related frailty, it has become increasingly difficult for her to fulfil this role. Previously they walked in the gardens daily, listened to music, the radio and had a lot of supportive friends, many of whom have now passed away. The occasional dinners they host for friends and helping a neighbour who lives on her own still gives this couple a sense of purpose. Their greatest help and support is Evelyn, their domestic assistant and caregiver.

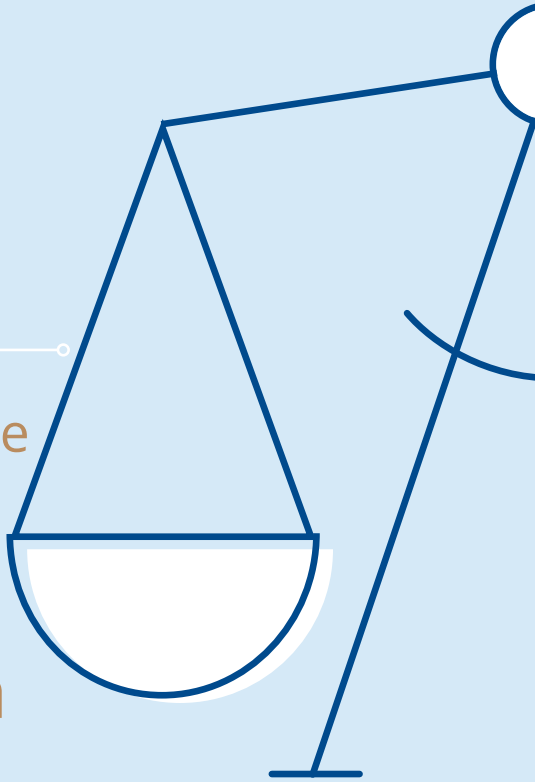
"Evelyn is a part of our family, we don't know what we would do without her", says Mrs Lyons.

On 1 August 2014 Mr Lyons sustained a burn to his foot and although it was managed by various visits to a general practitioner (GP) and wound dressings, the burn did not heal and deteriorated to the point where Mr Lyons had to be hospitalised for an amputation of his toe. Amazingly, he was discharged from hospital after only four days. Discovery Health's Coordinated Care team stepped in and organised daytime home nursing assistance for his recovery. They also arranged for an occupational therapist (OT) to assess and treat Mr Lyons, and with the help of the couple's daughter, full-time nursing assistance was put in place.

A Care Coordinator from the Seniors Care Coordination Programme (SCCP) held a meeting with the Lyons family and based on the recommendations of a coordinated team of health professionals, could make recommendations that would improve Mr and Mrs Lyons' quality of life. For example, assistive therapies and convenient medicine delivery service through Discovery Health's MedXpress medicine home delivery service. The couple's GP, with the help of the SCCP now acts as a coordinator of care for the couple, ensuring that they get the best possible medical care, tailored to their specific needs.

The Scheme paid Mr Lyon's in-hospital treatment from the available benefits on his chosen benefit plan. All out-of-hospital treatment is paid in accordance with the legislated Prescribed Minimum Benefits, the Scheme's Chronic Illness Benefit, and/or the couple's available plan benefits.

How we are governed



The Scheme's governance structure comprises an independent **Board of Trustees, Board Committees and a Principal Officer** with a management team (the Scheme office).

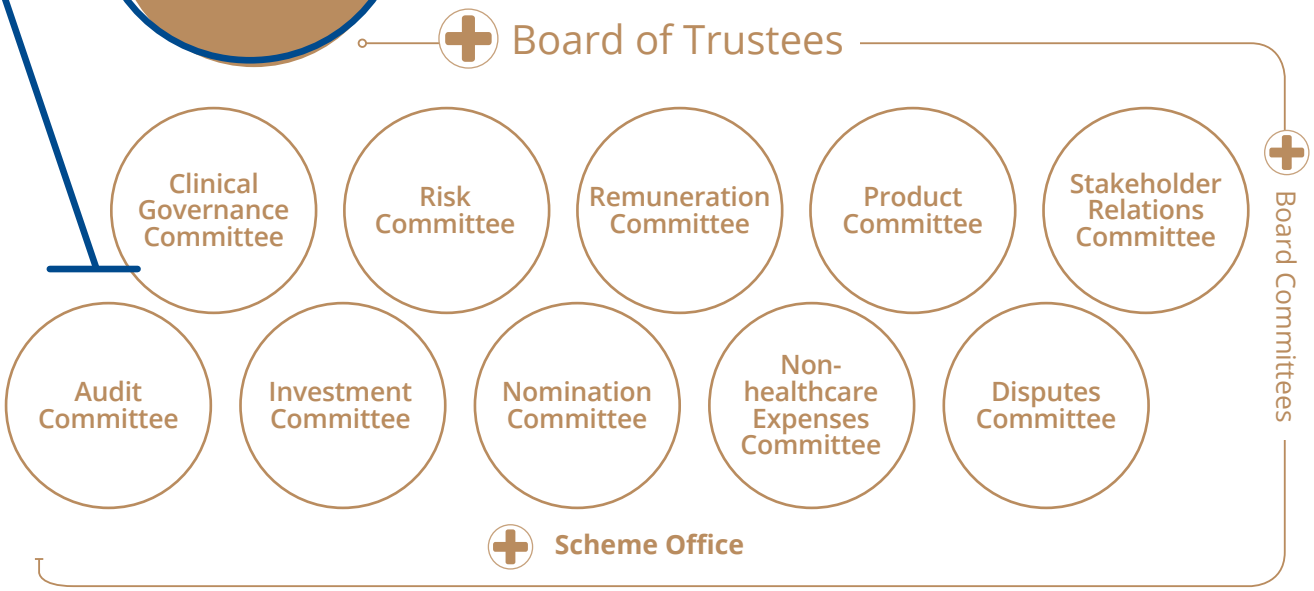
The Board and its committees are ultimately responsible for the implementation of the Scheme's strategy and the sound management of its business according to regulatory requirements.

The Act and the Scheme Rules which govern the operation and composition of the Board, ensure the following in terms of governance:

- First, the Act (in Section 57), stipulates that trustees cannot be employees, directors, officers, consultants or contractors of the administrator of a medical scheme, nor of the holding company, subsidiary, joint venture or associate of the administrator
- Second, at least half of the trustees must be elected by medical scheme members from among members (Scheme Rule 17.2). The balance of trustees may be elected by members, or appointed by incumbent member elected trustees, provided that the number of trustees appointed does not exceed twenty five percent of the total number of trustees at any given time. Trustees who are appointed need to have their appointment confirmed by members at the first annual general meeting of the Scheme following their appointment.

The Scheme's governance structure and processes, based on the provisions of the Act and best practice governance principles, are set up to ensure independence from the Administrator and that they are in the best interests of its members. The Board holds the decision-making power of the Scheme and all recommendations from the Administrator are presented to the Board for approval.

The Scheme's governance structure:



Ten board committees assist the Board to fulfil its fiduciary duties effectively. The committees all have written charters and clear reporting procedures. The Board and its committees perform annual peer reviews to assess effectiveness and strengthen governance processes. The Board has established a Disputes Committee in terms of the Scheme Rules and the Act, which hears and rules on all member disputes in an independent, open, transparent and fair manner.

The Principal Officer who is appointed by the Board ensures the day-to-day management of the Scheme according to the business model, policies and decisions determined by the Board. The Principal Officer and his management team collaborate actively with the Administrator, Discovery Health, and obtain the required information from the Administrator to effectively monitor and oversee the operations of the Scheme. The Board, Board Committees and the Scheme office make use of independent experts as necessary.

The Board has the requisite expertise, experience and independence to oversee the affairs of the Scheme in the most professional way and in the best interests of its members and stakeholders.

The role and duties of the Board are set out below:

ROLE OF BOARD	DUTIES OF BOARD
Evaluate and direct the Scheme's strategy and ensure the implementation of all strategic deliverables.	Act with due care, diligence, skill and good faith in the best interests of the Scheme and its members.
Review the sustainability of the Scheme and evaluate whether the services offered by the Administrator and managed care provider meet the needs of the Scheme and its members and offers value for money.	Ensure the proper and sound management of the Scheme by applying sound business principles to ensure the financial soundness of the Scheme.
Take responsibility for the governance of risk, combined assurance, and information technology (IT) and oversee risk-based internal audit activities to ensure effectiveness.	Take all reasonable steps to protect the confidentiality of medical records concerning the state of health of the Scheme's members, and ensure that the Scheme Rules, Scheme operations and administration comply with the provisions of the Act and all other applicable laws.
Monitor innovation and oversee the improvement of all levels of the Scheme's operations.	Oversee and direct the management of the Scheme's outsourced activities performed by the Administrator and managed care provider.
Monitor adherence to the Scheme Rules and the provisions of the Act in the day-to-day running of the Scheme's affairs.	Appoint, evaluate and delegate oversight functions to the Principal Officer.
Commission periodic independent governance reviews to assess the effectiveness of the Board and its committees to ensure it has the requisite skills and expertise.	Ensure that proper control systems are employed by and on behalf of the Scheme.
Consider stakeholder perceptions and the impact thereof on the Scheme's reputation.	Ensure that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and responsibilities in terms of the Rules of the Scheme.

The attendance of Trustees at Board meetings in the period is set out below:

BOARD MEETINGS	17 FEB	18 FEB	15 APR	2 JUN	26 AUG	11 NOV
TRUSTEES						
Mr Michael van der Nest SC	✓	✓	✓	✓	✓	✓
Mr Puke Maserumule	✓	✓	✓	✓	✓	✓
Mr Noel Graves SC	✓	✓	✓	✓	✓	✓
Prof Zephne van der Spuy	✓	✓	×	✓	✓	✓
Mr Giles Waugh	✓	×	✓	✓	✓	✓
Ms Daisy Naidoo	✓	✓	✓	✓	✓	✓
INDEPENDENT CO-OPTED MEMBER						
Dr Nozipho Sangweni	✓	×	✓	✓	✓	✓
CHAIR: AUDIT AND RISK COMMITTEE						
Mr Barry Stott	✓	✓	✓	✓	✓	✓

AUDIT COMMITTEE

The Audit Committee is a statutory Committee established in terms of Sections 36 (10) to (13) of the Act. The Committee is responsible for assisting the Board of Trustees in discharging their responsibilities relating to the safeguarding of assets, the operation of adequate and effective systems and control processes, and the preparation of fairly presented financial statements in compliance with all applicable legal and regulatory requirements and accounting standards.

The Committee consists of six highly skilled and experienced members with extensive actuarial, financial and information technology skills. The majority of the members, including the Chairperson, are independent and not Trustees of the Scheme.

The responsibilities of the Audit Committee are to:

- Oversee that a Combined Assurance Model is applied to provide a coordinated approach to all assurance activities in relation to significant risks facing the Scheme
- Oversee that the finance function of the Scheme has sufficient expertise, resources and experience
- Assist in the execution of the Board of Trustees' role of accountability
- Review the integrity, reliability and accuracy of accounting and financial reporting systems
- Oversee the disclosure of risk, internal financial controls, fraud and IT risks in relation to financial reporting
- Oversee that appropriate systems are in place for the monitoring of risk, control and compliance with laws, regulations and codes of conduct
- Oversee that the significant risks facing the Scheme are adequately addressed
- Maintain a transparent and appropriate relationship with the external auditors, approve fees and set the policy regarding the use of external auditors for non-audit services
- Review the scope, quality and cost of the statutory audit and the independence of the auditors
- Examine and review the Scheme's Annual Financial Statements before submission and approval by the Board of Trustees
- Oversee that matters relating to the sustainability of the Scheme to the extent that they have an impact on the financial results, are addressed
- Monitor and review the performance of the outsourced internal audit function.

The members of the Committee may consult any expert or specialist to assist the committee in performing its duties. The external auditors and the Principal Officer of the Scheme, as well as the internal auditors and the heads of the outsourced administration functions attend all Committee meetings by invitation and have unrestricted access to the Chairperson of the Audit Committee. The internal audit function is independent and objective and evaluation of their independence is conducted annually. The Committee meets at least four times per year and schedules additional meetings if necessary. The external and internal auditors regularly meet with the Committee without the Administrator being present.

The Committee's report
is presented on page 51.

During the 2014 financial year, attendance at Audit Committee meetings was as follows:

AUDIT COMMITTEE	12 MAR	25 MAR	15 JUL	12 AUG	27 OCT
INDEPENDENT MEMBER/CHAIR					
Mr Barry Stott	✓	✓	✓	✓	✓
TRUSTEES					
Ms Daisy Naidoo	✓	✓	✓	✓	✓
Mr Giles Waugh	✓	×	✓	✓	✓
INDEPENDENT MEMBERS					
Mr Neil Novick	✓	✓	✓	✓	✓
Mr Steven Green	✓	✓	✓	✓	✓
Mr Don Eriksson	✓	✓	✓	✓	✓

RISK COMMITTEE

King III makes the Board responsible for the governance of risk, and states that either the Risk Committee or Audit Committee should assist the Board in carrying out its responsibilities in this regard. The Board of Trustees has established a Risk Committee on this basis.

The Board of Trustees appoints the members of the Committee on an annual basis, with members consisting of representatives from the Board of Trustees, independent members, and Scheme management.

Risk management

The Scheme is operated in accordance with a best practice risk management framework that covers all its activities, underpins its sustainability and protects its members.

The Scheme has an outsourced risk management function that is responsible for day-to-day risk management activities.

The risk management function is responsible for:

- Providing tools, methodologies and standards that meet the risk management requirements of King III and other regulations
- Assisting the Board of Trustees and Scheme management through the Risk Committee in the understanding and active consideration of risks as a key part of decision-making
- Providing risk assessment, monitoring and reporting, which provides a clear view on the risks faced by the Scheme and the actions the Scheme and Administrator's management need to take
- Building and developing risk management understanding and expertise within the Scheme and the Administrator.

Compliance management

The Trustees recognise their responsibility to internal and external stakeholders in terms of the regulatory requirements applicable to all operations of the Scheme. The Scheme has implemented a coordinated Compliance Framework to ensure all operations are conducted in accordance with applicable legal, regulatory and supervisory requirements and guidelines.

The Scheme has an outsourced compliance function, which is independent of Scheme management. Its primary responsibility is to assist the Principal Officer and the Board of Trustees to discharge their responsibilities.

The compliance function is responsible for:

- Managing regulatory change, including identifying changes and ensuring that appropriate controls are implemented to address new requirements
- Providing general guidance and support to the Scheme specifically in assisting Scheme management to implement appropriate controls and monitor compliance, as well as to manage any incidences of non-compliance
- Maintaining a risk-based methodology to independently assess the appropriateness and efficiency of controls related to compliance
- Managing regulatory relationships with all applicable regulators, including the implementation of controls to ensure:
  - A single point of entry for regulatory complaints and enquiries
  - That all statutory returns are submitted on time
  - Ongoing contact with regulators regarding regulatory and supervisory developments that may impact the operations of the Scheme.

During the 2014 financial year, attendance at the Risk Committee meetings was as follows:

RISK COMMITTEE	12 MAR	15 JUL	27 OCT
INDEPENDENT MEMBER/CHAIR			
Mr Barry Stott	✓	✓	✓
TRUSTEES			
Ms Daisy Naidoo	✓	✓	✓
Mr Giles Waugh	✓	✓	✓
INDEPENDENT MEMBERS			
Mr Neil Novick	✓	✓	✓
Mr Steven Green	✓	✓	✓
Mr Don Eriksson	✓	✓	✓
SCHEME MANAGEMENT			
Mr Milton Streak	✓	✓	✓
Mrs Yashmita Mistry	✓	✓	✓
Mr Selwyn Kahlberg	✓	✓	✓
Dr Bhadrashil Modi	✓	✓	✓
Mr Shaun Osner	✓	✓	✓
Mr Calvin Hope	✓	×	✓

CLINICAL GOVERNANCE COMMITTEE

Clinical governance is recognised as an integral part of the funded healthcare environment, whether public or private, in ensuring that high-quality and affordable clinical care is provided to members. It is clinical best practice to recognise the need to account for clinical performance. The Scheme operates according to a best practice clinical governance structure that incorporates the following principles:

- Transparency
- Accountability
- Responsibility
- Fairness
- Independence
- Ethical behaviour
- Social responsibility

The Committee is responsible for overseeing:

- That the healthcare benefits, as prescribed by the Act and the Rules of Discovery Health Medical Scheme, are upheld
- That the managed healthcare mandate of the Scheme to offer members the highest level of appropriate, affordable quality care is complied with, taking into account the balance between cost-effective quality healthcare and effective clinical risk management
- Continued quality improvements and meeting members' expectations and needs
- Various clinical projects implemented by the Administrator. It also oversees clinical risk management principles for the Scheme, ensuring that the Scheme funds treatment that is clinically appropriate and evidence-based. In addition, it monitors ex gratia requests (where members request benefits outside of what their registered plan offers), Council for Medical Scheme complaints, and queries or disputes lodged by members or any other persons.

The Clinical Governance Committee serves as a second-line-of-defence assurance provider to the Board of Trustees, in their Combined Assurance Model, for clinical risks, benefit compliance and clinical exceptions.

The Scheme measures the quality of care members receive in terms of structures, processes and outcomes. The Scheme also subscribes to Health Quality Assessment (HQA), which assesses process measures on behalf of the Scheme, relative to the medical scheme industry. The Clinical Governance Committee reviews these measures and recommends the appropriate course of action where necessary.

The Clinical Governance Committee consists of one Trustee, one independent member and a member of Scheme management.

During the 2014 financial year, attendance at the Clinical Governance Committee meetings was as follows:

CLINICAL GOVERNANCE	13 FEB	9 MAY	4 AUG	10 NOV
TRUSTEE/CHAIR Prof Zephne van der Spuy	✓	✓	✓	✓
INDEPENDENT MEMBER Dr Nozipho Sangweni	✓	✓	✓	✓
SCHEME MANAGEMENT Dr Bhadrashil Modi	✓	✓	✓	✓

INVESTMENT COMMITTEE

The Committee is mandated to invest the Scheme's assets in line with the Act and the Scheme's approved investment policy.

The Investment Committee advises the Trustees on strategic and operating matters in respect of investing Scheme funds, to ensure that the investments made are in the best interest of the Scheme and its members and within the risk appetite of the Scheme, as determined by the Board of Trustees from time to time.

The Committee is responsible for:

- Evaluating and recommending to the Board of Trustees an investment policy for the Scheme with regard to the requirement that the assets invested should maximise returns whilst maintaining solvency
- Monitoring the effectiveness and implementation of the investment policy
- Making recommendations to the Board of Trustees on asset allocation, investment policy and strategy
- Reviewing the investment strategies, capital market assumptions, performance of the portfolio against established performance benchmarks and reporting to the Board of Trustees quarterly on the performance of the portfolio and asset managers
- Monitoring the performance of each investment with a view to maximising the total return, according to the Scheme's risk appetite
- Making recommendations to the Board of Trustees on the appointment, terms of engagement and fee levels of investment consultants and asset managers
- Advising the Board of Trustees on withdrawing funds from relevant portfolios to support daily operations
- Supervising the safekeeping and handling of the Scheme's investments, which are under the Investment Committee's jurisdiction

- Monitoring all reported investment activities in compliance with the Scheme's investment policy and statutory requirements, investigating the reasons for any deviations and recommending corrective action to the Board of Trustees
- Assisting the Board of Trustees in preparing their annual report on investment performance and compliance
- Monitoring the matching of assets and liabilities.

The Investment Committee consists of three trustees and one independent member.

During the 2014 financial year, attendance at Investment Committee meetings was as follows:

INVESTMENT COMMITTEE	14 FEB	27 MAY	6 AUG	6 NOV
TRUSTEE/CHAIR				
Mr Puke Maserumule	✓	✓	✓	×
TRUSTEES				
Mr Noel Graves SC	✓	✓	✓	✓
Ms Daisy Naidoo	✓	✓	✓	✓
INDEPENDENT MEMBER				
Mr Barry Stott	✓	✓	✓	✓

REMUNERATION COMMITTEE

The Remuneration Committee, established in line with King III, assists the Board of Trustees to oversee the Scheme's remuneration strategies and other human resource policies.

The remuneration of the Scheme's Board of Trustees and its committees is periodically benchmarked through independent reviews. The Committee uses expert input, independent benchmarking surveys, and the circulars issued by the Council for Medical Schemes as guidelines for its remuneration policy.

The Committee is responsible for:

- Assisting the Board of Trustees in setting and administering remuneration policies in the Scheme's long-term interest
- Confirming that the Scheme's employees are remunerated fairly and equitably taking into account remuneration best practice, external market trends and benchmarks
- Submitting recommendations to the Board of Trustees on trustee and committee remuneration to ensure that the Scheme is able to attract and retain the required skills and expertise.

The Committee consists of two Trustees and one independent member. The Principal Officer attends committee meetings by invitation.

During the 2014 financial year, attendance at the Remuneration Committee meeting was as follows:

REMUNERATION COMMITTEE	28 OCT
INDEPENDENT MEMBER/CHAIR	
Mr Don Eriksson	✓
TRUSTEES	
Mr Michael van der Nest SC	✓
Mr Noel Graves SC	✓

NON-HEALTHCARE EXPENSES COMMITTEE

The Committee is established in terms of governance best practice.

The Committee is responsible for:

- Reviewing and recommending the proposed contracted administration and managed healthcare fees to the Board of Trustees for consideration and approval
- Reviewing the service level agreements and assisting the Board of Trustees to ensure that these have been complied with
- Monitoring the value the Scheme and its members receive from the Administrator
- Approving and monitoring the Scheme's non-healthcare expenses budget.

The Committee consists of three Trustees and the Principal Officer of the Scheme.

During the 2014 financial year, attendance at Non-healthcare Expenses Committee meetings was as follows:

NON-HEALTHCARE EXPENSES COMMITTEE	10 APR	17 JULY	15 OCT
TRUSTEE/CHAIR			
Mr Noel Graves SC	✓	✓	✓
TRUSTEES			
Mr Giles Waugh	✓	✓	✓
Ms Daisy Naidoo	✓	✓	✓
SCHEME MANAGEMENT			
Mr Milton Streak	✓	✓	✓

PRODUCT COMMITTEE

The Product Committee was established in terms of governance best practice.

The Committee is responsible for:

- Evaluating and reviewing the Scheme's benefit design on an annual basis
- Evaluating benefits based on clinical best practice, financial sustainability, members' best interests (fairness principles) and communication best practice
- Recommending benefit amendments to the Board of Trustees.

The Committee consists of three Trustees, one independent member and the Principal Officer of the Scheme.

During the 2014 financial year, attendance at Product Committee meetings was as follows:

PRODUCT COMMITTEE	13 FEB	2 JUNE	4 AUG	7 NOV
TRUSTEE/CHAIR Mr Giles Waugh	✓	✓	✓	✓
TRUSTEES Prof Zephne van der Spuy Mr Noel Graves SC	✓	✓	✓	✓
INDEPENDENT MEMBER Dr Nozipho Sangweni	✓	×	✓	✓
SCHEME MANAGEMENT Mr Milton Streak	✓	✓	✓	✓

STAKEHOLDER RELATIONS COMMITTEE

The Committee was established in 2013, following a recommendation from Deloitte after their independent assessment of the Scheme's operating model and governance review.

The Committee is responsible for:

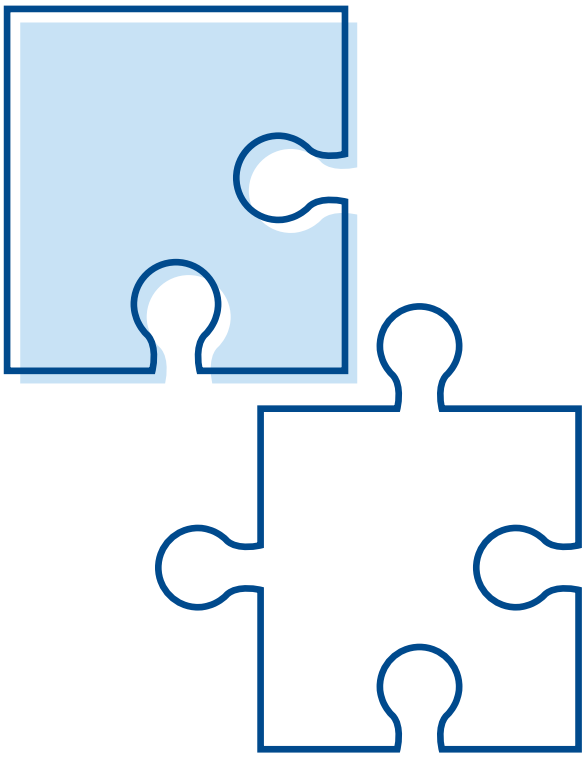
- Assisting the Board to identify important stakeholders, including those who could materially affect the Scheme's reputation and operations
- Understanding the legitimate interests and expectations of stakeholders and ensuring that these inform the Scheme's strategic objectives and decisions, in relation to long-term sustainability
- Ensuring the development of adequate stakeholder engagement processes and monitoring and evaluating engagement plans.

The Committee consists of two Trustees, two independent members and the Principal Officer of the Scheme.

During the 2014 financial year, attendance at the Stakeholder Relations Committee meetings was as follows:

STAKEHOLDER RELATIONS	25 FEB	8 MAY	29 OCT
TRUSTEE/CHAIR Mr Michael van der Nest SC	×	✓	✓
TRUSTEES Mr Puke Maserumule	✓	✓	✓
INDEPENDENT MEMBERS Dr Nozipho Sangweni* Mr Dave King	– ✓	✓ ✓	✓ ✓
SCHEME MANAGEMENT Mr Milton Streak	✓	✓	✓

* *Member from 8 May 2014*



OUR BUSINESS MODEL

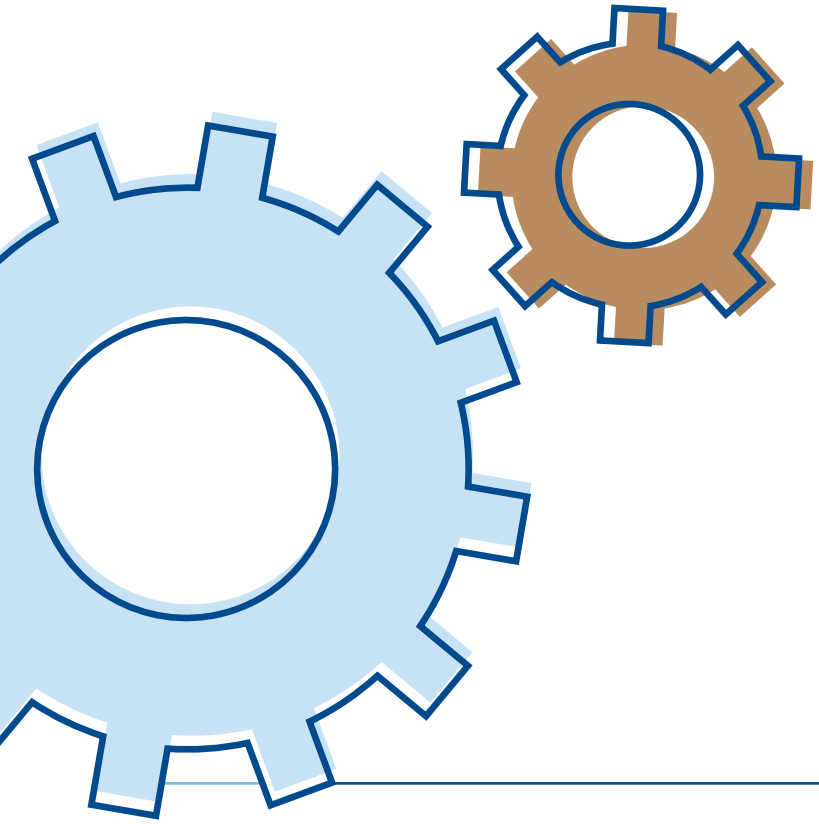
Discovery Health Medical Scheme continued to successfully implement its goal of **deriving the best possible value for money for its members.**

Through the sustainable funding of evidence-based, cost-effective, quality healthcare cover and supporting the development of the healthcare system for Scheme members and stakeholders, the Scheme makes a significant contribution to the effective functioning of the South African healthcare system. This objective is underpinned by sound financial management, best practice governance and effective risk management efforts.

The Scheme operates a business model based on Vested Outsourcing[1].

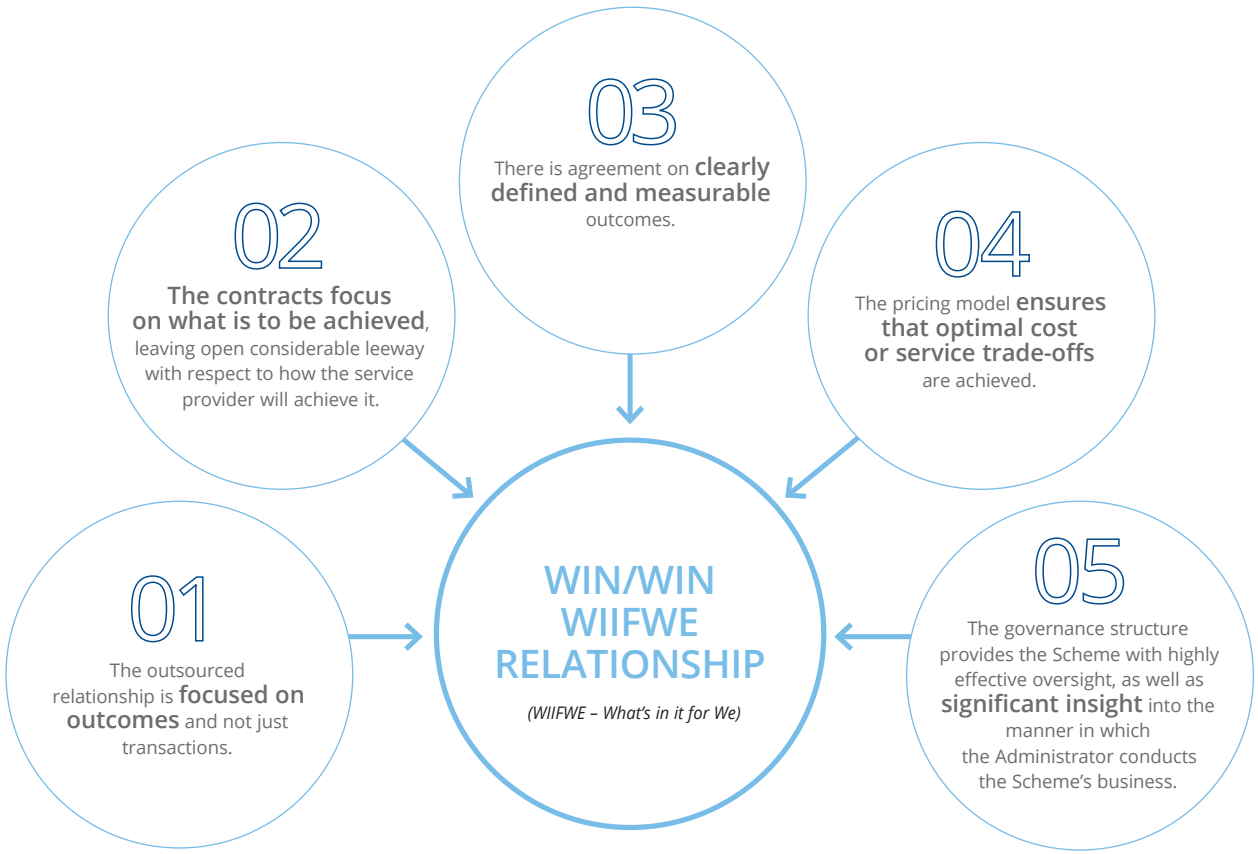
This model recognises the Scheme's independence through robust governance arrangements, while allowing the Scheme to leverage the Administrator's considerable knowledge, expertise, systems, innovations and value-added services in the best interests of the Scheme and its members.

