Discovery
Health Medical Scheme

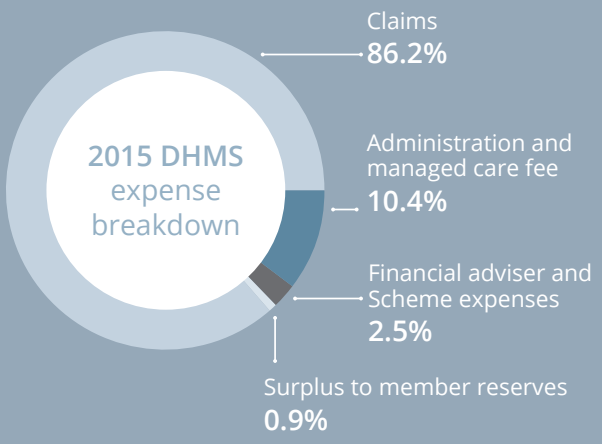
For the benefit of our members

2015 Integrated Annual Report

We exist for **our members.**

The core purpose of the Discovery Health Medical Scheme (DHMS) is to achieve, in a sustainable manner, the best possible value for its members, which comprises the benefits, quality of care and service levels to members relative to their contributions to the Scheme.

The Scheme's commitment to its members and its high levels of efficiency are evidenced by the fact that 87% of contributions received are used for members' direct benefit by funding claims and reserves (to meet regulatory solvency requirements) and in accordance with the fundamental operating principles of a non-profit organisation. The remainder of the contributions are used to fund activities for the support and benefit of members such as innovation, administration, managed care, financial advisers and the daily operations of the Scheme.



The Scheme's ability to pay claims and its sustainability over the long term are of critical importance to its members. The Scheme considers the following to be key metrics for its sustainability:

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

Read more about these key aspects of our sustainability in our Chairperson's statement, our Principal Officer's review of the year, and Discovery Health Medical Scheme performance, starting on pages 32, 52 and 54 respectively.

2015 Integrated Annual Report

About our Report

Discovery Health Medical Scheme's 2015 Integrated Annual Report (the Report) provides its members and other stakeholders with a holistic view of the Scheme's business model, governance, strategy and performance, in the context of the key risks and opportunities that affect the private healthcare industry.

The Scheme uses the International Integrated Reporting Framework as a guideline for developing its Report, insofar as it is relevant and applicable to medical schemes in South Africa. The Report also takes guidance from the King Code of Governance Principles (King III) in this regard. In 2015, the Board of Trustees (the Board) commissioned an independent review by Deloitte of the 2014 Integrated Annual Report, which has informed improvements in this year's report. The Integrated Annual Report is a function of the Board's accountability to the Scheme's members, and to its other stakeholders who are integral to its ability to create value for members and ensure the sustainability of the Scheme.

Scope and boundary

The Report covers the financial year from 1 January 2015 to 31 December 2015. This period is also referred to as the benefit year in the Report.

The Report discusses how the Scheme manages its available resources responsibly to create value for its members. In doing so, it details the Scheme's interactions and activities pertaining to its members and other key stakeholders, including health professionals, healthcare intermediaries, employer groups and regulatory authorities.

Balancing the needs and expectations of the Scheme's stakeholders, particularly in a time of increasing economic demands on Scheme members and above inflation increases in healthcare costs, is integral to the way the Scheme conducts its business. This underpins the Scheme's financial and operational sustainability, which in turn has a positive impact on society.

The Report considers the value that Discovery Health, as the Scheme's Administrator and Managed Care provider, delivers to the Scheme and its members. The Scheme monitors its Administrator in respect of sustainable business practice and is confident that it meets its obligations.

The terms 'the Scheme', 'we' and 'our' refer to Discovery Health Medical Scheme (or DHMS). The terms 'the Administrator' and 'Discovery Health' refer to Discovery Health (Pty) Ltd.

A glossary of terms is provided on **page 154**.

Materiality determination

The Board is responsible for determining the matters that materially impact the Scheme's ability to create value for its members and ensure the sustainability of the Scheme. Materiality determination is undertaken annually, and those issues established as material for the benefit year are set out on page 9, and discussed comprehensively in the Report.

The Board uses information from Board and Scheme Office reports, the Scheme's risk register, membership growth and benefit enhancement opportunities available to the Scheme, and the Scheme's strategic objectives to determine material matters. It also uses stakeholder feedback obtained through a range of formal (stakeholder activities and feedback sessions) and informal (emails and calls to the Scheme) interactions.

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

Combined assurance

The Scheme uses a combined assurance model based on three lines of defence, which can be summarised as follows:

- Management provides the Board with assurance that the Scheme's risk management plan is integrated into the day-to-day running of the Scheme and that it is monitored on an ongoing basis.
- The internal assurance providers, Compliance and Risk functions (including Forensics) and the Scheme's Board Committees assess the effectiveness of the Scheme's internal control and risk management processes.
- The Scheme and the Board receive external assurance on the Scheme's financial performance and internal control frameworks.

This Report is assured by Management and the functions that comprise the second lines of defence, with independent assurance of the Annual Financial Statements provided by the external auditors.

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 and non-audit services are included in the Annual Financial Statements. The Scheme has a formal policy governing non-audit services. The non-audit service fees have been disclosed and agreed with the Audit Committee.

Board responsibility

The Scheme is committed to ensuring that our members have access to accurate and reliable information. The Board recognises its responsibility to assure the integrity of the Integrated Annual Report, and is confident that the content of the 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 satisfied that the Report complies with the requirements of the Medical Schemes Act 131 of 1998, as amended, the Scheme Rules, and also the Accounting Guide for Medical Schemes, issued by the South African Institute of Chartered Accountants (SAICA), including compliance with International Financial Reporting Standards (IFRS), and all additional financial reporting requirements by the Council for Medical Schemes.

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 going concern basis.

Signed on behalf of the Board

Michael van der Nest, SC
Chairperson

Milton Streak
Principal Officer

Important sources of information

For more information within this Report.

For more information available online.

More information about the various health plans offered by the Scheme are available at **https://www.discovery.co.za/portal/individual/medical-aid-plan-range**.

A full version of the Scheme Rules is available to registered members at **https://www.discovery.co.za/portal/individual/dhms-rules**.

The Medical Schemes Act 131 of 1998, as amended, which regulates medical schemes, is available on the Council for Medical Schemes' website at **https://www.medicalschemes.com/Content.aspx?130**.

The International <IR> Framework can be found at **http://integratedreporting.org/**.

Find more important contacts and information in the Information Toolkit on **pages 152 – 153**.

About Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme is an open medical scheme. Any member of the public can join the Scheme, subject to its Rules[1]. Covering 2 691 852 beneficiaries at 31 December 2015, it is the largest open medical scheme in South Africa with an open medical scheme market share of some 53%[2].

The Scheme is a non-profit entity governed by the Medical Schemes Act[3] (the Act), and is regulated by the Council for Medical Schemes (CMS). The Scheme belongs to its members and an independent Board of Trustees (the Board) oversees its business.

The Scheme operates by way of a formal contractual arrangement with Discovery Health, with its business model based on Vested® outsourcing.

Read more about the Board and management structures from **page 10**.

Read more about the Vested outsourcing model and how we conduct our operations on **page 18**.

1 *The Scheme Rules are available to registered users at https://www.discovery.co.za/portal/individual/dhms-rules.*
2 *Based on beneficiaries, according to the Council for Medical Schemes 2014 – 2015 Annual Report (https://www.medicalschemes.com/Publications.aspx).*
3 *Medical Schemes Act 131 of 1998, as amended.*

Unfamiliar terms? See the glossary on **page 154**.

This depiction of our operating environment shows how some of our key stakeholders interact to create value for our members.

Board of Trustees

The Board oversees the affairs of the Scheme in the best interests of its members and stakeholders. Trustees are highly skilled individuals who offer their knowledge and experience to the Scheme. They may be elected or appointed, but at any time at least half of the Board must be elected by Scheme members.

Board Committees

The Board delegates aspects of its work to various Board Committees equipped with the necessary specialist skills. These Committees may consist of Trustees and/or additional independent members. All Committees report back to the Board and make recommendations in line with their respective mandates.

Council for Medical Schemes

The CMS is a statutory body responsible for regulating the medical schemes industry in South Africa; it administers and enforces the Act.

Discovery Health Medical Scheme

DHMS is a registered medical scheme, and like all other medical schemes in South Africa is a non-profit entity. The Scheme pools all members' contributions to fund members' claims. Any surplus funds are transferred to Scheme reserves for the benefit of members. The Scheme exists to serve its members' interests by enabling the sustainable provision of high-quality and affordable healthcare to all of its members.

Discovery Health (Administration and Managed Care services)

Discovery Health (Pty) Ltd provides medical scheme administration services as well as a broad range of additional services, including:

- Member and provider servicing;
- Marketing, communication and advertising;
- Financial and actuarial services;
- Governance, risk, compliance and internal audit;
- Research and development;
- Actuarial and business analytics;
- Benefit design; and
- Fraud and forensics investigation.

Discovery Health also provides managed care services, which is the provision of appropriate, affordable, quality healthcare services through rules-based clinical and disease management programmes. These include:

- Active disease risk management services and disease risk management support services;
- Hospital benefit management services;
- Managed care network management services and risk management services; and
- Pharmacy benefit management services.

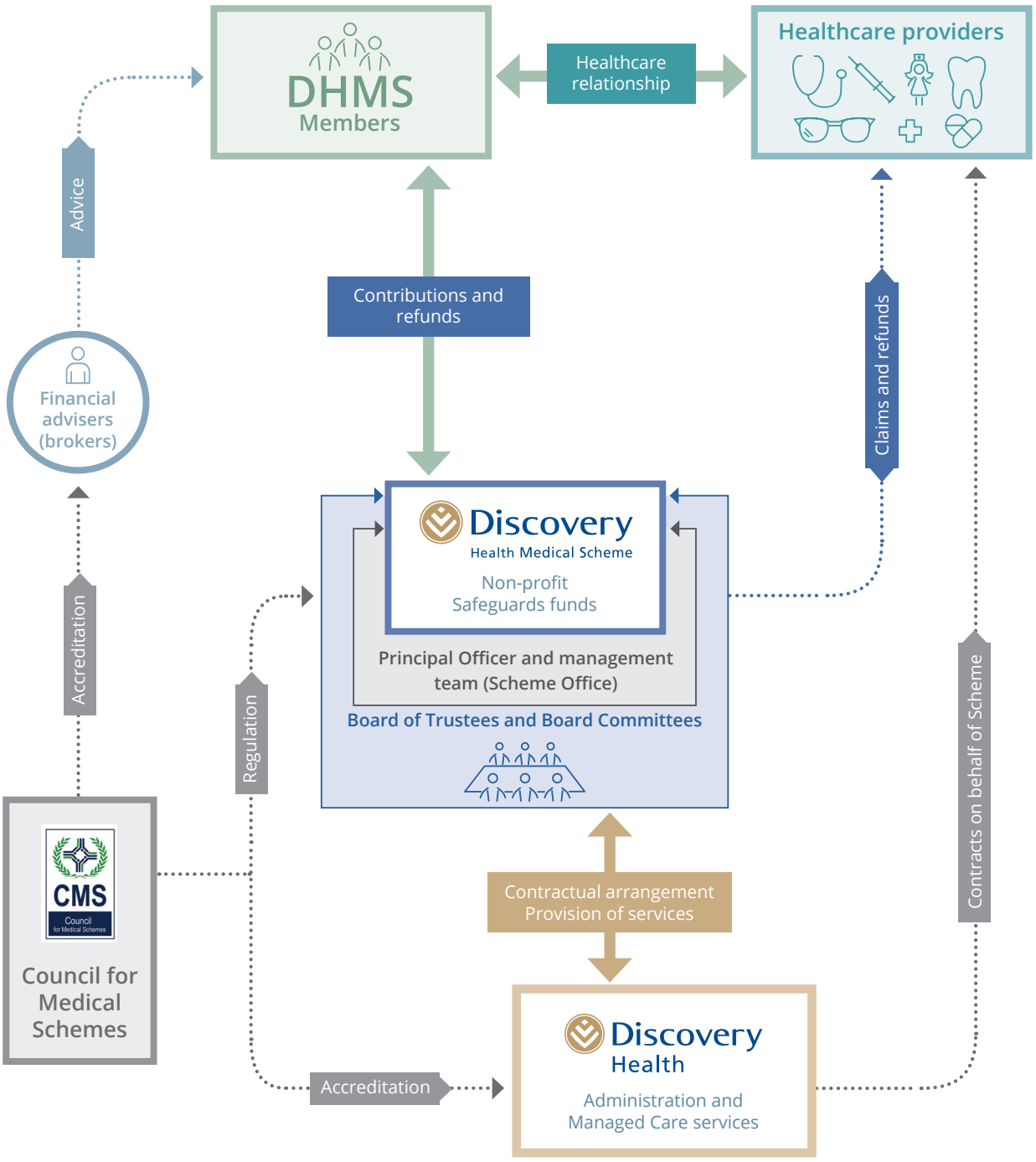
Financial advisers

Financial advisers (commonly known as brokers) provide members with independent advice about their health plan options based on individual medical and affordability needs. Financial advisers must be registered with the Financial Services Board and accredited by the CMS. The Scheme pays contracted financial advisers a legislated commission.