1. *Adapted from The Vested Outsourcing Manual (Palgrave McMillan, 2011). Kate Vitasek with Jaqui Crawford, Jeanette Nyden and Katherine Kawamoto*



*Read more about the Scheme's governance structure in **How we are governed** on page 16.*

The Vested Outsourcing business model promotes five basic tenets, namely:



1. *Adapted from The Vested Outsourcing Manual (Palgrave McMillan, 2011). Kate Vitasek with Jaqui Crawford, Jeanette Nyden and Katherine Kawamoto. (Model used by: Coca-Cola, Microsoft, Proctor and Gamble, Jones Lang LaSalle and Rolls-Royce)*

A LONG-TERM OUTSOURCING ARRANGEMENT WITH DISCOVERY HEALTH

The principles of Vested Outsourcing are the basis for a successful relationship between the Scheme and Discovery Health for two primary reasons. First, the outsourcing relationship is an **integrated** outsourcing relationship, meaning that all the service components – including administration, managed healthcare and broker relations – are outsourced to a single provider. This allows the Scheme to leverage Discovery Health's economies of scope and its history of market-leading innovations, to create efficiencies for the Scheme. Other synergies between these activities are harnessed to provide best-in-class service levels on all aspects of the administration and managed healthcare agreements between the Scheme and Discovery Health.

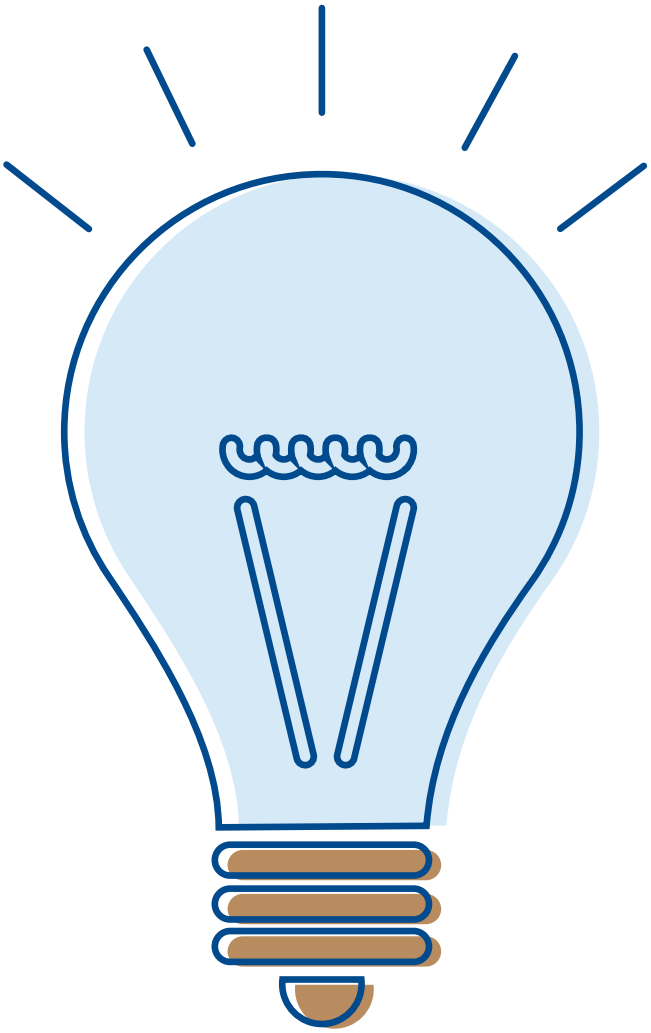
Second, the relationship is governed through **active collaboration** between the Scheme and Discovery Health and supported by independent robust governance arrangements.

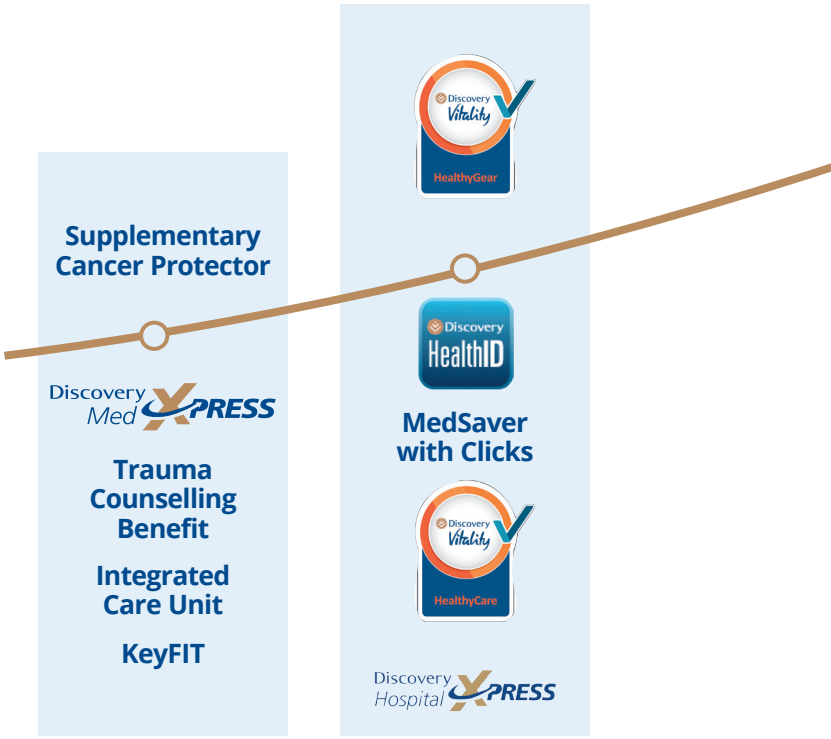
HOW THE SCHEME'S OPERATING MODEL CREATES VALUE FOR MEMBERS

The relationship between the Scheme and Discovery Health has sustained a record of innovation unmatched by any other medical scheme or administrator in South Africa.

Innovation focused on improving the quality of care and member experience is a key aspect of the Scheme's competitive advantage.

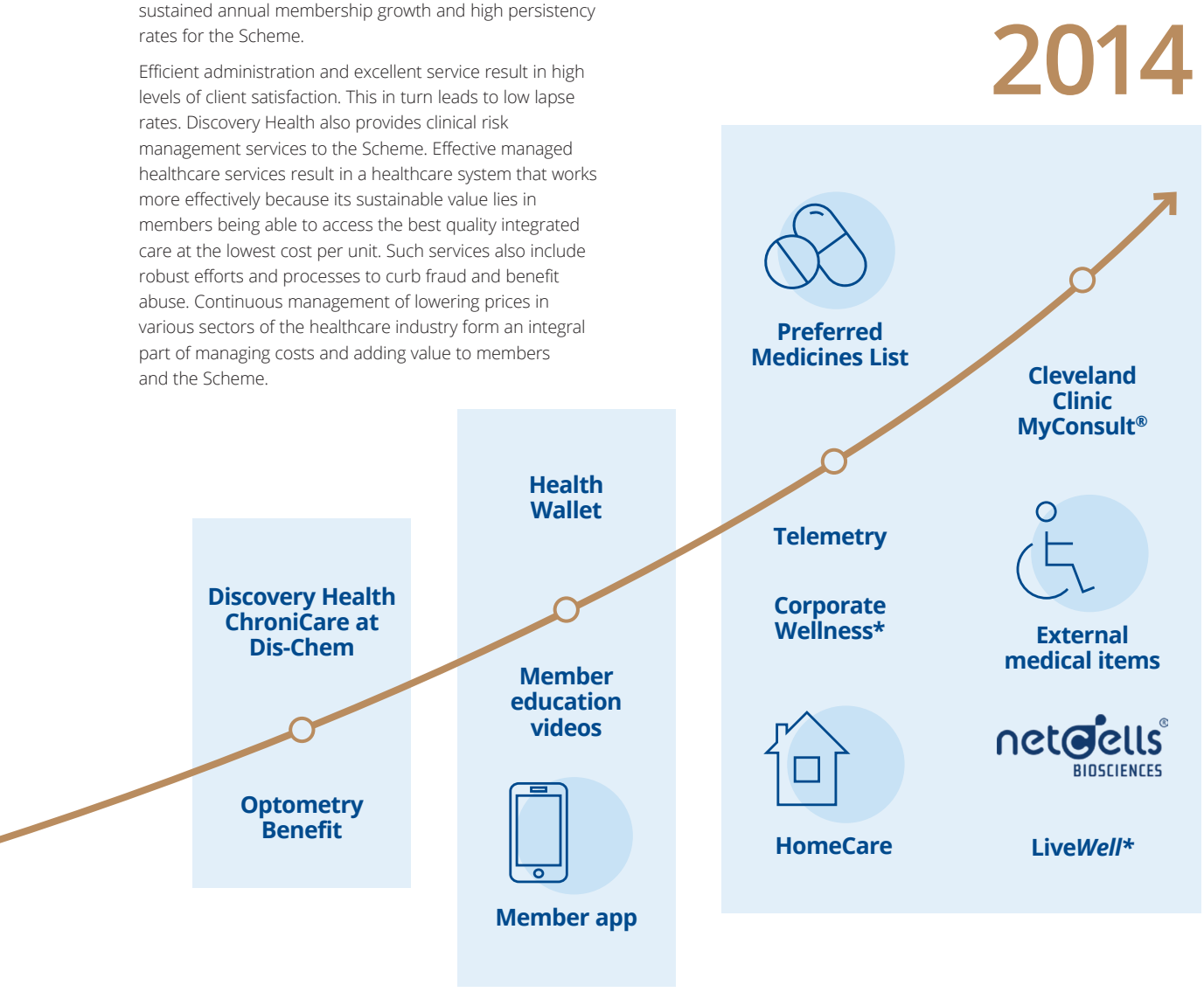
The Scheme, with the support of Discovery Health, has consistently been disrupting the market with significant innovation to improve quality of care and member experience. Some two hundred and fourteen (214) innovations were introduced between 2004 and 2014, most of which relate to Scheme benefits and how these are managed. Other innovations have focused on improving administration efficiency, which enhances the convenience and service that members experience. Significant enhancements to the Scheme's product range are planned for 2015 including the introduction of Personal Health Programmes for members registered with certain





chronic conditions, virtual consultations with members' GPs via their smartphones, and improvements to support member wellness, among others. Innovative benefit design and implementation has always been one of the hallmarks of Discovery Health Medical Scheme, consistently resulting in sustained annual membership growth and high persistency rates for the Scheme.

Efficient administration and excellent service result in high levels of client satisfaction. This in turn leads to low lapse rates. Discovery Health also provides clinical risk management services to the Scheme. Effective managed healthcare services result in a healthcare system that works more effectively because its sustainable value lies in members being able to access the best quality integrated care at the lowest cost per unit. Such services also include robust efforts and processes to curb fraud and benefit abuse. Continuous management of lowering prices in various sectors of the healthcare industry form an integral part of managing costs and adding value to members and the Scheme.



* *These are products relating to Discovery Vitality. Vitality is not part of Discovery Health Medical Scheme. Vitality is a separate product sold and administered by Discovery Vitality (Pty) Ltd. Vitality is an authorised financial services provider. Registration number: 1999/007736/07.*

Stakeholder relationships that are integral to the Scheme's ability to create value

ROLE IN RELATION TO VALUE CREATION

MEMBERS

Members entrust their healthcare funding needs to us, and the Scheme aims to ensure the long-term affordability of its services, to enable members to remain with the Scheme. We successfully manage a complex set of relationships with a diverse range of stakeholders to ensure that our members receive the best possible quality of care at the most affordable cost, both now and in the future.

METHODS OF ENGAGEMENT

The Scheme reports its operational and financial performance to members at its **Annual General Meeting**.

Members are able to contact our **call centre** for assistance. They can also visit any of the five **walk-in centres** across the country.

EMPLOYER GROUPS

Employer groups offer individuals the opportunity to access medical scheme cover. This may be through a specified subsidy or through a structured salary package that affords the employee the opportunity to purchase medical scheme cover.

METHODS OF ENGAGEMENT

Corporate wellness days allow us to interact with members who are part of an employer group, specifically regarding matters related to their health.

Focused service and engagement strategies are developed with employer groups, tailored to suit their workforce's servicing needs.

HEALTHCARE INTERMEDIARIES (BROKERS)

Brokers play an important role in the private healthcare sector, because they are able to provide advice to prospective and existing members about the healthcare cover best suited to their specific health and financial needs. Without advice and support from brokers, many members would find it daunting to navigate the complexities of the private healthcare system.

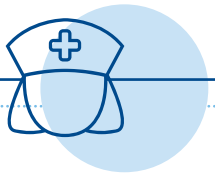
METHODS OF ENGAGEMENT

Provide **comprehensive analysis** of the South African medical schemes industry, and comparative analysis of 2014 open medical scheme financials to major corporate brokerages.

Present **annual product updates** regarding the Scheme's product and benefit enhancements for the new benefit year.

Broker perception surveys help us establish how satisfied brokers are with the service they receive.

The Scheme's business model **relies on building and maintaining critical relationships** with its stakeholders.



HEALTH PROFESSIONALS AND PROFESSIONAL SOCIETIES

Health professionals (for example doctors, specialists, nurses, pharmacists, etc.) form an integral part of the country's healthcare system. The health professionals who participate in the Scheme's payment arrangements provide quality care to members at agreed rates, helping to minimise any gaps in cover for our members. The networks of both primary care and specialist care ensure a high coverage ratio with extensive full-cover options for members, and access that spans across the country.

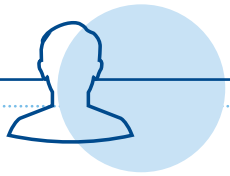
METHODS OF ENGAGEMENT

Hold **provider workgroups** with various healthcare providers and professional societies to address a variety of topics, including new technology and claims coding services.

Host and attend **clinical and healthcare conferences**.

Doctor perception surveys measure doctors' perception of the service they receive.

The formulation of alternative reimbursement models with professionals from various healthcare disciplines, such as pathology, radiology and interventional cardiology.



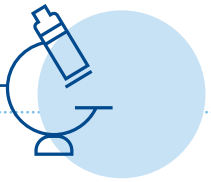
EMPLOYEES

The individuals employed by the Scheme contribute to ensuring that the Scheme remains relevant and sustainable, while making a positive contribution to society. It is imperative that we nurture and develop employees' talents, in order to ensure maximum value from fulfilled, engaged members of staff.

METHODS OF ENGAGEMENT

Quarterly **performance discussions** help employees stay on track in terms of their career development.

A **talent management programme** ensures that talent is identified, nurtured and grown, to enable placement of suitable candidates as the need arises.



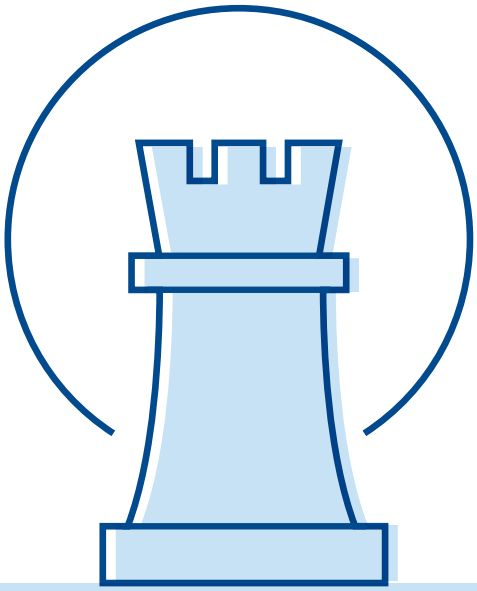
REGULATORS, INDUSTRY BODIES AND GOVERNMENT

Maintaining constructive and collaborative relationships with these entities is crucial to our ability to create value. The Scheme and its Administrator are required to adhere to strict legislation, mainly but not exclusively in the form of the Medical Schemes Act No 131 of 1998, as amended. The intensity and frequency of our interactions with the various entities will differ every year, based on the business need. It is vital that we keep the lines of communication open with industry bodies, government and regulators, so that the Scheme can continue its operations within the confines of legislation, yet to the ultimate benefit of its members and society as a whole.

METHODS OF ENGAGEMENT

Regular meetings with the Council for Medical Schemes on various regulatory matters affecting the Scheme and the healthcare industry. Frequent engagement with the Council for Medical Schemes regarding disputes, appeals and other issues of concern to members and other stakeholders.

The Scheme made a **detailed submission to the Competition Commission** in respect of its market inquiry into the private healthcare system in South Africa.



STRATEGY

The Scheme's strategic objectives are adapted annually or more frequently if needed to ensure that the Scheme **remains focused on creating value for its members**, its products remain relevant and its financial position remains robust within the broader context of the private healthcare industry.

PERFORMANCE AGAINST PRIORITIES SET IN 2014

OBJECTIVES	PERFORMANCE
Further enhance the Scheme's outsourcing business model based on international outsourcing best practice principles	The Board ensures that the Scheme's vested outsourcing business model recognises its independence through periodic evaluation. The Board is satisfied that members continue to derive maximum value from the outsourced nature of the relationship.
Maintain the Scheme's industry leadership position and competitive advantage by continuing to provide rich benefits and contribution stability across the product range	The Scheme's comprehensive range of benefit plans ensures that the needs of its diverse membership base are met. Membership grew by 2.7% to 2.6 million lives in 2014. Additional differentiating factors are competitive contributions (on average 14% lower than the average contributions of the next nine largest open medical schemes), this despite the fact that the Scheme's benefits are richer than those provided by its competitors. For example, the Scheme's contribution increases have been 1.2% lower per year than the average of its competitors over the 2008 to 2015 period. The Scheme also has the highest rating in terms of claims-paying ability (AA+) and the lowest lapse rates in the industry (4.5%).
Continue investment in a unique and superior service experience for Scheme members and healthcare service providers at every touchpoint in the healthcare system	The expansion of value-added services like the MedXpress medicine home delivery system and HealthID, an application for doctors, have further enhanced the service experience for members and doctors. MedXpress now offers the dispensing and delivery of chronic medicines to members' homes or selected pharmacies. HealthID has been updated to include a function for doctors to record clinical notes, a hospital admissions summary, telemetric diabetic glucose monitoring and wellness measures.

MATERIAL ISSUES THAT IMPACTED THE SCHEME'S STRATEGIC PRIORITIES

The **affordability** and ultimate accessibility of our plan benefits.

Strict adherence to regulatory requirements and a complete understanding of the ever-evolving legislative landscape as it affects the Scheme's ability to manage its affairs.

The Board of Trustees meets annually to evaluate the strategic objectives in respect of contribution competitiveness, driving innovation, containing healthcare and non-healthcare costs, enhancing benefits and strengthening the Scheme's long-term sustainability. **The following are considered when determining the Scheme's strategic objectives:**

- The evolving needs of our members
- The Scheme's value proposition to its stakeholders
- New legislative requirements that affect the Scheme and its operations
- The Scheme's competitiveness in the private healthcare funding market
- The guiding principles of best practice corporate governance
- Stakeholder relations.

The strategic objectives are included in management's performance scorecards and the Board of Trustees regularly monitors implementation. **The Scheme reviews performance against key performance indicators on a monthly basis and the Board conducts quarterly and annual reviews. These indicators include:**

- Monthly and quarterly monitoring of detailed service level agreement (SLA) metrics
- Periodic independent review of Discovery Health's performance based on the Scheme's operating model
- Annual value-for-money calculations and review
- Annual review of the return on investment of managed care services
- Annual review of the Administrator's innovation activities.

Facilitate the continuous improvement of quality of healthcare provided to Scheme members

The Scheme keeps the goal of value-based healthcare as the central principle when assessing the Administrator's performance in this area. Interventions like the enhanced focus on reducing infections acquired in hospital and responsible antibiotic use in hospital has led to measurable improvements in the quality of care our members receive.

Implement more refined stakeholder relations engagement strategies and plans

The Scheme has established a Stakeholder Relations Committee to oversee and direct the scope and intensity of stakeholder engagement practices outsourced to Discovery Health. A key enhancement in our stakeholder engagement practices is the recognition of a commitment to the Treating Customers Fairly initiative during the second quarter of 2014. This programme provides significant insight into the stated needs of our members and stakeholders and allows us to adapt our engagement strategies and service offerings to address their needs.

Maintain overall focus on best practice governance

The integrated business model employed by the Scheme ensures that members' best interests are protected. The Board ensures that the Scheme and the Administrator serve the members of the Scheme by ensuring that the Scheme:

- Is managed properly and in a financially sustainable manner
- Protects the confidentiality of members' data
- Gives members sufficient information regarding their benefits and contributions
- Drives a constant agenda for innovation
- Is at all times satisfied that the Administrator and managed care provider delivers value to members.

The overarching goal of **value creation** remains central to the Scheme's sustained success.

An ongoing focus on **maintaining enhanced** stakeholder relations.

The Scheme will focus on the following **five key strategic objectives** during the **2015 benefit year**:

01

Evaluate and enhance the Scheme's outsourcing business model based on international outsourcing best practice principles

02

Maintain the Scheme's industry position and competitive advantage, focusing on product development, contribution competitiveness and service

The Scheme carefully monitors the risks associated with its strategic priorities

STRATEGIC RISK

The risk of failing to meet the Scheme's strategic objectives arising from a poor choice of strategy or arising from factors in the external environment such as competition or regulatory developments

RISK MITIGATION

The Scheme is led by a strong independent Board of Trustees that have the right skills, knowledge and experience to act in the best interests of the Scheme and its members. The Scheme's governance framework is structured to provide oversight of the Scheme's affairs to the Board, Scheme office and the Administrator.

OPERATIONAL RISK

The risk of direct or indirect loss or regulatory non-compliance resulting from inadequate or failed internal processes, people and systems or from external events. This includes the risk of not collecting contributions from members and amounts owed by other debtors.

RISK MITIGATION

The Scheme has formal arrangements to monitor the contracts in place and service levels delivered by the Administrator and assess their readiness to deal with operational risks the Scheme faces.

03 **Ensure best practice** governance and legislative compliance

04 **Make members healthier** through increased wellness engagement at home and in the workplace

05 **Enhance clinical risk** management interventions and strategies

FINANCIAL RISK

The risk of harm to the Scheme due to:

- Failure of counterparties to meet their financial obligations
- Unanticipated movements in the value of the Scheme's investments or income generated from those investments
- Inability of the Scheme to meet its short-term obligations as they become due.

RISK MITIGATION

The Scheme's Investment Committee, in conjunction with the appointed asset consultants, sets the investment strategy, which takes into account the Scheme's operating results, solvency requirements and cashflow needs. The Investment Committee receives regular reports to assess whether the strategy meets its intended objectives.

INSURANCE RISK

The risk of claims being higher than the expected contribution income for each plan and the Scheme in aggregate, with a resultant negative impact on the Scheme's operating result.

RISK MITIGATION

The Scheme approves the benefit changes and contribution rates for the forthcoming benefit year after a detailed actuarial evaluation and review process. Extensive technical and actuarial reports are received from the Administrator on a monthly basis. These analyse the Scheme's performance and highlight any areas of concern.

Despite persistent difficult economic conditions, the Scheme has achieved **strong financial and operational** performance in the year under review.

The net healthcare result (contributions less cost of claims, including all other expenses) for the year ended 31 December 2014 amounted to R753 million (2013: R860 million). Investment income of R859 million contributed to a substantial net surplus of R1.5 billion for the year.

The Scheme's strong financial performance increased members' funds to over R11.7 billion, increasing solvency to 25.76% of gross annual contribution income, exceeding its statutory solvency requirement of 25%. Scheme investments and cash exceeded R11.9 billion at the end of the financial year. The Scheme's high level of financial strength and claims-payment ability was once again confirmed by a credit rating of AA+, the highest possible rating in the industry, by an independent credit rating agency, Global Credit Rating Co.

LIVES COVERED

Membership (lives)
2 634 819
2 564 313 IN 2013
2.7% CHANGE

Principal members as at current year end
1 231 116
1 191 987 IN 2013

Increase in principal membership numbers
39 129
51 897 IN 2013

% Increase in principal membership numbers
3.28%
4.55% IN 2013

Lapse rate (rolling 12 months)
4.50%
4.15% IN 2013
0.35% CHANGE

Average age of beneficiaries (years)
33.58
33.29 IN 2013
0.87% CHANGE

Pensioner ratio (beneficiaries over 65 years)
8.17%
7.76% IN 2013
0.41% CHANGE

Loss ratio
81.67%
80.68% IN 2013
0.99% CHANGE
Relevant healthcare expenditure/ Risk contribution income

OPERATING RATIOS

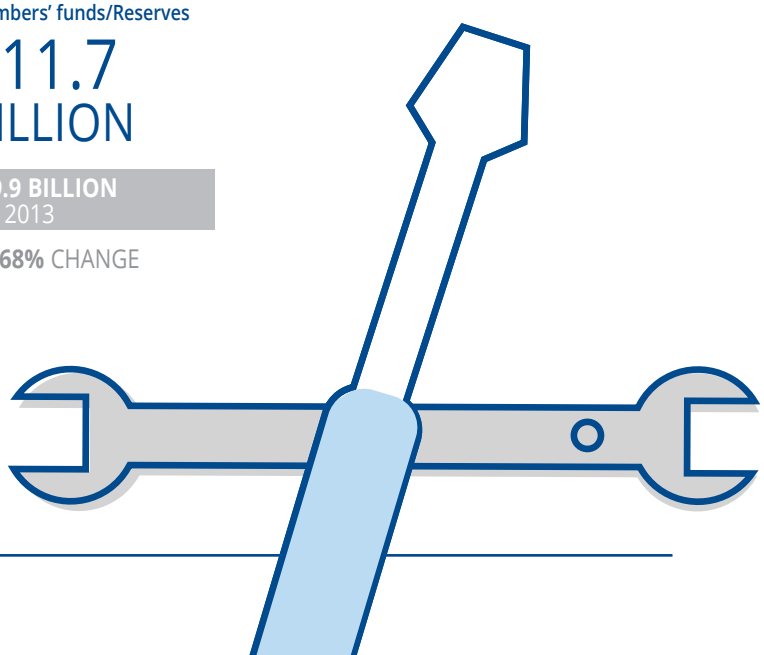
Gross contribution income
R44.91 BILLION
R40.46 BILLION IN 2013
11% CHANGE

Risk contribution income
R36.1 BILLION
R32.5 BILLION IN 2013
11.11% CHANGE

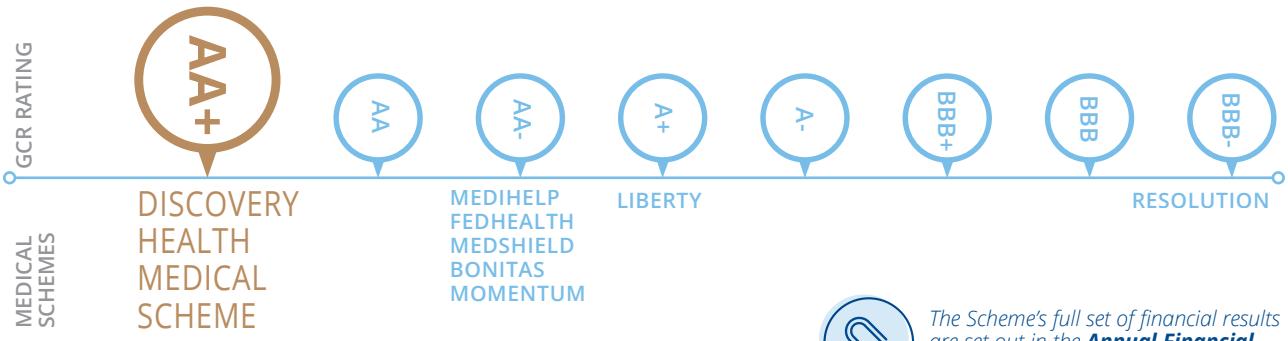
Members' funds/Reserves
R11.7 BILLION
R9.9 BILLION IN 2013
17.68% CHANGE

Statutory solvency capital requirement
25%

Solvency ratio
25.76%
24.30% IN 2013
1.46% CHANGE



DHMS MAINTAINS AA+ CREDIT RATING



Source: Global Credit Rating Co.

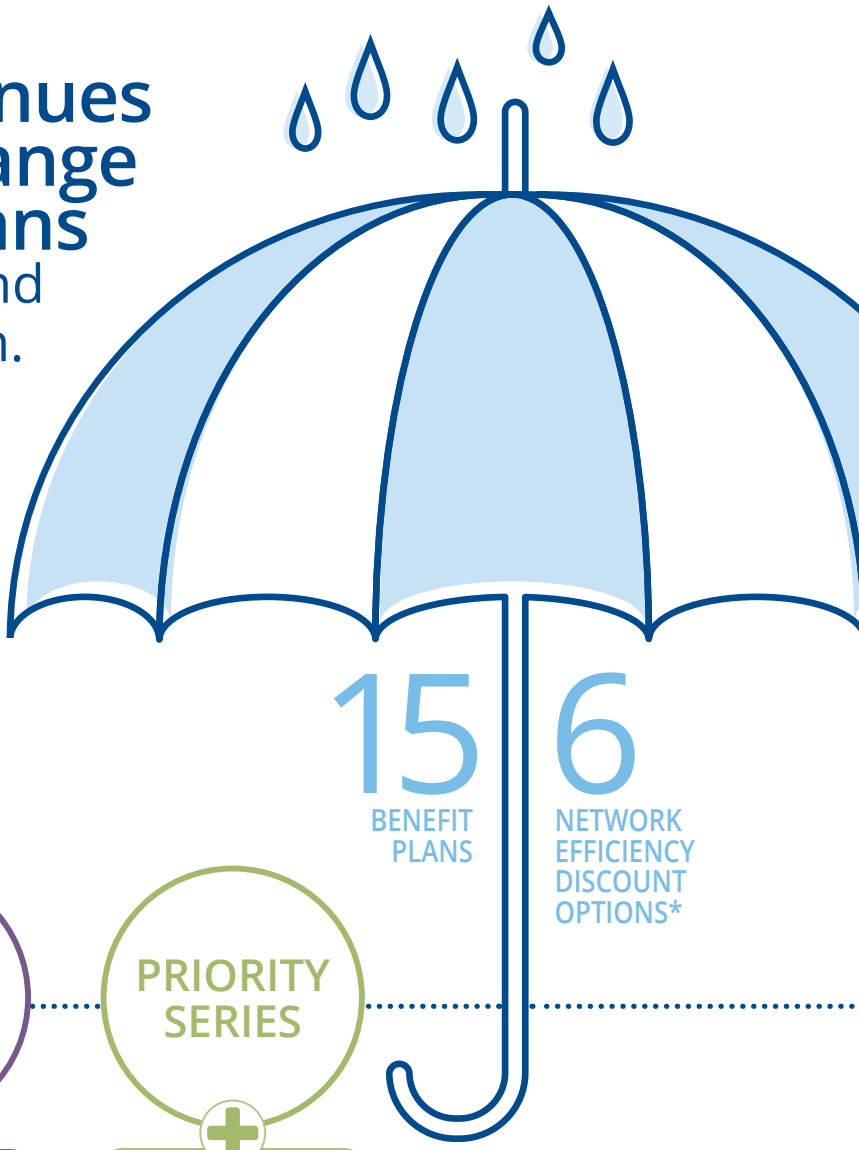
*The Scheme's full set of financial results are set out in the **Annual Financial Statements** on pages 49 to 113.*

In an environment in which most open medical schemes are shrinking, the Scheme continues to attract and retain members with a net growth in lives of 2.7% (2013: 3.9%) from an already high base. At 31 December 2014, the Scheme provided cover to 2 634 819 (2013: 2 564 313) lives. The ability of the Scheme to retain members is demonstrated by extremely low lapse rates with an annualised lapse rate for 2014 of 4.5% (2013: 4.15%). The Scheme continues to offer the widest range of well-priced plans and the richest benefits compared to its peers, which is why the vast majority of Scheme members remain on their chosen benefit plans.

OPERATING RATIOS	2014	2013	% CHANGE	EXPLANATORY NOTES
Average net contributions per member per month	**R2 489**	R2 320	7.30%	*Risk contribution income/12/average member*
Average net claims per member per month	**R2 037**	R1 876	8.58%	*Net claims incurred/average members/12*
Average accumulated funds per member at year end	**R9 639**	R8 364	15.25%	*Accumulated funds/average members*
Average administration costs per member per month	**R247.18**	R238.37	3.69%	
Average administration costs per beneficiary per month	**R115.13**	R110.49	4.20%	
Average managed care: management services per member per month	**R82.80**	R78.56	5.40%	
Average managed care: management services per beneficiary per month	**R38.57**	R36.41	5.93%	
Average combined administration and managed care fees per member per month	**R329.98**	R316.93	4.12%	
Average combined administration and managed care fees per beneficiary per month	**R153.70**	R146.90	4.63%	
Administration fees as a % of gross contributions	**7.98%**	8.26%	(0.28%)	*Expenses charged for administration/Gross contribution*
Managed care fees as a % of gross contributions	**2.67%**	2.72%	(0.05%)	*Expenses charged for managed care: management services/gross contribution*
Combined administration and managed care fees as a % of gross contributions	**10.65%**	10.98%	(0.32%)	*Administration and managed care fees/ gross contributions*
Average total non-healthcare expenses per member per month	**R418.18**	R397.31	5.25%	*Administration, managed care, broker fees and other expenses/average members*
Average total non-healthcare expenses per beneficiary per month	**R194.78**	R184.15	5.77%	*Administration, managed care, broker fees and other expenses/average beneficiaries*
Average return on Scheme assets	**8.21%**	8.59%	(0.38%)	*Investment income/ scheme assets excluding operating cash)*

BENEFIT PLANS

The **Scheme continues to offer a wide range of well-priced plans** with comprehensive and effective benefit design.



15 BENEFIT PLANS

6 NETWORK EFFICIENCY DISCOUNT OPTIONS*

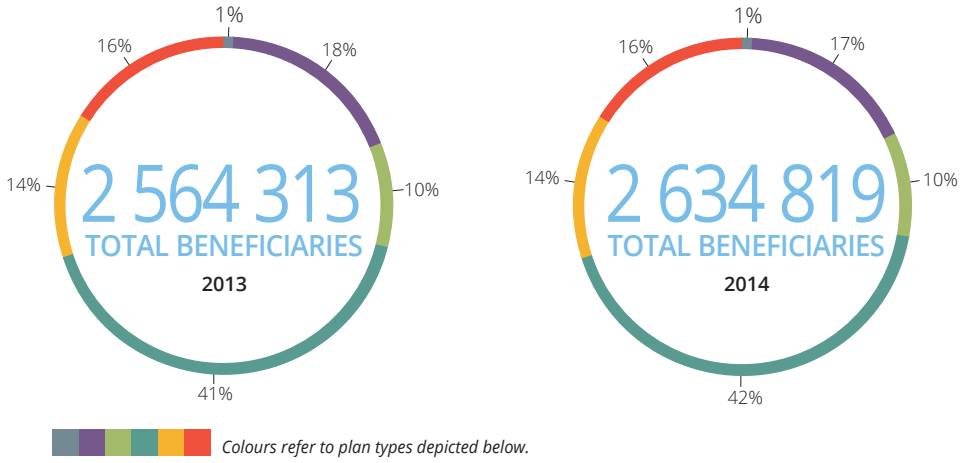
EXECUTIVE SERIES
- Executive

COMPREHENSIVE SERIES
- Classic Comprehensive
- Classic Comprehensive Zero MSA
- Essential Comprehensive
- Classic Delta* Comprehensive
- Essential Delta* Comprehensive

PRIORITY SERIES
- Classic Priority
- Essential Priority

DISCOVERY HEALTH MEDICAL SCHEME PLAN STABILITY

DISTRIBUTION OF SCHEME BENEFICIARIES ON VARIOUS PLANS



Colours refer to plan types depicted below.

Stability in both contribution increases and benefit design has been of key importance in an environment characterised by volatile contributions in many other open medical schemes.

SAVER SERIES

- Classic Saver
- Essential Saver
- Coastal Saver
- Classic Delta* Saver
- Essential Delta* Saver

CORE SERIES

- Classic Core
- Essential Core
- Coastal Core
- Classic Delta* Core
- Essential Delta* Core

KEYCARE SERIES

- KeyCare Plus
- KeyCare Core
- KeyCare Access

* *The Delta range of efficiency discount options offers a reduced contribution in return for in-hospital cover at a defined list of network hospitals.*

OPERATIONAL STATISTICS PER BENEFIT PLAN

2014	EXECUTIVE	CLASSIC COMP	CLASSIC CORE	CLASSIC SAVER	CLASSIC PRIORITY	ESSENTIAL COMP
Number of members at the end of the accounting period	11 678	172 180	53 854	245 478	102 694	22 606
Number of beneficiaries at the end of the accounting period	26 315	401 095	115 334	536 024	236 354	46 186
Average number of members for the accounting period	11 864	175 101	52 628	240 665	103 324	22 933
Average number of beneficiaries for the accounting period	26 791	408 846	113 157	525 154	237 085	47 011
Average risk contributions per member per month (R')	5 464	4 400	2 518	2 397	3 007	3 846
Average risk contributions per beneficiary per month (R')	2 420	1 884	1 171	1 098	1 310	1 876
Average net claims incurred per member per month (R')	7 016	4 247	1 705	1 707	2 284	3 079
Average net claims incurred per beneficiary per month (R')	3 107	1 819	793	782	995	1 502
Average administration costs per member per month (R')	272	272	272	272	272	272
Average administration costs per beneficiary per month (R')	120	116	126	124	118	132
Average managed care: Management services per member per month (R')	83	83	83	83	83	83
Average managed care: Management services per beneficiary per month (R')	37	35	39	38	36	40
Average family size at 31 December	2.26	2.33	2.15	2.18	2.29	2.05
Loss ratio (%)	128%	97%	68%	71%	76%	80%
Total non-healthcare expenses as a % of risk contributions	8%	10%	17%	18%	15%	12%
Average age of beneficiaries (years)	40.83	37.97	36.68	30.46	34.35	4.92
Pensioner ration (beneficiaries over 65 years)	17%	13%	11%	5%	8%	20%
Average relevant healthcare expenses per member per month (R')	7 021	4 253	1 704	1 706	2 284	3 085
Net surplus/(deficit) for the year (R'000)	(276 655)	(508 405)	279 309	889 218	415 838	101 857

2013	EXECUTIVE	CLASSIC COMP	CLASSIC CORE	CLASSIC SAVER	CLASSIC PRIORITY	ESSENTIAL COMP
Number of members at the end of the accounting period	11 799	178 842	52 601	225 984	103 192	24 966
Number of beneficiaries at the end of the accounting period	26 964	421 848	113 169	494 169	237 210	51 961
Average number of members for the accounting period	11 955	181 512	51 300	219 959	103 333	25 469
Average number of beneficiaries for the accounting period	27 420	428 857	110 892	480 197	236 795	53 283
Average risk contributions per member per month (R')	5 056	4 063	2 324	2 206	2 751	3 576
Average risk contributions per beneficiary per month (R')	2 204	1 719	1 075	1 011	1 200	1 709
Average net claims incurred per member per month (R')	6 394	3 847	1 524	1 563	2 082	2 767
Average net claims incurred per beneficiary per month (R')	2 788	1 628	705	716	909	1 323
Average administration costs per member per month (R')	263	263	263	263	263	263
Average administration costs per beneficiary per month (R')	115	111	122	120	115	126
Average managed care: Management services per beneficiary per month (R')	34	33	36	36	34	38
Average family size at 31 December	2.29	2.36	2.16	2.18	2.29	2.09
Loss ratio (%)	127%	95%	66%	71%	76%	78%

ESSENTIAL CORE	ESSENTIAL SAVER	ESSENTIAL PRIORITY	COASTAL SAVER	COASTAL CORE	KEYCARE PLUS	KEYCARE CORE	KEYCARE ACCESS	CLASSIC COMP ZERO MSA	TOTAL
31 763	88 124	9 383	173 302	83 786	215 296	14 961	5 302	709	1 231 116
67 204	188 203	19 756	396 774	184 882	383 438	23 745	7 910	1 599	2 634 819
29 913	83 751	9 370	170 680	81 045	207 677	14 145	5 081	685	1 208 862
63 581	179 838	19 671	391 649	179 464	371 553	22 432	7 605	1 531	2 595 368
2 012	2 044	2 711	2 030	1 948	1 357	1 130	774	4 303	2 489
947	952	1 291	885	880	759	713	517	1 924	1 159
1 331	1 269	1 661	1 629	1 474	1 230	651	421	3 921	2 037
626	591	791	710	666	688	410	281	1 753	949
272	272	272	272	272	147	78	93	272	247
128	126	129	118	123	82	49	62	121	115
83	83	83	83	83	83	83	83	83	83
39	39	39	36	37	46	52	55	37	39
2.13	2.15	2.10	2.29	2.21	1.79	1.59	1.50	2.24	2.15
66%	62%	61%	80%	76%	88%	58%	58%	92%	82%
21%	21%	16%	21%	22%	21%	18%	27%	10%	16%
33.76	28.84	33.66	31.66	35.42	27.52	32.72	28.84	35.72	33.58
8%	4%	9%	5%	9%	4%	8%	4%	8%	8%
1 330	1 268	1 660	1 629	1 473	1 198	650	445	3 937	2 033
113 230	403 527	75 192	44 779	105 746	(172 747)	55 655	10 431	(167)	1 536 808

ESSENTIAL CORE	ESSENTIAL SAVER	ESSENTIAL PRIORITY	COASTAL SAVER	COASTAL CORE	KEYCARE PLUS	KEYCARE CORE	KEYCARE ACCESS	CLASSIC COMP ZERO MSA	TOTAL
28 721	78 912	9 963	164 114	79 508	211 779	15 233	5 853	520	1 191 987
60 773	170 402	20 971	377 795	176 353	378 568	24 063	8 894	1 173	2 564 313
26 881	75 100	9 487	161 962	76 912	203 589	14 366	5 624	459	1 167 906
57 233	162 848	19 966	373 042	170 952	365 960	22 684	8 571	1 042	2 519 743
1 859	1 906	2 488	1 866	1 791	1 249	1 028	684	3 918	2 320
873	879	1 182	810	806	695	651	449	1 726	1 075
1 231	1 138	1 549	1 468	1 308	1 106	509	396	3 805	1 876
578	525	739	637	589	615	323	260	1 676	869
263	263	263	263	263	140	74	89	263	238
124	121	125	114	118	78	47	58	116	110
37	36	37	34	34	44	50	52	35	39
2.13	2.17	2.10	2.30	2.30	1.80	1.58	1.52	2.27	2.15
66%	60%	62%	79%	73%	86%	50%	61%	98%	80%

SOLVENCY

Legislation requires that the Scheme maintains accumulated funds of 25% of gross annual contributions for the accounting period under review in terms of Regulation 29(2) of the Act.

CALCULATION OF REGULATORY CAPITAL REQUIREMENT	2014	2013
Total Members' Funds	**11 652 804**	9 970 118
Less: Cumulative net gain on re-measurement of investments	**(85 833)**	(136 666)
Total net assets (regulations 29)	**11 566 971**	9 833 452
Gross annual contributions	**44 905 716**	40 463 702
Solvency margin	**25.76%**	24.30%

At 31 December 2014 the Scheme's solvency level of 25.76% of gross annual contributions was R340 million more than the statutory solvency requirement of 25%, and exceeded the business plan level of 24.3% by R655 million.

PRUDENT FINANCIAL MANAGEMENT

The table below shows the high level of contribution management control achieved during the year.

YEAR ENDED	DEC 2014 R'000	DEC 2013 R'000
Gross annual contributions	**44 905 716**	40 463 702
Total outstanding contributions – excluding December contributions	**14 224**	10 172
% Outstanding	**0.03%**	0.03%

DUE APPLICATION OF THE SCHEME RULES

The Trustees keep a constant check on appropriate and consistent application of Scheme Rules in relation to beneficiary entitlement and healthcare provider reimbursements. This check is very important, as it is an integral component of the Board of Trustees' fiduciary responsibility.

ENSURING STATUTORY AND REGULATORY COMPLIANCE

The Trustees are committed to ensuring statutory and regulatory compliance, viewing this as one of their most important responsibilities.

The Scheme's external auditors and Audit and Risk Committees, as well as the internal auditors and Compliance function, have an ongoing role in monitoring compliance to ensure the Scheme meets all the regulatory requirements.

In addition, the Board of Trustees and the Council for Medical Schemes continue to monitor the Scheme's compliance within the broader regulatory framework.

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2014

The Council for Medical Schemes issued Circular 11 of 2006 dealing with issues to be addressed in the audited financial statements of medical schemes. The circular requires that all non-compliance matters noted should be disclosed in the audited financial statements, irrespective of whether the auditor considers it as material or immaterial.

During the year the Scheme did not comply with the following Sections and Regulations of the Act.

STATUTORY SCHEME SOLVENCY

In terms of Regulation 29 (2) the Scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may be no less than 25%.

The Scheme's accumulated funds expressed as a percentage of gross annual contributions was below the statutory solvency requirement of 25% during the year. However, at 31 December 2014, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 25.76% (2013: 24.30%) which exceeds the statutory solvency requirement of 25% and the approved phase-in solvency level of 24.30%, as set out in the business plan submitted to the Council for Medical Schemes.

SUSTAINABILITY OF BENEFIT PLANS

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

At 31 December 2014 the following plans did not comply with Section 33 (2):

PLANS	NET UNDER-WRITING DEFICIT R'000	NET (DEFICIT)/ SURPLUS R'000
Executive	(287 170)	(276 655)
Classic Comprehensive	(663 601)	(508 405)
Classic Comprehensive Zero MSA	(617)	(167)
Coastal Saver	(106 330)	44 779
KeyCare Plus	(310 309)	(172 747)

The Trustees continue to monitor these plans with a view to improving their financial outcomes and will evaluate different strategies to address the deficits in these plans. The different financial positions reflect the different disease burdens in each plan, among many other factors. The Scheme's strategy on the sustainability of plans has to balance short- and long-term financial considerations, with considerations of fairness to both healthy and sick members and with continued affordability of cover for members with different levels of income and different healthcare needs. While the Trustees are committed to complying wherever possible with the applicable legislation, we also focus intensively on the overall stability and financial position of the Scheme as a whole and not only individual benefit plans.

INVESTMENTS IN EMPLOYER GROUPS

Section 35 (8)(a) of the Act states that a medical scheme will 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. Due to the large number of the Scheme's employers being listed on the JSE, investments were made in certain of its employers listed on the JSE. The Council for Medical Schemes has granted the Scheme an exemption from this section of the Act.

INVESTMENTS IN OTHER ASSETS IN TERRITORIES OUTSIDE THE REPUBLIC

In terms of Annexure B to the Regulations of the Act, the Scheme will not invest in other assets in territories outside the Republic. The Scheme's asset managers make use of foreign derivative instruments for the purpose of risk mitigation and efficient portfolio construction. These derivatives fall under Category 7(b) of Annexure B, which prohibits investment in territories outside South Africa and therefore the foreign derivative instruments result in non-compliance. The Council for Medical Schemes has directed the Scheme to dispose of these instruments or to apply for an exemption in terms of Section 8(h) of the Act. The exemption application was submitted on 18 July 2014.

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 thereof becoming due. There are instances where the Scheme received contributions after three days of becoming due, however, there are no contracts in place agreeing to this practice. The procedures that the Scheme follows regarding these contributions are set out in Note 31 of the Annual Financial Statements.

BROKER FEES PAID

In terms of Regulation 28(5) of the Act, broker fees will be paid on a monthly basis upon receipt by the 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 represents less than 0.007% of the total broker fees paid for the year.

RESERVE ACCOUNTS

Movement in the reserves are set out in the Statement of Changes in Funds and Reserves on page 56.

OUTSTANDING CLAIMS

Movements in the outstanding claims provision are set out in Note 6 to the Annual Financial Statements.

PERSONAL MEDICAL SAVINGS ACCOUNT

The Personal Medical Savings Account (PMSA) enables members to manage day-to-day healthcare expenses. Members pay an agreed sum of 15% or 25% of their gross contributions, depending on their plan choice, into this savings account. The full annual amount is available for use immediately, although members only contribute towards this monthly. The Personal Medical Savings Account provides a variety of benefits to members for medical expenses outside of hospital, such as day-to-day medicines, visits to GPs and specialists, dental care and optometry.

The balance remaining in the Personal Medical Saving Account at the end of each calendar year is carried over to the following year for the benefit of the member.

The Scheme's liability to members in respect of the savings account is reflected as a current liability in the Annual Financial Statements (Note 8) and is repayable in terms of Regulation 10 of the Act. These funds are invested separately from the Scheme's assets and have earned interest over the period at an average of 6% per annum.

GOING CONCERN

The Board of Trustees is satisfied that the Scheme has adequate resources to continue its operations in the foreseeable future. The Scheme's financial statements have accordingly been prepared on the going-concern basis.

AUDITOR INDEPENDENCE

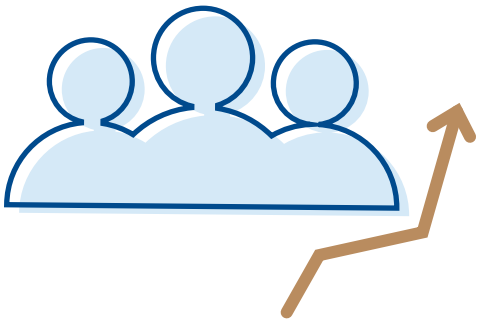
The Scheme's Annual Financial Statements have been audited by independent auditors PricewaterhouseCoopers Inc. The Scheme believes that the external auditors have observed the highest level of business and professional ethics. It has no reason to believe that the external auditors have not at all times acted with unimpaired independence and the Audit Committee is satisfied that the auditor was independent of the Scheme.

Details of fees paid to the external auditors for audit services are included in the Annual Financial Statements. The Scheme has accepted a policy governing non-audit services. The fees have been disclosed and agreed with the Audit Committee.

OPERATIONAL STATISTICS

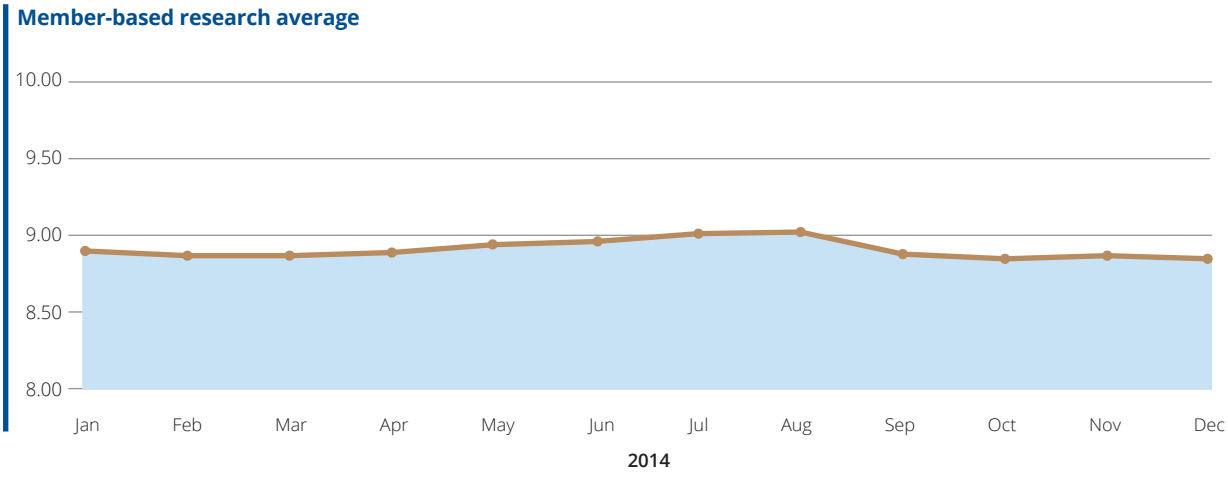
The Scheme believes the **quality of client services Discovery Health provides to its members enhances member retention** and contributes to the growth of the Scheme.

The Scheme uses a number of key metrics to monitor and measure Discovery Health's performance on a monthly basis. Three of these metrics are discussed below, all of which illustrate the consistently high levels of service provided by Discovery Health.



MEMBER-BASED RESEARCH (MBR)

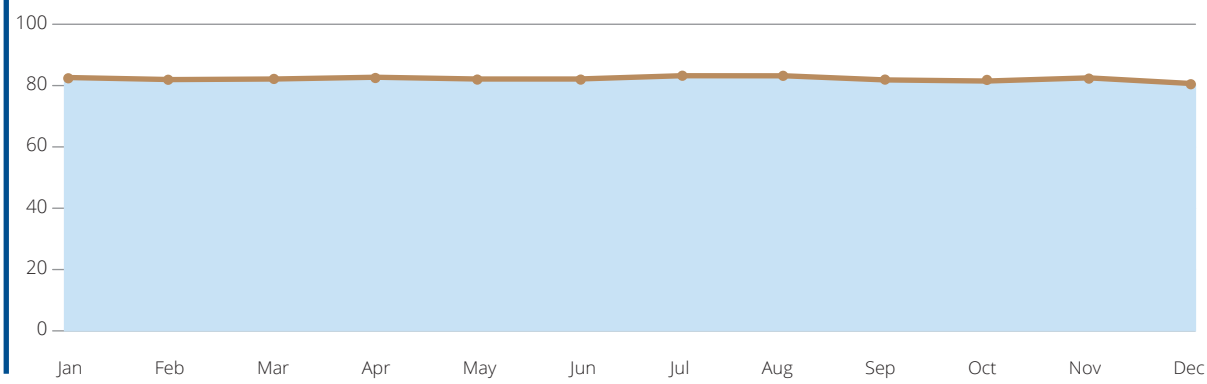
MBR measures a member's perception of service received during interactions with Discovery Health. It is based on responses received from members on surveys sent via email and SMS asking for ratings of individual client service consultants. The best possible score is 10/10; the lowest is 1/10. The figure below, which depicts the average monthly MBR aggregated across Discovery Health's operations, shows that the MBR has always been higher than 8.75.



FIRST-CONTACT RESOLUTION (FCR)

FCR measures a member's perception of inquiries resolved by Discovery Health on first contact. It is based on responses received from members on surveys sent via email and SMS asking if interactions were resolved on first contact. The FCR score is the average percentage of "Yes" responses from all surveys per month. The best possible score is 100 percent; the lowest possible score is 0 percent. The figure below shows the average monthly FCR aggregated across Discovery Health's operations. It illustrates that the FCR has consistently remained above 80% for the period in review.

First-contact resolution percentages (%)

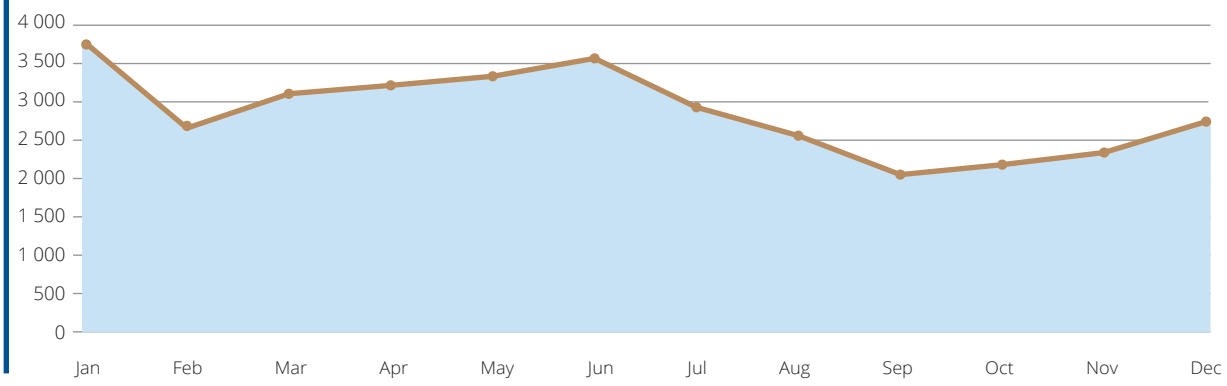


2014

DEFECTS PER MILLION OPPORTUNITIES (DPMO)

DPMO measures the quality of service rendered by Discovery Health in terms of how processes conform to required operational standards. It is based on quality assurance audits conducted on multiple operational processes within Discovery Health. DPMO is the number of all defects per million opportunities. The figure below, which indicates the average monthly DPMO aggregated across Discovery Health's operations, shows that the number of errors is relatively low and decreased significantly between January 2014 and December 2014.

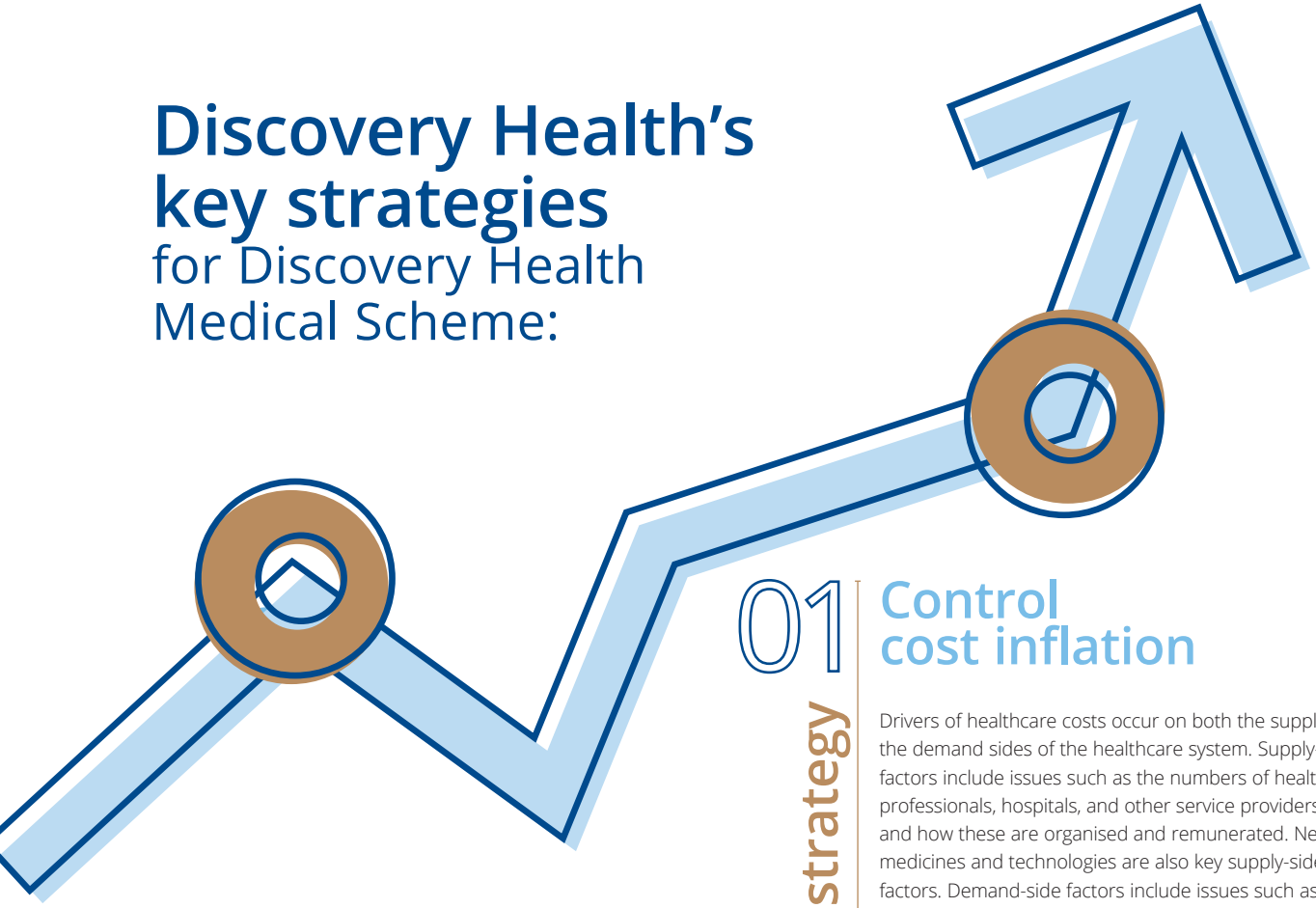
Defects per million opportunities



2014

Sources: Internal operational statistics produced by Discovery Health

Discovery Health's key strategies
for Discovery Health Medical Scheme:



key strategy 01

Control cost inflation

Drivers of healthcare costs occur on both the supply and the demand sides of the healthcare system. Supply-side factors include issues such as the numbers of health professionals, hospitals, and other service providers, and how these are organised and remunerated. New medicines and technologies are also key supply-side factors. Demand-side factors include issues such as the age and disease profile of the population, which in turn influence the demand for healthcare services. In addition, strong membership growth also places inflationary pressure on contributions, since reserves must be held immediately for new members in order to reach and maintain the regulatory solvency requirement.

The components of the Scheme's 2015 contribution increases, taking the main inflation drivers into account, are as follows:

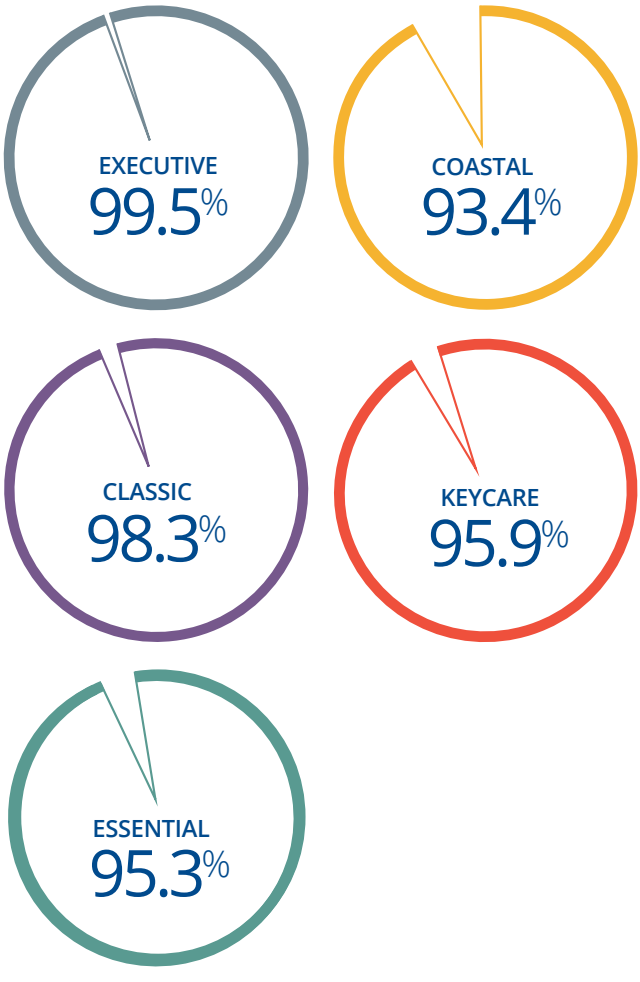
	Driver	Inflation %	Comments
	Tariff for hospitals, health professionals and medicines	CPI ± 1%	Tariff increases remain close to CPI for 2015
	Demographic and utilisation changes	2.9% – 4.9%	Increase in cost of healthcare delivery due to changes including ageing membership and advances in medical technology
	Administration and managed care fees	(0.4%)	Fees paid by the Scheme increase by less than CPI, reducing the overall required contribution increase
Overall medical inflation		8.0 – 12.0%	Contribution **increase of 9.9%**

02 key strategy

Build a healthcare system that ensures superior quality and value for members

By creating a range of proprietary healthcare networks and assets, in combination with advanced clinical risk management, the Discovery Health System delivers better healthcare to Scheme members. This manifests in higher cover ratios (see figures below), care that is coordinated across medical disciplines and elimination of waste and abuse within the system.