Healthcare providers

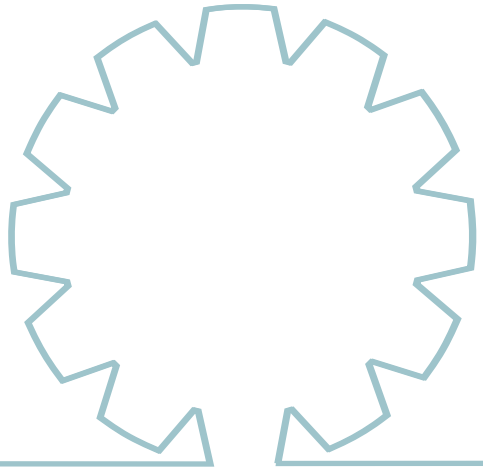
Healthcare providers are the health professionals who deliver healthcare services, for example doctors, nurses, dentists, specialists, hospitals, pharmacies and managed care organisations.

Our operating environment



Read more about how the Scheme creates value for all its stakeholders from **page 20**.

Our operating context



The South African healthcare environment is complex, incorporating both public and private healthcare sectors. Within the private sector the CMS regulates the operation of medical schemes. The CMS publishes regular circulars to provide guidance to medical schemes on interpreting and implementing the Act.

Read more about the regulatory and industry matters dealt with in 2015 from **page 48**.

Medical schemes facilitate the funding of private healthcare services. At the end of 2014 private medical schemes covered 3 921 232 members, which equates to 8 814 458 beneficiaries[1], or about 16% of the South African population. The industry is highly competitive, with 23 open medical schemes and 60 restricted membership medical schemes operating at January 2015. This is despite significant consolidation over the last few years in response to market forces. The CMS predicts that the number of medical schemes is likely to almost halve by 2025.

A major concern for medical schemes in 2015 has been the escalating cost of healthcare, with healthcare inflation being consistently well above CPI, primarily driven by increased utilisation of services.

Utilisation is increased by effects on both the demand and supply side, as follows:

- Demand side effects refer to the extent to which increasing consumption of healthcare services among members drives claims inflation. This is because an aging population with a higher burden of disease drives claims expenses, and because as people become sicker they buy more expensive and comprehensive plans.
- Supply side effects refer to the extent to which health professionals and other service providers influence the utilisation of healthcare services for a given disease burden, with the introduction and utilisation of new and extremely high-cost medications and technologies contributing to this.

Another major driver of healthcare inflation is the need to fund scheme solvency requirements. Other factors that impact contribution increases to a lesser extent include:

- The investment income schemes are able to generate;
- Non-healthcare expenses (the costs of operating the scheme); and
- The price of healthcare services or products (tariffs), which largely track CPI year-on-year.

The legal requirement for schemes to hold large solvency reserves, regardless of the risks they face, and regardless of their size, investment strategy, membership growth, general financial prudence and whether their contributions are sufficient to cover their risks, adds to medical scheme contribution increases. Growing schemes have to increase contributions to ensure that solvency levels are maintained, since new members join without any reserves but the scheme has to provide for 25% of the members' total gross contribution income in the year that they join. This effectively means that the only source of capital to fund members' claims and solvency requirements is a medical scheme's contribution income.

All these factors require active management to contain annual contribution increases to at or below the industry target level of CPI+3% every year.

1 *Council for Medical Schemes 2014-2015 Annual Report (https://www.medicalschemes.com/Publications.aspx).*

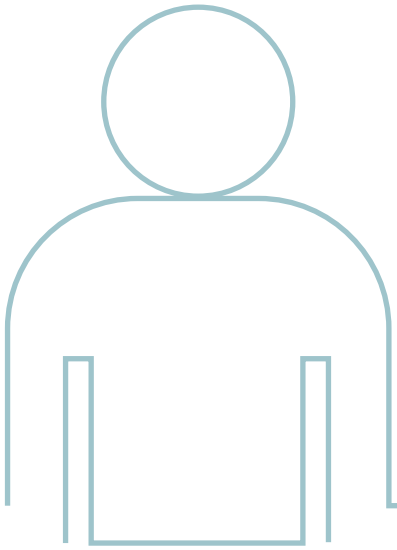
Our material matters

Navigating this complex operating environment requires a responsive strategy, significant management skill, governance expertise and financial discipline. This is reflected in the Scheme's material matters, which are interrelated:

- Keeping contributions affordable while ensuring the Scheme is able to pay claims.
- Maintaining financial sustainability.
- Balancing stakeholder needs.
- Ensuring the Scheme's operating model is effective and adds value to the Scheme and its members.
- Strengthening the Scheme's industry-leading and competitive positioning.
- Navigating the complex regulatory environment.

Read about the Scheme's strategy and risks from **page 16**.

Who leads us



Our Board of Trustees

The Board of Trustees (the Board) comprises high-calibre professionals with diverse skills, experience, background and gender. This brings multiple perspectives to bear in discussion and debate, ensuring robust oversight and strategic decision-making. The Trustees dedicate a significant amount of time and effort to their fiduciary duties, well beyond meeting attendance requirements.

The Board focuses its attention on overseeing the Scheme's material matters in discharging its duties and ensuring the Scheme's sustainability, which forms the basis for any Board decisions. The Board is accountable to the Scheme's members.

Trustees may be elected or appointed. At least half of the Trustees are elected by Scheme members, and the Board may appoint additional Board Committee members to fill any knowledge, experience and skills gaps.

Read more about the legislation under which the Scheme operates and its governance structure and framework from **page 34**.

Mr Michael van der Nest, SC

BA (Law), LLB (Stellenbosch)

CHAIRPERSON

Mr van der Nest, SC has been in private practice for 29 years and was appointed Senior Counsel in 2000. He has been an Acting Judge of the High Court of South Africa on various occasions, and has arbitrated various commercial disputes. His practice is of a specialised commercial nature in merger and competition cases, accounting and valuation, mining, contractual disputes, insurance, aviation and construction disputes, financial instruments, banking and regulatory matters.

Mr van der Nest was appointed as a Trustee in 2011 and 2014, and has served as Chairperson of the Board for both periods. He serves on the Remuneration and Stakeholder Relations Committees.

Mr Noel Graves, SC

BA, LLB (UCT)

Mr Graves, SC had a BA LLB degree conferred on him by the University of Cape Town in 1985, after which he practiced law as an attorney at Bowman Gilfillan, and subsequently as a partner at the Sampson, Okes, Higgins law practice. He was admitted as an advocate in 1993 and was appointed Senior Counsel in 2009. He is a member of Advocates Group 621, the oldest group of advocates at the Johannesburg Bar.

Mr Graves was elected as a Trustee in 2010 and 2013. He chairs the Non-healthcare Expenses Committee and serves on the Product, Remuneration and Investment Committees.

Mr Puke Maserumule

BA (Law), LLB (UCT),
Postgraduate Diploma in Labour Law (UJ)

Mr Maserumule has been an admitted attorney for 26 years, 24 of which he has spent in private practice. He specialises in all aspects of employment law and general litigation, and has acted as a Labour Court and High Court Judge. He is also an accredited Tokiso mediator, facilitator and arbitrator.

Mr Maserumule was elected as a Trustee in 2010 and 2013. He chairs the Investment Committee and serves on the Stakeholder Relations Committee.

Ms Daisy Naidoo

B.Com (Postgraduate Diploma in Accounting)
CA(SA), Masters of Accounting (Taxation)

Ms Naidoo is a Chartered Accountant. She is a professional independent non-executive director and currently serves on a number of listed and non-listed company boards, investment and credit committees. She has extensive knowledge in finance, accounting, banking, investment, risk and general business. She was previously a dealmaker for almost a decade at Sanlam Capital Markets where she headed the Debt Structuring Unit. Prior to that she was a tax consultant at Deloitte, consulting mostly to financial services companies, and prior to that she was a financial planner at South African Breweries.

Ms Naidoo was elected as a Trustee in 2013. She serves on the Audit, Risk, Investment and Non-healthcare Expenses Committees.

Who leads us *continued*

Dr Nozipho Sangweni

MBChB, DOH DCAM MBA

Dr Nozipho Sangweni received her undergraduate medical degree at the then University of Natal (now UKZN). She attained her postgraduate diploma in Occupational Health at the University of the Witwatersrand and having entered the world of aviation medicine, studied further at the International Air Transport Association Training and Development Institute where she received her postgraduate diploma in Civil Aviation Management. She had a thirteen-year career in aviation at both regulatory and operator levels where she served in senior management positions. She also worked in the NGO sector, specifically for PEPFAR/USAID where she oversaw multiple NGO sub-recipients. She later entered the laboratory medicine environment as an executive. She has a Masters Degree in Business Administration from the Gordon Institute of Business Science.

Dr Sangweni was appointed as an independent Board member after June 2013, and served on the Clinical Governance, Product and Stakeholder Relations Committees. From 1 October 2015 she resigned from these positions to join the Scheme Office in the role of Chief Medical Officer.

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)

Professor van der Spuy is Emeritus Professor/Senior Scholar in the Department of Obstetrics and Gynaecology at the University of Cape Town. An obstetrician gynaecologist by training, Professor van der Spuy has a particular interest in women's health and reproductive medicine and brings a wealth of clinical knowledge and experience to the oversight function of the Board. She is an Honorary Fellow of: the Academy of Medicine, Singapore; the Ghana College of Surgeons; the Academy of Medicine, Malaysia; the Royal Australasian College of Physicians; the Royal College of Physicians of Ireland; and most recently The Colleges of Medicine of South Africa. She has 62 publications in peer reviewed journals and 40 invited articles and chapters in books.

Prof van der Spuy was elected as a Trustee in 2010 and 2013. She serves on the Clinical Governance and Product Committees.

Mr Giles Waugh

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

Mr Waugh has worked as an actuarial consultant for the past 30 years in South Africa and the UK, and now operates as an independent actuary involved in life and short-term insurance.

Mr Waugh was appointed as a Trustee in 2011 and 2014. He chairs the Product Committee and serves on the Audit, Risk and Non-healthcare Expenses Committees.

Our Board Committees

Ten Board Committees assist the Board to fulfil its fiduciary and oversight duties effectively. The Committees are established in terms of the requirements of the Scheme, and in accordance with legislative requirements and governance best practice.

Board Committees operating during 2015 were:

- Audit;
- Risk;
- Investment;
- Clinical Governance;
- Disputes;
- Nomination;
- Non-healthcare Expenses;
- Product;
- Remuneration; and
- Stakeholder Relations.

Trustees and Committee members are remunerated for their service according to the Scheme's Remuneration Policy.

Read more about the Committees and their activities from **page 37**.

Read more about the remuneration of Trustees and Committee Members from **page 46**, and refer to the Annual Financial Statements on **pages 106 – 107** for more information.

Our Audit Committee

The Audit Committee is a statutory committee.

Mr Barry Stott

CA(SA)

CHAIRPERSON

Mr Stott commenced articles with PricewaterhouseCoopers in February 1968 in the audit division. He was appointed partner in 1982 and worked in the audit division, responsible for audits in the insurance and asset management industry. Mr Stott also led the financial services industry practice and financial services knowledge management division, and ensured that PwC staff were up to date on all issues in the industry, trained in industry specialisation and on all IFRS issues relating to the financial services industry. Since retiring from PwC in June 2009, Mr Stott has been a member of audit panels for Momentum Asset Management, Momentum Wealth, Rand Merchant Bank Asset Management and Advantage Asset Management. Since January 2010, Mr Stott has been an independent non-executive director of Clientele Holdings Ltd, Clientele Life Limited and Clientele and General Limited. He is the Chairman of the Clientele Group Audit Committee, Chairman of the Clientele Group Risk Committee and Chairman of the Clientele Group Remuneration Committee and a member of the Investment and Actuarial Committees.

Mr Stott serves on the Investment Committee and chairs the Audit and Risk Committees.

Other Audit Committee members for 2015 were:

- **Ms Daisy Naidoo**
  BCom (Postgraduate Diploma in Accounting)
  CA(SA), Masters of Accounting (Taxation)
- **Mr Giles Waugh**
  MA (Cantab)
  FIA (Fellow of the Institute of Actuaries UK)
  FASSA (Fellow of the Actuarial Society of South Africa)
- **Mr Neil Novick**
  CA(SA)
- **Mr Steven Green**
  BSc (Hons)
- **Mr Don Eriksson**
  CA(SA)
- **Mr Dave King**
  BSc (Hons), Higher Diploma in Education, MBA

See **page 38** for more information about the role of the Audit Committee.

Who leads us *continued*

Our management team

> The Board appoints a Principal Officer, in accordance with the Act and Scheme Rules. The Principal Officer is the Executive Officer of the Scheme and is accountable to the Board for the day-to-day management of the Scheme and the implementation of its strategy.

The Principal Officer, supported by his management team, is key to the effective operation of the Scheme. The Board and Remuneration Committee direct and oversee remuneration for the Scheme Office, which is based on best practice, carefully structured and independently benchmarked, according to the experience and skills required, and to attract and retain high-calibre staff.

The Principal Officer and his management team collaborate closely with the Scheme's Administrator, Discovery Health, in the implementation of strategy and daily operations. The management team's expertise includes medical, actuarial, risk management, business management, financial management, legal, compliance and research functions.