IN-HOSPITAL COVER RATIOS



NETWORK COVERAGE

GP (FAMILY DOCTOR) NETWORK

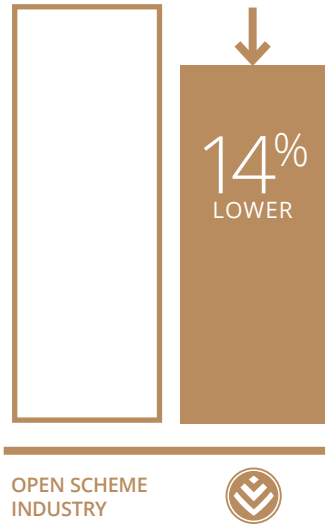
SPECIALIST PAYMENT ARRANGEMENTS

KEYCARE GP (FAMILY DOCTOR) AND CASUALTY NETWORK

03 key strategy

Selectively intervene in healthcare delivery by leveraging digital assets

The Discovery Health System uses technology to deliver a member experience that is simple and intuitive. In addition to world-class call centre support, a responsive website plus a mobile app with unique features all contribute to Discovery Health Medical Scheme being voted the most loved medical scheme by members, doctors and financial advisers.



04 key strategy

Ensure outstanding financial performance and sustained healthy growth

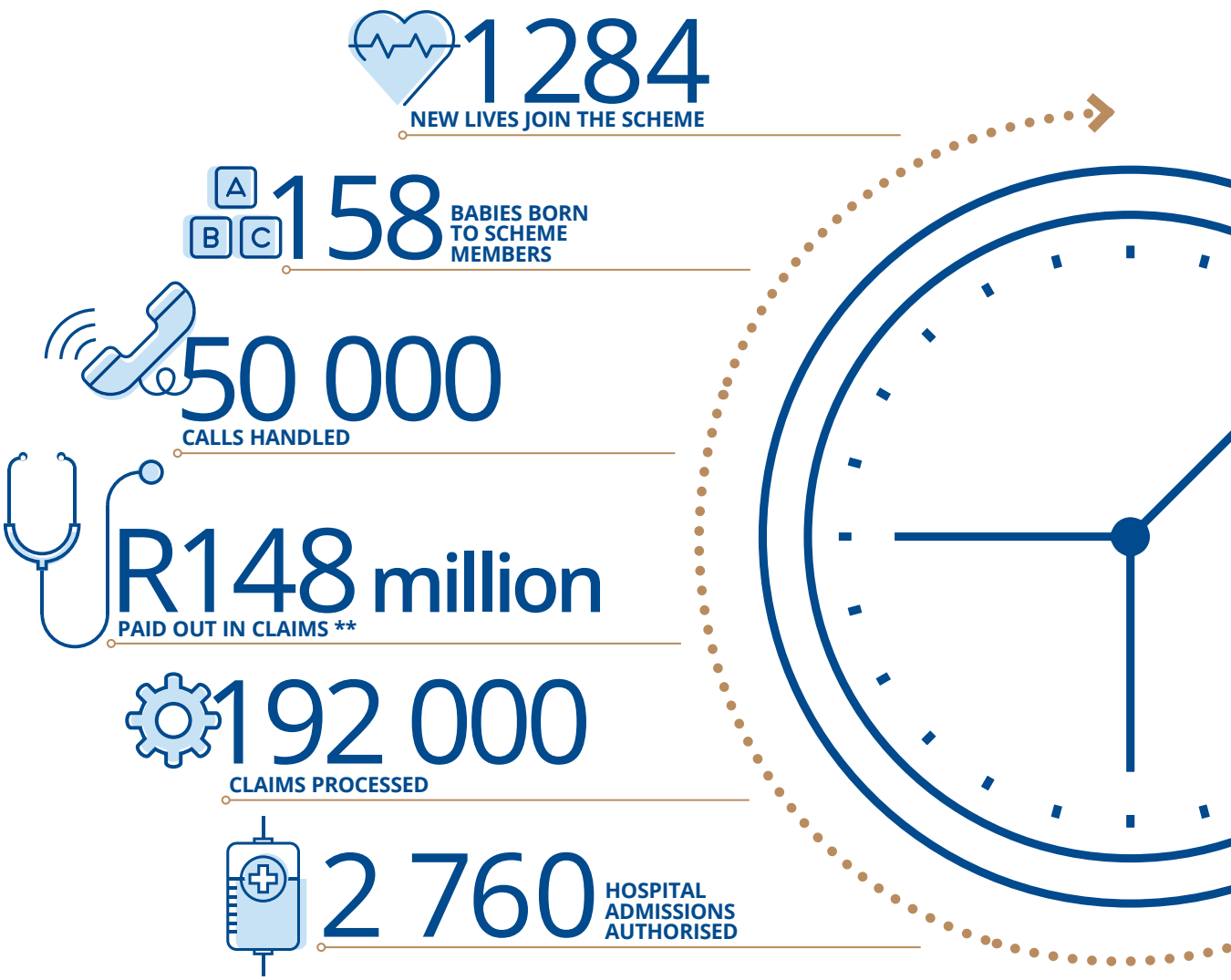
The combined impact of lower relative morbidity rates and healthier members as a result of wellness interventions, and lower healthcare tariffs and delivery costs, manifest in the lowest overall cost per unit of benefit in the market across Discovery Health Medical Scheme plan range. The contribution increase for 2015 was 9.9%, maintaining contribution levels that are, on average, 14% lower than the average for the next nine largest open medical schemes.

05 key strategy

Help build the South African healthcare system

Fundamental to an improved healthcare system is the availability of skills needed across a variety of disciplines. The Discovery Foundation makes a meaningful impact by increasing the pipeline of specialists in South Africa.

The Scheme monitors Discovery Health's performance across a number of operational activities it performs on the Scheme's behalf. Here is a view of some of the activities that take place during the course of a working day*:



* *Assuming 249 working days in a year*

** *Subject to change as claims can be submitted for payment up to four months after the reporting period.*

Annual Financial Statements 2014

Annual Financial Statements // **Statement of Responsibility by the Board of Trustees** for the year ended 31 December 2014

The Board of Trustees is responsible for ensuring that adequate accounting records are maintained and for the preparation, integrity and fair presentation of the Annual Financial Statements of Discovery Health Medical Scheme (the Scheme). The Annual Financial Statements comprise the Statement of Financial Position at 31 December 2014, the Statement of Comprehensive Income, the Statement of Changes in Funds and Reserves and Statement of Cash Flows for the year ended, and the Notes to the Annual Financial Statements. The Annual Financial Statements have been prepared in accordance with International Financial Reporting Standards and the Medical Schemes Act, No 131 of 1998, as amended, ("the Act") and include amounts based on judgements and reasonable estimates.

The Trustees consider that in preparing the Annual Financial Statements they have used the most appropriate accounting policies, consistently applied and that all applicable International Financial Reporting Standards have been followed. The Trustees are satisfied that the information contained in the Annual Financial Statements fairly presents the results of operations for the year and the financial position of the Scheme at year end. The Trustees also reviewed the other information included in the integrated report and are responsible for both its accuracy and its consistency with the Annual Financial Statements.

The Trustees are responsible for the Scheme's systems of internal control and incorporate risk management and internal control procedures, which are designed to provide reasonable, but not absolute assurance that assets are safeguarded and the risks facing the business are being controlled. Reliance is placed on Discovery Health (Pty) Ltd's system of internal controls.

Even an effective system of internal control, no matter how well designed, has inherent limitations, including the possibility of circumvention and the overriding of controls. An effective system of internal control therefore aims to provide reasonable assurance with respect to the reliability of financial information and, in particular, the presentation of Annual Financial Statements.

To the best of their knowledge and belief, based on the above, the Trustees are satisfied that no material breakdown in the operation of the systems of internal control and procedures have occurred during the year under review.

The Board of Trustees has reviewed the Scheme's budget for the year ending 31 December 2015. On the basis of this review and in light of the current financial position and available cash resources, the Trustees have no reason to believe that the Scheme will not be a going concern for the foreseeable future. The going concern basis has therefore been adopted in preparing the Annual Financial Statements and these financial statements support the viability of the Scheme.

The Scheme's external auditors, PricewaterhouseCoopers Incorporated, have audited the Annual Financial Statements and their unqualified report is presented on page 53.

The Annual Financial Statements, which are presented on page 54 to 113, were approved by the Board of Trustees on 21 April 2015 and are signed on its behalf by:

M VAN DER NEST SC
CHAIRPERSON

N GRAVES SC
TRUSTEE

M STREAK
PRINCIPAL OFFICER

We are pleased to present our report for the financial year ended 31 December 2014.

The Audit Committee (the Committee) is an independent statutory committee. Duties are delegated to the Committee by the Board of Trustees.

AUDIT COMMITTEE TERMS OF REFERENCE

The Committee has adopted formal terms of reference that have been approved by the Board of Trustees and are reviewed at least annually. The Committee has conducted its affairs in compliance with its terms of reference.

AUDIT COMMITTEE MEMBERS, MEETING ATTENDANCE AND ASSESSMENT

The Committee consists of four independent members and two Trustee members and meets at least four times per year.

The executive officers of the Scheme and representatives of the Administrator attend meetings or parts of meetings by invitation. Internal Audit and the external auditor attend meetings or parts of meetings by invitation and meet with the Committee after each meeting without the Administrator present.

The membership, qualifications and attendance of the members of the Committee are as follows:

Committee member	Qualifications	Number of meetings held during the financial year	Number of meetings attended
Mr B Stott (Chairperson)	CA(SA)	5	5
Mr N Novick	CA(SA)	5	5
Mr S Green	BSc (Hons)	5	5
Mr D Eriksson	CA(SA)	5	5
Mr G Waugh (Trustee)	FIA, FASSA	5	4
Ms D Naidoo (Trustee)	CA(SA), Masters of Accounting (Taxation)	5	5

Members of the Committee collectively keep up to date with key developments affecting their required skill set. The effectiveness of the Committee and its individual members is assessed annually. The last assessment was performed at the end of 2014. Based on the result of the assessment, the Committee is satisfied with its effectiveness.

ROLE AND RESPONSIBILITIES

The Committee's role and responsibilities include statutory duties as set out in the Act and further responsibilities assigned to it by the Board. The Committee executed its duties in accordance with its terms of reference and applicable laws and regulations in force during the financial year.

External auditor appointment and independence

The Committee considered the matters set out in Section 36 of the Act and nominated PricewaterhouseCoopers Inc. for appointment as external auditor of the Scheme.

The Committee has satisfied itself that the external auditor is independent of the Scheme as set out in Section 36(3) of the Act. Requisite assurance was sought and provided by the auditor that internal governance processes within the audit firm support and demonstrate its independence.

The Committee ensured that the appointment of the auditor at the Annual General Meeting complied with the Act and Rules relating to the appointment of auditors.

The Committee, following consultation with the Scheme's executive officers, approved the engagement letter, audit plan, budgeted audit fees and representation letter for the year ended 31 December 2014.

There is a formal policy in respect of the provision of non-audit services by the external auditors of the Scheme and a formal procedure governs the process whereby the auditor is appointed to provide any non-audit services. The Chairperson of the Committee approves the nature and extent of any non-audit services that the external auditor provides in terms of the agreed pre-approval policy and a schedule of approved non-audit services is reviewed annually by the Committee.

Financial statements and accounting practices

The Committee has reviewed the accounting policies and the Scheme's Annual Financial Statements and is satisfied that they are appropriate and comply with International Financial Reporting Standards.

Internal financial controls

The Committee is responsible for overseeing the Scheme's system of internal controls. This included a formal documented review by the Internal Audit function of both the internal controls and risk management of the Administrator as it pertains to the Scheme and the design, implementation and effectiveness of the Administrator's system of internal financial controls pertaining to the Scheme. Based on the results of this review, it is the view of the Committee that *Reasonable Assurance*** can be placed on the internal controls and risk management and *High Assurance** can be placed on the adequacy and effectiveness of the Scheme's internal financial controls, relative to the fair presentation of the Annual Financial Statements.

* *High Assurance = The existing control framework provides a high level of assurance that the financial statements are fairly presented.*

** *Reasonable Assurance = The existing control framework provides reasonable assurance that material risks are identified and managed effectively.*

Report of the Audit Committee

Evaluation of the expertise and experience of the Administrator's finance function pertaining to the Scheme

The Committee reviewed and satisfied itself of the appropriateness of the expertise, resources and experience of the Administrator's finance function pertaining to the Scheme.

Whistle blowing

The Committee receives and deals with any concerns or complaints, whether from within or outside the Scheme, relating to the accounting practices and Internal Audit of the Scheme, the content or auditing of the Scheme's financial statements, the internal financial controls of the Scheme and related matters. The Administrator's forensic department assists the Committee in discharging this responsibility. No such concerns or complaints were received during the year.

Compliance

The Committee is responsible for reviewing any major breach of the relevant legal and regulatory obligations. The Committee is satisfied that there has been no material breach or material non-compliance with laws and regulations, except for the matters of non-compliance with the Act as detailed in Note 33 of the Annual Financial Statements.

Risk management

The Committee monitors the risk management processes and systems of internal control of the Scheme through review of reports from and discussions with the Scheme's internal and external auditors and the risk management function.

The Committee is satisfied that the system and the process of risk management is effective.

Going concern

The Committee has reviewed the Scheme's financial position for the year ended 31 December 2014 as well as the budget for the year ending 31 December 2015. The Committee took note of the positive solvency and liquidity position of the Scheme. The Scheme members' funds exceed R11.6 billion, with cash and investments exceeding R11.9 billion.

On the basis of this review and taking note of the current net surplus of R1.5 billion, the Committee considers that:

- The Scheme's assets currently exceed its liabilities
- The Scheme will be able, in the ordinary course of the Scheme's business, to settle its liabilities as they arise for the foreseeable future.

The Committee agreed that based on the assessment conducted, the Board of Trustees could be advised that there is no reason to believe that the Scheme will not be a going concern in the foreseeable future.

OPINION

Based on the information and explanations given by the Scheme's management, the Administrator and discussions with the independent external auditor regarding the results of their audit, the Committee is satisfied that there was no material breakdown in the internal accounting controls during the financial year under review.

The Committee has evaluated the Scheme's Annual Financial Statements for the year ended 31 December 2014 and, based on the information provided to the Committee, considers (except for the matters mentioned above) that the Scheme complies, in all material respects, with the requirements of the Act and International Financial Reporting Standards.

The Committee has recommended the Annual Financial Statements to the Board for approval. The Board has subsequently approved the Annual Financial Statements, which will be open for discussion at the forthcoming Annual General Meeting.

MR B STOTT
CHAIRPERSON: AUDIT COMMITTEE
21 April 2015

To the Members of Discovery Health Medical Scheme

REPORT ON THE FINANCIAL STATEMENTS

We have audited the financial statements of Discovery Health Medical Scheme, as set out on page 54 to 113 which comprise the Statement of Financial Position at 31 December 2014, and the Statements of Comprehensive Income, Changes in Funds and Reserves and Cash Flows for the year then ended, and the notes, comprising a summary of significant accounting policies and other explanatory information.

Trustees' Responsibility for the Financial Statements

The Scheme's trustees are responsible for the preparation and fair presentation of these financial statements in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa, and for such internal control as the Trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, these financial statements present fairly, in all material respects, the financial position of Discovery Health Medical Scheme at 31 December 2014, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS

Non-compliance with the Medical Schemes Act of South Africa

As required by the Council for Medical Schemes, we report the following material instance of non-compliance with the requirements of the Medical Schemes Act of South Africa as amended that have come to our attention during the course of our audit:

1 Section 33(2)(b) of the Medical Schemes Act of South Africa: Certain benefit options were not self-supporting in terms of financial performance, as disclosed in note 33 of the financial statements

2 Regulation 29(2) of the Medical Schemes Act of South Africa: The Scheme's accumulated funds expressed as a percentage of gross annual contributions was below the statutory solvency requirement of 25% during the year. However, at 31 December 2014, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 25.76% which exceeds the statutory solvency requirement of 25%, as disclosed in note 33 of the financial statements.

PricewaterhouseCoopers Inc
DIRECTOR: CORLIA VOLSCHENK
Registered Auditor

21 April 2015

Sunninghill

Statement of Financial Position as at 31 December 2014

R'000	Notes	2014	2013
ASSETS			
Non-current assets		**1 511**	1 717
Long Term Employee Benefit Plan asset	26	**1 511**	1 717
Current assets		**16 785 039**	14 571 535
Financial assets at fair value through profit or loss	2	**9 474 520**	7 607 085
Derivative financial instruments	7	**22 700**	17 250
Trade and other receivables	3	**1 604 550**	1 497 921
Cash and cash equivalents			
– Personal Medical Savings Account trust assets	4	**3 188 789**	2 619 305
– Medical Scheme assets	5	**2 494 480**	2 829 974
Total assets		**16 786 550**	14 573 252
FUNDS AND LIABILITIES			
Members' funds		**11 652 804**	9 970 118
Accumulated funds		**11 652 804**	9 970 118
Current liabilities		**5 133 746**	4 603 134
Outstanding claims provision	6	**845 795**	812 190
Derivative financial instruments	7	**5 969**	40 685
Personal Medical Savings Account trust liabilities	8	**3 250 743**	2 776 720
Trade and other payables	9	**1 031 239**	973 539
Total funds and liabilities		**16 786 550**	14 573 252

Statement of Comprehensive Income for the year ended 31 December 2014

R'000	Notes	2014	2013
Risk contribution income	10	**36 111 000**	32 509 819
Relevant healthcare expenditure		**(29 491 013)**	(26 230 531)
Net claims incurred	11	**(29 552 978)**	(26 285 077)
Claims incurred		**(29 652 737)**	(26 310 242)
Third party claim recoveries		**99 759**	25 165
Net income on risk transfer arrangements	12	**61 965**	54 546
Risk transfer arrangement fees		**(325 975)**	(297 760)
Recoveries from risk transfer arrangements		**387 940**	352 306
Gross healthcare result		**6 619 987**	6 279 288
Managed care: management services	13	**(1 201 155)**	(1 101 009)
Broker service fees	14	**(918 871)**	(825 263)
Expenses for administration		**(3 585 641)**	(3 340 754)
Other operating expenses	15	**(161 129)**	(152 486)
Net healthcare result		**753 191**	859 776
Other income		**983 126**	824 297
Investment income	20	**859 112**	682 482
Net gains on financial assets at fair value through profit or loss	21	**116 457**	135 990
Sundry income	22	**7 557**	5 825
Other expenditure		**(199 509)**	(149 573)
Expenses for asset management services rendered		**(17 704)**	(12 619)
Interest paid	23	**(181 805)**	(136 954)
Net surplus for the year		**1 536 808**	1 534 500
Other comprehensive income		**–**	–
Total comprehensive income for the year		**1 536 808**	1 534 500

R'000	Note	**2014 Accumulated funds**	2013 Accumulated funds
Balance at beginning of the year		**9 970 118**	8 240 820
Total comprehensive income for the year		**1 536 808**	1 534 500
Reserves transferred from other medical schemes	24	**145 878**	194 798
Balance at end of the year		**11 652 804**	9 970 118

Statement of Cash Flows for the year ended 31 December 2014

R'000	Notes	**2014**	2013
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows from operations before working capital changes	28	**799 556**	906 936
Working capital changes:			
Increase in trade and other receivables	28.1	**(160 458)**	(68 704)
Increase in outstanding claims provision		**33 605**	43 515
Increase in Personal Medical Savings Accounts		**474 023**	485 140
Increase in trade and other payables	28.2	**15 689**	136 248
Cash generated by operations		**1 162 415**	1 503 135
Purchases of financial instruments	28.3	**(3 448 243)**	(1 655 782)
Proceeds from sale of financial instruments	28.4	**1 737 654**	1 335 595
Cash transferred from other medical schemes		**104 624**	40 624
Interest received	20	**835 728**	667 924
Dividend income	20	**23 617**	14 648
Interest paid	23	**(181 805)**	(136 954)
Net cash flows from operating activities		**233 990**	1 769 190
NET INCREASE IN CASH AND CASH EQUIVALENTS		**233 990**	1 769 190
Cash and cash equivalents at beginning of year		**5 449 279**	3 680 089
CASH AND CASH EQUIVALENTS AT END OF YEAR		**5 683 269**	5 449 279
Cash and cash equivalents comprise:			
Personal Medical Savings Account trust assets	4	**3 188 789**	2 619 305
Medical Scheme assets	5	**2 494 480**	2 829 974
		5 683 269	5 449 279

GENERAL INFORMATION

The Discovery Health Medical Scheme (the Scheme) offers the insurance of hospital, chronic illness and day-to-day benefits and is administered by Discovery Health (Pty) Ltd, a wholly owned subsidiary of Discovery Limited, listed in the insurance sector of the Johannesburg Stock Exchange (JSE).

The Scheme is an open medical scheme registered in terms of the Medical Schemes Act No. 131 of 1998, as amended, ("the Act") and is domiciled in South Africa.

These Annual Financial Statements were authorised for issue by the Board of Trustees on 21 April 2015.

1 BASIS OF PREPARATION

The Annual Financial Statements have been prepared in accordance with International Financial Reporting Standards (IFRS), which are set by the International Accounting Standards Board (IASB). The Annual Financial Statements are also prepared in accordance with the Act, which requires additional disclosures for registered medical schemes.

The accounting policies applied in the preparation of these Annual Financial Statements are set out below. These policies have been consistently applied to all years presented, unless otherwise stated.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement, or areas where estimates are significant to the Annual Financial Statements, are disclosed in Note 32.

The Annual Financial Statements are prepared in accordance with the going concern principle using the historical cost basis, except for certain financial assets and liabilities, which include:

- Financial instruments at fair value through profit or loss.
- Derivative financial instruments carried at fair value through profit or loss.

All monetary information and figures presented in these financial statements are stated in thousands of rand (R'000), unless otherwise indicated.

New standards, amendments and interpretations effective in 2014 and relevant to the Scheme:

The following amendments for the current accounting period have been adopted. They have not had any material impact on the Scheme's financial results or disclosure in the financial statements.

Standard	Scope	Effective date
IFRS 12 (Amendment): Disclosures of interest in other entities	Disclosures required from an investment entity.	1 January 2014
IAS 32 (Amendment): Financial instruments: Presentation	The amendment clarifies some of the requirements for offsetting financial assets and financial liabilities on the statement of financial position.	1 January 2014

New standards, amendments and interpretations effective in 2014 and not relevant to the Scheme:

Standard	Scope	Effective date
IFRS 10 (Amendment): Consolidated financial statements	Exception to the principle that all subsidiaries should be consolidated.	1 January 2014
IAS 27 (Amendment): Consolidated and separate financial statements	Requirement to account for interests in investment entities.	1 January 2014
IAS 36 (Amendment): Impairment of assets	Disclosure of information about the recoverable amount of impaired assets.	1 January 2014
IAS 39 (Amendment): Financial instruments	Amendment to provide relief from discontinuing hedge accounting.	1 January 2014
IFRIC 21 (Interpretation): Accounting for levies	The interpretation addresses diversity in practice around when the liability to pay a levy is recognised.	1 January 2014

1 BASIS OF PREPARATION CONTINUED

New standards, amendments and interpretations not yet effective and relevant to the Scheme:

The following new standards, amendments and interpretations to the existing standards have been published and are not yet effective for the current financial year. The Scheme has not early adopted them and it is not expected that they will have any material impact to the Scheme's results but may result in additional disclosure in the financial statements.

Standard	Scope	Effective date
IFRS 9 (Standard): Financial instruments (2009)	This standard introduces new requirements for the classification and measurement of financial assets. All recognised financial assets that are currently within the scope of IAS 39 will be measured at either amortised cost or fair value.	1 January 2018
IFRS 9 (Standard): Financial instruments (2010)	The standard has been updated to include guidance on financial liabilities and the derecognition of financial instruments.	1 January 2018
IFRS 9 (Amendment): Financial Instruments (2011)	This amendment delays the effective date of IFRS 9: Financial Instruments to annual periods beginning on or after 1 January 2018. The original effective date was for annual periods beginning on or after 1 January 2013.	1 January 2018
IFRS 13 (Amendment): Fair value measurement	The IASB has amended the basis for conclusions of IFRS 13 to clarify that it did not intend to remove the ability to measure short-term receivables and payables at invoice amounts in such cases.	1 July 2014
IAS 19 (Amendment): Employee benefits	This amendment applies to contributions from employees or third parties to defined benefit plans. Its objective is to simplify the accounting for contributions that are independent of the number of years of employee service.	1 July 2014
IAS 24 (Amendment): Related parties	Amendment to include, as a related party, an entity that provides key management personnel services to the reporting entity or to the parent of the reporting entity ('the management entity').	1 July 2014

1 BASIS OF PREPARATION CONTINUED

New standards, amendments and interpretations not yet effective and not relevant to the Scheme:

Standard	Scope	Effective date
IFRS 1: First-time adoption of International Financial Reporting Standards	The basis for conclusions on IFRS 1 is amended to clarify that, where a new version of a standard is not yet mandatory but is available for early adoption, a first-time adopter can use either the old or the new version, provided the same standard is applied in all periods presented.	1 July 2014
IFRS 2 (Amendment): Share based payments	Clarification of the vesting condition.	1 July 2014
IFRS 3 (Amendment): Business combinations	Clarification of an obligation to pay contingent consideration and that the standard does not apply to the accounting for formation of a joint arrangement.	1 July 2014
IFRS 5 (Amendment): Non-current assets held for sale and discontinued operations	This is an amendment to the changes in methods of disposal.	1 January 2016
IFRS 7 (Amendment): Financial instruments	Applicability of the offsetting disclosures to condensed interim financial statements.	1 January 2016
IFRS 7 (Amendment): Financial instruments	The amendment clarifies that a servicing contract that includes a fee can constitute continuing involvement in a financial asset.	1 January 2016
IFRS 8 (Amendment): Operating segments	The amendment requires the disclosure of the judgements made by management in aggregating operating segments.	1 July 2014
IFRS 11 (Amendment): Joint arrangements	The amendment specifies the appropriate accounting treatment for the acquisition of an interest in a joint operation.	1 January 2016
IFRS 14 (Standard): Regulatory deferral accounts	Interim standard on the accounting for certain balances that arise from rate-regulated activities.	1 January 2016
IFRS 15 (Amendment): Revenue from contracts with customers.	Revenue recognition model for all contracts with customers.	1 January 2017
IAS 16 (Amendment): Property, plants and equipment	Clarifies the use of revenue-based methods to calculate depreciation of an asset.	1 January 2016
IAS 19 (Amendment): Employee benefits	The amendment clarifies that market depth of high-quality corporate bonds is assessed based on the currency in which the obligation is denominated, rather than the country where the obligation is located.	1 January 2016
IAS 34 (Amendment): Interim financial reporting	Interim financial reporting disclosure.	1 January 2016
IAS 38 (Amendment): Intangible assets	Clarifies the use of revenue-based methods to calculate depreciation of an asset.	1 January 2016
IAS 40 (Amendment): Investment property	The amendment clarifies that IAS 40 and IFRS 3 are not mutually exclusive.	1 July 2014

2 CLASSIFICATION, RECOGNITION, PRESENTATION AND DERECOGNITION OF FINANCIAL INSTRUMENTS

The Scheme recognises a financial instrument when, and only when, it becomes a party to the contractual provisions of the instrument. The Scheme classifies its financial instruments into the following categories: financial assets or financial liabilities at fair value through profit or loss, and loans and receivables.

The classification depends on the purpose for which the financial instruments are acquired. Management determines the classification of financial instruments at initial recognition. All purchases and sales of financial instruments are recognised on the trade date, which is the date on which the Scheme commits to purchase the financial asset or assume financial liability.

Offsetting financial instruments

This applies where a legally enforceable right to set off exists for recognised financial assets and financial liabilities, and there is an intention to realise the asset and settle the liability simultaneously or to settle on a net basis.

The Scheme will disclose the net asset or liability in the Statement of Financial Position or accompanying notes if the above conditions are met.

Derecognition of financial assets and liabilities

The Scheme derecognises a financial asset or part of a financial asset when:

- The contractual right to the cash flows from the asset expires.
- The Scheme retains the contractual right to receive cash flows of the asset, but assumes the obligation to pay one or more third parties the cash flow without material delay.
- The Scheme transfers the asset, while transferring substantially all the risks and rewards of ownership.
- The Scheme neither transfers the financial asset nor retains significant risk and reward of ownership, but has transferred control of the financial asset.

The Scheme derecognises a financial liability when the obligation under the liability is discharged, cancelled or expires.

When an existing financial liability is replaced by another from a third party on substantially different terms or the terms of an existing liability are substantially modified, such exchange or modification is treated as a derecognition of the original liability and the recognition of a new liability, and the difference in the respective carrying amounts is recognised in the surplus or deficit section of the Statement of Comprehensive Income.

3 FINANCIAL ASSETS

Financial assets at fair value through profit or loss

The Scheme recognises a financial asset when any of the following conditions are met:

- The asset is acquired principally for the purpose of selling in the near term.
- The portfolio of assets are traded for short-term profit.
- A derivative that is not designated as an effective hedge.
- Upon initial recognition the Scheme designated the asset as at fair value through profit or loss.

A group of financial assets is designated as at fair value through profit or loss if it is managed and its performance is evaluated on a fair value basis, in accordance with the Scheme's documented risk management strategy, and information about the group of assets is provided internally on that basis to the Scheme's key management personnel.

Financial assets at fair value through profit or loss are initially recognised at fair value and the transaction costs are expensed in the profit or loss 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.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market, other than those the Scheme intends to sell in the short term.

Loans and receivables are initially recognised at fair value plus transaction costs and subsequently measured at amortised cost using the effective interest method, less provision for impairment.

4 FOREIGN CURRENCY TRANSLATION

Functional and presentation currency

Items included in the Annual Financial Statements are measured using the currency of the primary economic environment in which the entity operates (functional currency).

The functional and presentation currency of the Scheme is the South African rand (R).

Transactions and balances

Foreign currency transactions are translated into the functional currency using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets denominated in foreign currencies are recognised in the Statement of Comprehensive Income.

5 SCHEME AMALGAMATIONS

Scheme amalgamations are accounted for by applying the acquisition method.

The cost of an amalgamation is measured as the fair value of the assets transferred and liabilities incurred or assumed at the date of exchange.

When an entity is amalgamated into the Scheme, all identifiable assets, liabilities and members' funds are accounted for at their fair values at the acquisition date. No consideration is paid for these transactions and they are recognised as from the transaction date.

The Scheme recognises the net assets from amalgamated schemes as a direct addition to reserves in its Statement of Financial Position.

Section 63(14) of the Act, prescribes that assets and liabilities of the parties to amalgamations shall vest and become binding upon the party to which the transfer effected.

No goodwill is recognised on the amalgamation of schemes.

6 CASH AND CASH EQUIVALENTS

Cash and cash equivalents are short-term, highly liquid instruments that are readily convertible to known amounts of cash and are subject to an insignificant risk of changes in value.

In the Statement of Cash Flows, cash and cash equivalents comprise:

- Coins and bank notes.
- Money on call and short notice.
- Balances with banks.

Cash and cash equivalents only include items held for the purpose of meeting short-term cash commitments rather than for investing or other purposes and are carried at cost, which, due to their short-term nature, approximates fair value.

7 IMPAIRMENT OF FINANCIAL ASSETS

Financial assets carried at amortised cost

The Scheme assesses at each reporting date whether there is objective evidence that a financial asset is impaired. A financial asset or group of financial assets is impaired and impairment losses are incurred if, and only if, there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset (a "loss event") and that loss event (or events) has an adverse impact on the estimated future cash flows of the financial asset that can be reliably estimated.