Chief Risk and Operations Officer
BSc (Hons), FIA, FASSA, CFA

Chief Financial Officer
B Accounting (Hons) (Stellenbosch), CA(SA), CFA

Head: Compliance and Stakeholder Relations
LLB

Executive Principal Officer
(appointed by the Board in 2009)
B.Pharm – North West University
Master of Management (MM) (Entrepreneurship and New Venture Creation) (with distinction) – University of the Witwatersrand

Head: Special Projects
BA (Hons), MBA in Executive Management (with distinction) (UCT GSB)

Chief Medical Officer Designate
MBChB, MBA, Postgraduate Diploma in Occupational Health, Postgraduate Diploma in Civil Aviation Management

Head: Legal and Regulatory Affairs
LLB, MSc Med (Bioethics and Health Law), Dip Sports Management, Adv Dip Sports Management

Not shown

Dr Buddy Modi
(resigned on 31 December 2015)
Chief Medical Officer
MBChB, MBA in Executive Management (with distinction) (UCT GSB)

Mr Selwyn Kahlberg | Mr Jan van Staden | Mrs Yashmita Mistry | Mr Milton Streak | Ms Michelle Culverwell | Dr Nozipho Sangweni | Mr Howard Snoyman

How we execute our strategy

Developing our strategy

Each year the Board reviews past performance, current focus areas and potential challenges and opportunities to determine the Scheme's strategic direction.

Internal and external factors, including material matters and top risks are taken into account, to ensure the strategy is responsive to the operating environment and the needs of stakeholders, in the context of the Scheme's long-term sustainability. Importantly, the strategy incorporates mitigation actions to reduce the likelihood of top risks, or the impact that they may have if they materialise. While these considerations require that the strategy evolves over time, its development is always guided by the Scheme's core purpose to achieve, in a sustainable manner, the best possible value for its members.

Once the Board has set the strategy, it is distilled into a number of strategic themes. These are broken down further into work streams relevant to a particular year, which aim to achieve the objectives related to the theme. Key performance indicators are specified for each work stream so that outcomes can be objectively measured and assessed by the Board.

Our strategy and risk management

The work involved in achieving strategic objectives (which incorporates risk mitigation) is monitored on a monthly basis by the Scheme Office, and on a quarterly and annual basis by the Board. The work streams are not necessarily tied to the twelve-month time frame of the Report, however, and may be carried over to the following year or even over several years depending on the complexity of the objectives. Work streams are also expected to evolve and adjust in response to changing circumstances.

For commentary on performance, read the Performance section starting on **page 51**.

For information on the Scheme's strategic objectives and performance in previous years, see our previous Integrated Annual Reports at **https://www.discovery.co.za/portal/individual/dhms-financials**.

Our top risks:

What may prevent us from achieving our strategic objectives?

Governance

Within a complex, highly regulated environment, the Board carries the obligation of ensuring the Scheme's sustainability and that optimised benefits are designed and delivered to members. Their fiduciary duties require the effective functioning of extensive governance structures tailored to the needs of the Scheme. Governance failures would impact the future sustainability of the Scheme.

Contribution competitiveness and affordability

Maintaining annual contribution increases at the lowest possible level while offering members access to optimised benefits and service levels in accordance with their chosen benefit plan is core to the Scheme's strategy. Claims and therefore contributions are expected to continue increasing at a rate higher than consumer price inflation due to tariff and utilisation increases, supply and demand side factors, including new technology, high-cost procedures and drugs, and legislative requirements within the private healthcare system.

Stakeholder engagement

The Scheme exists to serve its members and other key stakeholders, and it aims to actively manage its relationship with all its stakeholders. This entails maintaining a delicate balance between the sometimes conflicting needs of the various stakeholders. Failure to maintain positive stakeholder relationships could have a negative impact on the Scheme's ability to meet its strategic objectives.

Regulatory impact

The Scheme operates in a highly regulated environment requiring extensive controls to ensure ongoing compliance with its legislated obligations. Non-compliance with regulatory requirements would adversely affect the operations of the Scheme.

Outsourcing risk

The Scheme conducts its operations through formal arm's-length administration and managed care outsourcing agreements with Discovery Health. The failure to execute on these outsourcing agreements would result in an inability to service members and providers, as an inherent consequence of the outsourcing model.

Insurance risk

Contribution rates are set before the end of each benefit year for the following year. In addition, benefits are changed and innovations are introduced with the aim of increasing value to members. There is a risk of claims being higher than the expected contribution income, taking into account the actual impact of the benefit changes and innovations with a resultant negative impact on the Scheme's financial position.

Investment risk

The Scheme invests members' funds across a variety of asset classes with the objective of maximising targeted investment returns within a specified risk appetite. The Scheme could be harmed by:

- A poorly selected or implemented investment strategy.
- The failure of counterparties to meet their financial obligations.
- Negative movements in the value of the Scheme's investments or income generated from those investments due to market factors.

Our strategic themes:

How have we done in 2015?

For the Scheme, value creation means providing value to members. We strongly support the development of a member-centric healthcare system that is focused on making members healthier, providing access to the highest quality care at the lowest costs with excellent member service. Our strategic themes are developed in support of this overarching objective.

The Board has determined that **these five strategic themes** will be carried forward into 2016.

Optimise and evaluate the Scheme's business model based on international outsourcing best practice principles

- The Scheme's administration and managed care agreements with Discovery Health were renegotiated and renewed.
- Work has begun on an expert review of the Scheme's Vested outsourcing business model and is expected to be concluded in 2016.
- Various additional processes and oversight structures have been implemented to measure operational outcomes and the working relationship with Discovery Health.

Read more about how we operate on **pages 18 – 19**.

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

- A multi-year work stream on contribution competitiveness is underway. The contribution increase for 2015 was 9.9% across all plan types, maintaining contribution levels that were, on average, 14% lower than the average for the next nine largest open medical schemes.
- On behalf of the Scheme, Discovery Health delivered a variety of product and service enhancements for members, and member satisfaction levels remained high throughout the year.

Read more about the Scheme's price differential against competitors on **page 56**.

Ensure best practice governance and legislative compliance

- Best practice governance is a dynamic process, and the Scheme has assessed its governance framework to ensure that optimised governance arrangements are in place.
- The CMS publishes regular circulars and other guidelines to the industry, and the Scheme developed and submitted comprehensive responses to these as required.

Read more about the Scheme's governance practices from **page 34**.

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

- The Scheme strongly supports the goal of making members healthier in addition to only funding claims when they are ill. Our members have access to a science-based wellness programme, Vitality[1], on a voluntary basis. During 2015, Vitality developed and implemented various initiatives to enhance the impact and experience of the programme for members of the Scheme.

Read more about the initiatives to make members healthier from **page 66**.

Enhance clinical and other risk management interventions and strategies

- Scheme members benefited from an estimated R4.3 billion of savings achieved in 2015 (13.1% of the Scheme's risk expenditure).

1 *Vitality is a separate wellness product sold and administered by Discovery Vitality (Pty) Ltd. Registration number 1999/007736/07, an authorised financial services provider.*

How we operate

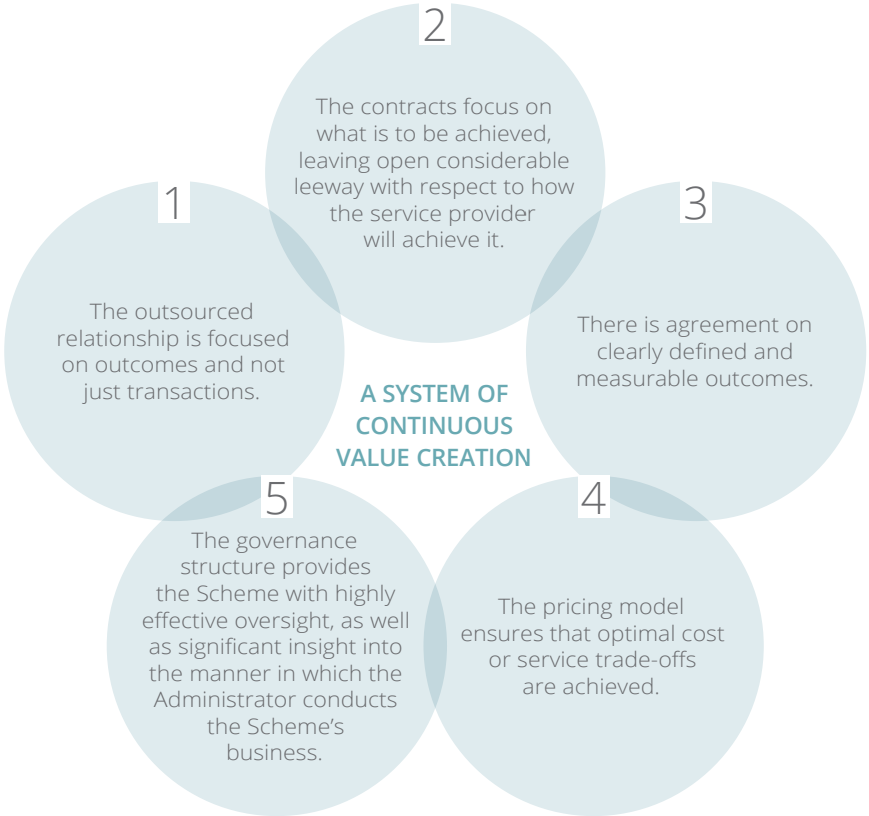
The Act and the Scheme Rules allow the Board to appoint an accredited administrator and managed care provider on terms and conditions required for the execution of the Scheme's operations.

Discovery Health Medical Scheme purchases its administration and managed care services from a single provider, Discovery Health (Pty) Ltd, as the Scheme believes that this integrated business model (as opposed to a fragmented model, using multiple service providers) delivers optimal efficiency and value to members. Administration and managed care agreements ensure that clearly defined and measured outcomes are achieved, and that performance management principles through service level agreements (SLAs) are strictly adhered to and reported on.

These SLAs set out the expected level of performance across a wide range of key operational measures. Discovery Health reports to the Scheme on contractually agreed key performance indicators on a monthly, quarterly and annual basis.

The transactional and relational governance elements of the working relationship between the two organisations is governed by a Vested outsourcing model.

Our Vested® outsourcing



The five core concepts of Vested outsourcing have been adapted from "The Vested Outsourcing Manual" (Palgrave McMillan, 2011) by Kate Vitasek with Jaqui Crawford, Jeanette Nyden and Katherine Kawamoto.

The business model used to optimise the relationship between Discovery Health Medical Scheme and Discovery Health is Vested outsourcing and aligns with global best outsourcing practice.

A Vested outsourcing agreement is characterised by a shared vision and aligned objectives, with organisations working to find the best solutions together. The agreement also balances risk and reward for both parties, leading to fairness, sustainability and the best outcomes. In effect, it frees both organisations to do what they do best by contracting for results, and not activities – which allows for innovation, improved service and continuous value creation.

Vested relationships depend on active collaboration, transparency, flexibility and trust and commit both organisations to the success of each business. This strengthens the strategic alignment between organisations and encourages a value-driven relationship.

Validating the value for money Discovery Health provides

Value for money is a relative term and needs to capture both the cost and quality of services rendered to schemes and their members by administrators and managed care organisations. In comparing these services across various third-party administrators (TPAs) in the industry, it is important to capture the quality of service, rather than just transactional activities in relation to the fees paid to TPAs.

This value for money assessment is an important tool used by the Scheme's Board of Trustees to evaluate the annual performance of Discovery Health, the Scheme's Administrator and Managed Care Provider. The value for money calculation was developed independently by Deloitte, and is based on a quality adjusted fee value compared to the actual amount paid to the Administrator. A quality adjusted fee value of greater than one implies that a beneficiary receives more value than what has been paid for. The incremental value is attributable to the impact of Discovery Health's services to the Scheme, relative to the rest of the open medical scheme industry. For 2014, the result of the value for money calculation for the Scheme is shown below.

R1 For every R1 spent on administration and managed care fees in 2014, beneficiaries of the Scheme derived R1.69 in value[1].

This calculation is done on an annual basis, and shows a positive trend from 2011 (the first time this assessment was done).

This is an important indication that the relationship with Discovery Health is effective in providing the Scheme and its members with significant value for money.

Quality adjusted TPA fee value (pabpm[2])

2011	2012	2013	2014
R1.45	R1.53	R1.62	R1.69

1 *Deloitte Value Formula Review, November 2015.*
2 *Per average beneficiary per month.*

business model

The Vested model recognises and embeds the Scheme's independence through robust governance arrangements, while allowing the Scheme to leverage Discovery Health's considerable knowledge, expertise, systems, innovation and value-added services in the best interests of the Scheme and its members. The Scheme engages in an operating relationship characterised more by insight rather than merely oversight, according to the five principles of Vested outsourcing shown alongside.

What this means for our members

The improved outcomes from the Vested outsourcing model has seen the following tangible results based on the relationship between the Scheme and Discovery Health:

- An unmatched record of innovation.
- High levels of member satisfaction with service levels.
- More focused and sustainable clinical risk management solutions resulting in significant claims cost reduction.
- Improved stakeholder relations through a shared vision and aligned objectives.
- Continued membership growth from an already high base.
- Improved outsourcing governance translating into robust reporting and evaluation processes.

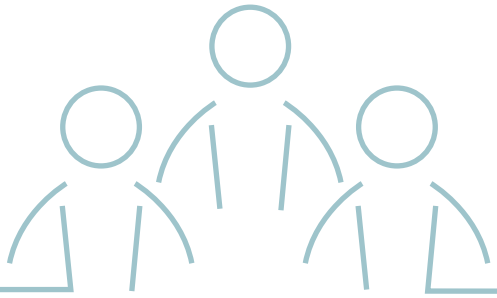
Read more about the innovations that Discovery Health has developed for the Scheme from **page 66**.