Objective evidence that a financial asset or group of financial assets is impaired includes observable data that comes to the attention of the Scheme regarding the following loss events:

- Significant financial difficulty of service provider or member debtors.
- Breach of contract, such as non-payment of member contributions when due and if these remain unpaid for extended periods.
- Default or delinquency in payments due by service providers and other debtors.
- Observable data indicating that there is a measureable decrease in the estimated future cash flows from other Scheme assets since the initial recognition of those assets, although the decrease cannot yet be attributed to the individual financial assets in the Scheme.
- Adverse changes in the payment status of members of the Scheme.
- National or local economic conditions that correlate with non-payment of debtor contributions.

The Scheme first assesses whether objective evidence of impairment exists, individually for financial assets that are individually significant, such as service provider debtors. In the case of assets that are not individually significant, such as contribution debtors, financial assets are grouped on the basis of similar credit characteristics, such as asset type and past due status. These characteristics are used in the estimation of future cash flows recoverable.

If there is objective evidence that an impairment loss on a financial asset has been incurred, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. The carrying amount of the asset is reduced and the amount of the loss is recognised in the Statement of Comprehensive Income.

When a receivable is uncollectable, it is written off against the related provision for impairment. Such receivables are written off after all the necessary procedures have been completed and the amount of the loss has been determined. Subsequent recoveries of amounts previously written off decrease the amount of the provision for impairment in the Statement of Comprehensive Income.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed by adjusting the allowance account. The amount of the reversal is recognised in the Statement of Comprehensive Income.

8 MEMBERS' FUNDS

The funds represent the accumulated funds of the Scheme. The funds are mainly held as statutory reserves in lieu of the solvency requirement as required by the Act.

9 FINANCIAL LIABILITIES

Financial liabilities are initially recognised at fair value net of transaction costs incurred. After initial recognition the financial liabilities are measured at amortised cost, using the effective interest rate method. In addition, the Scheme is not permitted to borrow, in terms of Section 35 (6)(c) of the Act. The Scheme therefore has no long-term financial liabilities.

Derivative liabilities include liabilities that exist at year end as a result of marked-to-market losses accrued on derivative instruments.

Trade payables

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Trade payables are classified as current liabilities if payment is due within one year or less. If not, they are presented as non-current liabilities.

Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest rate method.

Personal Medical Savings Accounts trust liabilities

Members' Personal Medical Savings Accounts, which are managed by the Scheme on behalf of its members, 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 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 that Act.

Advances on savings contributions are funded from the Scheme's funds and the risk of impairment carried by the Scheme.

Interest payable on members' Personal Medical Savings Accounts is expensed when incurred.

10 PROVISIONS

The Scheme recognises a provision once the following conditions are met:

- It has a present legal or constructive obligation as a result of past events.
- It is probable that an outflow of resources embodying economic benefits will be required to settle the obligation.
- A reliable estimate of the amount of the obligation can be made.

Provisions are measured as the present value of management's best estimate of the expenditure required to settle the obligation at the reporting date. Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

Outstanding claims provision

Claims outstanding comprise provisions for the Scheme's best estimate of the ultimate cost of settling all claims incurred but not yet reported at the reporting date. Claims outstanding are determined as accurately as possible based on a number of factors. These include previous experience in claims patterns, claims settlement patterns, trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim.

Claims handling expenses are not separately accounted for as this service is provided by the Administrator and a fixed fee is paid for the full administration service including claims handling. No provision for claims handling expenses is required as the Scheme has no further liability to the Administrator at year end.

Estimated co-payments and payments from members' Personal Medical Savings Accounts are deducted in calculating the outstanding claims provision. The Scheme does not discount its provision for outstanding claims since the effect of the time value of money is not considered material.

11 CONTINGENT LIABILITY

The Scheme will disclose a contingent liability if one of the following conditions are met:

- A possible obligation arising from past events, the existence of which will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Scheme.
- A present obligation that arises from past events but not recognised because:
  - It is not probable that an outflow of resources will be required to settle an obligation.
  - The amount of the obligation cannot be measured with sufficient reliability.

12 MEMBER INSURANCE CONTRACTS

Contracts under which the Scheme accepts significant insurance risk from another party (the member) by agreeing to compensate the member or other beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary are classified as insurance contracts.

The contracts issued compensate the Scheme's members for healthcare expenses incurred and are detailed in Note 30.

13 CONTRIBUTION INCOME

Gross contributions comprise risk contributions and Personal Medical Savings Account contributions.

Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably assured. Risk contributions represent gross contributions after the deduction of Personal Medical Savings Account contributions. Risk contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis. The earned portion of risk contributions received is recognised as revenue.

Risk contributions are shown before the deduction of broker service fees and other acquisition costs.

14 RELEVANT HEALTHCARE EXPENDITURE

Relevant healthcare expenditure consists of net claims incurred and net income or expense from risk transfer arrangements.

14.1 Claims incurred

Gross claims incurred comprise the total estimated cost of all claims arising from healthcare events that have occurred in the year and for which the Scheme is responsible, whether or not reported by the end of the year.

Risk claims incurred comprise:

- Claims submitted and accrued for services rendered during the year.
- Payments under provider contracts for services rendered to members.
- Over or under provisions relating to prior year claims estimates.
- Claims incurred but not yet reported.
- Claims settled in terms of risk transfer arrangements.

Net of:

- Claims from members' Personal Medical Savings Accounts.
- Recoveries from members for co-payments.
- Recoveries from third parties.
- Discount received from service providers.

Anticipated recoveries under risk transfer arrangements are disclosed separately as assets and are assessed in a manner similar to the assessment of the outstanding claims provision and claims reported not yet paid.

14.2 Risk transfer arrangements

Risk transfer arrangements are contractual arrangements entered into by the Scheme with a third party that undertakes to indemnify the Scheme against all or part of the loss that the Scheme may incur as a result of carrying on the business of a medical scheme. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependants, but the arrangements only decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

Risk transfer arrangement fees (including Managed care: healthcare services) are recognised as an expense over the indemnity period on a straight-line basis.

The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the Statement of Comprehensive Income on a gross basis. Amounts recoverable under such contracts are therefore recognised in the same year as related claims. The claims-incurred liability under risk transfer arrangements and the equivalent receivable is also presented in the Statement of Financial Position on a gross basis.

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding claims provisions and claims reported not yet paid. Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the outstanding claims provision, claims reported not yet paid and settled claims associated with the risk transfer arrangement.

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. These assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement. The Scheme gathers the objective evidence that a risk transfer arrangement asset is impaired using the same process adopted for financial assets held at amortised cost. The impairment loss is also calculated following the same method used for these financial assets. These processes are described in Accounting Policy Note 7.

15 LIABILITY ADEQUACY TEST

Liability adequacy tests are performed to ensure the adequacy of the member insurance contract liabilities as at the reporting date. In performing these tests, current estimates of future cash flows under the Scheme's insurance contracts are used. Any deficiency is immediately recognised in the Scheme's surplus or deficit.

Accounting policies

16 MANAGED CARE: MANAGEMENT SERVICES FEES

Managed care: management services fees comprise amounts paid or payable to a third party for managing the utilisation, costs and quality of healthcare services to the members of the Scheme. Managed care: management services fees are expensed as incurred.

17 BROKER SERVICE FEES

Broker service fees are fees paid as acquisition costs for the introduction and provision of ongoing services to members and are expensed as incurred.

18 EXPENSES FOR ADMINISTRATION AND OTHER OPERATING EXPENSES

Fees paid to the Scheme Administrator are included in Expenses for administration and are expensed as incurred. Other operating expenses include expenses other than administration fees and are expensed as incurred.

19 INVESTMENT INCOME

Investment income comprises dividends and interest received and accrued on investments and interest on cash and cash equivalents.

Interest income is recognised using the effective interest method, taking into account the principal amount outstanding and the effective rate over the period to maturity, when it is determined that such income will accrue to the Scheme.

Dividend income from investments is recognised when the right to receive payment is established – this is the ex dividend date for equity securities.

20 REIMBURSEMENTS FROM THE ROAD ACCIDENT FUND

The Scheme grants assistance to its members in defraying expenditure incurred in connection with the rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made to the Road Accident Fund, administered in terms of the Road Accident Fund Act No 56 of 1996. If the member is reimbursed by the Road Accident Fund, they are obliged contractually to cede that payment to the Scheme to the extent that they have already been compensated.

Due to the uncertainty around the confirmation and measurability of the Road Accident Fund amounts, the Scheme accounts for these amounts on a cash basis and recognises them as a reduction of net claims incurred.

21 UNALLOCATED FUNDS

Unallocated funds arise on the receipt of unidentified deposits in favour of the Scheme.

Unallocated funds that have legally prescribed, that is funds older than three years, are written back and are included under sundry income on the face of the Statement of Comprehensive Income.

A liability for unallocated funds that have not legally prescribed is recognised and disclosed under Trade and other payables. Initially the liability is measured at its fair value plus transaction costs. Subsequent to initial measurement, the liability is measured at amortised cost using the effective interest method.

22 EMPLOYEE BENEFITS

Pension obligations

All employees of the Scheme are members of defined contribution plans. A defined contribution plan is a pension plan under which the Scheme pays fixed contributions into a separate entity.

The Scheme has no legal or constructive obligations to pay further contributions if the fund does not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods. The Scheme has no further payment obligations once the contributions have been paid. Contributions to the defined contribution funds are recognised in the net surplus or deficit for the year in which they are incurred.

Other post-employment obligations

The Scheme has no liability for the post-retirement medical benefits of employees.

Other long-term employee benefit

The Long Term Employee Benefit plan refers to awards made to qualifying employees.

The amount recognised in the Statement of Financial Position in respect of the defined benefit plan is the present value of the defined benefit obligation at the end of the reporting period less the fair value of plan assets out of which the obligations are to be settled directly. The defined benefit obligation is calculated using the Projected Unit Credit Method.

Leave pay accrual

The Scheme recognises in full employees' rights to annual leave entitlement in respect of past service.

Bonuses

Management and staff bonuses are recognised as an expense in staff costs as incurred.

23 INCOME TAX

In terms of Section 10 (1)(d) of the Income Tax Act 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

24 ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT PLANS

The following items are directly allocated to benefit plans:

- Contribution income.
- Claims incurred.
- Risk transfer arrangement fees.
- Managed care: management service fees.
- Expenses for administration.
- Broker service fees.
- Interest paid on Personal Medical Savings Accounts.

The remaining items are allocated as detailed below:

- For contributions that are not directly allocated to benefit plans these amounts are apportioned based on a percentage of net contribution income per plan.
- For claims that are not directly allocated to benefit plans these amounts are apportioned based on a percentage of net claims incurred per plan.
- Other operating expenditure is apportioned based on the number of members per benefit plan.
- Investment income is apportioned based on the number of members per benefit plan.
- Net fair value gains/(losses) on financial assets at fair value through profit or loss are apportioned based on the number of members per benefit plan.
- Other income is apportioned based on the number of members per benefit plan.
- Expenses for asset management services rendered are apportioned based on the number of members per benefit plan.
- Interest paid, excluding Personal Medical Savings Accounts, is apportioned based on the number of members per benefit plan.

25 STRUCTURED ENTITIES

A structured entity is an entity that has been designed so that voting or similar rights are not the dominant factor in deciding who controls the entity, such as when any voting rights relate to administrative tasks only, and the relevant activities are directed by means of contractual agreements. A structured entity often has some or all of the following features or attributes:

- Restricted activities.
- A narrow and well-defined objective, such as to provide investment opportunities for investors by passing on risks and rewards associated with the assets of the structured entity to investors.
- Insufficient equity to permit the structured entity to finance its activities without subordinated financial support.
- Financing in the form of multiple contractually linked instruments to investors that create concentrations of credit or other risks (tranches).

The Scheme has determined that some of its investments in pooled funds and in collective investments ("funds") are investments in unconsolidated structured entities. The objectives include achieving medium- to long-term capital growth.

These funds are managed by unrelated asset managers who apply various investment strategies to accomplish their respective investment objectives. The investment strategy does not include the use of leverage.

The change in fair value of each fund is included in the Statement of Comprehensive Income in 'Net fair value gains/(losses) on financial assets at fair value through profit or loss.'

R'000	2014	2013
1 ACCOUNTING POLICIES		
The accounting policies of the Scheme are set out on page 57 to 65.		
2 FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS		
The Scheme's financial assets are summarised by measurement category as follows:		
Financial assets at fair value through profit or loss	**9 474 520**	7 607 085
Loans and receivables (Note 3)	**120 894**	100 207
Total financial assets	**9 595 414**	7 707 292
The details of assets in each of the categories are detailed below.		
Financial assets held at fair value through profit or loss		
Current assets	**9 474 520**	7 607 085
– Offshore bonds	**1 089 600**	967 571
– Equities	**1 026 342**	706 870
– Yield-enhanced bonds	**996 091**	879 120
– Inflation-linked bonds	**343 737**	–
– Money market instruments	**6 018 750**	5 053 524
	9 474 520	7 607 085
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	**7 607 085**	6 968 790
Acquisitions	**3 447 623**	1 605 375
Disposals	**(1 745 608)**	(1 140 869)
Gain on revaluation of investments to fair value	**165 420**	173 789
Net gains on financial assets at fair value through profit or loss including derivatives (Note 21)	**116 457**	135 990
Add: Net loss on revaluation of derivative financial instruments (Note 7)	**49 254**	37 930
Less: Net gains on revaluation of Long Term Employee Benefit Plan asset	**(291)**	(121)
At the end of the year	**9 474 520**	7 607 085
3 TRADE AND OTHER RECEIVABLES		
Insurance receivables		
Contribution receivables	**1 392 667**	1 316 364
Contributions outstanding	**1 399 772**	1 322 098
Less: Provision for impairment	**(7 105)**	(5 734)
Member and service provider claims receivables	**58 181**	52 922
Amount due	**235 639**	224 878
Less: Provision for impairment	**(177 458)**	(171 956)
Other risk transfer arrangements	**2 684**	2 601
Recoveries due from other risk transfer arrangements	**179**	111
Share of outstanding claims provision (Note 6)	**2 505**	2 490
Broker fee receivables	**68**	144
Amounts due from brokers	**668**	570
Less: Provision for impairment	**(600)**	(426)
Other insurance receivables	**30 056**	25 683
Total receivables arising from insurance contracts	**1 483 656**	1 397 714

R'000	2014	2013
3 TRADE AND OTHER RECEIVABLES (continued)		
Loans and receivables		
Balance due by related party	**9 557**	13 191
Discovery Third Party Recovery Services (Pty) Ltd	**9 557**	13 191
Sundry accounts receivable	**110 142**	85 661
Interest receivable	**1 195**	1 355
Total receivables arising from loans and receivables	**120 894**	100 207
	1 604 550	1 497 921

At 31 December 2014 the carrying amounts of Trade and other receivables approximate their fair values due to the short-term maturities of these assets. Interest is not charged on overdue balances. The estimated future cash flow receipts have not been discounted as the effect would be immaterial.

4 CASH AND CASH EQUIVALENTS – PERSONAL MEDICAL SAVINGS ACCOUNT TRUST ASSETS		
(Monies managed by the Scheme on behalf of members)		
PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO		
(Managed by Momentum Asset Management)		
Balance at beginning of the year	**1 309 747**	1 129 982
Additional investments	**193 859**	112 676
Interest income	**91 645**	66 856
Fair value adjustments	**(676)**	233
Balance at the end of the year	**1 594 575**	1 309 747
PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO		
(Managed by Taquanta Asset Managers (Pty) Ltd)		
Balance at beginning of the year	**1 309 558**	1 130 159
Additional investments	**198 056**	116 543
Interest income	**86 818**	62 856
Fair value adjustments	**(218)**	–
Balance at the end of the year	**1 594 214**	1 309 558
Total Personal Medical Savings Account trust assets	**3 188 789**	2 619 305

These funds represent members' Personal Medical Savings Account assets managed by the Scheme on behalf of its members. As required by Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes, these assets have been invested separately from the Scheme's assets. The difference between total Personal Medical Savings Account trust assets and Personal Medical Savings Account trust liabilities arises from timing of cash flows to or from the portfolios.

5 CASH AND CASH EQUIVALENTS – MEDICAL SCHEME ASSETS		
Call accounts	**208 000**	499 654
Current accounts	**406 068**	367 252
Money market instruments	**1 880 412**	1 963 068
	2 494 480	2 829 974

At 31 December 2014 the carrying amounts of cash and cash equivalents approximate their fair values due to the short-term maturities of these assets.

R'000	2014	2013
6 OUTSTANDING CLAIMS PROVISION		
Outstanding claims provision – not covered by risk transfer arrangements	**843 290**	809 700
Outstanding claims provision – covered by risk transfer arrangements (Note 3)	**2 505**	2 490
	845 795	812 190
Analysis of movement in outstanding claims		
Balance at beginning of the year	**812 190**	768 675
Payments in respect of prior year	**(806 779)**	(784 317)
Over/(under) provision in prior year (Note 11)	**5 411**	(15 642)
Adjustment for current year	**840 384**	827 832
Not covered by risk transfer arrangements	**837 879**	825 342
Covered by risk transfer arrangements	**2 505**	2 490
Balance at end of the year	**845 795**	812 190
Analysis of outstanding claims provision		
Estimated gross claims	**899 168**	882 067
Less:		
Estimated recoveries from savings plan accounts (Note 8)	**(53 373)**	(69 877)
Balance at end of the year	**845 795**	812 190
7 DERIVATIVE FINANCIAL INSTRUMENTS		
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments held for trading	**22 700**	17 250
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments held for trading	**(5 969)**	(40 685)
Derivative financial asset/(liability) at the end of the year	**16 731**	(23 435)
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
Derivative financial (liability) at the beginning of the year	**(23 435)**	(32 673)
Additions to derivative financial instruments:	**–**	47 966
– Zero cost equity collar	**–**	37 289
– Zero cost currency collar	**–**	10 677
Realised loss/(gain) on derivative financial instruments	**89 419**	(797)
Realised gain on derivative financial instruments	**–**	(3 643)
– Equity portfolio derivatives	**–**	(3 643)
Realised losses on derivative financial instruments	**89 419**	2 846
– Equity portfolio derivatives	**2 430**	1 132
– Bond portfolio derivatives	**413**	1 714
– Zero-cost equity collars	**34 119**	–
– Zero-cost currency collars	**52 457**	–

R'000	2014	2013
7 DERIVATIVE FINANCIAL INSTRUMENTS (continued)		
Net loss on revaluation of derivative financial instruments	**(49 254)**	(37 930)
Gain on revaluation of derivative financial instruments to fair value	**7 697**	16 465
– Bond portfolio derivatives	**–**	516
– Zero-cost equity collars	**2 258**	15 949
– Zero-cost currency collars	**5 439**	–
Loss on revaluation of derivative financial instruments to fair value	**(56 950)**	(54 395)
– Equity portfolio derivatives	**(1 967)**	(2 991)
– Zero-cost equity collar	**(31 748)**	(9 072)
– Zero-cost currency collar	**(21 522)**	(42 332)
– Bond portfolio derivatives	**(1 713)**	–
Derivative financial asset/(liability) at the end of the year	**16 731**	(23 435)

Derivative instruments

The Trustees approved a strategy to protect the value of the Scheme's investments by entering into zero-cost equity collars to protect the Scheme's equity portfolios, and zero-cost currency collars to protect the Scheme's offshore bond portfolios.

The Scheme's equity managers entered into All Shareholder Index (ALSI) futures contracts to generate an equity-related return on cash held in the equity portfolios.

One of the Scheme's bond managers entered into bond futures to hedge the bond portfolio and provide protection against market risk.

Details of the Scheme's derivatives and the impact of these instruments on investment return are set out in the Financial Risk Management Report (Note 31).

8 PERSONAL MEDICAL SAVINGS ACCOUNT TRUST LIABILITIES (Personal Medical Savings Account trust monies managed by the Scheme on behalf of its members)		
Balance on Personal Medical Savings Accounts at the beginning of the year	**2 776 720**	2 291 580
Add:		
Personal Medical Savings Accounts contributions received or receivable	**8 794 716**	7 953 882
For the current year (Note 10)	**8 794 716**	7 953 882
Interest on Personal Medical Savings Accounts (Note 23)	**181 687**	136 673
Transfers received from other medical schemes	**14 231**	17 883
Less:		
Claims paid to or on behalf of members (Note 11)	**(8 301 351)**	(7 445 345)
Refunds on death or resignation	**(215 260)**	(177 953)
Balance due to members on Personal Medical Savings Accounts held in trust at the end of the year	**3 250 743**	2 776 720

It is estimated that claims to be paid out of members' Personal Medical Savings Accounts in respect of claims incurred in 2014 but not recorded will amount to approximately R53 373 459 (2013: R69 876 504) (Note 6).

As at 31 December 2014 the carrying amount of the members' Personal Medical Savings Accounts were deemed to be equal to their fair values, which is the amount payable on demand. The amounts were not discounted, due to the demand feature.

Interest is allocated on these Personal Medical Savings Account balances monthly in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes. The Scheme does not charge interest on negative Personal Medical Savings Account balances.

R'000	2014	2013
9 TRADE AND OTHER PAYABLES		
Insurance payables		
Contributions received in advance	**101 162**	72 833
Premium refunds due to employers	**173**	197
Reported claims not yet paid		
Balance at the beginning of the year	**470 518**	351 682
Movement for the year	**(135 999)**	118 836
Balance at the end of the year	**334 519**	470 518
Broker fee creditors	**87 973**	73 292
Accredited brokers	**87 973**	73 292
Other insurance liabilities	**16**	20
Total liabilities arising from insurance contracts	**523 843**	616 860
Financial liabilities		
Balance due to related parties	**368 555**	327 313
Discovery Health (Pty) Ltd	**368 555**	327 313
Unallocated funds	**2 724**	25 253
Total accruals	**136 117**	4 113
General accruals	**136 101**	4 006
Leave pay provision	**16**	107
Total arising from financial liabilities	**507 396**	356 679
	1 031 239	973 539
At 31 December 2014 the carrying amounts of insurance and other payables approximate their fair values due to the short-term maturities of these liabilities.		
10 RISK CONTRIBUTION INCOME		
Gross contributions per registered Scheme rules	**44 905 716**	40 463 701
Less:		
Personal Medical Savings Account contributions (Note 8)	**(8 794 716)**	(7 953 882)
Risk contribution income per Statement of Comprehensive Income	**36 111 000**	32 509 819
11 NET CLAIMS INCURRED		
Current year claims per registered Scheme rules	**37 920 483**	33 712 072
Claims not covered by risk transfer arrangements	**37 532 543**	33 359 766
Claims covered by risk transfer arrangements (Note 12)	**387 940**	352 306
Movement in outstanding claims provision	**33 605**	43 515
(Over)/Under provision in prior year (Note 6)	**(5 411)**	15 642
Adjustment for current year	**39 016**	27 873
	37 954 088	33 755 587
Less:		
Claims charged to members' Personal Medical Savings Accounts (Note 8)	**(8 301 351)**	(7 445 345)
Claims incurred	**29 652 737**	26 310 242
Third party claim recoveries	**(99 759)**	(25 165)
	29 552 978	26 285 077

11 NET CLAIMS INCURRED (continued)

Risk transfer arrangements

During 2014 the Scheme had four risk transfer arrangements in place. The methodologies used to determine the claims covered by these arrangements are set out below.

1. Risk transfer arrangement covering in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus and KeyCare Access plans.

   The claims experience for members on the KeyCare Plus and KeyCare Access plans for the 2014 benefit year was used as the basis for determining the claims under this arrangement. These claim amounts are adjusted to include a provision for outstanding claims and then converted to a Per Life Per Month (PLPM) rate using the membership on the KeyCare Plus and KeyCare Access plans.

   In order to determine the value of claims under this arrangement, the average 2014 PLPM rate is multiplied by the lives' exposure for this arrangement's membership and reduced by the actual claims that the Scheme has paid under this arrangement.

2. Risk transfer arrangement providing optometry services to members on the KeyCare Plus and KeyCare Access plans.

   An analysis as to the expected costs of optometry benefits using the experience from other Scheme plans was conducted. These claim amounts are adjusted to include a provision for outstanding claims and converted to a PLPM rate. Generally the claims experience on KeyCare Plus and KeyCare Access is different to that of other Scheme plans as KeyCare Plus and KeyCare Access is aimed at a specific target market and the benefits are restricted. To allow for this, the overall PLPM is adjusted by the ratio of KeyCare Plus and KeyCare Access claims experience to the other plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Access.

3. Risk transfer arrangement providing dentistry services to members on the KeyCare Plus and KeyCare Access plans.

   The cost of the dental group of procedure codes was isolated. Using claims data linked to this group, the overall PLPM cost of dental services on all plans excluding KeyCare Plus and KeyCare Access was estimated. These claim amounts are adjusted to include a provision for outstanding claims. Generally, the claims experience on KeyCare Plus and KeyCare Access is different to that of other Scheme plans as KeyCare Plus and KeyCare Access is aimed at a specific target market and the benefits are restricted. To allow for this, the overall PLPM is adjusted by the ratio of KeyCare Plus and KeyCare Access claims experience to the other benefit plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Access.

4. Risk transfer arrangement covering treatment for Executive and Comprehensive Plan members diagnosed with diabetes (type I and II).

   For their diabetes-related treatment, members have a choice of using the managed care organisation under this risk transfer arrangement or not. As the risk profile of the two groups of members is similar, the claims experience of the Executive and Comprehensive Plan members who have not elected to use this provider, was used to estimate the members' fee-for-service cost for those who have elected to use this provider.

   As no underlying fee-for-service data is available, the cost of providing the capitated services was estimated as follows:

   - Per Life Per Month estimates were calculated for consultations, procedures, medication and hospital admissions to the extent that these services were covered under this risk transfer arrangement for the Executive and Comprehensive Plan members who have not elected this provider.
   - The expected fee-for-service cost was calculated by multiplying the calculated Per Life Per Month costs by the number of members exposed for the period on this programme.

12 NET INCOME ON RISK TRANSFER ARRANGEMENTS

R'000	**2014**	2013
Capitation fees paid	**(325 975)**	(297 760)
Recoveries under risk transfer arrangements	**387 940**	352 306
Claims incurred in respect of related risk transfer arrangements	**303 624**	264 949
Recoveries received	**84 316**	87 357
	61 965	54 546

R'000	2014	2013
13 MANAGED CARE: MANAGEMENT SERVICES		
The managed care: management services have been grouped into the following categories of services.		
Discovery Health (Pty) Ltd		
Clinical protocols/disease management	**210 203**	192 678
Hospital management	**624 602**	572 524
Pharmaceutical benefit management	**180 174**	165 151
Provider networks	**186 176**	170 656
	1 201 155	1 101 009
14 BROKER SERVICE FEES		
Brokers' fees	**918 871**	825 263
	918 871	825 263
15 OTHER OPERATING EXPENSES		
Association fees	**240**	4 635
Audit fees	**5 078**	4 774
Audit services for the year ended 2014	**2 099**	1 828
Audit services for the year ended 2013	**2 201**	2 027
Other services	**778**	919
Audit and Risk Committees fees (Note 16)	**998**	924
Bank charges	**9 880**	8 275
Clinical Governance Committee fees	**121**	57
Council for Medical Schemes	**33 151**	29 642
Custodian fees	**11**	6
Debt collecting fees	**3 250**	2 037
Dispute Committee fees	**426**	285
General meeting costs	**1 993**	2 269
Investment Committee fees	**121**	69
Investment reporting fees	**2 412**	1 438
Legal fees	**1 704**	1 994
Net impairment losses (Note 17)	**55 962**	53 320
Other expenses	**16 417**	11 650
Principal Officer fees – Remuneration	**4 816**	4 544
Principal Officer fees – Unvested Long Term Employee Benefit	**1 116**	855
Scheme office costs	**3 691**	3 010
Printing, postage and stationery	**409**	368
Professional fees	**5 701**	13 602
Staff costs (Note 18)	**9 893**	5 540
Sundry amounts written off	**22**	14
Trustees' remuneration and consideration expenses (Note 19)	**3 717**	3 178
	161 129	152 486

R'000	2014	2013
16 AUDIT AND RISK COMMITTEES' FEES		
B Stott – Independent member (Chairperson)*	**446**	223
D Eriksson – Independent member	**182**	304
N Novick – Independent member	**191**	211
S Green – Independent member	**179**	186
	998	924

These are payments to independent members of the Audit and Risk Committees. These members are not Trustees of the Scheme. Amounts paid to Trustee members of these Committees are disclosed in Note 19.

** Independent Member and Chairperson of the Committee since July 2013.*

17 NET IMPAIRMENT LOSSES		
Insurance and other receivables		
Contributions that are not collectable	**1 371**	1 856
Movement in provision	**1 371**	1 856
Members' and service providers' portions that are not recoverable	**54 086**	48 710
Movement in provision	**54 086**	48 710
Amounts due by brokers that are not recoverable	**173**	85
Movement in provision	**173**	85
Amounts due by forensic debtors that are not recoverable	**(1)**	2 538
Movement in provision	**(1)**	2 538
Receivables written off	**379**	308
Less:		
Previously written off receivables recovered	**(46)**	(177)
	55 962	53 320

18 STAFF COSTS		
Salaries and bonuses	**8 850**	5 024
Pension costs – defined contribution plans	**501**	276
Medical and other benefits	**448**	317
Increase/(decrease) in leave pay accrual	**94**	(77)
	9 893	5 540

19 TRUSTEES REMUNERATION AND CONSIDERATION EXPENSES

The following table records the remuneration and consideration paid to Trustees during the year:

31 December 2014	Services as Trustee R'000	Committee fees: Audit and Risk Committees R'000	Investment Committee R'000	Clinical Governance Committee R'000	Product Committee R'000	Non-Healthcare Expenses Committee R'000
M van der Nest SC (Chairperson)	**432**	**–**	**–**	**–**	**–**	**30**
P Maserumule	**249**	**–**	**162**	**–**	**–**	**–**
N Graves SC	**251**	**–**	**120**	**–**	**120**	**189**
Z van der Spuy	**225**	**–**	**–**	**179**	**120**	**–**
G Waugh	**239**	**120**	**–**	**–**	**179**	**126**
D Naidoo	**250**	**132**	**126**	**–**	**–**	**96**
Total	**1 646**	**252**	**408**	**179**	**419**	**441**

31 December 2013	Services as Trustee R'000	Committee fees: Audit and Risk Committees R'000	Investment Committee R'000	Clinical Governance Committee R'000	Product Committee R'000	Non-Healthcare Expenses Committee R'000
M van der Nest SC (Chairperson)	461	–	–	–	–	6
P Maserumule[1]	241	–	206	–	–	–
N Sangweni[2]	160	–	–	86	–	–
B Stott[2]	137	57	69	–	–	–
N Graves SC[1]	241	–	69	–	11	14
Z van der Spuy[1]	253	–	–	143	17	–
G Waugh	262	131	80	–	23	14
D Naidoo[3]	127	63	69	–	–	–
Total	**1 882**	**251**	**493**	**229**	**51**	**34**

1 Re-elected 20 June 2013.
2 Term ended 20 June 2013.
3 Elected 20 June 2013.

	Committee fees					
	Remuneration Committee R'000	Stakeholder Relations Committee R'000	Nomination Committee	Governance Review Committee R'000	Trustee Travel R'000	Total R'000
	10	**144**	**–**	**–**	**–**	**616**
	–	**114**	**–**	**–**	**–**	**525**
	10	**–**	**–**	**–**	**–**	**690**
	–	**–**	**–**	**–**	**94**	**618**
	–	**–**	**–**	**–**	**–**	**664**
	–	**–**	**–**	**–**	**–**	**604**
	20	**258**	**–**	**–**	**94**	**3 717**

	Committee fees					
	Remuneration Committee R'000	Stakeholder Relations Committee R'000	Nomination Committee	Governance Review Committee R'000	Trustee Travel R'000	Total R'000
	–	–	24	12	–	503
	–	–	–	–	–	447
	–	–	–	–	–	246
	–	–	–	30	–	293
	–	–	–	30	–	365
	–	–	–	–	106	519
	–	–	13	23	–	546
	–	–	–	–	–	259
	–	**–**	**37**	**95**	**106**	**3 178**

R'000	2014	2013
20 INVESTMENT INCOME		
Financial assets at fair value through profit or loss:	**812 261**	640 217
Dividend income	**23 617**	14 648
Interest income	**788 644**	625 569
Cash and cash equivalents interest income	**46 851**	42 265
Investment income per Statement of Comprehensive Income	**859 112**	682 482
The Scheme's total interest income is summarised below.		
Financial assets not at fair value through profit or loss:	**47 084**	42 355
Interest received from Administrator (Note 22)	**233**	90
Cash and cash equivalents interest income	**46 851**	42 265
Financial assets at fair value through profit or loss:		
Interest income	**788 644**	625 569
Total interest income	**835 728**	667 924
21 NET GAINS/(LOSSES) ON FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS		
Net foreign exchange gains on financial assets at fair value through profit or loss:	**113 058**	218 855
– Offshore bonds	**113 058**	218 855
Net fair value gains on financial assets at fair value through profit or loss including derivatives:	**160 258**	117 746
– Equities	**83 707**	65 910
– Derivatives held for trading	**7 697**	16 465
– Money market instruments	**–**	1 656
– Offshore bonds	**64 059**	33 554
– Inflation-linked bonds	**2 753**	–
– Yield-enhanced bonds	**2 042**	161
Net fair value losses on financial assets at fair value through profit or loss including derivatives:	**(156 859)**	(200 611)
– Derivatives held for trading	**(56 950)**	(54 395)
– Money market instruments	**(39 103)**	–
– Offshore bonds	**(56 787)**	(140 526)
– Yield-enhanced bonds	**(4 019)**	(5 690)
	116 457	135 990
22 SUNDRY INCOME		
Interest received from Administrator (Note 20)	**233**	90
Prescribed amounts written back	**5 966**	2 504
Stale cheques written back	**1 358**	3 231
	7 557	5 825
23 INTEREST PAID		
Financial assets not at fair value through profit or loss:		
Interest on Personal Medical Savings accounts (Note 8)	**181 687**	136 673
Interest paid to Administrator	**118**	281
	181 805	136 954

R'000	2014	2013
24 RESERVES TRANSFERRED FROM OTHER MEDICAL SCHEMES		
Movement in and reserves transferred from amalgamated schemes during the year under review.		
Altron Medical Scheme	**49 435**	–
PG Bison Medical Scheme	**16 890**	–
Afrox Medical Scheme	**84 685**	–
Nampak SA Medical Scheme	**(3 290)**	162 984
IBM South Africa Medical Scheme	**(1 851)**	28 284
Umed Medical Scheme	**–**	1 568
Afrisam Medical Scheme	**–**	363
Edcon Medical Scheme	**9**	1 599
	145 878	194 798

25 AMALGAMATIONS

Altron Medical Aid Scheme

An amalgamation between the Scheme and Altron Medical Aid Scheme ("Altron MAS") was confirmed and effective from 1 January 2014.