The continual improvement journey

Optimising an outsourcing business model through Vested outsourcing is a journey. Both organisations have to adapt to working in new ways, and these changes need to be embedded at all levels, creating a sustainable system for continuous value creation.

In 2016, the Scheme is conducting a review of the current state of the outsourcing relationship, which will identify areas of development and map a way forward. This will be done in conjunction with international Vested outsourcing experts.

How we add value to our key stakeholders



The core purpose of Discovery Health Medical Scheme is to achieve, in a sustainable manner, the best possible value for its members, which comprises the benefits, quality of care and service levels to members, relative to their contributions to the Scheme.

To achieve this purpose, the Scheme must manage its relationships with the stakeholders that are integral to its ability to create value.

Balancing the expectations of these stakeholders, in a way that protects the long-term sustainability of the Scheme, is a constant challenge. The Scheme's approach is to engage with stakeholders on the basis that working towards a common purpose is paramount, notwithstanding their differing needs in some instances. The Scheme conducts all its interactions with stakeholders in good faith, with the common purpose of ensuring access to affordable, quality healthcare for its members, now and in the future.

Our stakeholder engagement principles are:

- Transparency and accountability;
- Inclusivity and responsiveness;
- Honesty and integrity; and
- Complete, timely, relevant, accurate and accessible information.

Our approach to stakeholder relations

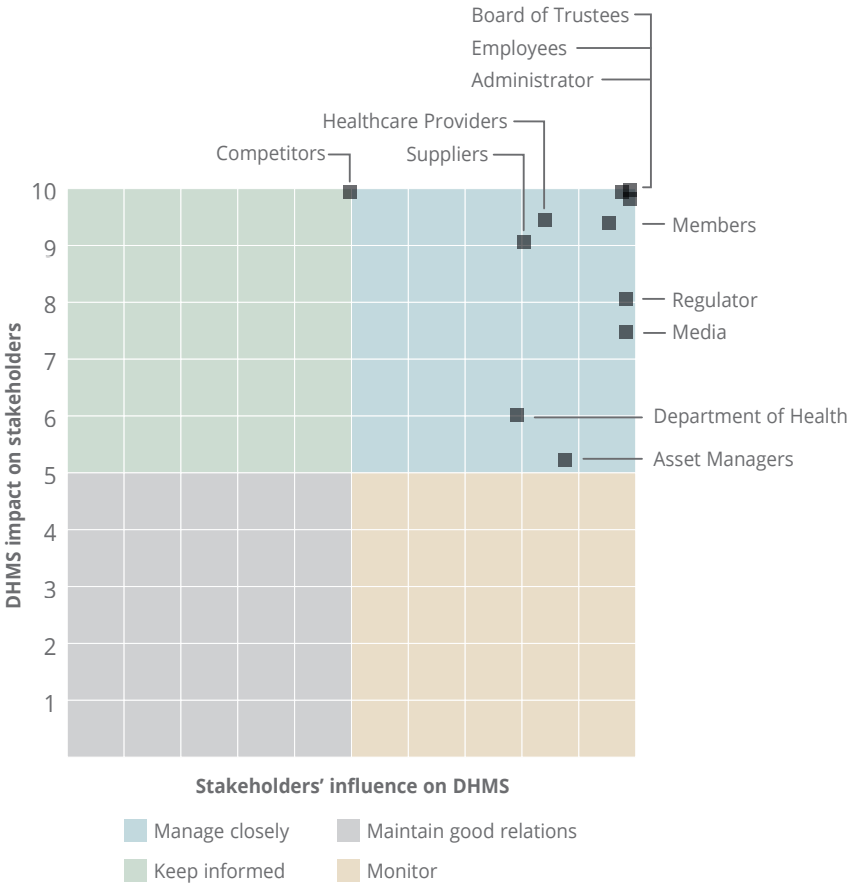
The Scheme outsources its operations to Discovery Health, in terms of its Vested outsourcing business model. This includes some work relating to stakeholder engagement: for example, Discovery Health operates the call centre for Scheme members; engages with healthcare providers to develop innovative healthcare delivery and quality of care initiatives; and negotiates on the Scheme's behalf to develop healthcare provider networks that keep costs down for members.

Read more about Vested outsourcing and how we operate on **page 18 – 19**.

The Stakeholder Relations Committee oversees all stakeholder engagement, according to a defined methodology and risk assessment framework. This entails identifying stakeholder groups, assessing each stakeholder's needs, putting engagement plans in place and monitoring their effectiveness. Specifically, this takes the following into account:

- Identifying the individual or group responsible for the stakeholder relationship.
- Choosing an appropriate medium of engagement (formal meetings, workshops, annual forum, surveys, etc.).
- The frequency and details of engagement.
- Monitoring concerns, expectations and negative perceptions, to inform plans to address these and improve the effectiveness of the engagement strategy.
- Monitoring positive perceptions and experience.
- Monitoring stakeholder-related incidents and their resolution.

Read more about the Stakeholder Relations Committee on **page 45**.



Stakeholder risk assessments are conducted annually and monitored continually, using a specific methodology to risk-rate stakeholders. Engagement strategies are defined according to each assessment. An example of the risk assessment is shown alongside.

Our approach to ethics

The Scheme operates according to the highest ethical standards relevant to a medical scheme and as an employer. The Scheme's policies specify the standards of ethical behaviour expected of its Trustees and employees in such areas as compliance with the law, human rights, employee rights, the protection of personal information and practices in the operating environment (including anti-competitive behaviour).

These standards of behaviour are aligned with the ethical values and moral duties of King III, and the expectations of the CMS.

Moral duties:

- Conscience;
- Stakeholder inclusivity;
- Competence;
- Commitment; and
- Courage.

Ethical values for governance, management and operations:

- Discipline;
- Transparency;
- Independence;
- Accountability;
- Fairness; and
- Responsibility.

The Scheme encourages the reporting of fraudulent or unethical behaviour.

See the Information Toolkit on **page 152** for information on how to report.

How we add value to our key stakeholders *continued*

Members

The Scheme exists for its members. Its primary purpose is to maximise the overall value they receive relative to the overall cost, in the context of the Scheme's sustainability. Engagement with all of our other stakeholders is undertaken to support this aim.

Members entrust their healthcare funding needs to the Scheme, which aims to ensure the long-term affordability of contributions so that its members are able to remain with the Scheme.

The Scheme works to empower its members and ensure excellent quality and service delivery. Member engagement is done through Discovery Health's infrastructure and member support systems: members can make contact through a call centre, via the website (www.discovery.co.za), through the Discovery App for smart phones and tablets, or by visiting five walk-in centres around the country. These member support systems are designed to provide members easy access to accurate information about their benefits, claims and other plan information. Various customer satisfaction and operational metrics are monitored on an ongoing basis to assess whether members' service expectations are being met.

Do you want to submit a complaint or compliment, or lodge a dispute?

Find out how on **page 153**.

The Scheme ensures that all members are continuously informed of changes in benefits and contributions, formularies and the Rules governing their health plans. This enables members to make informed decisions about the plan type which is best suited to their healthcare and affordability needs, even as these needs change.

Communication to all members happens during October of a benefit year, advising them of the changes made to benefits and the contributions for the following year. Members are encouraged to familiarise themselves with the benefit options available and ensure that their plan meets their healthcare needs and those of their dependants for the following year. Members are offered the opportunity to upgrade their plan options once a year. Members can also visit a financial adviser for assistance in choosing an appropriate plan type. Members are encouraged to understand how they can obtain full cover for treatment and avoid co-payments and shortfalls by using designated service providers and hospitals in the Scheme's networks.

Read more about how to get the most out of the Scheme's plans at **https://www.discovery.co.za/portal/individual/medical-aid-full-medical-cover**.

In addition to this communication, which is emailed to each principal member, information on the benefits and contributions as well as plan comparisons are made available on the website and communicated through newsletters. Where applicable, training sessions are hosted by employers or financial advisers.

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

Notable initiatives undertaken in 2015 to enhance benefits, access to healthcare and empower members with knowledge and choice are set out as follows:

Empowering members and supporting healthcare providers

Discovery Health Medical Scheme and Discovery Health believe that informed and empowered members in partnership with skilled, knowledgeable, and motivated healthcare professionals can build a better healthcare system.

Patient Satisfaction Survey (PASS)

During 2015, Discovery Health started publishing the results of members' perceptions of their experience of hospital care on the Scheme's website, www.discovery.co.za. This allows Scheme members to assess the quality of care received in specific facilities, and supports hospitals in the Scheme's network to improve the overall quality of care they provide.

Patient Guides

By actively taking part in the care offered by their doctors, members can help to increase the effectiveness of that care. To encourage Scheme members to be fully informed about their illness and care, Discovery Health has published two guides on the website:

- Visiting your doctor; and
- Safer hospital care.

These guides will be added to over time.

Discovery HomeCare

Discovery HomeCare is a service provider that offers home-based care. Using the services of Discovery HomeCare, Scheme members can receive care in the comfort and familiar surroundings of their homes despite their illness or condition. Discovery HomeCare is an accredited service provider that offers high-quality service provided by professional nurses and qualified care workers who have received additional quality training from Discovery Health.

Quality nursing and care worker support is available through Discovery HomeCare for these therapeutic areas:

- Post-natal care.
- End of life, palliative care delivered in partnership with the Hospice Palliative Care Association of South Africa.
- Home infusions into the vein (IV infusions) of antimicrobials, biologics, iron and immunoglobulins for stable patients.
- Wound care of venous ulcers, diabetic foot ulcers, pressure sores and other moderate to severe wounds for stable patients.
- Respite care – short-term care services that offer temporary relief for caregivers looking after the healthcare needs of beneficiaries.

Discovery HomeCare is covered according to the Scheme's individual plan benefits with the exception of respite care, which is not included and so would require a co-payment from the member.

Benefits of Discovery HomeCare

Improved member experience and service: members do not have to travel to a facility to receive care, but can receive treatment and have accredited nurses or care workers take care of them in the comfort of their own home.

Maintaining and improving quality of care and outcomes: highly skilled nurses and care workers deliver quality homecare in a professional manner.

Prevention of hospital admissions and shortening length of stays: certain treatment can be rendered in a home environment, making it possible to receive care without being admitted to hospital. Discovery HomeCare can also assist to reduce the standard number of days in hospital, making it possible for members to recover in the familiar surroundings of their homes.

A unique, home-based healthcare service that offers members quality care in the comfort of their own home.

Discovery HomeCare is available in Gauteng, Durban, Cape Town and Port Elizabeth, and is covered by members' relevant existing benefits.

How we add value to our key stakeholders *continued*

Members *continued*

Personalised healthcare for improved outcomes

Discovery Health announced a partnership with Human Longevity, Inc. (HLI), a world leader in genome sequencing and research. During 2016, HLI will provide Scheme members with access to an advanced genome (DNA) test that can begin to form part of a precise medicine programme for each member.

The test that will be made available to participating members, which is a screening test involving the analysis and interpretation of the exome, is a world first. The exome is the region of DNA that contains our genes, and the purpose of the screening test is to identify certain health risks and predict reactions to medicines. Through their participation, Scheme members will also be making a significant contribution to research, generating new knowledge that will be relevant globally and to South Africa.

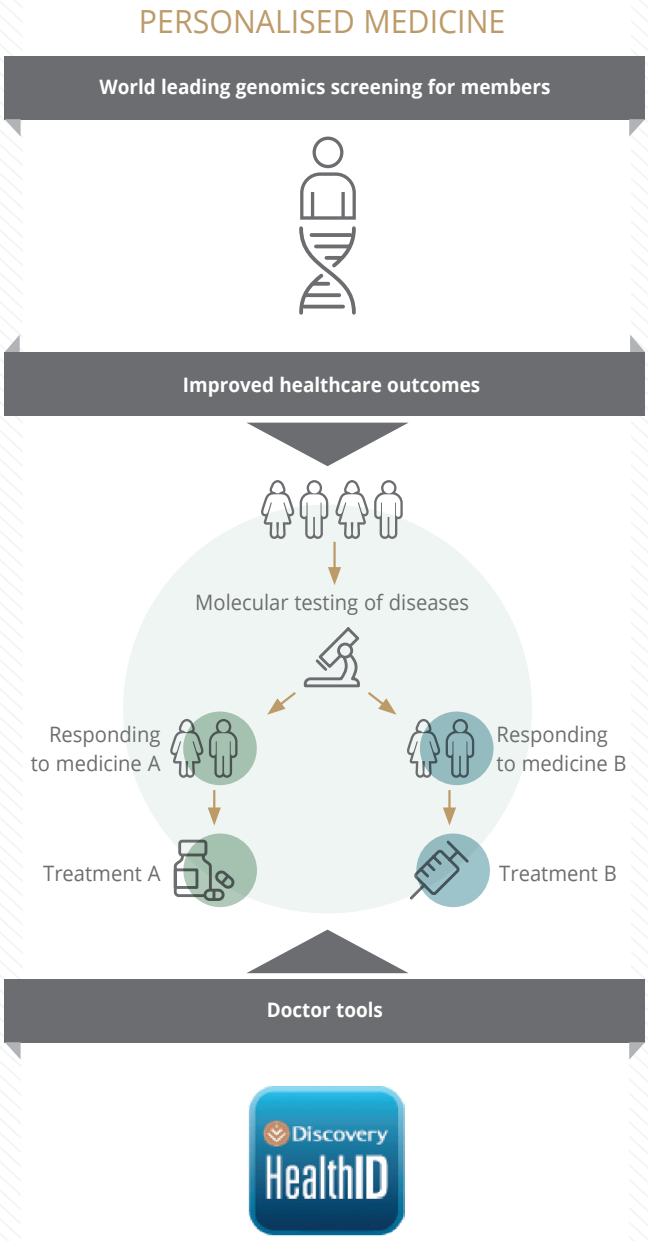
The Smart Plan and accessing networks through mobile technology

In 2015, the Scheme launched the Smart Plan, which embraces the dynamic world of digital technology, empowering members to manage their health plan and access healthcare professionals through their smart phone or other devices.

Read more about the Smart Plan on **page 74** or at **https://www.discovery.co.za/portal/individual/medical-aid-plan-range**.

Read more about Discovery Health's initiatives for the Scheme and its members in 2015 from **page 66**.

Delivering personalised healthcare and service journeys



Healthcare providers and professional societies

Discovery Health Medical Scheme believes that healthcare providers (which include doctors and specialists, nurses, pharmacists and paramedics, as well as private hospital groups and specialist practices), as an integral part of South Africa's healthcare system, are a national asset.

Healthcare professionals work in a challenging environment of rapidly increasing costs, and are often placed in a position of conflict between their patients, for whom they wish to provide the best possible care, and medical schemes, who must balance the needs of all their members (and indeed all their beneficiaries) with those of individual members, while ensuring the Scheme's sustainability over the long term.

Healthcare inflation is a challenge for the entire sector, and it is particularly hard for healthcare providers to see their patients' care being affected by it. For this reason, the Scheme and Discovery Health work closely with healthcare providers to facilitate access to quality of care with managed costs through the Scheme's primary and specialist care networks.

Doctors and other healthcare providers play a crucial role in ensuring the sustainability of private healthcare delivery. The majority of general practitioners and specialists in private practice participate in the Scheme's network and payment arrangements.

The Scheme has also led the industry in the implementation of innovative alternative payment arrangements with the major hospital groups. These, together with effective risk management by Discovery Health, have allowed the Scheme to achieve a substantial cost advantage over competitor schemes in relation to hospital costs, a key component of the Scheme's claims expenditure.

The Scheme also has contracts with all major pathology groups and radiology practices, as well as the majority of other healthcare professionals. These arrangements provide members with certainty of cover and a wide range of options to avoid co-payments, while also allowing the Scheme to comply with Prescribed Minimum Benefit legislation in terms of the Act.

The Scheme and Discovery Health engage actively and continuously with the representatives of healthcare professionals through their respective professional societies, to understand how best to support them in meeting quality of care challenges. Regular meetings, workshops and thought leadership summits are held where pertinent issues affecting healthcare delivery in South Africa are examined. Other engagement includes meeting with representative bodies and societies on specific industry issues. Continuous engagement with the pharmaceutical industry is undertaken to secure the best possible prices of medicines for members, thereby protecting the pool of funds from which members' claims are paid.

In 2015 the following engagement activities were conducted:

- Workgroups with various healthcare providers and professional societies to address a variety of topics, including provider challenges, new technology and claims coding services.
- Discovery Health hosted thought leadership summits, clinical and healthcare conferences and mutual listening sessions.
- Ongoing engagement with societies and representative bodies in the industry.
- Articles were published in medical journals and the press to showcase initiatives and collaboration with doctors.
- Formulation of alternative reimbursement models with professionals from various healthcare disciplines, such as interventional cardiology, urologists, surgeons, paediatricians, physicians, and GPs.

The Scheme is committed to working in collaboration with and supporting healthcare providers in the pursuit of quality, cost-effective healthcare for their patients – our members.

How we add value to our key stakeholders *continued*

Healthcare providers and professional societies *continued*

Recognising excellence in quality of care

In 2015, Discovery Health hosted the second annual Discovery Health Quality Summit, bringing together doctors, hospital groups, the Department of Health and other thought leaders within the industry. The Summit focused on how to innovate towards a better quality, patient-centred healthcare system, and allowed the participants to share best practice. The international keynote speaker's focus was the importance of informed and empowered patients and families.

The Quality Summit ended with the Quality Awards for 2015; where leading hospitals and other providers were recognised for their contribution to the care of Discovery members. In addition, eleven finalists were recognised in the Discovery Excellence Awards for Nurses (DEAN), where one enrolled nurse assistant received a R50 000 scholarship from Discovery Health to further his studies, and four registered nurses were rewarded with a two-week nurse leadership programme at Massachusetts General Hospital in Boston, USA. Given that South Africa is experiencing a serious shortage of nurses, this new award has been created to reward and enhance nursing excellence and create opportunities for further education and training, as well as highlight the important work nurses do within the healthcare system.

Read more about how the Scheme works to empower members on **pages 22 – 24**.

Partnerships with healthcare professionals

Discovery Health Medical Scheme, with Discovery Health, continues to engage with healthcare professionals individually and through various professional bodies to form partnerships that enhance and support the quality of care provided to its members.

Joint Care

Joint Care is a hip and knee arthroplasty programme with a unique alternative reimbursement funding model. Joint Care has proven successful with early findings demonstrating high-quality cost-effective access to joint arthroplasty surgery for Scheme members.

Orthopaedic specialists perform the surgery with quality and cost containment as clear areas of focus. All activity is transparent with an internally reviewed peer programme and published results.

The care pathway has demonstrated excellent clinical outcomes and cost efficiency over an extended period. This offers a significant opportunity for Scheme members if these learnings were to be implemented by other surgeons.

SASCI CAD Care Project

Discovery Health, in collaboration with the South African Society of Cardiovascular Intervention (SASCI), launched a care delivery programme to demonstrate that collaborative learning and data sharing can improve healthcare quality and cost outcomes for members diagnosed with coronary artery disease (CAD). Cardiologists who choose to participate benefit from access to more flexible funding and a more efficient benefit reimbursement process as well as enhanced professional remuneration.

Read more about healthcare professional partnerships, and other Discovery Health initiatives for the Scheme and its members in 2015 from **page 66**.

HealthID

HealthID is the first electronic health record application of its kind in South Africa. It makes members' health records available to their doctors (once consent is given) and assists doctors in interacting with the Scheme. During 2015, HealthID was made available on the website, **www.discovery.co.za**.

Read more about HealthID on **pages 70 – 71**.

Financial advisers (brokers)

Financial advisers play a critical role in the private healthcare sector as they provide comprehensive and independent advice to prospective and existing members about the healthcare cover best suited to their specific health and affordability needs. Without advice and support from financial advisers, many members would find it daunting to navigate the complexities of the private healthcare system.

Financial advisers introduce individual consumers and employers to the full spectrum of medical schemes in the industry, and help to educate and empower them by presenting detailed comparisons of the benefits, pricing and service levels of competing medical schemes. They then advise on relative strengths and weaknesses of each scheme relative to the needs of the consumer or organisation's employees in order to match needs with the most suitable medical scheme offering. Once consumers have joined a scheme, financial advisers continuously provide services to members through annual reviews, and update members and employers on product and service changes.

Financial advisers are accredited by the CMS and the Financial Services Board (FSB) and must be Financial Advisory and Intermediary Services Act compliant.

Members do not pay financial advisers directly as they are reimbursed for their services in terms of legislated fees, according to the advisers' contractual arrangements with the Scheme.

Discovery Health engages extensively with advisers on the Scheme's behalf. Annual product launches and updates are complemented by in-depth training and assessment sessions to support advisers. The Scheme has a particular focus on ensuring that our health plan information is written in an easily understood and accessible way, for the benefit of both members and advisers.

In 2015 the following engagement activities were conducted:

- Annual product updates regarding the Scheme's product and benefit enhancements for the new benefit year were provided in a nationwide rollout to over 200 broker consultants and agents, and broadcast to more than 7 000 financial advisers from the annual product launch event.
- Presentations to corporate brokerages included information on the Scheme's strategies, industry position, financial results and fraud management.
- Broker consultants were trained and their knowledge was assessed regarding the Scheme's products, the private healthcare industry, and sales and presentation skills.
- The Discovery Financial Planning Summit brought together some of the best local and international experts in financial planning to share insights and best practices on topics such as regulatory developments, branding, succession planning and practice management.
- Major corporate brokerages were provided with comprehensive analysis of the South African medical schemes industry, and comparative analysis of 2015 open medical scheme financials.
- Broker perception surveys were conducted to establish how satisfied brokers are with the service they receive.

How we add value to our key stakeholders *continued*

Employer groups

Employer groups offer their employees the opportunity to access specific medical scheme cover by virtue of their employment. This may be through a specified subsidy or a structured salary package that affords the employee the opportunity to purchase medical scheme cover.

In 2015 the following engagement activities were conducted:

- Corporate wellness days allowed interaction with members who are part of an employer group.
- Focused service and engagement strategies were developed with employer groups, tailored to suit their workforce's servicing needs.
- Nationwide product updates for employers.

HealthyCompany: a comprehensive wellness solution for employers

The workplace environment provides the ideal opportunity to influence people's health and wellness behaviour. Healthy employees mean less costs related to healthcare, higher productivity and lower absenteeism.

The Scheme funds various screening tests as part of the HealthyCompany programme, according to members' plan benefits. The programme is also fully integrated with Vitality[1], Discovery's world-class science-based wellness programme that is available on a voluntary basis to Scheme members and rewards people for knowing and improving their health.

Read more about Discovery Health's initiatives for the Scheme in 2015 from **page 66**.

1 *Vitality is a separate wellness product sold and administered by Discovery Vitality (Pty) Ltd. Registration number 1999/007736/07, an authorised financial services provider.*

Discovery Health (Pty) Ltd

The Board of Trustees (the Board) has appointed Discovery Health as its Administrator and Managed Care provider. The Scheme and Discovery Health have an arm's-length contractual relationship that directs all outsourced activities. The working relationship between the two organisations is governed by a Vested® outsourcing business model, which focuses on outcomes and is characterised by a shared vision and aligned objectives.

Read more about the Vested outsourcing model and how we conduct our operations on **pages 18 – 19**.

Discovery Health reports extensively to the Board, its Committees and the Scheme Office on a regular basis. The Board can therefore ensure that Discovery Health meets the strategic and operational requirements agreed on, and is acting in the best interests of members.

The agreement that the Scheme has with Discovery Health specifies extensive service level requirements, against which the Board monitors and measures Discovery Health's performance.

The engagements between the Scheme and Discovery Health are frequent and focus on:

- Scheme performance and risk management;
- Implementation of Scheme strategy;
- Product design and implementation of Scheme benefits;
- Marketing and sales;
- Member and other key stakeholder communication;
- Regulatory and industry matters;
- Service level agreement assessments and monitoring;
- Combined assurance; and
- Stakeholder relations.

Regulators

Maintaining constructive and collaborative relationships with regulators is crucial to the Scheme's ability to create value. The Scheme and Discovery Health are required to adhere to strict legislation, mainly but not limited to the Act. The intensity and frequency of the Scheme's interactions with these entities will differ every year, but it is vital that the lines of communication are kept open. This allows the Scheme to operate within the confines of legislation, to the ultimate benefit of its members and society as a whole.

The Competition Commission

The Competition Commission is conducting a market inquiry into the private healthcare sector, to determine whether there are aspects of the private health industry which distort, restrict or prevent competition. Its final report is expected in December 2016.

During the course of 2015, the Scheme engaged regularly with the Health Market Inquiry Panel, made data and information submissions as required, and co-operated fully and openly in the process.

Council for Medical Schemes

The CMS regulates all medical schemes in South Africa. Its role includes: protecting and educating the public with regard to medical schemes; assessing and registration of scheme rules and benefits; handling complaints and disputes between the public and medical schemes; ensuring that schemes comply with the Act and maintain a high standard of governance and management; and working with the Department of Health regarding regulatory and policy interventions.

The Scheme engages actively with the CMS on matters of policy, application and interpretation of rules, benefit design, scheme finances and resolution of disputes with members. The Scheme enjoys a professional and transparent working relationship with the CMS.

In 2015, the CMS published 75 circulars and the Scheme submitted responses where required.

Find out more about the CMS at **https://www.medicalschemes.com**.

Employees

The Scheme's employees 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 their talent, to ensure the best efforts from fulfilled, engaged members of staff.

Quarterly performance assessments and 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. Periodic assessment and audit of the Scheme's value proposition to employees ensure staff satisfaction and retention.

Governance

Our Chairperson's statement

The Board of Trustees of Discovery Health Medical Scheme continues to act with due care, diligence, skill and good faith in the best interests of the Scheme and its members. The Scheme's governance structures are carefully designed to ensure independence and compliance with all applicable laws, codes and standards, and to support the Board in overseeing the operations of the Scheme as a non-profit entity.

Sound financial management, governance best practice and effective risk management underpin the Scheme's pursuit of its strategic objectives, which are focused on ensuring its long-term sustainability. The strong performance delivered in 2015 has once again provided evidence of the Scheme's effectiveness in all these areas. Furthermore, the Scheme's continued success is a direct result of its business model, which aligns the objectives of the Scheme with those of its Administrator and Managed Care provider, Discovery Health (Pty) Ltd. The Board remains confident that this Vested® outsourcing model works to the absolute advantage of its members.

The Scheme's strong financial performance in the year was achieved in a difficult operating environment. The domestic economy has weakened further, and spiralling healthcare costs remain a significant challenge. The Scheme and its Administrator have continued to engage with health professionals to find

Sound financial management, governance best practice and effective risk management underpin the Scheme's pursuit of its strategic objectives, which are focused on ensuring its long-term sustainability.