Altron MAS is a not-for-profit restricted medical scheme registered in terms of the Act. Membership of the Scheme is open to all current and retired employees of Allied Electronics Corporation Limited, its subsidiaries and associates. Retired employees of subsidiaries and associates, which have been disposed of, may continue their membership if they so elect.

In terms of the Act, medical schemes do not have equity, therefore the Scheme did not acquire any voting equity interest.

The members of the Scheme and Altron MAS voted that the amalgamation of Altron MAS with the Scheme would be in the best interest of the Altron MAS members.

The Scheme obtained control of Altron MAS by means of the exposition requirements as set out in Section 63 of the Act.

On the date of the amalgamation 3 894 principal members and 8 008 beneficiaries joined the Scheme.

No goodwill be recognised as a result of this transaction.

R'000		2014
25 **Amalgamations** (continued)		
Altron Medical Aid Scheme (continued)		
The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:		
Reserves effectively transferred:		
(Acquisition date fair value of Altron MAS's members' interest)		**40 990**
Net recognised values of Altron MAS's identifiable assets and liabilities:		**40 990**
Current assets	**77 963**	
Cash and cash equivalents	**76 878**	
Contribution receivables	**1 018**	
Member and service provider claims receivables	**40**	
Interest receivable	**6**	
Other accounts receivable	**21**	
Current liabilities	**(36 973)**	
Outstanding claims provision	**(4 200)**	
Reported claims not yet paid	**(2 516)**	
Unallocated funds	**(200)**	
Discovery Health (Pty) Ltd	**(942)**	
General accruals	**(661)**	
Personal medical savings accounts	**(28 454)**	
Goodwill		**–**
As a result of the amalgamation, the Scheme acquired the following receivables information of which is set out below.		
Fair value of receivables acquired:	**1 085**	
Insurance receivables	**1 079**	
Contribution debtors	**1 018**	
Member claim debtors	**532**	
Service provider claim debtors	**279**	
Other accounts receivable	**21**	
Provision for impairment	**(771)**	
Loans and receivables	**6**	
Interest receivable	**6**	
Gross contractual amounts receivable:	**1 856**	
Insurance receivables	**1 850**	
Contribution debtors	**1 018**	
Member claim debtors	**532**	
Service provider claim debtors	**279**	
Other accounts receivable	**21**	
Loans and receivables	**6**	
Interest receivable	**6**	
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	**(772)**	
Contribution debtors	**(49)**	
Member claim debtors	**(478)**	
Service provider claim debtors	**(245)**	

R'000	2014
25 Amalgamations (continued)	
Altron Medical Aid Scheme (continued)	
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.	
Current assets	**77 963**
Cash and cash equivalents	**76 878**
Contribution debtors	**969**
Member claim debtors	**54**
Service provider claim debtors	**35**
Interest receivable	**6**
Other accounts receivable	**21**
Current liabilities	**(36 973)**
Outstanding claims provision	**(4 200)**
Reported claims not yet paid	**(2 516)**
Unallocated funds	**(200)**
Discovery Health (Pty) Ltd	**(942)**
General accruals	**(661)**
Personal medical savings accounts	**(28 454)**
	40 990

Afrox Medical Aid Society

An amalgamation between the Scheme and Afrox Medical Aid Society ("Afrox MAS") was confirmed and effective from 1 May 2014.

Afrox MAS is a not-for-profit restricted medical scheme registered in terms of the Act. Membership of the Scheme is open to all current and retired employees of African Oxygen Limited, its subsidiaries and associates. Retired employees of subsidiaries and associates, which have been disposed of, may continue their membership if they so elect.

In terms of the Act, medical schemes do not have equity, therefore the Scheme did not acquire any voting equity interest.

The members of the Scheme and Afrox MAS voted that the amalgamation of Afrox MAS with the Scheme would be in the best interest of the Afrox MAS members.

The Scheme obtained control of Afrox MAS by means of the exposition requirements as set out in Section 63 of the Act.

On the date of the amalgamation 2 967 principal members and 6 768 beneficiaries joined the Scheme.

No goodwill be recognised as a result of this transaction.

R'000		2014
25 Amalgamations (continued)		
Afrox Medical Aid Society (continued)		
The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:		
Reserves effectively transferred: (Acquisition date fair value of Afrox MAS's members' interest)		**82 907**
Net recognised values of Afrox MAS's identifiable assets and liabilities:		**82 907**
Non-current assets	**86 597**	
Available-for-sale financial assets	**86 597**	
Current assets	**8 829**	
Cash and cash equivalents	**8 170**	
Contribution receivables	**608**	
Member and service provider claims receivables	**161**	
Provision for impairment	**(110)**	
Current liabilities	**(12 519)**	
Outstanding claims provision	**(7 413)**	
Reported claims not yet paid	**(4 700)**	
General accruals	**(406)**	
Goodwill		**–**
As a result of the amalgamation, the Scheme acquired the following receivables information of which is set out below.		
Fair value of receivables acquired:	**659**	
Insurance receivables	**659**	
Contribution debtors	**608**	
Members/supplier claim debtors	**161**	
Provision for impairment	**(110)**	
Gross contractual amounts receivable:	**769**	
Insurance receivables	**769**	
Contribution debtor	**608**	
Members/supplier claim debtors	**161**	
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	**(110)**	
Contribution debtor	**(87)**	
Members/supplier claim debtors	**(23)**	
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.		
Non-current assets	**86 597**	
Available-for-sale financial assets	**86 597**	
Current assets	**8 829**	
Cash and cash equivalents	**8 170**	
Contribution debtor	**521**	
Members/supplier claim debtors	**138**	
Current liabilities	**12 519**	
Outstanding claims provision	**(7 413)**	
Reported claims not yet paid	**(4 700)**	
General accruals	**(406)**	
	82 907	

25 Amalgamations (continued)

PG Bison Medical Aid Society

An amalgamation between the Scheme and PG Bison Medical Aid Society ("PG Bison MAS") was confirmed and effective from 1 May 2014.

PG Bison MAS is a not-for-profit restricted medical scheme registered in terms of the Act. Membership of the Scheme is open to all current and retired employees of PG Bison Limited, its subsidiaries and any franchised or associated companies. Retired employees of subsidiaries and associates, which have been disposed of, may continue their membership if they so elect.

In terms of the Act, medical schemes do not have equity, therefore the Scheme did not acquire any voting equity interest.

The members of the Scheme and PG Bison MAS voted that the amalgamation of PG Bison MAS with the Scheme would be in the best interest of the PG Bison MAS members.

The Scheme obtained control of PG Bison MAS by means of the exposition requirements as set out in Section 63 of the Act.

On the date of the amalgamation 351 principal members and 673 beneficiaries joined the Scheme.

No goodwill be recognised as a result of this transaction.

R'000	2014	
The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:		
Reserves effectively transferred: (Acquisition date fair value of PG Bison MAS's members' interest)		**17 535**
Net recognised values of PG Bison MAS's identifiable assets and liabilities:		**17 535**
Current assets	**19 631**	
Cash and cash equivalents	**19 575**	
Contribution receivables	**77**	
Provision for impairment	**(21)**	
Current liabilities	**(2 096)**	
Outstanding claims provision	**(1 819)**	
Reported claims not yet paid	**(66)**	
General accruals	**(211)**	
Goodwill		**–**
As a result of the amalgamation, the Scheme acquired the following receivables information of which is set out below.		
Fair value of receivables acquired: Insurance receivables	**56** **56**	
Contribution debtors	**77**	
Provision for impairment	**(21)**	
Gross contractual amounts receivable: Insurance receivables	**77** **77**	
Contribution debtors	**77**	
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are: Insurance receivables	**21**	
Contribution debtor	**21**	
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.		
Current assets	**19 631**	
Cash and cash equivalents	**19 575**	
Contribution debtors	**56**	
Current liabilities	**(2 096)**	
Outstanding claims provision	**(1 819)**	
Reported claims not yet paid	**(66)**	
General accruals	**(211)**	
	17 535	

26 RELATED PARTY TRANSACTIONS

The Scheme is controlled by the Board of Trustees who are elected by the members of the Scheme.

Key management personnel and their close family members

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the Board of Trustees and the executive officers of the Scheme. The disclosure deals with full-time personnel who are compensated on a salary basis, and part-time personnel who are compensated on a fee basis (Board of Trustees).

Close family members include close family members of the Board of Trustees and executive officers of the Scheme.

Parties with significant influence over the Scheme

Administrator

Discovery Health (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions, but does not control the Scheme. Discovery Health (Pty) Ltd provides administration, managed care services and wellness programmes. Third party collection services are provided through Discovery Third Party Recovery Services (Pty) Ltd and specialist pharmaceutical services through Southern RX Distributions (Pty) Ltd, both wholly-owned subsidiaries of Discovery Health (Pty) Ltd.

Transactions with related parties

The following provides the total amount in respect of transactions, which have been entered into with related parties for the relevant financial year.

Transactions with key management personnel and their close family members:

R'000	2014	2013
Statement of Comprehensive Income transactions		
Compensation		
Short-term employee benefits	**(21 578)**	(11 279)
Unvested Long Term Employee Benefit	**(1 117)**	(855)
Contributions and claims		
Gross contributions received	**788**	582
Claims paid from the Scheme	**(778)**	(133)
Claims paid from the Personal Medical Savings Account	**(138)**	(122)
Statement of Financial Position transactions		
Long Term Employee Benefit Plan asset	**1 511**	1 717
Plan asset	**3 483**	2 572
Plan liability	**(1 972)**	(855)
Contribution debtors	**20**	24
Amounts due to executive officers	**–**	(38)
Personal Medical Savings Account balances	**(38)**	(22)

26 RELATED PARTY TRANSACTIONS (continued)

The terms and conditions of the related party transactions were as follows:

Transactions	Nature of transactions and their terms and conditions
Contributions received	This constitutes the contributions paid by the related party as a member of the Scheme, in their individual capacity. All contributions were on the same terms as applicable to other members.
Claims incurred	This constitutes amounts claimed by the related parties, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to other members.
Contribution debtors	This constitutes outstanding contributions receivable. The amounts are due immediately. No impairment provisions have been raised on these amounts.
Amounts due to executive officers	These are amounts due to the Scheme's executive officers in terms of their cellphone expenditure and provision for leave pay.
Personal Medical Savings Account balances	The amounts owing to the related parties relate to Personal Medical Savings Account balances to which the parties have a right. In line with the terms applied to third parties, the balances earn interest monthly at predetermined interest rates, on an accrual basis. The amounts are all current and would need to be payable on demand if an appropriate claim is issued, or if the member resigns from the Scheme, as applicable to other members.

R'000	2014	2013
Transactions with entities that have significant influence over the Scheme		
Discovery Health (Pty) Ltd – Administrator		
Statement of Comprehensive Income transactions		
Administration fees paid	**(3 585 641)**	(3 340 754)
Interest received on monthly balances (Note 22)	**233**	90
Interest paid on monthly balances (Note 23)	**(118)**	(281)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 9)*	**(266 988)**	(234 114)
Discovery Health (Pty) Ltd – Managed care organisation		
Statement of Comprehensive Income transactions		
Managed care fees paid	**(1 201 158)**	(1 101 009)
Managed care: management services (Note 13)	**(1 201 158)**	(1 101 009)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 9)*	**(101 567)**	(93 199)
Discovery Third Party Recovery Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Third party collection fees	**(13 970)**	(10 420)
Statement of Financial Position transactions		
Balance due to the Scheme at year end (Note 3)	**9 557**	13 191
Southern RX Distributors (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(4 661)**	–
Discovery Wellness Experience		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(3 043)**	–

* *Total amount due to Discovery Health (Pty) Ltd for the current financial year is R369 million (2013: R327 million), disclosed in Note 9.*

26 RELATED PARTY TRANSACTIONS (continued)
Transactions with entities that have significant influence over the Scheme (continued)

The terms and conditions of the transactions with entities with significant influence over the Scheme were as follows:

Administration agreement

The administration agreement is in terms of the Rules of the Scheme and in accordance with instructions given by the Board of Trustees. The agreement is automatically renewed each year unless notification of termination is received or following the cancellation of the Administrator's accreditation or the issue of a lawful directive to this effect by the Council for Medical Schemes in terms of the Act. The Scheme and the Administrator will be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears interest at prime less 4.5% and is due within 30 days.

Administration fees are calculated on a Per Member Per Month basis. The total expense for administration cost increases in line with membership growth, however, the Per Member Per Month fee has increased at a rate lower than inflation for a number of years.

Managed care agreements

Managed care means the management of member healthcare benefit entitlements by providing, and/or assessing, and/or facilitating the appropriateness and cost-effectiveness of relevant healthcare services to members and their dependants, including accepted clinical practices and treatment protocols. This process can be categorised into two expenditure classifications, namely Managed care: healthcare services and Managed care: management services. The Scheme did not have any Managed care: healthcare services arrangements with Discovery Health (Pty) Ltd during the year under review or prior year.

Managed care: management services

Managed care: management services is the cost of managing healthcare expenditure, such as bill review, specialist and hospital referrals, case management, disease management (where healthcare benefits are not included in the contract), peer review, claims audits and statistical analysis, but does not include the cost of any relevant healthcare services.

The managed care agreement is in accordance with instructions given by the Board of Trustees. The agreement is automatically renewed each year unless notification of termination is received or following the cancellation of Discovery Health (Pty) Ltd's accreditation or the issue of a lawful directive to this effect by the Council for Medical Schemes in terms of the Act. The Scheme and Discovery Health (Pty) Ltd will be entitled to terminate the agreement by giving notice in writing of not less than 90 days and not more than 180 days. The outstanding balance bears interest at Prime less 4.5% and is due within 30 days.

The services provided by the managed care organisation include:

- Managed healthcare services as defined in the Act and the rules of the Scheme
- Prospective review services including pre-authorisation and ensuring benefit availability
- Concurrent case management services, including managing each beneficiary's medical event on an individual case basis
- Acute case management services, including managing each beneficiary's treatment for severe medical conditions on at least a daily basis
- On-site case management services, including managing each beneficiary's medical treatment at the site where the treatment is provided in appropriate circumstances, and auditing clinical notes to assess coding accuracy
- Disease case management services, including managing each disease for which the Scheme provides benefits, by determining the cost and incidence of each disease and suggesting appropriate measures to reduce the cost of treating the disease
- Auditing and reviewing accounts received from service providers in respect of treatment provided to members and beneficiaries
- Continually analysing and reporting on data including data, on a case mix adjusted basis in order to monitor both cost and utilisation of Scheme benefits with a view to identifying areas for intervention
- Managing all contracts with service providers to the Scheme with the aim of reducing costs while maintaining and/or improving quality of service
- Implementing, managing and reviewing reimbursement models and making recommendations on alternative reimbursement models
- Auditing and reviewing provider servicing behaviour with the aim of reducing costs while maintaining and/or improving the provision of appropriate levels of care.

26 RELATED PARTY TRANSACTIONS (continued)

Transactions with entities that have significant influence over the Scheme (continued)

Third party collection services

The Scheme has contracted with Discovery Third Party Recovery Services (Pty) Ltd, a wholly-owned subsidiary of Discovery Health (Pty) Ltd, to manage the identification and collection of third party recoveries from the Road Accident Fund and the Compensation for Occupational Injuries and Diseases. The Scheme has sold all Road Accident Fund claims incurred by the Scheme during the period 1 January 2014 to 31 December 2014 for the amount of R9.6 million.

Specialist Pharmaceutical Services

The Scheme is contracted with Southern RX Distributors (Pty) Ltd, a wholly-owned subsidiary of Discovery Health (Pty) Ltd to provide specialist pharmaceutical services to members of the Scheme.

Discovery Wellness Experience

Discovery Health (Pty) Ltd provides a wellness experience through lifestyle and health assessments to Scheme members with the use of information technology and on-site medical evaluations of key health indicators.

27 SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN

2014	Executive R'000	Classic Comp R'000	Classic Comp Zero MSA R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comp R'000	Essential Saver R'000
Risk contribution income	**777 946**	**9 244 351**	**35 352**	**1 590 440**	**6 922 006**	**3 727 918**	**1 058 306**	**2 054 238**
Net claims incurred	(998 894)	(8 924 731)	(32 212)	(1 076 578)	(4 929 335)	(2 831 958)	(847 293)	(1 275 217)
Claims incurred	(999 841)	(8 938 683)	(32 270)	(1 080 942)	(4 949 226)	(2 840 299)	(849 124)	(1 282 358)
Third party claims recoveries	946	13 952	57	4 364	19 891	8 321	1 832	7 141
Net income/(expense) on risk transfer arrangements	(721)	(12 970)	(151)	–	–	–	(1 864)	–
Risk transfer arrangement fees	(9 743)	(125 594)	(672)	–	–	–	(13 701)	–
Recoveries from risk transfer arrangements	9 022	112 624	521	–	–	–	11 837	–
Relevant healthcare expenditure	**(999 615)**	**(8 937 701)**	**(32 363)**	**(1 076 578)**	**(4 929 335)**	**(2 831 958)**	**(849 157)**	**(1 275 217)**
Gross healthcare result	**(221 669)**	**306 650**	**2 989**	**513 862**	**1 992 671**	**895 960**	**209 149**	**779 021**
Managed care: management services	(11 789)	(173 985)	(680)	(52 293)	(239 131)	(102 665)	(22 786)	(83 217)
Broker service fees	(10 651)	(160 774)	(592)	(37 828)	(203 799)	(93 985)	(21 606)	(62 296)
Expenses for administration	(38 671)	(570 727)	(2 231)	(171 530)	(784 395)	(336 770)	(74 746)	(272 960)
Other operating expenses	(1 581)	(23 329)	(91)	(7 017)	(32 085)	(13 768)	(3 055)	(11 164)
Net healthcare result	**(284 362)**	**(622 165)**	**(605)**	**245 194**	**733 261**	**348 772**	**86 956**	**349 384**
Investment income	9 272	136 852	384	29 496	188 390	80 792	17 924	65 647
Net fair value gains on financial assets at fair value through profit or loss	1 168	17 236	65	5 064	23 119	10 088	2 258	7 865
Sundry income	75	1 108	1	329	1 502	649	144	517
Other income	**10 515**	**155 196**	**450**	**34 889**	**213 011**	**91 529**	**20 326**	**74 029**
Expenses for asset management services rendered	(174)	(2 564)	(12)	(771)	(3 524)	(1 512)	(333)	(1 227)
Interest paid	(2 634)	(38 872)	–	(3)	(53 530)	(22 951)	(5 092)	(18 659)
Other expenditure	**(2 808)**	**(41 436)**	**(12)**	**(774)**	**(57 054)**	**(24 463)**	**(5 425)**	**(19 886)**
Net surplus/(deficit) for the year	**(276 655)**	**(508 405)**	**(167)**	**279 309**	**889 218**	**415 838**	**101 857**	**403 527**

27 SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN (continued)

2014	Essential Core R'000	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	KeyCare Plus R'000	KeyCare Core R'000	KeyCare Access R'000	Total R'000
Risk contribution income	**722 202**	**304 775**	**4 157 214**	**1 894 766**	**3 382 448**	**191 843**	**47 195**	**36 111 000**
Net claims incurred	(477 674)	(186 715)	(3 336 836)	(1 433 201)	(3 066 176)	(110 486)	(25 672)	(29 552 978)
Claims incurred	(480 248)	(187 476)	(3 350 879)	(1 439 990)	(3 083 621)	(111 699)	(26 102)	(29 652 737)
Third party claims recoveries	2 574	760	14 043	6 789	17 446	1 212	430	99 759
Net income/(expense) on risk transfer arrangements	–	–	–	–	79 174	–	(1 503)	61 965
Risk transfer arrangement fees	–	–	–	–	(173 519)	–	(2 746)	(325 975)
Recoveries from risk transfer arrangements	–	–	–	–	252 693	–	1 243	387 940
Relevant healthcare expenditure	**(477 674)**	**(186 715)**	**(3 336 836)**	**(1 433 201)**	**(2 987 002)**	**(110 486)**	**(27 175)**	**(29 491 013)**
Gross healthcare result	**244 528**	**118 060**	**820 378**	**461 565**	**395 446**	**81 357**	**20 020**	**6 619 987**
Managed care: management services	(29 722)	(9 310)	(169 592)	(80 528)	(206 353)	(14 055)	(5 049)	(1 201 155)
Broker service fees	(19 443)	(7 850)	(137 614)	(52 835)	(102 433)	(5 703)	(1 462)	(918 871)
Expenses for administration	(97 492)	(30 540)	(556 298)	(264 146)	(366 231)	(13 211)	(5 693)	(3 585 641)
Other operating expenses	(3 991)	(1 249)	(22 750)	(10 806)	(27 678)	(1 887)	(678)	(161 129)
Net healthcare result	**93 880**	**69 111**	**(65 876)**	**53 250**	**(307 249)**	**46 502**	**7 138**	**753 191**
Investment income	16 787	7 330	133 577	45 439	116 434	7 937	2 851	859 112
Net fair value gains on financial assets at fair value through profit or loss	2 819	911	16 465	7 745	19 832	1 337	485	116 457
Sundry income	186	59	1 067	505	1 296	88	31	7 557
Other income	**19 792**	**8 300**	**151 109**	**53 689**	**137 562**	**9 362**	**3 367**	**983 126**
Expenses for asset management services rendered	(439)	(137)	(2 499)	(1 187)	(3 044)	(207)	(74)	(17 704)
Interest paid	(3)	(2 082)	(37 955)	(6)	(16)	(2)	–	(181 805)
Other expenditure	**(442)**	**(2 219)**	**(40 454)**	**(1 193)**	**(3 060)**	**(209)**	**(74)**	**(199 509)**
Net surplus/(deficit) for the year	**113 230**	**75 192**	**44 779**	**105 746**	**(172 747)**	**55 655**	**10 431**	**1 536 808**

27 SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN (continued)

2013	Executive R'000	Classic Comp R'000	Classic Comp Zero MSA R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comp R'000	Essential Saver R'000
Risk contribution income	**725 245**	**8 848 843**	**21 583**	**1 430 897**	**5 823 541**	**3 411 256**	**1 092 932**	**1 717 538**
Net claims incurred	(917 240)	(8 379 890)	(20 957)	(938 323)	(4 124 240)	(2 581 702)	(845 673)	(1 026 019)
Claims incurred	(918 283)	(8 388 490)	(20 974)	(939 181)	(4 128 039)	(2 584 185)	(846 392)	(1 027 111)
Third party claim recoveries	1 043	8 600	17	858	3 799	2 483	719	1 092
Net income/(expense) on risk transfer arrangements	(2 095)	(29 193)	(94)	–	–	–	(3 513)	–
Risk transfer arrangement fees	(8 596)	(109 498)	(318)	–	–	–	(12 110)	–
Recoveries from risk transfer arrangements	6 501	80 305	224	–	–	–	8 597	–
Relevant healthcare expenditure	**(919 334)**	**(8 409 083)**	**(21 052)**	**(938 323)**	**(4 124 240)**	**(2 581 702)**	**(849 186)**	**(1 026 019)**
Gross healthcare result	**(194 089)**	**439 760**	**532**	**492 574**	**1 699 301**	**829 554**	**243 746**	**691 519**
Managed care:								
management services	(11 270)	(171 115)	(433)	(48 361)	(207 361)	(97 414)	(24 010)	(70 798)
Broker service fees	(10 482)	(160 983)	(394)	(34 983)	(171 137)	(87 337)	(22 315)	(51 122)
Expenses for administration	(37 728)	(572 848)	(1 448)	(161 893)	(694 148)	(326 109)	(80 381)	(236 993)
Other operating expenses	(1 557)	(23 654)	(60)	(6 700)	(28 742)	(13 475)	(3 316)	(9 825)
Net healthcare result	**(255 126)**	**(488 840)**	**(1 803)**	**240 637**	**597 913**	**305 219**	**113 724**	**322 781**
Investment income	7 618	115 720	217	24 234	140 429	65 911	16 232	48 027
Net fair value gains on financial assets at fair value through profit or loss	1 378	20 869	55	5 977	25 669	11 941	2 925	8 807
Sundry income	59	910	–	256	1 096	516	126	374
Other income	**9 054**	**137 498**	**272**	**30 467**	**167 194**	**78 368**	**19 283**	**57 208**
Expenses for asset management services rendered	(129)	(1 963)	(3)	(554)	(2 379)	(1 115)	(272)	(813)
Interest paid	(2 034)	(30 936)	(3)	(273)	(37 687)	(17 643)	(4 335)	(12 942)
Other expenditure	**(2 163)**	**(32 899)**	**(6)**	**(827)**	**(40 066)**	**(18 758)**	**(4 607)**	**(13 755)**
Net surplus/(deficit) for the year	**(248 234)**	**(384 241)**	**(1 537)**	**270 277**	**725 041**	**364 828**	**128 400**	**366 234**

27 SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN (continued)

2013	Essential Core R'000	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	KeyCare Plus R'000	KeyCare Core R'000	KeyCare Access R'000	Total R'000
Risk contribution income	**599 515**	**283 261**	**3 626 695**	**1 653 286**	**3 051 870**	**177 169**	**46 188**	**32 509 819**
Net claims incurred	(397 237)	(176 399)	(2 853 740)	(1 207 339)	(2 701 813)	(87 800)	(26 705)	(26 285 077)
Claims incurred	(397 666)	(176 511)	(2 856 230)	(1 208 428)	(2 704 105)	(87 906)	(26 741)	(26 310 242)
Third party claim recoveries	429	112	2 490	1 089	2 292	106	36	25 165
Net income/(expense) on risk transfer arrangements	–	–	–	–	91 091	–	(1 650)	54 546
Risk transfer arrangement fees	–	–	–	–	(164 128)	–	(3 110)	(297 760)
Recoveries from risk transfer arrangements	–	–	–	–	255 219	–	1 460	352 306
Relevant healthcare expenditure	**(397 237)**	**(176 399)**	**(2 853 740)**	**(1 207 339)**	**(2 610 722)**	**(87 800)**	**(28 355)**	**(26 230 531)**
Gross healthcare result	**202 278**	**106 862**	**772 955**	**445 947**	**441 148**	**89 368**	**17 833**	**6 279 288**
Managed care: management services	(25 341)	(8 944)	(152 685)	(72 506)	(191 927)	(13 543)	(5 301)	(1 101 009)
Broker service fees	(16 175)	(7 263)	(121 298)	(46 885)	(88 348)	(5 146)	(1 396)	(825 263)
Expenses for administration	(84 826)	(29 939)	(511 129)	(242 718)	(341 887)	(12 729)	(5 978)	(3 340 754)
Other operating expenses	(3 519)	(1 230)	(21 140)	(10 049)	(26 605)	(1 879)	(735)	(152 486)
Net healthcare result	**72 417**	**59 486**	**(33 297)**	**73 789**	**(207 619)**	**56 702**	**4 423**	**859 776**
Investment income	12 703	6 062	103 359	36 337	96 187	6 789	2 657	682 482
Net fair value gains on financial assets at fair value through profit or loss	3 181	1 154	18 799	8 995	23 878	1 698	665	135 990
Sundry income	134	47	809	383	1 015	72	28	5 825
Other income	**16 018**	**7 263**	**122 967**	**45 715**	**121 080**	**8 559**	**3 350**	**824 297**
Expenses for asset management services rendered	(291)	(103)	(1 750)	(831)	(2 200)	(155)	(61)	(12 619)
Interest paid	(149)	(1 629)	(27 704)	(413)	(1 099)	(78)	(29)	(136 954)
Other expenditure	**(440)**	**(1 732)**	**(29 454)**	**(1 244)**	**(3 299)**	**(233)**	**(90)**	**(149 573)**
Net surplus/(deficit) for the year	**87 995**	**65 017**	**60 216**	**118 260**	**(89 838)**	**64 398**	**7 683**	**1 534 500**

R'000	2014	2013
28 CASH FLOWS FROM OPERATIONS BEFORE WORKING CAPITAL CHANGES		
Net surplus for the year	**1 536 808**	1 534 500
Adjustments for:		
Impairment losses	**55 629**	53 189
Interest received	**(835 728)**	(667 924)
Dividend income	**(23 617)**	(14 648)
Interest paid	**181 805**	136 954
Unvested Long Term Employee Benefit	**1 116**	855
Net gains on financial assets at fair value through profit or loss (Note 21)	**(116 457)**	(135 990)
	799 556	906 936
RECONCILIATION OF MOVEMENTS IN THE CASH FLOW STATEMENT		
28.1 Increase in trade and other receivables	**(160 458)**	(68 704)
Balance at beginning of the year	**1 497 921**	1 459 601
Balance at end of the year	**(1 604 550)**	(1 497 921)
Receivables related to amalgamated schemes	**1 800**	22 805
Movement in impairment losses	**(55 629)**	(53 189)
28.2 Increase in trade and other payables	**15 689**	136 248
Balance at beginning of the year	**(973 539)**	(774 732)
Balance at end of the year	**1 031 239**	973 539
Payables related to amalgamated schemes	**(42 011)**	(62 559)
28.3 Purchases of financial instruments	**(3 448 243)**	(1 655 782)
Financial assets at Fair value	**(3 447 623)**	(1 605 375)
Derivatives	**–**	(47 966)
Restricted equity fund	**(620)**	(2 441)
28.4 Proceeds from sale of financial instruments	**1 737 654**	1 335 595
Financial assets at Fair value	**1 745 608**	1 140 869
Derivatives	**(89 419)**	797
Financial instruments from amalgamated schemes	**81 465**	193 929

29 EVENTS AFTER THE REPORTING PERIOD

No significant events occurred between the reporting date and the date the financial statements were authorised for issue.