1 *Source: Stats SA (http://www.statssa.gov.za/)*

ways of countering ever-increasing healthcare inflation while also adopting the newest technologies to facilitate improvements in clinical quality and health outcomes. The Scheme also supports the voluntary engagement of members in wellness interventions and programmes, which have had a significantly positive impact on the Scheme's claims experience. The efficient coordination of care, better information gathering and sharing, and optimised processes remain a core focus for the Scheme.

A feature of the year was the Competition Commission's Healthcare Private Market Inquiry, which is ongoing. The Scheme has made substantial submissions in response to information requests from the Commission. During 2016, the Commission will conduct public hearings in which the Scheme will take part. The Scheme will continue to actively support the process, seeing it as a catalyst for positive change in the provision of private healthcare funding and delivery in South Africa.

Private healthcare is a national asset that is essential to the functioning of the broader healthcare system, and which strives to service its beneficiaries in a cost-effective manner. The country's private healthcare system can and must thrive, and it must expand its services beyond the 16% of South Africans it currently covers. The 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.

During 2015, the Scheme enhanced its engagement with all its key stakeholders in the fulfilment of its strategic objectives. As an important forum to interact directly with its members, the Scheme held its Annual General Meeting in June 2015. The Scheme's performance and financial results were reported, the re-appointment of a Trustee and the appointment of the external auditors were confirmed, and an updated Trustee remuneration methodology and policy (which can be read on pages 46 – 47) were presented.

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 diligence in fulfilling their duties. The Principal Officer and his management and support 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 strategies and operations.

MICHAEL VAN DER NEST, SC
CHAIRPERSON

How we are governed

Medical schemes are governed by the Medical Schemes Act 131 of 1998, as amended (the Act). The Scheme Rules are developed in accordance with the Act and approved annually by the Council for Medical Schemes (CMS). Additional governance guidance is taken from the King Code of Governance Principles, 2009 (King III), which sets the standard for good corporate governance in South Africa, and is recognised internationally as best practice.

Governance framework and structure

Discovery Health Medical Scheme is governed by an independent Board of Trustees (the Board). The members of the Scheme elect at least half of the Trustees. The Board is responsible for the governance and oversight of the business of the Scheme. In compliance with the Act and the registered Rules of the Scheme, and in line with best practice governance principles, the Board has implemented appropriate governance structures to navigate and manage the complex operating environment, risks and strategic objectives of the Scheme.

The Board of Trustees is set out on **pages 10 – 12**.

The Board holds the decision-making power of the Scheme and is ultimately responsible for the implementation of the Scheme's strategy and the sound management of its business. The Board's overriding objective is to ensure the best interests of Scheme members are served in the context of the sustainability of the Scheme.

Scheme Rules are available to registered members at **https://www.discovery.co.za/portal/individual/dhms-rules**.

The Board is supported by ten Board Committees, constituted and structured based on the needs of the Scheme, and to assist the Board to fulfil its fiduciary and oversight duties effectively. Board Committee members consist of both Trustees and independent members. The Committees report regularly to the Board, and each has its own terms of reference and clear procedures for reporting. The terms of reference set out each Committee's role and responsibilities, which are reviewed on an annual basis to ensure that they remain relevant to the business of the Scheme, and that the skill and expertise of members on the Committee are appropriate and relevant. The Committees make recommendations to the Board for approval of any decisions to be taken.

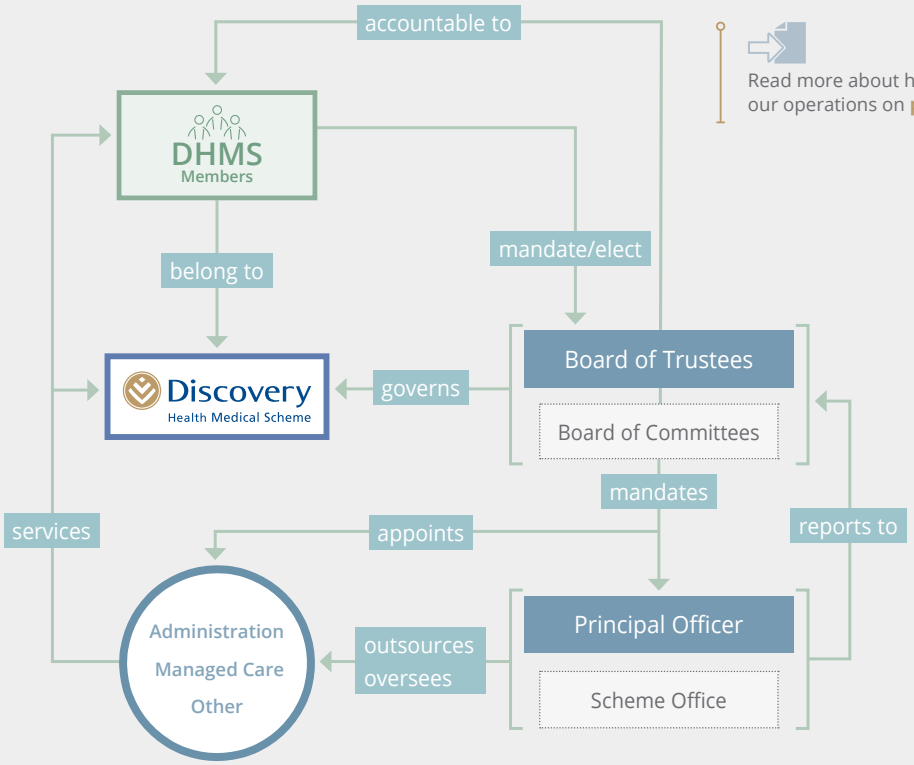
Read more about the responsibilities and activities of the Board Committees from **page 37**.

Read more about the Scheme Office on **pages 14 – 15**.

The Board appoints and delegates to an Executive Principal Officer the accountability for the day-to-day management of the Scheme. The Principal Officer executes the Board's decisions and implements strategy. The Principal Officer is supported by an executive management team.

The Board and its Committees perform annual peer reviews and self-assessments to assess effectiveness and strengthen governance processes. Assessment questionnaires refer to the Board Charter and terms of reference of each Board Committee to ensure that the Board and the individual Committees effectively fulfil their roles and responsibilities. Any issues raised are noted and addressed; no significant issues were raised in 2015.

The Scheme's governance structures and processes, based on the provisions of the Act and best practice governance principles, are also set up to ensure independence from the appointed Administrator, Discovery Health (Pty) Ltd. The Principal Officer and his executive team collaborate actively with Discovery Health and obtain the information required to effectively monitor and oversee the operations of the Scheme. Recommendations from Discovery Health are presented to the Board for review and approval.



Read more about how we conduct our operations on **pages 18 – 19**.

The Scheme uses the Governance Assessment Instrument (GAI) to evaluate the implementation of governance structures and processes as recommended in King III. The survey tool shows a meaningful score which reflects the Scheme's adoption of King III.

Role and duties of the Board

The Board comprises independent, highly skilled professionals with distinctive expertise in clinical, financial, business, legal and actuarial disciplines.

The role of the Board includes the following:

- Evaluate, direct and monitor the Scheme's strategy, ensuring that it is aligned with the purpose and value drivers of the Scheme, and the legitimate interests and expectations of stakeholders.
- 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 offer value for money.
- Monitor innovation and oversee the improvement of all levels of the Scheme's operations.
- Monitor adherence to the Scheme Rules and the provisions of the Act in the day-to-day running of the Scheme's affairs.
- Commission periodic independent governance reviews to assess the effectiveness of the Board and its Committees and to ensure it has the requisite skills and expertise.
- Consider stakeholder perceptions and their impact on the Scheme's reputation.

The Board is required at all times to act with due care, diligence, skill and good faith in the best interests of the Scheme and its members. The duties of the Board are set out in the Act and Scheme Rules and include the following:

- Take all reasonable steps to ensure that the interests of beneficiaries in terms of the Scheme Rules and the provisions of the Act, are protected at all times, acting with impartiality in respect of all beneficiaries.
- Ensure the proper and sound management of the Scheme by applying sound business principles to ensure the Scheme's financial position is sound.
- 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, operations and administration comply with the provisions of the Act and all other applicable laws.
- Oversee and direct the management of the Scheme's outsourced activities performed by the Administrator and Managed Care provider.
- Appoint, evaluate and delegate oversight functions to the Principal Officer.
- Ensure that proper control systems and record keeping are employed by and on behalf of the Scheme.
- Ensure that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and responsibilities in terms of the Scheme Rules.

Board of Trustees attendance in 2015

		20 Feb	5 Mar	26 Mar	16 Apr	21 Apr	7 May	23 Jun	25 Aug	11 Sept	23 Sept	2 Oct	10 Nov	8 Dec
Trustees	Mr Michael van der Nest, SC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Noel Graves, SC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Mr Puke Maserumule	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	×
	Ms Daisy Naidoo	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Prof Zephne van der Spuy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓
	Mr Giles Waugh	✓	✓	×	✓	✓	✓	✓	✓	×	×	✓	✓	✓
Independent co-opted member	Dr Nozipho Sangweni*	✓	✓	✓	✓	✓	✓	×	✓	✓	✓			
Chair: Audit, and Risk Committees	Mr Barry Stott	×	✓	✓	✓	✓	×	✓	✓	✓	✓	×	✓	✓

* *Resigned on 1 October 2015.*

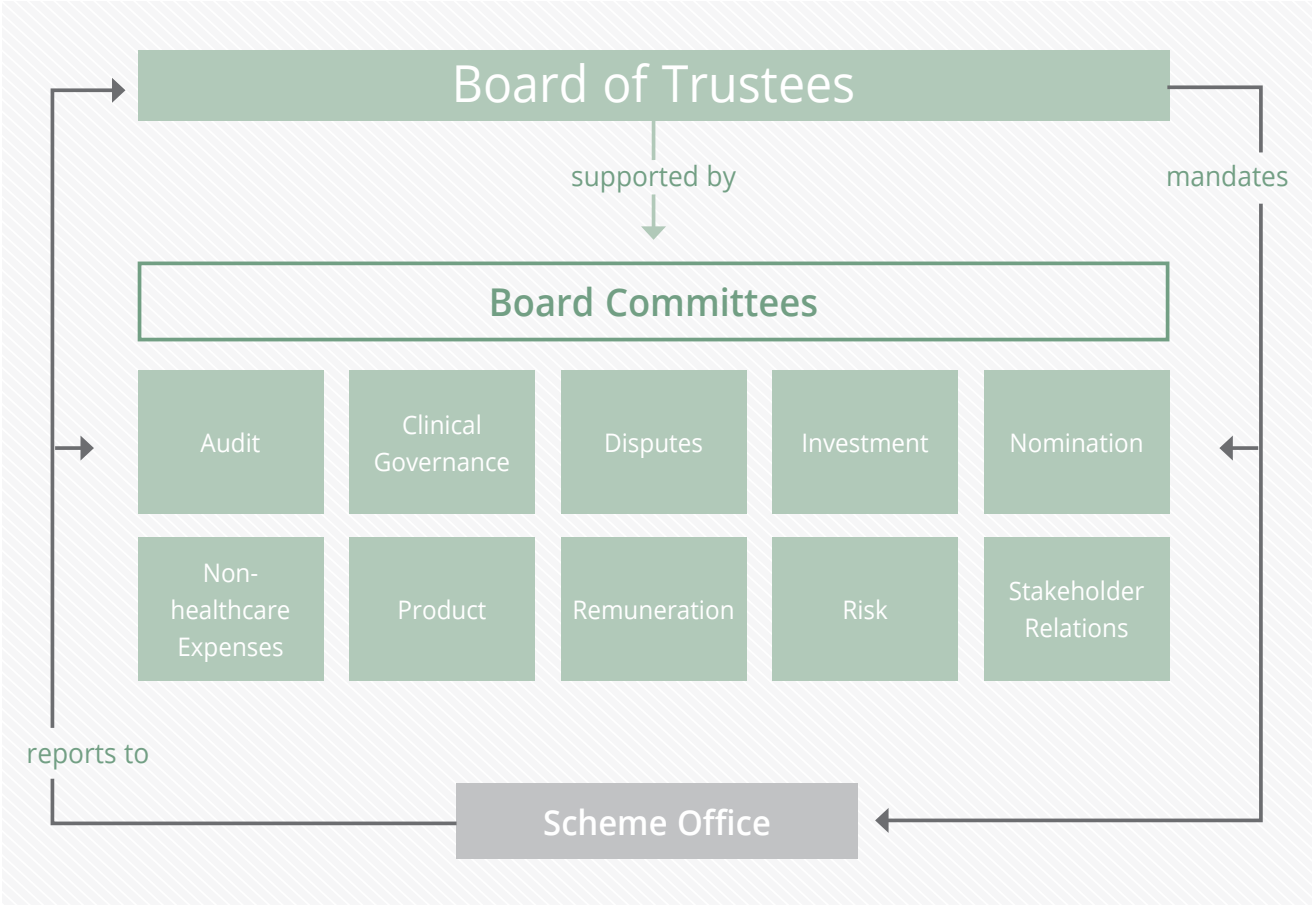
Our Board Committees

The Board is supported by ten Board Committees which assist it to fulfil its fiduciary and oversight duties effectively, and which are established according to governance best practice and the requirements of legislation.

Committee members are remunerated for their service to the Scheme on the basis of a market-benchmarked professional fee, discounted based on the non-profit status of the Scheme.