30 INSURANCE RISK MANAGEMENT REPORT

Nature and extent of risks arising from insurance contracts

The Scheme issues contracts that transfer insurance risk. The primary insurance activity carried out by the Scheme indemnifies covered members and their dependants against the risk of loss arising as a result of the occurrence of a health event, in accordance with the Scheme Rules and the requirements of legislation.

This section summarises these risks and the way in which they are managed.

Insurance risk

The risk under any insurance contract can be expressed as the probability that an insured event occurs, multiplied by the expected amount of the resulting claim. Insurance events are random and therefore the actual number and size of events during any year are unknown and vary from those estimated. The principal risk that the Scheme faces under its insurance contracts is that the actual claim payments exceed the projected amount of the insurance liabilities. This could occur because the frequency and severity of claims are greater than estimated.

A larger number of members will result in smaller variability of the actual claims experience relative to expected levels. This is because an adverse experience is diluted by a larger group of members whose claims are stable and thus predictable.

Factors that aggravate insurance risk include unanticipated demographic movements, adverse experience due to an unexpected epidemic, changes in members' disease profiles, unexpected price increases, prevalence of fraud, supplier-induced demand and the cost of new technologies or drugs.

The risks that the Scheme faces can be discussed for the different benefits offered. The three main types of benefits offered by the Scheme in return for monthly contributions are indicated below:

Hospital benefits

The hospital benefit covers medical expenses incurred arising from admission to hospital. This includes accommodation, theatre, professional, medication, equipment and consumables.

Day-to-day benefits

The day-to-day benefits include both the Personal Medical Savings Account (PMSA) and an insurance risk element – the Insured Network Benefit and Above Threshold Benefit (ATB). The Scheme does not carry risk for PMSA benefits. Day-to-day benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed non-chronic medicines.

Chronic benefits

The Chronic Illness Benefit (CIB) covers approved medication and treatment for up to 61 listed conditions, including the 27 Prescribed Minimum Benefit chronic conditions. These include conditions such as HIV/AIDS, high blood pressure, cholesterol and asthma.

30 INSURANCE RISK MANAGEMENT REPORT (continued)

The risks associated to the Scheme with the types of benefits offered to members are addressed below:

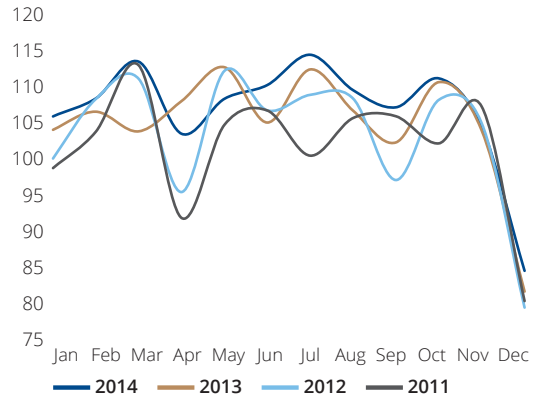
Hospital benefit risk

The main factors affecting the frequency and severity of hospital claims are the number of admissions and the cost per event. An increase in the frequency and severity of claims result in an increase in the cost of claims.

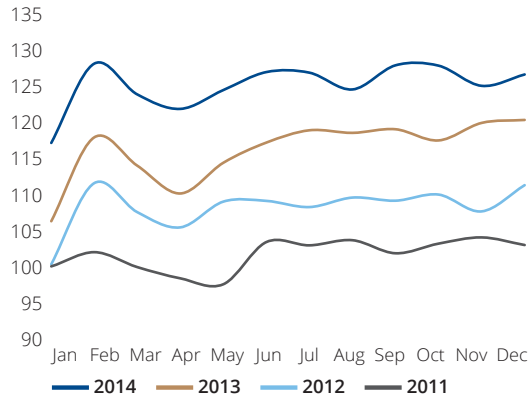
An increase in the admission rate is often linked to increases in the number of beneficiaries at older ages. The increase in cost per event is driven by annual tariff and other cost increases. An increased cost per event can also be caused by an increased case-mix, severity of admissions and the introduction of new hospital-based technologies.

The following graphs indicate the change in the admission rate over the past four years as well as the impact on the cost per event. These graphs are indexed to a value of 100 as at January 2011.

Hospital Admission Rate
(Indexed to Jan 2011 = 100)



Total Cost Per Event
(Indexed to Jan 2011 = 100)

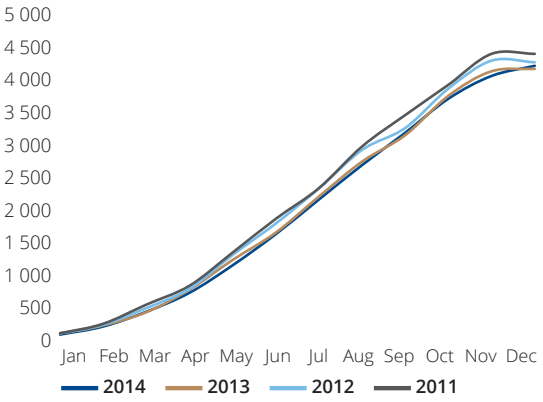


Day-to-day benefits risk

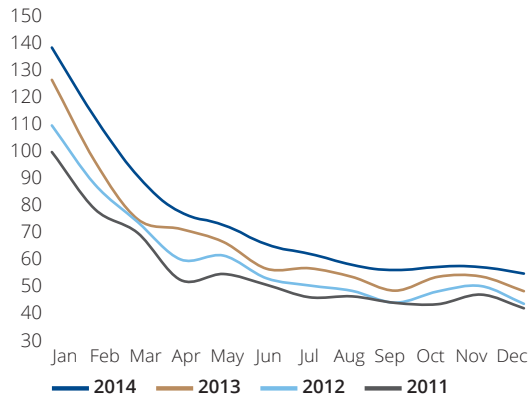
For the Above Threshold Benefit component, the frequency and severity of claims are driven by the number and disease burden of claimants. The mix of members between the different benefit options will also have an impact on the claims.

The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant. An increase in the cost of claims results from an increase in the frequency and/or severity of claims.

Claimants Per 1000 Beneficiaries From Above Threshold Benefits (Indexed to Jan 2011 = 100)



Cost Per ATB Claimant
(Indexed to Jan 2011 = 100)



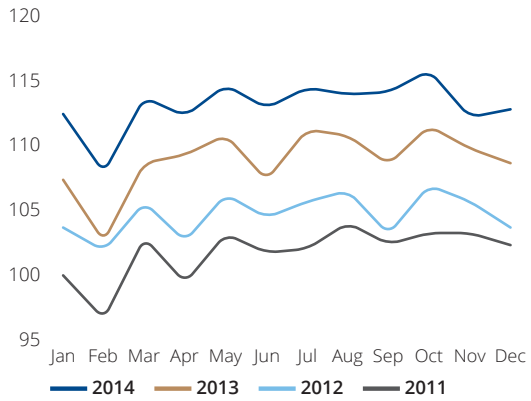
30 INSURANCE RISK MANAGEMENT REPORT (continued)

Chronic benefits risk

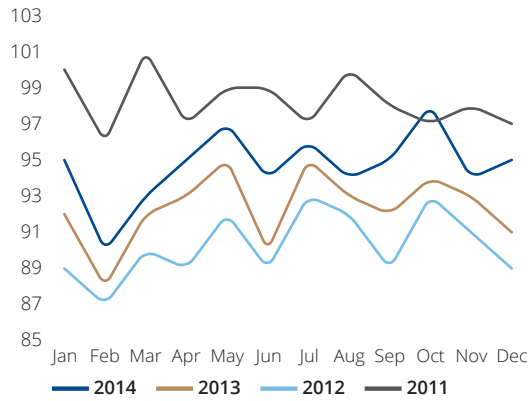
Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. Increases in the regulated prices for chronic medication, the Single Exit Price, will also result in an increase in costs per claim. The mix between the various chronic conditions will also have an impact on the frequency and severity of claims.

The following graphs indicate the change in the number of claimants over the past four years as well as the impact on the cost per claimant. These graphs are indexed to a value of 100 as at January 2011.

Chronic Claimants Per 1 000 Beneficiaries
(Indexed to Jan 2011 = 100)



Chronic Cost Per Claimant
(Indexed to Jan 2011 = 100)



Risk management

The Scheme has various initiatives that are used to manage the risks associated with claims experience. These include:

- Members have to be referred by a doctor prior to an elective admission.
- All hospital admissions have to be pre-authorised. There have also been amendments to the pre-authorisation length of stay benchmarks.
- Case managers monitor members with hospital stays that are longer than expected to ensure that members are discharged at appropriate times.
- The work of the Clinical Policy Unit, which evaluates the effectiveness of new technologies and recommends whether the Scheme should cover these.
- The development of protocols around various high-cost conditions, such as lower back surgery.
- The establishment of a unit to focus on reducing surgical consumable spend.
- The profiling of statistically significant outlier doctors on admission rate and generated costs as well as peer reviewing them.
- The establishment of the Coordinated Care Programme (CCP). This is a dedicated unit to ensure direct coordination of care from medical providers to high-risk beneficiaries that are exposed to conditions that would generate multiple admissions if not managed.
- The establishment of a disease management unit dedicated to managing high-risk beneficiaries with complex diseases.
- Alternative reimbursement contracts exist with hospitals to mitigate the risk of additional utilisation above that which is expected for the demographics of the Scheme and severity of admissions.
- The Scheme manages and mitigates the risks associated with chronic illness benefits through an extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, all of which comply with the Regulations on Prescribed Minimum Benefits. In addition, the Clinical Policy Unit is involved in evaluating the effectiveness of new drugs and recommends whether the Scheme should cover these drugs or not.

30 INSURANCE RISK MANAGEMENT REPORT (continued)

Concentration of insurance risk

As the largest open medical scheme in South Africa, the Scheme is not subject to a significant degree of concentration risk. The Scheme offers a wide range of benefit plans that meet a variety of members' needs. This results in the Scheme being representative of the medical scheme market and, as such, it experiences limited variability of the outcome.

An annual actuarial valuation is performed, which specifies the contribution to be charged in return for the benefits to be provided given the expected demographic profile of each benefit option.

Risk transfer arrangements

The Scheme has four risk transfer agreements in which suppliers are paid to provide certain minimum benefits to Scheme members, as and when it is required by the members. These arrangements in a way fix the cost to the Scheme of providing these benefits.

The first risk transfer arrangement covers in-hospital and out-of-hospital benefits for certain members on the KeyCare Plus and KeyCare Access plans. There are two arrangements providing optometry and dentistry services to members on the KeyCare Plus and KeyCare Access plans. The fourth arrangement covers the treatment for Executive and Comprehensive plan members diagnosed with diabetes (type I and II).

Risk in terms of risk transfer arrangements

The Scheme does, however, remain liable to its members to provide the benefits. If any supplier fails to meet the obligations of the risk transfer arrangement, the Scheme will cover the cost of the benefit.

When selecting a supplier, the Scheme assesses their ability to provide the relevant service. The Scheme also monitors the performance of the suppliers, assesses the quality of care provided and has access to data on the underlying fee-for-service claims that are included in the arrangement.

Claims development

Detailed claims development tables are not presented as the uncertainty regarding the amount and timing of claim payments is typically resolved within one year and in the majority of cases within three months. At year end, a provision is made for those claims outstanding that are not yet reported at that date.

The methodology followed in setting the outstanding claims provision is the generally accepted actuarial methodology of chain ladder estimation. This methodology is the most objective, but the accuracy of the estimate is sensitive to changes in the average time from treatment to payment of claims. For hospital claims in the latest service month, another method using the estimated cost per event and pre-authorised admissions is also followed.

The estimation of the December 2014 outstanding claims provision was made in accordance with Advisory Practice Note 304 of the Actuarial Society of South Africa. In accordance with this guidance note, the following factors are considered to determine whether they would have any impact on the outstanding claims provision estimate:

- The homogeneity of claims data
- The credibility of claims data
- Changes in emergence and settlement patterns
- The impact of seasonality
- The impact of re-opened or adjusted claims
- The impact of benefit limits and benefit changes
- External influences
- The demographic profile of the Scheme.

30 INSURANCE RISK MANAGEMENT REPORT (continued)

Concentration of insurance risk (continued)

Claims development (continued)

Based on the processing patterns and claims development up to the end of February 2015 in respect of treatment dates during 2014, the recommended provision for outstanding claims as at December 2014 is R846 million.

R'000	2014	2013
The total estimate of incurred claims and the provision for outstanding claims is as follows:		
Total estimate of incurred claims		
In-hospital claims incurred	**21 091 639**	18 592 142
Chronic claims incurred	**1 886 367**	1 721 699
Out-of-hospital risk claims incurred	**6 411 385**	5 748 318

The table below outlines the sensitivity of insured liability estimates to particular movements in assumptions used in the estimation process. It should be noted that this is a deterministic approach with no correlations between the key variables. For each sensitivity illustrated, all other assumptions have been left unchanged.

Impact on the outstanding claims provision and reported surplus caused by changes in key variables:

	Change in variable %	Impact on outstanding claims provision 2014 R'000	Impact on outstanding claims provision 2013 R'000
In-hospital claims incurred	1% increase in claims costs	**210 916**	185 921
Chronic claims incurred	1% increase in claims costs	**18 864**	17 216
Out-of-hospital risk claims incurred	1% increase in claims costs	**64 114**	57 483

Liquidity risk

The main component of the Scheme's insurance liabilities is the outstanding claims provision. These are generally settled in a short period of time; approximately 95% of this provision is settled within three months after the claim was incurred and the balance is settled within six months. The remaining insurance liabilities are generally settled within 30 days.

Assumption risk

The Scheme's profitability, reserves and therefore solvency are most sensitive to changes in claims development patterns. Another relevant assumption is medical inflation. Other assumptions that are considered include assumptions regarding utilisation trends, the impact of new technology and the expected demographic profile of the Scheme membership.

31 FINANCIAL RISK MANAGEMENT REPORT

Overview

The Scheme is exposed to financial risk through its financial assets, financial liabilities and insurance liabilities. In particular the financial risk is that the proceeds, for any reason, from its financial assets are not sufficient to fund the obligations arising from its insurance contracts. The most important components of financial risk include market risk, interest rate risk, credit risk and liquidity risk.

The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potential adverse effects on the Scheme's statutory solvency requirement.

The Board of Trustees has overall responsibility for the establishment and oversight of the Scheme's risk management framework.

The Scheme manages these risks through various risk management processes. These processes have been developed to ensure that the long-term investment return on assets supporting the insurance liabilities is sufficient to contribute towards funding members' reasonable benefit expectations.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Overview (continued)

The Scheme manages the financial risks as follows:

- The Investment Committee, a Committee of the Board of Trustees, determines, recommends, implements and maintains investment policies and procedures. The Investment Committee advises the Board of Trustees on the strategic and operating matters in respect of the investment of Scheme funds and meets at least quarterly.
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly.
- An external asset consulting company has been appointed to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the asset managers.
- Asset management agreements and mandates are concluded and reviewed by an external legal advisor.

Personal Medical Savings Account trust assets

These portfolios have been established to manage members' Personal Medical Savings Account balances in portfolios that are distinct and separate from the Scheme.

The Scheme appointed two asset managers, Momentum Asset Management and Taquanta Asset Managers, to manage the assets underlying the members' Personal Medical Savings Account balances. These portfolios are managed in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes.

Changes in the interest rates have no bearing on the Scheme's surplus or deficit as the investment income earned, net of fees, is allocated to the members' Personal Medical Savings Account balance. Consequently, no further analysis is presented.

Market risk

Market risk is the risk that changes in market variables, such as foreign exchange rates, interest rates and equity prices, will affect the Scheme's income or the value of its holdings in financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on risk.

The table below summarises the Scheme's financial assets at fair value through profit or loss exposure to market risk.

R'000	Total	Currency risk	Price risk	Interest rate risk
For the year ended 31 December 2014				
Investments	**9 474 520**			
Offshore bonds	**1 089 600**	✓		✓
Equities	**1 026 342**		✓	
Yield-enhanced bonds	**996 091**			✓
Inflation-linked bonds	**343 737**			✓
Money market instruments	**6 018 750**			✓

The Scheme's insurance liabilities are settled within one year and the Scheme does not discount insurance liabilities. Consequently changes in market interest rates would not affect the Scheme's surplus or deficit arising from changes in the insurance liability.

Currency risk

The majority of the Scheme's benefits are Rand-denominated and therefore the Scheme does not have significant net currency risk relating to benefits.

For the purpose of seeking investment diversification, the Scheme has invested 11% of its investments and cash in offshore bond portfolios. At 31 December 2014 this equates to R1 090 million (2013: R968 million) (Note 2).

- **Currency derivatives financial instruments (zero-cost currency collars)**

The Scheme entered into zero-cost currency collar arrangements with South African banks to hedge exposure to changes in foreign currency for investments in the offshore bond portfolios. The current contract expires during 2015 and was entered into with the cap around R12.60 to the US Dollar. The spot level (the floor) was entered into at around R11.60 to the US Dollar.

The collars are not designated as a hedge instrument and hedge accounting will not be applicable to the collars. The collars are categorised as fair value through profit or loss.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Currency risk (continued)

At the time of expiry the following transactions could occur depending on the rate at which the Rand is trading against the US Dollar:

- If the spot rate is higher than the cap, the Scheme would be required to pay the difference between the cap and the spot rate to the counterparty.
- If the spot rate is trading lower than the cap but higher than the floor, no action would take place.
- If the spot rate is trading lower than the floor, the counterparty would be required to pay the difference between the floor and the spot rate to the Scheme.

The fair value of these contracts has been included in financial assets. Gains and losses on these arrangements are included in the surplus (Note 7).

• Currency risk sensitivity analysis

A 5% depreciation in the Rand would result in a gain of R54 million and a 15% depreciation in the Rand would result in a gain of R163 million. A 5% appreciation in the Rand would result in a loss of R54 million and a 15% appreciation in the Rand would result in a loss of R163 million. This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that the Rand has strengthened or weakened against the US Dollar by 5% or 15%, with all other variables held constant. The analysis is performed without taking into account the effect of the currency hedges.

Price risk

The Scheme is exposed to equity securities price risk due to equity investments held by the Scheme that are classified as fair value through profit and loss. The Scheme is indirectly exposed to commodity risk through its investments in listed equities. The value of the equity investments was R1 billion (2013: R707 million) (Note 2).

The Scheme manages the price risk arising from investments in equity securities, through the diversification of its investment portfolios. Diversification of the portfolios is performed by asset managers in accordance with the mandate set by the Scheme.

The Scheme purchased derivative financial instruments to protect the solvency of the Scheme as a result of fluctuations in the equity market.

• Equity derivative financial instruments (zero-cost equity collars)

The Scheme entered into zero cost equity collar arrangements to hedge exposure to changes in market prices for investments in the equity portfolios. The contracts provide downside protection of up to 20% (the floor) after a reduction in equity prices of 5%. To achieve this, the Scheme agreed to forego upside benefit from an increase in equity prices above the pre-determined level (the cap). The cap for these contracts range between 12% and 13% above the pre-determined level. These contracts expire during 2015.

The fair value of these contracts has been included in financial assets. Gains and losses on these arrangements are included in the Net Surplus (Note 7).

At the time of expiry the following transactions could occur depending on the level at which the equity index trades:

- If the index level is higher than then cap, the Scheme would be required to pay the difference between the cap and the index level to the counterparty.
- If the index level is trading lower than the cap but higher than the floor, no action would take place.
- If the index level is trading lower than the floor, the counterparty would be required to pay the difference between the floor and the index level to the Scheme.

• Equity price risk sensitivity analysis

A 5% increase in the price of equities within the equity portfolios would result in a gain of R55 million and a 15% increase would result in a gain of R164 million. A 5% decrease would result in a loss of R55 million and a decrease of 15% would result in a loss of R164 million. This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that equity prices had increased or decreased by 5% or 15%, with all other variables held constant. The analysis is performed without taking into account the effect of the equity hedges.

In the event that stock markets perform particularly well during 2014, the equity hedge collar will dampen the increase on the instruments in the portfolios. The Scheme may not therefore experience the full market escalation – this is the cost of the downside protection.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Interest rate risk

The Scheme is exposed to interest rate risk as it places funds in short-dated investments, money market accounts and bonds. The risk is managed by maintaining an appropriate mix between fixed and floating rate investments within the Scheme's money market investment portfolio as well as additional fixed and call deposit investments.

The table summarises the Scheme's exposure to interest rate risks. Included in the table are the Scheme's investments at carrying amounts, categorised by the earlier of contractual repricing or maturity dates.

As at 31 December 2014	0 – 3 Months R'000	3 – 12 Months R'000	> 12 Months R'000	Total R'000
Cash and cash equivalents	**2 494 480**	**–**	**–**	**2 494 480**
Money market instruments carried at fair value through profit or loss	**–**	**6 018 750**	**–**	**6 018 750**
Yield-enhanced bonds carried at fair value through profit or loss	**–**	**996 091**	**–**	**996 091**
Inflation-linked bonds carried at fair value through profit or loss	**–**	**343 737**	**–**	**343 737**
Offshore bonds carried at fair value through profit or loss	**–**	**1 089 600**	**–**	**1 089 600**

As at 31 December 2013	0 – 3 Months R'000	3 – 12 Months R'000	> 12 Months R'000	Total R'000
Cash and cash equivalents	2 829 974	–	–	2 829 974
Money market instruments carried at fair value through profit or loss	–	5 053 524	–	5 053 524
Yield-enhanced bonds carried at fair value through profit or loss	–	879 120	–	879 120
Offshore bonds carried at fair value through profit or loss	–	967 571	–	967 571

The following table summarises the effective interest rate for monetary financial instruments:

%	2014	2013
Money market instruments carried at fair value through profit or loss	**5,86**	6,62
Cash and cash equivalents	**5,33**	4,76

The weighted average effective interest rate on short-term bank deposits (namely call account deposits) was 5.71% (2013 – 5.02%). These deposits have an average maturity of 25 days (2013 – 28 days).

Interest rate risk sensitivity analysis

A 5% increase in local interest rates would result in a loss of R15 million and a 15% increase would result in a loss of R44 million. A 5% decrease in local interest rates would result in a gain of R15 million and a decrease of 15% would result in a gain of R44 million. This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that local interest rates had increased or decreased by 5% or 15%, with all other variables held constant.

A 5% increase in foreign interest rates would result in a loss of R4 million and a 15% increase would result in a loss of R11 million. A 5% decrease in foreign interest rates would result in a gain of R4 million and a decrease of 15% would result in a gain of R11 million. This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that foreign interest rates had increased or decreased by 5% or 15%, with all other variables held constant.

The majority of the Scheme's assets are invested in variable interest rate instruments, with a significant portion of the fixed rate instruments maturing in the short-term. As a result, interest rate changes are not expected to have a material impact on the valuation of Scheme assets.

Legal risk

Legal risk is the risk that the Scheme will be exposed to contractual obligations that have not been provided for. At 31 December 2014 the Scheme did not consider there to be any significant concentration of legal risk that had not been provided for.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Fair value estimation

The fair value of financial instruments traded in active markets is based on quoted market prices at the reporting date. The quoted market price used for financial assets held by the Scheme is the current closing price.

The fair value of financial instruments that are not traded in an active market (for example, investments in pooled funds and collective investment schemes) is determined by using valuation techniques. These valuation techniques maximise the use of observable market data where it is available and rely as little as possible on entity-specific estimates. Specific valuation techniques used to value financial instruments include quoted market prices or dealer quotes for similar instruments.

The carrying value, less impairment provision of trade receivables, and payables are assumed to approximate their fair values due to their short-term nature.

The members' Personal Medical Savings Accounts contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's Personal Medical Savings Account must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit plan, and enrols in another benefit plan or medical scheme without a savings account or does not enrol in another medical scheme. Therefore the carrying values of the members' Personal Medical Savings Accounts are deemed to be equal to their fair values, which is the amount payable on demand.

Capital management

The Scheme is subject to the capital requirement imposed by Regulation 29 (2) of the Act, which requires a minimum solvency ratio of accumulated funds expressed as a percentage of gross contributions to be 25%.

The Scheme's objectives when managing capital are to maintain the capital requirements of the Act, and to safeguard the Scheme's ability to continue as a going concern in order to provide benefits for its stakeholders.

The calculation of the regulatory capital requirement is set out below.

R'000	2014	2013
Total members' funds per Statement of Financial Position	**11 652 804**	9 970 118
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**(85 833)**	(136 666)
Accumulated funds per Regulation 29	**11 566 971**	9 833 452
Gross contribution income	**44 905 716**	40 463 701
Solvency margin = Accumulated funds/gross contribution income x 100	**25,76%**	24,30%

At 31 December 2014, the Scheme's regulatory capital level of 25.76% was R341 million more than the statutory capital requirement of 25%.

Investment risk

Investment risk is the risk that the investment returns on accumulated assets will not be sufficient to cover future liabilities. Continuous monitoring takes place to ensure that appropriate assets are held where the Scheme's liabilities are dependent upon the performance of the investment portfolio and that a suitable match of assets exists for all liabilities.

The Scheme's Investment Committee invests excess funds in line with the Act.

The Scheme's investment objectives are to maximise the return on its investments on a long-term basis at minimal risk, subject to any constraints imposed by legislation or the Board of Trustees. The Scheme diversifies its investment portfolio by investing in short-term deposits, bond, money market and equity portfolios managed by reputable asset managers.

The Investment Committee monitors the performance of the Scheme's asset managers to ensure that the Scheme receives the benefit of top performing asset managers.

To assist the Regulator in monitoring the Scheme's compliance with Annexure B of the Act, the Scheme submits detailed investment schedules to the Council for Medical Schemes, supplemented by the Scheme's asset manager's reports on a quarterly basis.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Investment risk (continued)

Breakdown of investments

The investments managed by the Investment Committee are split between the following in the Annual Financial Statements:

- Investments carried at fair value through profit and loss
- Cash and cash equivalents.

R'000	Segregated funds	Collective investment schemes	Policy of insurance	Total
For the year ended 31 December 2014				
Investments	**8 384 920**	**564 321**	**525 279**	**9 474 520**
Offshore bonds	**–**	**564 321**	**525 279**	**1 089 600**
Equities	**1 026 342**	**–**	**–**	**1 026 342**
Yield-enhanced bonds	**996 091**	**–**	**–**	**996 091**
Inflation-linked bonds	**343 737**	**–**	**–**	**343 737**
Money market instruments	**6 018 750**	**–**	**–**	**6 018 750**
Cash and cash equivalents:	**112 088**	**1 766 707**	**–**	**1 878 795**
Money market instruments	**112 088**	**1 766 707**		**1 878 795**
	8 497 008	**2 331 028**	**525 279**	**11 353 315**

Money market portfolios:

Local portfolios:

The two local money market portfolios are each managed by an independent asset manager. The investment mandate is for an actively managed portfolio of financial products aimed at achieving outperformance of the targeted return.

The investment mandates are subject to the provisions of the Act.

For the one portfolio, the weighted modified duration of the portfolio will not exceed 180 days. The weighted term to maturity of the portfolio will not exceed 2 years. The term of each individual instrument is also limited.

The second portfolio has a number of liquidity restrictions, ranging from a minimum of 20% of the assets under administration being available within 24 hours to an average portfolio duration of 180 days.

The performance of these portfolios is measured against the Short Term Fixed Income (STeFI) Composite Index.

The local money market portfolios comprise approximately 64% of the Scheme's Financial assets at fair value through profit or loss.

Bond portfolios:

Local portfolios:

The one portfolio invests in a broad spectrum of listed and unlisted fixed income instruments. The instruments are typically investment grade and include, but are not limited to, asset types such as listed bonds, credit-linked notes, floating rate notes, interest rate swaps and bond futures. This portfolio is managed by an independent asset manager. The benchmark for this portfolio is the Johannesburg Interbank Agreed Rate (JIBAR) over a period of one year.

The second portfolio is a specialist yield-enhanced bond portfolio investing in a broad spectrum of fixed interest and yield-enhanced debt instruments. This portfolio is managed by an independent asset manager. The benchmark for this portfolio is 20% BEASSA All Bond Index (ALBI) and 80% STeFI.

The mandates set specific exposure limits depending on the credit rating of the individual counterparty and sets exposure limits to unrated investments.

These portfolios comprise approximately 10% of the Scheme's Financial assets at fair value through profit or loss.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Breakdown of investments (continued)

Offshore portfolio:
The Scheme has two offshore portfolios managed by independent asset managers. The primary objective of the first portfolio is the generation of a high-level of income by means of investments in high-yielding-fixed or floating rate securities of varying maturities denominated in a spread of currencies.

The investment mandate is subject to any applicable exchange control regulations and the provisions of the Act. The portfolio complies with the requirements of the Luxembourg law of 20 December 2002 relating to collective investment undertakings.

The benchmark for this portfolio is a Composite Global Strategic Income Bond Index, comprising of the different areas in which the manager may invest.

The primary objective of the second portfolio is the long-term growth of capital and income and is a policy of insurance referencing participatory interests in a foreign collective investment scheme portfolio investing in fixed income instruments. The benchmark for this portfolio is the Barclays Capital Global Aggregate.

These portfolios comprise approximately 11% of the Scheme's Financial assets at fair value through profit or loss.

Inflation-linked bonds:
The Scheme has two inflation-linked bond portfolios, each managed by an independent asset manager. The primary mandate of the first portfolio is aimed at generating inflation-linked bond returns on initial capital invested and achieving outperformance of the benchmarks on the JSE Composite Inflation-Linked Index (CILI). The Scheme does not place any restrictions on its asset managers who should invest at their own discretion within the investment strategy.

The second portfolio is a fully discretionary, actively managed portfolio of inflation-linked and fixed income instruments. The portfolio only invests funds in domestic instruments. The returns of the portfolio will be measured against the JSE Bond Exchange and Actuarial Society of South Africa (JSE BEASSA IGOV Index).

These portfolios comprise approximately 3% of the Scheme’s Financial assets at fair value through profit or loss.

Equity portfolios:
The Scheme has three equity portfolios, each managed by an independent asset manager.

The primary goal is to maximise long-term investment performance with due regard to the relevant risks, including volatility of returns, risk of capital loss and liquidity. The portfolios are managed on a moderate risk basis.

The portfolios may only be invested in South African equities and are subject to a maximum cash allocation of 5%. The portfolios are prohibited from investing in Discovery Limited or its subsidiaries and must comply with the Act.

The performance for the portfolios is the FTSE/JSE Shareholder weighted index (SWIX).

These portfolios comprise approximately 11% of the Scheme’s Financial assets at fair value through profit or loss.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Investment risk (continued)

Breakdown of investments (continued)

The following table compares the fair value and carrying amounts of financial assets and liabilities per class of assets and liabilities.