An annual self-assessment of effectiveness is performed by each Committee, which covers such areas as:

- Committee composition;
- Number of meetings held;
- Maintenance of a constructive relationship with management;
- Interaction between Committee members; and
- Adherence to specific deliverables in the terms of reference.



Our Board Committees *continued*

Audit Committee

The Audit Committee is a statutory committee established in terms of Sections 36 (10) to (13) of the Act, and assists the Board in discharging its 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 role of the Audit Committee, as per its terms of reference, is to assist the Board in fulfilling its governance and oversight responsibilities for:

- Financial reporting processes;
- Integrated and sustainability reporting processes;
- Internal financial controls;
- Monitoring the performance of internal and external audit processes;
- The impact of information technology and information technology-related matters on the financial results;
- The sustainability of business strategy, risk management and good governance;
- Business conduct and compliance with laws, regulations and relevant codes of conduct;
- Matters relating to the sustainability of the Scheme to the extent that it has an impact on the financial results; and
- Monitoring the appropriateness of the Scheme's combined assurance model.

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

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, 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 its independence is evaluated annually. The Committee meets at least five times per year and schedules additional meetings as necessary. The external and internal auditors regularly meet with the Committee without the Administrator and Scheme management being present.

The Annual Financial Statements can be found from **page 77**.

Read the Audit Committee's report on **pages 79 – 80** for information on its 2015 activities, and more about non-compliance matters on **pages 61 – 62**.

Audit Committee attendance in 2015

		4 Mar	11 Mar	21 Jul	20 Aug	21 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*	✓	×	×		
	Mr Dave King*			×	✓	✓

* *Mr Don Eriksson resigned in July 2015.*

* *Mr Dave King has been a member since July 2015.*

* *Mr Neil Novick resigned on 31 December 2015.*

During the first quarter of 2016, Mrs Sue Ludolph and Mrs Philile Maphumulo were appointed to the Audit Committee.

Risk Committee

King III governance principles set out that the Board should be responsible for the governance of risk. The Board established the Risk Committee to ensure good governance and best practice in this regard.

The Scheme operates in accordance with a best practice risk management framework that covers all of its activities, underpins its sustainability and protects its members. In addition to risk management, areas of particular oversight which reside with the Risk Committee include compliance, combined assurance, information technology governance, fraud, ethics, forensics and whistleblowing, legal and regulatory matters and litigation.

The role of the Committee in no way reduces the responsibility of the Board under relevant laws and regulations in respect of governance and oversight of the Scheme.

The principal purpose and objectives of the Risk Committee are to:

- Provide independent and objective oversight of the strategic, financial, insurance, operational, business and regulatory risks faced by the Scheme;
- Consider the risk management policy and processes, and monitor the risk management process and mitigation plans;
- Review the compliance policy, plan and universe and the adequacy and effectiveness of the system for monitoring compliance with laws and regulations, as well as management's response to operational compliance incidents;
- Monitor the effectiveness and appropriateness of the Scheme's combined assurance model, ensuring that it satisfactorily addresses all the significant risks facing the Scheme;
- Review the adequacy and effectiveness of the information technology (IT) control framework and governance structure, ensuring that the risk management process covers the IT environment, and review the Scheme's disaster recovery and business continuity plans;
- Review anti-fraud programmes, controls, procedures and reports, including identification of fraud risks and implementation of anti-fraud measures; and
- Review significant cases of conflict of interest, misconduct or fraud, or any other unethical activity by officials of the Scheme, its Administrator and any other third-party service provider to the Scheme.

Some further detail on key functions follows.

Compliance management

The Trustees recognise their responsibility to internal and external stakeholders in terms of the regulatory requirements applicable to 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 outsources certain compliance activities to the Discovery Group Compliance Function.

This framework is structured to facilitate the process of obtaining information from Discovery Health to monitor and oversee the outsourced operations. A compliance monitoring plan is approved on an annual basis. Changes to regulations that could impact the Scheme's strategy and operations are monitored. Where required, action plans implemented by management are monitored and reported to the Risk Committee on a quarterly basis.

Combined assurance

The Scheme's combined assurance model, which was approved by the Risk Committee during the year, is based on three lines of defence:

- Scheme management;
- Internal assurance providers (Group Risk Management, Compliance, and Forensics); and
- External assurance providers (Internal Audit, external audit and independent actuary).

The Audit Committee monitored the effectiveness of the combined assurance model applied during 2015. The assessment showed that overall, adequate assurance has been provided and received in respect of all significant risks for the 2015 benefit year. The Board is comfortable with the level and type of assurance that the Scheme obtains.

The goal of combined assurance is to prevent business and corporate failure and to contribute to business success and value creation. The combined assurance process is a holistic and strategically focused assurance model, which integrates assurance activities based on the business model and risk profile, matched with the effectiveness of systems, controls and reporting structures. It aims to preserve, protect and grow value, while minimising risk exposure and optimising opportunities and returns in the best long-term interest of the Scheme, its members and other stakeholders.[1]

1 *Adapted from Dr John Hendrikse at the Institute of Risk Management South Africa (http://www.irmsa.org.za/blogpost/951512/186198/Combined-Assurance-model-a-key-to-business-failure-prevention).*

Our Board Committees *continued*

Risk management

The Board recognises that risk management is an integral part of the strategy setting process and delegates the responsibility of designing, implementing and monitoring the risk management process and system to management. Risk management is facilitated by the Chief Risk and Operations Officer who ensures that risk management is embedded into daily management activities. The Scheme outsources certain risk management activities to the Discovery Group Risk Management function.

During the year PwC conducted a review of the progress of the Risk Management function and concluded that Discovery Health Medical Scheme exhibits a number of leading practice risk management protocols and activities when compared to other organisations of similar nature, size and complexity.

Activities in 2015

During 2015, the Committee undertook the following activities:

- Conducted the annual risk assessment, which included representatives of the Committee, the Scheme Office and the Administrator. The amended risk register was subsequently presented to the Board to provide it with sufficient oversight of the Scheme's risk management profile and to allow the Board to discharge its accountability in respect of risk management.
- Reviewed regular risk management reports to monitor developments, and performed its annual review of the risk management framework. The Committee approved the framework and subsequently recommended it to the Board for approval.
- Considered regular compliance reports and monitored exposure and actions taken to mitigate such risks, as well as performed its annual review of the Compliance Policy. The Committee approved the policy and subsequently recommended it to the Board for approval.
- Reviewed a revised combined assurance framework which meets the requirements of King III and supports the Audit Committee in making their control statements in the Integrated Annual Report.
- Monitored the implementation of a Scheme-specific IT governance framework and had an independent third party conduct a special review of IT governance.
- Noted the results of an independent review of the Risk Management function.

The Board is satisfied that the risk process is effective in continuously identifying and evaluating risks and ensuring that these risks are managed in line with business strategy.

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

Risk Committee attendance in 2015		4 Mar	21 Jul	21 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*	✓	×	
	Mr Dave King*		×	✓
Scheme management	Mr Milton Streak	✓	✓	✓
	Mrs Yashmita Mistry	✓	✓	✓
	Mr Selwyn Kahlberg	✓	✓	✓
	Dr Bhadrashil Modi	✓	✓	✓
	Mr Jan van Staden*		✓	✓
	Dr Nozipho Sangweni*			✓

* *Mr Neil Novick resigned on 31 December 2015.*

* *Mr Dave King has been a member since July 2015.*

* *Mr Don Eriksson resigned in July 2015.*

* *Mr Jan van Staden joined in June 2015.*

* *Dr Nozipho Sangweni joined in October 2015.*

During the first quarter of 2016, Mrs Sue Ludolph and Mrs Philile Maphumulo were appointed to the Risk Committee.

Investment Committee

The Investment Committee was established for the purpose of recommending and overseeing the implementation and maintenance of investment policies and mandates. The Investment Committee advises the Board on the strategic and operational matters in respect of the investment of Scheme reserves, to ensure that the investments made are in the best interest of members and within the risk appetite of the Scheme, as determined by the Board from time to time.

Some of the specific responsibilities of the Investment Committee are to:

- Monitor the effectiveness and implementation of the investment policy;
- Make recommendations to the Board regarding the asset allocation principles of the Scheme's investment portfolio and the investment policy and strategy;
- Review investment strategies, capital and equity market assumptions, performance of the overall investment portfolio and performance of asset managers against established benchmarks and report to the Board quarterly on the performance of the portfolio (as appropriate);
- Monitor the performance of each asset class with a view to maximising the total return, keeping in mind the risk appetite of the Scheme;
- Report to the Board annually on the overall performance of the asset managers;
- Make recommendations to the Board on the appointment of asset consultants and asset managers, including the recommendation on fees payable and other terms on which the appointments are made and, if appropriate, put out for tender the appointment of asset consultants and asset managers;
- Assist the Board in their decision-making processes, whether to withdraw funds from relevant portfolios as required from the invested funds, to support daily operations;
- Supervise the safekeeping and handling of the Scheme's investments;
- Monitor all reported investment activities for compliance with the Scheme's investment policy as well as statutory requirements. In instances where there is deviation from the investment policy, the Investment Committee investigates the reasons and recommends corrective action to the Board; and
- Assist the Board in preparing their annual report on investment performance and compliance.

The Investment Committee comprised three Trustees and one independent Committee member during 2015.

Activities in 2015

During 2015, the Committee undertook the following activities:

- Considered the Scheme's strategic and tactical asset allocation given the difficult market conditions experienced during 2015.
- Developed and implemented a Responsible Investing Policy.
- Reviewed the results of the offshore asset manager due diligences conducted by the Scheme Office.
- Commissioned the development of a Credit Risk Policy, the purpose of which is to guide the Scheme on credit risk identification, measurement, monitoring and management in its oversight capacity.

Investment Committee attendance in 2015		4 Mar	21 Jul	21 Oct	21 Oct
Trustee/Chair	Mr Puke Maserumule	✓	✓	✓	✓
Trustees	Mr Noel Graves, SC	✓	✓	×	✓
	Ms Daisy Naidoo	✓	✓	✓	✓
Independent member	Mr Barry Stott	✓	✓	✓	✓

During the first quarter of 2016, Mr Imtiaz Ahmed was appointed to the Investment Committee.

Our Board Committees *continued*

Clinical Governance Committee

The primary purpose of the Clinical Governance Committee is to assist the Board in the oversight of funding policies for benefits based on clinical best practice, clinical governance and balancing access to appropriate cost-effective quality healthcare with the needs and expectations of all stakeholders in a consistent and equitable manner.

The Committee comprises members with the requisite skills to consider the clinical complexities in healthcare funding. The members include one Trustee who is the Chairperson of the Committee, one co-opted independent member and the Chief Medical Officer of the Scheme.

Clinical governance is integral to the funded healthcare environment, in ensuring that high-quality and affordable clinical care is offered to members. It employs internationally recognised clinical best practice to account for clinical performance. The Scheme therefore operates according to a best practice clinical governance structure that adheres to the following principles:

- Transparency;
- Accountability;
- Responsibility;
- Fairness;
- Independence;
- Ethical behaviour; and
- Social responsibility.

The Committee oversees the functions performed by Discovery Health, the Scheme's Managed Care provider, in terms of the managed care agreement. In this regard it has insight into clinical risk management, clinical policies and protocols, ex-gratia requests and decisions, clinical pilot projects, member queries, research and development of clinical best practice, and health benefit formulation.

The Committee's responsibilities are to:

- Ensure healthcare benefits as prescribed by the Act and the Scheme Rules are upheld; and
- Ensure the Scheme's managed care mandate to offer members the highest level of appropriate, affordable quality care is complied with, taking into account the balance between cost-effective quality healthcare, effective clinical risk management, and affordability.

The Scheme's approach to ensuring the quality of care received by its members considers the structures, processes and outcomes in their healthcare journey. The complexity of the healthcare model requires that the member is placed at the centre of this journey, and that different stakeholders in the provision of care collectively take responsibility for a sustainable healthcare funding model.

Read more about our member-focused quality of care approach on **pages 69 – 70**.

The Committee reviews and monitors all initiatives formulated to reduce unnecessary healthcare costs without negatively impacting on the quality of care, and to support superior member experience and value-based care. The Committee also oversees the engagement strategies with healthcare professionals facilitated by Discovery Health, which foster shared purpose by re-engineering the delivery of care according to a team-based approach.

Read more about these initiatives on **pages 25 – 26** and **68**.

Health Quality Assessment (HQA) is an industry body that performs an annual assessment of clinical quality offered by medical schemes through the use of quality indicators. As a participating scheme, DHMS receives an annual Scheme-specific report that assists the Clinical Governance Committee in fulfilling its mandate to oversee and improve the quality of healthcare received by Scheme members. In 2015, the Scheme achieved the highest overall results for process measures in the industry.

In considering the member experience and ensuring adherence to the Act and the Scheme Rules, the Committee also monitors and evaluates complaints, queries and disputes lodged by members with DHMS or the CMS.

Read more about the Disputes Committee on the next page.

Clinical Governance Committee attendance in 2015		19 Mar	14 Jul	9 Nov
Trustee/Chair	Prof Zephne van der Spuy	✓	✓	✓
Independent member	Dr Nozipho Sangweni*	✓	✓	✓
Scheme management	Dr Bhadrashil Modi**	✓	✓	✓

* *Dr Nozipho Sangweni resigned in October 2015 and joined Scheme Management, replacing Dr Bhadrashil Modi.*

** *Dr Bhadrashil Modi resigned in December 2015.*

During the last quarter of 2015, Professor Mike Sathekge and Professor Selma Smith were appointed to the Clinical Governance Committee.