For the year ended 31 December 2014	Financial assets and liabilities at fair value through profit and loss		Loans and receivables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
	Designated upon initial recognition R'000	Classified as held for trading R'000	R'000	R'000	R'000	R'000	R'000
Investments							
– Offshore bonds	**1 089 600**	**–**	**–**	**–**	**–**	**1 089 600**	**1 089 600**
– Listed equities	**1 026 342**	**–**	**–**	**–**	**–**	**1 026 342**	**1 026 342**
– Yield-enhanced bonds	**996 091**	**–**	**–**	**–**	**–**	**996 091**	**996 091**
– Inflation-linked bonds	**343 737**	**–**	**–**	**–**	**–**	**343 737**	**343 737**
– Money market instruments	**6 018 750**	**–**	**–**	**–**	**–**	**6 018 750**	**6 018 750**
Cash and cash equivalents:							
Medical Scheme assets	**–**	**–**	**2 494 480**	**–**	**–**	**2 494 480**	**2 494 480**
Personal Medical Savings Account trust assets			**3 188 789**			**3 188 789**	**3 188 789**
Trade and other receivables	**–**	**–**	**120 894**	**1 483 656**	**–**	**1 604 550**	**1 604 550**
Personal Medical Savings Accounts	**–**	**–**	**–**	**(3 250 743)**	**–**	**(3 250 743)**	**(3 250 743)**
Trade and other payables	**–**	**–**	**–**	**(523 843)**	**(507 396)**	**(1 031 239)**	**(1 031 239)**
Derivatives held for trading							
– Zero-cost collars	**–**	**(29 490)**	**–**	**–**	**–**	**(29 490)**	**(29 490)**
– Other	**–**	**46 221**	**–**	**–**	**–**	**46 221**	**46 221**
	9 474 520	**16 731**	**5 804 163**	**(2 290 930)**	**(507 396)**	**12 497 088**	**12 497 088**

For the year ended 31 December 2013	Financial assets and liabilities at fair value through profit and loss		Loans and receivables	Insurance receivables and (payables)	Financial liabilities at amortised cost	Total carrying amount	Fair value amount
	Designated upon initial recognition R'000	Classified as held for trading R'000	R'000	R'000	R'000	R'000	R'000
Investments							
– Offshore bonds	967 571	–	–	–	–	967 571	967 571
– Listed equities	706 870	–	–	–	–	706 870	706 870
– Yield-enhanced bonds	879 120	–	–	–	–	879 120	879 120
– Money market instruments	5 053 524	–	–	–	–	5 053 524	5 053 524
Cash and cash equivalents:							
Medical Scheme assets	–	–	2 829 974	–	–	2 829 974	2 829 974
Personal Medical Savings Account trust assets			2 619 305			2 619 305	2 619 305
Trade and other receivables	–	–	100 207	1 397 714	–	1 497 921	1 497 921
Personal Medical Savings Accounts	–	–	–	(2 776 720)	–	(2 776 720)	(2 776 720)
Trade and other payables	–	–	–	(616 860)	(356 680)	(973 540)	(973 540)
Derivatives held for trading							
– Zero-cost collars	–	13 352	–	–	–	13 352	13 352
– Other	–	(36 787)	–	–	–	(36 787)	(36 787)
	7 607 085	**(23 435)**	**5 549 486**	**(1 995 866)**	**(356 680)**	**10 780 590**	**10 780 590**

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Fair value hierarchy for financial assets measured at fair value

Assets measured at fair value

2014		Fair value measurement at end of the year using:	
	R'000	**Level 1 R'000**	**Level 2 R'000**
Financial assets at fair value through profit or loss:			
Equities	**1 026 365**	**1 026 342**	**23**
Government bonds	**1 422 111**	**901 718**	**520 393**
Corporate bonds	**4 329 899**	**2 251 889**	**2 078 010**
Money market instruments	**1 869 998**	**9 676**	**1 860 322**
Other investments	**826 147**	**612 711**	**213 436**
	9 474 520	**4 802 336**	**4 672 184**

2013		Fair value measurement at end of the year using:	
	R'000	Level 1 R'000	Level 2 R'000
Financial assets at fair value through profit or loss:			
Listed equities	706 870	706 870	–
Government bonds	569 908	569 908	–
Corporate bonds	6 270 103	–	6 270 103
Other investments	60 204	–	60 204
	7 607 085	**1 276 778**	**6 330 307**

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements.

The fair value hierarchy has the following levels:
Level 1 – These are assets measured using quoted prices in an active market.
Level 2 – These are assets measured using inputs other than quoted prices included within Level 1, that are either directly or indirectly observable.
Level 3 – These are assets measured using inputs that are not based on observable market data. The Scheme does not have any assets falling under Level 3.

The table below details the valuation techniques and observable inputs for assets falling under Level 2:

Description	**Fair value as at 31 December 2014**	**Valuation techniques**	**Observable input**
Financial assets at fair value through profit or loss:			
Unlisted:			
Debt securities	2 598 403	Reference to listed benchmark bond	Risk-free yield to maturity curve, risk-free zero curve
Money market securities	1 860 322	Discounted cash flow valuation, Black-Scholes model	Published exchange swap curve, published interest rate curve, published credit spread curve/implied credit spread curve, risk-free yield to maturity curve, risk-free zero curve, swap yield to maturity curve, swap zero curve
Other investments	213 459	Reference to listed benchmark bond	Risk-free yield to maturity curve, risk-free zero curve
	4 672 184		

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Fair value hierarchy for financial assets measured at fair value

Assets measured at fair value (continued)

Credit risk

Credit risk is the risk of financial loss to the Scheme, if a counterparty to a financial instrument fails to meet its contractual obligations.

Key areas where the Scheme is exposed to credit risk are:

Trade and other receivables comprising of insurance receivables and loans and receivables. The main components of insurance receivables are in respect of contributions due from members and amounts recoverable from members in respect of claims debt. The Scheme has exposure from its loans and receivables.

Financial assets are valued at fair value through profit or loss. These assets comprise money market and bond instruments entered into to fund the obligations arising from its insurance contracts and to invest surplus funds to maintain the statutory solvency requirement. The Scheme is exposed to the issuer's credit standing on these instruments. Exposure to credit risk is monitored and minimum credit ratings for these investments are set. Reputable asset managers have been appointed to manage these instruments. Information regarding the aggregated credit risk exposure is provided on page 110.

Cash and cash equivalents comprise cash deposits in financial institutions. The risks associated with these deposits are managed by monitoring the Scheme's exposure to external financial institutions against approved deposit limits per institution. Information regarding the credit quality of cash and cash equivalents is provided on page 110.

Trade and other receivables

The Scheme's Trade and other receivables at 31 December comprise:

R'000	Note	2014	2013
Insurance receivables	3	**1 483 656**	1 397 714
Contribution receivables[1]		**1 399 772**	1 322 098
Less provision for impairment		**(7 105)**	(5 734)
Member and service provider claims receivables[2]		**235 639**	224 878
Less provision for impairment		**(177 458)**	(171 956)
Recoveries due from other risk transfer arrangements		**179**	111
Share of outstanding claims provision (Note 6)		**2 505**	2 490
Broker fee receivables		**668**	570
Less provision for impairment		**(600)**	(426)
Other insurance receivables		**30 056**	25 683
Loans and receivables	3	**120 894**	100 207
Balance due by related parties		**9 557**	13 191
Sundry accounts receivables		**110 142**	85 661
Interest receivable		**1 195**	1 355
Total		**1 604 550**	1 497 921

1 *Contribution receivables are not credit rated by the Scheme as exposure to any single member is insignificant. Contribution receivables comprise amounts receivable from individuals and corporates and are collected by means of debit orders or cash payments. They are actively pursued if not received within three days of becoming due. Benefits are suspended on member accounts when contributions have not been received for 30 days and benefits are terminated when contributions have not been received for 60 days.*

2 *Member and service provider claim receivables are amounts recoverable in respect of claims debt. They are not credit rated by the Scheme as exposure to any single party is insignificant. Member receivables are separated between active and withdrawn members. Where amounts due by withdrawn members remain uncollected for more than 150 days, the debtors are then handed to specialist debt collection agencies.*

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk

The carrying amount of Trade and other receivables represents the maximum credit exposure.

The Scheme ages and pursues unpaid accounts on a monthly basis. The tables below highlight insurance receivables within Trade and other receivables which are due, past due (by number of days) and impaired.

Contribution debtors	Gross 2014 R'000	Impairment 2014 R'000	Gross 2013 R'000	Impairment 2013 R'000
Not past due	**1 385 549**		1 311 926	
Past due 4 – 30 days not impaired	**15 937**		6 111	
Past due 31 – 60 days not impaired	**(5 202)**		17 169	
Past due 61 – 90 days not impaired	**808**		(13 265)	
91 days to more than one year	**2 680**		157	
Total	**1 399 772**	**(7 105)**	**1 322 098**	**(5 734)**

Total member and service provider claims debtors	Gross 2014 R'000	Impairment 2014 R'000	Gross 2013 R'000	Impairment 2013 R'000
Not past due	**–**		–	
Past due 0 – 30 days not impaired	**17 054**		18 339	
Past due 31 – 60 days not impaired	**2 088**		9 987	
Past due 61 – 90 days not impaired	**3 638**		11 399	
Past due 91 – 120 days not impaired	**18 432**		3 514	
Past due 121 – 150 days not impaired	**4 539**		12 840	
151 days to more than one year	**189 888**		168 800	
Total	**235 639**	**(177 458)**	**224 878**	**(171 956)**

Active member claims debtors	Gross 2014 R'000	Impairment 2014 R'000	Gross 2013 R'000	Impairment 2013 R'000
Not past due	**–**		–	
Past due 0 – 30 days not impaired	**1 544**		3 346	
Past due 31 – 60 days not impaired	**1 857**		1 847	
Past due 61 – 90 days not impaired	**1 710**		1 769	
Past due 91 – 120 days not impaired	**2 110**		1 811	
Past due 121 – 150 days not impaired	**1 911**		1 450	
151 days to more than one year	**31 193**		27 787	
Total	**40 325**	**(18 358)**	**38 011**	**(17 005)**

Withdrawn member claims debtors	Gross 2014 R'000	Impairment 2014 R'000	Gross 2013 R'000	Impairment 2013 R'000
Not past due	**–**		–	
Past due 0 – 30 days not impaired	**3 163**		7 715	
Past due 31 – 60 days not impaired	**4 730**		4 973	
Past due 61 – 90 days not impaired	**5 999**		6 307	
Past due 91 – 120 days not impaired	**7 562**		7 211	
Past due 121 – 150 days not impaired	**6 466**		6 934	
151 days to more than one year	**151 015**		136 216	
Total	**178 935**	**(145 308)**	**169 355**	**(142 327)**

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk (continued)

Service provider claims debtors	Gross 2014 R'000	Impairment 2014 R'000	Gross 2013 R'000	Impairment 2013 R'000
Not past due	–		–	
Past due 0 – 30 days not impaired	**12 347**		7 277	
Past due 31 – 60 days not impaired	**(4 499)**		3 168	
Past due 61 – 90 days not impaired	**(4 071)**		3 323	
Past due 91 – 120 days not impaired	**8 761**		(5 509)	
Past due 121 – 150 days not impaired	**(3 838)**		4 456	
151 days to more than one year	**7 679**		4 797	
Total	**16 379**	**(13 792)**	**17 512**	**(12 623)**

Other risk transfer arrangements	Gross 2014 R'000	Impairment 2014 R'000	Gross 2013 R'000	Impairment 2013 R'000
Not past due	**2 684**		2 601	
Past due 0 – 30 days not impaired	**–**		–	
Past due 31 – 60 days not impaired	**–**		–	
Past due 61 – 90 days not impaired	**–**		–	
Past due 91 – 120 days not impaired	**–**		–	
Past due 121 – 150 days not impaired	**–**		–	
151 days to more than one year	**–**		–	
Total	**2 684**	**–**	**2 601**	**–**

Broker fee debtors	Gross 2014 R'000	Impairment 2014 R'000	Gross 2013 R'000	Impairment 2013 R'000
Not past due	**–**		–	
Past due 0 – 30 days not impaired	**91**		219	
Past due 31 – 60 days not impaired	**164**		–	
Past due 61 – 90 days not impaired	**(150)**		(23)	
Past due 91 – 120 days not impaired	**97**		81	
Past due 121 – 150 days not impaired	**14**		351	
151 days to more than one year	**452**		(57)	
Total	**668**	**(600)**	**571**	**(426)**

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk (continued)

Provision for impairment

The Scheme establishes an allowance for impairment that represents its estimate of incurred losses in respect of Trade and other receivables. The provision is based on the expected difference between the current carrying amount and the amount recoverable from the counterparty.

The main components of this provision are:

- A specific loss component that relates to individually significant exposures
- A collective loss component established for groups of similar assets in respect of losses that have been incurred but not yet identified.

The collective loss allowance is determined based on historical data of payment statistics for similar financial assets.

The movement in the provision for impairment, for each component of Trade and other receivables, during the year ended 31 December:

	Trade and other receivables				
	Insurance receivables				
R'000	Contribution debtors	Member and service provider claims debtors	Other risk transfer arrangements	Broker fee debtors	Total
Balance as at 1 January 2013	3 878	151 508	–	341	155 727
Increase in provision for impairment	1 856	48 711	–	84	50 651
Amounts utilised during the year	–	(28 263)	–	–	(28 263)
Balance as at 31 December 2013	5 734	171 956	–	425	178 115
Balance as at 1 January 2014	**5 734**	**171 956**	**–**	**425**	**178 115**
Increase in provision for impairment	**1 371**	**54 085**	**–**	**174**	**55 630**
Amounts utilised during the year	**–**	**(48 583)**	**–**	**1**	**(48 582)**
Balance as at 31 December 2014	**7 105**	**177 458**	**–**	**600**	**185 163**

Based on past experience, the Scheme believes that no provision for impairment is required in respect of Contribution debtors that are past due and outstanding for less than 90 days. For member and service provider claims debtors and broker fee debtors that are past due and outstanding for less than 180 days, past experience has indicated that no provision is required. The Scheme has not renegotiated the terms of receivables and does not hold any collateral or guarantees as security.

Credit quality

The credit quality of Trade and other receivables that are neither past due nor impaired can be assessed by reference to historical information about counterparty default:

R'000	2014	2013
Insurance receivables		
Counterparties without external credit rating net of provision for impairment:		
Contribution debtors	**1 392 667**	1 316 364
Member and service provider claim debtors	**58 181**	52 923
Active member claim debtors	**21 967**	21 006
Withdrawn member claim debtors	**33 627**	27 028
Service provider claim debtors	**2 587**	4 889
Other risk transfer arrangements	**2 684**	2 601
Broker fee debtors	**68**	144
Other insurance receivables	**30 056**	25 683
	1 483 656	**1 397 714**

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Contribution debtors

The Scheme collected over 97% (2013: 97%) of outstanding debt in January 2015. Therefore we can reasonably establish that the credit quality of contribution debtors is high. Consequently no additional disclosure of the credit quality is provided.

Active member claims debtors

These debtors are current members of the Scheme and are expected to have similar credit quality to the Contribution debtors. A provision for impairment covering 46% (2013: 45%) of the debtors has been raised.

Withdrawn member claims debtors

These amounts are due from members that have withdrawn from the Scheme. A provision for impairment covering 81% (2013: 84%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Other insurance receivables

Other insurance debtors mainly comprises of amounts due by hospitals, which are inherently of high quality. As agreed with the providers the majority of these receivables are recovered by reducing future provider payments, providing a high certainty of recoverability and no further analysis will be performed on these receivables.

Financial assets held at fair value through profit or loss

The Scheme's Financial assets held at fair value through profit or loss as at 31 December comprise:

R'000	2014	2013
Financial assets held at fair value through profit or loss		
Current assets		
− Offshore bonds	**1 089 600**	967 571
− Listed equities	**1 026 342**	706 870
− Yield-enhanced bonds	**996 091**	879 120
− Inflation-linked bonds	**343 737**	–
− Money market instruments	**6 018 750**	5 053 524
	9 474 520	**7 607 085**

The fair value of the listed equities has been determined by reference to quoted stock exchanges.

The Scheme has assessed whether any of the financial assets are impaired. Based on the risk management measures undertaken by the Scheme, there is no objective evidence that any financial assets are impaired below the fair market value stated above.

Exposure to credit risk

Derivative counterparties and cash transactions are limited to high credit quality financial institutions. The Scheme has a policy of limiting the amount of credit exposure to any one financial institution.

The Scheme manages credit risk through the appointment of reputable and appropriate asset managers, extensive diversification and ongoing monitoring and management of credit risk exposures and portfolio holdings.

Annexure B of the Regulations to the Act prescribes the limits per institution, which reduces the individual risk per institution. For institutions with lower credit ratings the Scheme has set specific exposure limits. The utilisation of credit limits is regularly monitored.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Credit quality

Credit rating scales

Credit ratings provide an opinion on the relative ability of an entity to meet its financial commitments, such as interest, dividends or the repayment of capital invested. They are used as indications of the likelihood of receiving the amounts owed in accordance with the terms on which they were invested.

Definitions of the symbols are presented below.

Short-term rating scales

F1: Highest short-term credit quality

F1 indicates the strongest intrinsic capacity for timely payment of financial commitments; they may have an added "+" to denote any exceptionally strong credit feature.

Long-term rating scales

AAA: Highest credit quality

AAA ratings denote the lowest expectation of default risk and are assigned only in cases of exceptionally strong capacity for payment of financial commitments. This capacity is highly unlikely to be adversely affected by foreseeable events.

AA: Very high credit quality

AA ratings denote expectations of very low default risk and indicate very strong capacity for payment of financial commitments. This capacity is not significantly vulnerable to foreseeable events.

A: High credit quality

A ratings denote expectations of low default risk. The capacity for payment of financial commitments is considered strong. This capacity may, nevertheless, be more vulnerable to adverse business or economic conditions than is the case for higher ratings.

BBB: Good credit quality

BBB ratings indicate that expectations of default risk are currently low. The capacity for payment of financial commitments is considered adequate but adverse business or economic conditions are more likely to impair this capacity.

In 2014 1.9% (2013: 1.1%) of the Scheme's Financial assets at fair value through profit or loss invested in instruments with this credit rating.

BB: Speculative

BB ratings indicate an elevated vulnerability to default risk, particularly in the event of adverse changes in business or economic conditions over time; however, business or financial flexibility exists which supports the servicing of financial commitments.

In 2014 0.5% (2013: 0.3%) of the Scheme's Financial assets at fair value through profit or loss invested in instruments with this credit rating.

B: Highly speculative

B ratings indicate that material default risk is present, but a limited margin of safety remains. Financial commitments are currently being met; however, capacity for continued payment is vulnerable to deterioration in the business and economic environment.

In 2014 1.2% (2013: 0.2%) of the Scheme's Financial assets at fair value through profit or loss invested in instruments with this credit rating.

CCC: Possibility of default

Obligations for which there is a current perceived possibility of default.

Timely repayment of principal and interest is dependent on favourable business economic or financial conditions.

In 2014 2% (2013: 0.02%) of the Scheme's financial assets at fair value through profit or loss invested in instruments with this credit rating.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Credit quality (continued)

	Short-term rating			Long-term rating								
R'000	Total	F1+	F1	Govt	AAA	AA+ to AA-	A+ to A-	BBB- to BBB+	BB- to BB+	B- to B+	CCC+ to CCC-	Not rated
2014 At fair value through profit or loss:	**8 449 795**	**1 067 938**	**55 931**	**392 089**	**857 136**	**1 134 454**	**4 126 723**	**128 044**	**50 190**	**194 431**	**188 351**	**254 509**
– Offshore bonds	**1 089 601**	**93 410**	**4 307**	**47 858**	**197 532**	**193 049**	**247 077**	**52 753**	**48 857**	**102 235**	**9 462**	**93 060**
– Yield-enhanced bonds	**996 091**	**13 584**	**1**	**52 348**	**169 879**	**214 164**	**265 751**	**18 156**	**1 332**	**91 688**	**7 740**	**161 448**
– Inflation-linked bonds	**343 737**	**7 524**	**–**	**189 329**	**–**	**–**	**146 884**	**–**	**–**	**–**	**–**	**–**
– Money market instruments	**6 020 367**	**953 420**	**51 623**	**102 553**	**489 726**	**727 241**	**3 467 012**	**57 135**	**–**	**508**	**171 149**	**–**
Cash and cash equivalents	**2 492 863**	**604 793**	**80 007**	**–**	**7 275**	**677 843**	**1 067 612**	**2 512**	**–**	**–**	**26 207**	**26 614**
Total	**10 942 659**	**1 672 730**	**135 938**	**392 089**	**864 412**	**1 812 297**	**5 194 335**	**130 556**	**50 190**	**194 431**	**214 558**	**281 122**
2013 At fair value through profit or loss:	6 900 215	70 839	13 837	569 908	697 569	3 937 694	1 304 707	–	–	144 971	1 995	158 695
– Offshore bonds	967 571	–	–	287 350	1 951	471 671	26 591	–	–	111 094	1 995	66 919
– Yield-enhanced bonds	879 120	–	–	130 550	139 970	243 991	238 956	–	–	33 877	–	91 776
– Money market instruments	5 053 524	70 839	13 837	152 008	555 648	3 222 032	1 039 160	–	–	–	–	–
Cash and cash equivalents	2 829 974	760 690	137 000	–	30 978	1 724 491	152 821	–	–	56	–	23 938
Total	9 730 190	831 529	150 837	569 908	728 547	5 662 185	1 457 528	–	–	145 027	1 995	182 633

The cash and cash equivalents for 2013 have been restated to exclude Personal Medical Savings Account trust assets of R2.6 billion, as these do not form part of the Scheme's financial assets.

During the year under review, the credit rating of certain institutions was reviewed and subsequently downgraded.

The Scheme's investments in pooled funds and collective investment schemes ("funds") are subject to the terms and conditions of the respective funds' offering documentation and are susceptible to market price risk arising from uncertainties about future values of those funds. The investment manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying funds' managers. All of the funds in the investment portfolio are managed by portfolio managers who are compensated by the respective funds for their services. Such compensation generally consists of an asset-based fee and a performance-based incentive fee and is reflected in the valuation of the investment in each of the funds.

These investments are included in financial assets at fair value through profit or loss in the statement of financial position and no other risks relating to these investments have been identified other than those already disclosed in previous sections of this report.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Credit quality (continued)

The exposure to investments in the funds at fair value, by strategy employed, is disclosed in the following table:

Name and description	2014 R'000	Authorised programme/ market size	% of authorised programme/ market size	Fair value hierarchy	Debt ranking	Credit ranking	Underlying assets
Asset-backed commercial paper	1	R25 billion	0,00	Level 1 – 56% Level 2 – 44%	Senior secured	AA: 90.37% F1+: 9.63%	Instalment sales agreements Corporate loans Credit card receivables bonds Equipment leases
Residential mortgage-backed securitisations	352 004	R48.7 billion	0,72	Level 1 – 100%	Senior secured	A to AAA: 98.18% BBB-: 1.82%	Prime home loans
Asset-backed securitisations	229 717	R27.0 billion	0,85	Level 1 – 42% Level 2 – 58%	Senior secured	A to AAA: 80.77% BB: 0.58% CCC: 4.12 Not rated: 14.53%	Vehicle loans Corporate loans Unsecured loans Equipment leases
Commercial mortgage-backed securitisations	51 516	R2.8 billion	1,55	Level 1 – 100%	Senior secured	A to AAA: 78.07% Not rated: 21.93%	Commercial property
Collateralised loan obligations	66 944	R32 billion	0,21	Level 1 – 94% Level 2 – 6%	Senior secured – 34.29% Unsecured – 65.71%	AAA: 88.06% AA-: 11.94%	Vehicle loans Corporate bonds
Collective investment schemes	564 321	R3.9 billion	14,41	Level 2		A	Investec Global Strategic Income Fund
	151 657	R48.5 billion	0,31	Level 2		AA+	ABSA Money Market Fund
	1 247 878	R7.3 billion	17,09	Level 2		AA+	NedGroup Money Market

Liquidity risk

Liquidity risk is the risk that the Scheme will not have sufficient liquid funds available to settle financial obligations as they fall due.

The Scheme's approach to managing liquidity is to ensure, with significant conservative margin, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation. In order to meet the conflicting objective of enhancing returns while also providing high liquidity, the combined Scheme portfolios have explicit constraints that guarantee liquidity of at least 20% of the Scheme assets within a period of one week.

The Scheme has complied with the requirements regarding the nature and categories of assets as prescribed by Section 35 and Regulation 30 of the Act.

Approximately 95% of the Scheme's insurance claim liabilities are settled within three months after the claim was incurred and the balance of the claims liability is settled within six months. The Scheme's remaining insurance liabilities are generally settled within 30 days.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Liquidity risk (continued)

A maturity analysis for financial liabilities, excluding insurance liabilities, is provided below:

As at 31 December 2014	Less than 1 year R'000	Between 1 and 2 years R'000	Between 2 and 5 years R'000
Personal Medical Savings Accounts (Note 8)	**3 250 743**	**–**	**–**
Insurance and other payables (Note 9)	**507 396**	**–**	**–**

As at 31 December 2013	Less than 1 year R'000	Between 1 and 2 years R'000	Between 2 and 5 years R'000
Personal Medical Savings Accounts (Note 8)	2 776 720	–	–
Insurance and other payables (Note 9)	356 680	–	–

32 CRITICAL ACCOUNTING ESTIMATES AND JUDGEMENTS

Critical accounting estimates and assumptions

The Scheme makes estimates and assumptions that affect the reported amounts of assets and liabilities within the next financial year. Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Outstanding claims provision

The critical estimates and judgements relating to the outstanding claims provision are set out under Note 30.

Other risk transfer arrangements

The critical estimates and judgements relating to other risk transfer arrangements are set out under Note 11.

Impairment of assets

The critical estimates made by the Scheme are set out under Note 31 and judgements relating to the impairment of assets are set out under Note 7 of the Accounting policies.

33 NON-COMPLIANCE MATTERS

The Council for Medical Schemes issued Circular 11 of 2006 dealing with issues to be addressed in the audited financial statements of medical schemes. The circular requires that all non-compliance matters noted should be disclosed in the audited financial statements, irrespective of whether the auditor considers it as material or immaterial.

During the year the Scheme did not comply with the following Sections and Regulations of the Act.

Statutory Scheme Solvency

In terms of Regulation 29 (2) the Scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may be no less than 25%.

The Scheme's accumulated funds expressed as a percentage of gross annual contributions was below the statutory solvency requirement of 25% during the year. However, at 31 December 2014, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 25.76% (2013: 24.30%) which exceeds the statutory solvency requirement of 25% and the approved phase-in solvency level of 24.30%, as set out in the business plan submitted to the Council for Medical Schemes.

33 NON-COMPLIANCE MATTERS (continued)

Sustainability of benefit plans

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

At 31 December 2014 the following plans did not comply with Section 33 (2):

Plans	Net underwriting deficit R'000	Net (deficit)/ surplus R'000
Executive	**(287 170)**	**(276 655)**
Classic Comprehensive	**(663 601)**	**(508 405)**
Classic Comprehensive Zero MSA	**(617)**	**(167)**
Coastal Saver	**(106 330)**	**44 779**
KeyCare Plus	**(310 309)**	**(172 747)**

The Trustees continue to monitor these plans with a view to improving their financial outcomes and will evaluate different strategies to address the deficits in these plans. The different financial positions reflect the different disease burdens in each plan, among many other factors. The Scheme's strategy on the sustainability of plans has to balance short- and long-term financial considerations, with considerations of fairness to both healthy and sick members and with continued affordability of cover for members with different levels of income and different healthcare needs. While the Trustees are committed to complying wherever possible with the applicable legislation, we also focus intensively on the overall stability and financial position of the Scheme as a whole and not only individual benefit plans.

Investments in employer groups

Section 35 (8)(a) of the Act states that a medical scheme will 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. Due to the large number of the Scheme's employers being listed on the JSE, investments were made in certain of its employers listed on the JSE. The Council for Medical Schemes has granted the Scheme an exemption from this section of the Act.

Investments in other assets in territories outside the Republic

In terms of Annexure B to the Regulations of the Act, the Scheme will not invest in other assets in territories outside the Republic. The Scheme's asset managers make use of foreign derivative instruments for the purpose of risk mitigation and efficient portfolio construction. These derivatives fall under Category 7(b) of Annexure B, which prohibits investment in territories outside South Africa and therefore the foreign derivative instruments result in non-compliance. The Council for Medical Schemes has directed the Scheme to dispose of these instruments or to apply for an exemption in terms of Section 8(h) of the Act. The exemption application was submitted on 18 July 2014.

Contributions received after due date

Section 26 (7) of the Act states that all subscriptions or contributions will be paid directly to a medical scheme not later than three days after payment thereof becoming due. There are instances where the Scheme received contributions after three days of becoming due, however, there are no contracts in place agreeing to this practice. The procedures that the Scheme follows regarding these contributions are set out in Note 31.

Broker fees paid

In terms of Regulation 28(5) of the Act, broker fees will be paid on a monthly basis upon receipt by the 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 represents less than 0.007% of the total broker fees paid for the year.

Who to contact and when

for any queries about your health plan

0860 99 88 77

WHEN YOU WANT TO LODGE A FORMAL DISPUTE

email **mydispute@discovery.co.za**

call **+27 11 529 2888** *Ask for the convener of the Disputes Committee in the DiscoveryCare team*

WHEN YOU WANT TO SUBMIT A COMPLAINT TO THE COUNCIL FOR MEDICAL SCHEMES

email **complaints@medicalschemes.com**

call **+27 12 431 0500** *You will need to have exhausted all avenues of trying to resolve the matter with the Scheme. You will be asked to complete a form detailing your complaint*

Principal Officer contact details

email **principalofficer@discovery.co.za**

call **+27 11 529 2522**

REGISTERED ADDRESSES

PRINCIPAL OFFICER

Milton Streak
Discovery Health Medical Scheme
16 Fredman Drive, Sandton
2196

REGISTERED OFFICE ADDRESS AND POSTAL ADDRESS

Discovery Health Medical Scheme
16 Fredman Drive
Sandton
2196

PO Box 78622
Sandton
2146

ADMINISTRATOR AND MANAGED CARE PROVIDER

Discovery Health (Pty) Ltd
155 West Street
Sandton
2196

PO Box 786722
Sandton
2146

INVESTMENT MANAGERS

MOMENTUM ASSET MANAGEMENT

13th Floor, Tower 2
102 Rivonia Road
Sandton
2196

PO Box 9959
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2146

TAQUANTA ASSET MANAGERS (PTY) LTD

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PO Box 23540
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7735

INVESTEC ASSET MANAGEMENT (PTY) LTD

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PO Box 1826
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8000

ELECTUS EQUITY SPECIALISTS

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Pinelands
7405

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Cape Town
8000

WHEN YOU:

want to **submit a claim**
Email **claims@discovery.co.za.** *Remember to put your membership number in the subject line of the email*

have a **query about how a claim was paid**
www.discovery.co.za/portal/individual/claims-search. *Register as a website user so you are able to find the information you need*

want to **find information about how we cover certain procedures**
www.discovery.co.za. *Log in, then go to* **Health – What we cover**

want to **find a doctor where you won't have to pay a co-payment**
www.discovery.co.za. *Log in, then go to* **Health – Hospital and doctor visits – Find a healthcare professional**

need a document, for example, a tax certificate or membership certificate
www.discovery.co.za. *Log in, then go to* **Health – Manage your medical aid plan – Find a document**

want to **submit a complaint or compliment**
Email **healthinfo@discovery.co.za.** *Remember to include your Discovery Health Medical Scheme membership number*

want to **escalate a complaint** to which you haven't received a satisfactory answer
Submit your query via our website **www.discovery.co.za.** *Then go to* **Contact us***. Specify in your email that you would like a Client Relationship Manager to contact you*

want to **submit a written complaint** about a query that has not been resolved or want to **submit a written compliment** about excellent service
Complete our online complaints form available at **www.discovery.co.za.** *Then go to* **Contact us**

want to **report fraud**
Email **forensicinvestigationsunit@discovery.co.za**

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Notes

FOR THE BENEFIT OF OUR MEMBERS

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