Disputes Committee

Section 29 (j) of the Act requires the rules of a scheme to provide for 'the settlement of any complaint or dispute'. Rule 27 of the Scheme Rules outlines the process for resolution of complaints and disputes. In terms of this, the Board has established an independent Disputes Committee which hears and rules on all member disputes in an open, transparent and equitable manner.

The Committee consists of three members drawn from a panel, all of whom have either legal or medical expertise. All Committee meetings held must be attended by at least one legal expert and at least one medical expert, so that there is always a combination of expertise. While not employed by the Scheme, Committee members are remunerated for their time and input in objectively hearing and adjudicating cases, regardless of the outcome of the hearings.

The Committee's purpose is to make consistent and fair decisions, carefully considering the provisions of the Act, all other laws that may be applicable, the Scheme Rules and the needs of all stakeholders.

The Committee's responsibilities are to:

- Hear the submissions presented to it by the member and the Scheme's representative (which may be verbal and/or in writing) in line with relevant legislation and the Scheme Rules;
- Ensure that it has sufficient information regarding the dispute to objectively adjudicate the case;
- Determine an outcome for the dispute and draft a ruling with due regard for all facts presented at the hearing; and
- Ensure that the process of hearing and adjudicating on disputes is handled as efficiently as possible and without any undue delay.

In the event of a member being dissatisfied with a ruling made by the Committee, they are able to lodge a complaint with the CMS.

Read more about how to lodge disputes on **page 153**.

Activities in 2015

- The Committee heard a total of 65 disputes, which included nine that were carried over from 2014. Although 326 disputes were lodged in 2015, most were escalated according to business processes and were resolved with the member before being referred to the Disputes Committee.
- A total of 14 disputes from 2015 were carried over to hearings in 2016.

The attendance at each Committee hearing varies in line with the expertise required, as per the requirements set out above.

Non-healthcare Expenses Committee

Established in terms of governance best practice, the Committee's responsibilities are to:

- Review and recommend the proposed contracted administration and managed care fees to the Board for consideration and approval;
- Review service level agreements and assist the Board to ensure that these have been complied with;
- Monitor the value the Scheme and its members receive from Discovery Health; and
- Recommend the non-healthcare budget to the Board for consideration and approval, and monitor actual non-healthcare expenses incurred against the approved budget.

The Committee comprises three Trustees and the Principal Officer.

Activities in 2015

During 2015 the Committee undertook the following activities:

- Oversaw the development of, reviewed and subsequently recommended for approval to the Board of Trustees a revised arm's-length administration agreement and managed care agreement between the Scheme and Discovery Health.
- Considered the results of an independent review of the value provided to the Scheme by the Administrator.
- Approved a review of the effectiveness of the Scheme's Vested® outsourcing business model.

Read more about on how we conduct our operations on **pages 18 – 19**.

Non-healthcare Expenses Committee attendance in 2015		9 Apr	15 Jul	22 Nov
Trustee/Chair	Mr Noel Graves, SC	✓	✓	✓
Trustees	Mr Giles Waugh	✓	✓	✓
	Ms Daisy Naidoo	✓	✓	✓
Scheme management	Mr Milton Streak	✓	✓	✓

Our Board Committees *continued*

Nomination Committee

The Nomination Committee's responsibilities are to:

- Oversee the nomination process of suitably fit and proper persons for election and appointment;
- Consider diversity, demographics and skills required by the Board; and
- Oversee the nominations process implemented by an independent electoral body.

The Committee is independent of the Board and comprises significantly experienced independent members who are not Trustees.

No Trustee elections were conducted or appointments made in 2015.

Activities in 2015

The Committee was constituted to oversee the 2016 Trustee election process, which commenced in 2015 and required the following activities:

- Considered the appointment of PwC's Forensic Services division to act as the Independent Electoral Body for the Scheme in its 2016 Trustee elections.
- Reviewed and approved the communication to Scheme members regarding the nominations process for the 2016 Trustee elections.

Nomination Committee attendance in 2015		6 Nov	11 Nov	23 Nov
Independent members	Mr Peter Goss	✓	✓	✓
Trustees	Mr Roy Shough	✓	✓	✓
	Mr Tom Wixley	✓	✓	✓

Product Committee

The primary purpose of the Product Committee is to oversee product development, amendments to benefits, proposed benefit plans and the development of annual product communication and marketing materials.

The Committee ensures that benefit proposals are assessed and measured against the following factors:

- Clinical appropriateness and clinical best practice;
- Financial affordability and sustainability;
- Consideration of the best interest of members and fairness;
- Value and appropriateness to members; and
- Marketing and communication best practice.

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

Activities in 2015

During 2015 the Committee undertook the following activities:

- Reviewed the performance of all benefit plans based on specific performance metrics.
- Reviewed and recommended to the Board for approval the 2016 benefit plan amendments.
- Reviewed and recommended to the Board for approval the Scheme's Marketing Policy and Communication Policy. These policies were aligned to the Communication Guidelines for Medical Schemes published by the CMS.

Product Committee attendance in 2015		20 Apr	14 Jul	13 Aug
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	✓	✓	×

* *Dr Nozipho Sangweni resigned in October 2015.*

Remuneration Committee

The Remuneration Committee assists the Board in overseeing the Scheme's remuneration strategies and other human resources policies.

The Remuneration Policy for the Board and its Committees is based on Circular 41 of 2014 issued by the CMS in November 2014. The Committee has reviewed and recommended for approval by the Board the Trustee and employee remuneration policies for the Scheme, based on the input of independent experts and benchmarking surveys. The Committee oversees compliance with these policies.

Read more about the Remuneration Policy on **pages 46 – 47**.

At its 2015 Annual General Meeting, the Scheme presented its Trustee Remuneration Policy to members for a non-binding advisory vote, which received approval. This gave Scheme members the opportunity to provide feedback on the policy, which sets out the principles that guide the way remuneration is structured and determined, as opposed to a vote on the quantum of remuneration paid. The formal approval of Trustee remuneration by members is a standing agenda item at each Annual General Meeting (AGM).

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

Activities in 2015

During 2015 the Committee undertook the following activities:

- Engaged with independent remuneration practice experts to perform remuneration market benchmarking.
- Recommended the 2016 Trustee remuneration to the Board for approval based on a benchmarked hourly professional fee rate (discounted based on the Scheme's non-profit status), taking into account the multi-year implementation of Trustee remuneration approved by members at the 2015 AGM.

Remuneration Committee attendance in 2015		28 May	4 Nov
Independent member/Chair	Mr Don Eriksson	✓	✓
Trustees	Mr Michael van der Nest, SC	✓	✓
	Mr Noel Graves, SC	✓	✓

Stakeholder Relations Committee

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

The Committee assists the Board to identify important stakeholder groups and their legitimate interests and expectations. The Committee also oversees the development and implementation of adequate processes and procedures on how to engage with the relevant stakeholders. The Committee ensures that all legitimate interests of stakeholders are balanced in the best interests of the Scheme as a whole.

The Committee comprises two Trustees, two independent Committee members and the Principal Officer.

Activities in 2015

During 2015 the Committee undertook the following activities:

- Reviewed member engagement, communication approaches and activities undertaken by the Scheme and Discovery Health.
- Monitored the interaction between the Scheme, Discovery Health and various stakeholders.
- Monitored the process being followed with regard to the Competition Commission's market inquiry into the private healthcare sector.

For more information on the regulatory matters dealt with in 2015, see **pages 48 – 49**.

- Reviewed health professional engagement strategies to develop and manage constructive relationships with this stakeholder group, and establish common purpose.

Stakeholder Relations Committee attendance in 2015		19 May	29 Oct
Trustee/Chair	Mr Michael van der Nest, SC	✓	✓
Trustees	Mr Puke Maserumule	✓	✓
Independent member	Dr Nozipho Sangweni*	✓	
	Mr Dave King	✓	✓
Scheme management	Mr Milton Streak	✓	✓

* *Dr Nozipho Sangweni resigned in October 2015.*

Trustee and Committee member remuneration

The Remuneration Committee engaged PwC to assist in developing a new remuneration methodology and benchmark applicable to Trustees, taking into account that the Scheme is a non-profit entity.

External remuneration benchmarks, King III and its Remuneration Practice Notes were used as additional guidance in determining the revised methodology and policy.

PwC recommended that the Scheme use a market benchmarking methodology based on professional fees charged in the fields of law, actuarial science, medicine, accounting and commerce, to be discounted at an appropriate rate to take into account the non-profit status of the Scheme.

This new methodology was submitted to the CMS at the end of 2014 and was implemented for the first time in 2015, following its approval by members at the Scheme's 2015 AGM. The new methodology will be implemented over the next three years, with fees paid to Trustees incrementally adjusted to the benchmark level.

REMUNERATION POLICY – TRUSTEES OF THE DISCOVERY HEALTH MEDICAL SCHEME

Purpose of policy

This policy contains a description of the core principles of the Scheme's Remuneration Policy for the Trustees and members of the Board Committees.

This policy also includes the provisions asserted in the Remuneration Guidelines published by the Council for Medical Schemes (Circular 41 of 2014).

Scope of policy

The provisions of this policy are binding on the Board of Trustees and Board Committees.

Policy statement

Significant responsibilities and fiduciary risks are borne by Trustees throughout the year, as well as the fact that all the Trustees and Board Committee members are independent professionals who are required to give up substantial amounts of their time to serve the needs of the Scheme and its members. The Scheme therefore strives to remunerate Trustees and Board Committee members appropriately to ensure that the appropriate skills are attracted and retained in a complex industry.

The role of the Remuneration Committee

The Remuneration Committee of the Scheme is responsible for recommending to the Board of Trustees and the members of the Scheme the Remuneration Policy, structure and/or fees which the Trustees and Board Committee members are due.

Remuneration of the Board of Trustees of the Scheme

Trustees are entitled to remuneration in respect of services rendered in their capacity as members of the Board as determined and recommended by the Scheme's Remuneration Committee, which is reviewed on an annual basis. Trustees are compensated a market-related professional fee commensurate with the level of skill and expertise required in relation to the nature of the duties and concomitant responsibility attributed to the specific role and function of Trustees. The fees take into account the fact that the Scheme is a non-profit entity. Trustees hold non-executive status within the Scheme and are, therefore, in terms of the Scheme's Remuneration Policy not permitted to be paid consulting fees for consulting services rendered. The remuneration of Trustees is limited to a fee and does not include any additional benefits such as participation in the Scheme's incentive programme. This ensures that Trustees are able to act independently of any personal interest in terms of their fiduciary duties.

The total annual fees payable to Trustees is split into an annual base fee (70%) and a fee per meeting (30%). This recognises the ongoing responsibility of Trustees for the efficient control of the Scheme. The annual base fee is paid quarterly in arrears. The Scheme does not pay Trustees any remuneration or fees for attending conferences or training events over and above the training provider's fees and travel, accommodation and subsistence costs. It is the view of the Scheme that attending a conference or training event is sufficient reward.

Remuneration of Board Committee members

Board Committee members shall be compensated a market-related fee commensurate with the level of skill and expertise required in relation to the nature of the duties and concomitant responsibility attributed to the specific role and function of the Board Committee of which he/she is a member, taking into account the fact that the Scheme is a non-profit entity.

Calculation of the remuneration of Trustees and Board Committee members

The Trustees' and Board Committee members' remuneration is based on a professional fee (based on an hourly rate paid) for professionals who are suitably skilled and qualified to serve as Trustees, discounted at an applicable rate to take into account the fact that the Scheme is a non-profit entity. Professional fees are based on the market-related fees charged by professionals in the field of law, actuarial science, medicine and commerce and will be benchmarked and adjusted annually. The total remuneration paid to Trustees and Board Committee members are determined by the following elements:

- Number of meetings per year.
- Preparation time for each meeting.
- Duration of meetings.
- Ad-hoc time required by the Chairperson of the Board of Trustees or Board Committees in the execution of his/her duties.
- A discount applied to the professional fee for being a non-profit entity.

Participation in incentive programmes

Trustees and Board Committee members are not permitted to participate in the Scheme's incentive reward programmes.

Reimbursements

Members of the Board of Trustees may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as a Trustee, which shall include but not be limited to travel outside of the Johannesburg Metropolis or Gauteng. In order to be reimbursed for travel expenses the Trustee must complete a Reimbursement Claim Form and submit the original tax invoices of the travel expenses he/she is claiming.

Market benchmarking

In accordance with the King III Code of Corporate Governance the remuneration of Trustees and Board Committee members are benchmarked periodically through independent review. The Scheme's Remuneration Committee uses market trends in professional fees/rates for professionals in the field of law, actuarial science, medicine and commerce for determining Trustee and Board Committee member fees. This provides the Scheme with information relating to market trends in remuneration practices and ensures that the Scheme compensates Trustees and Board Committee members in accordance with appropriate market norms. The benchmarked professional fees will be discounted to recognise the non-profit status of medical schemes.

Approval of Trustees' and Board Committee members' remuneration

The Scheme's Trustee remuneration for each financial year going forward is reviewed and recommended by the Remuneration Committee to the Board of Trustees for provisional approval and thereafter should be approved through a vote by members at the AGM of the Scheme. The Scheme's members and the Council for Medical Schemes shall be provided with the required information pertaining to the proposed remuneration of the Board of Trustees and Board Committee members at least 21 days prior to the AGM.

Disclosure of Trustees' and Board Committee members' remuneration

The principles of maximum transparency and disclosure regarding remuneration are endorsed by the Scheme. The members of the Board of Trustees shall disclose annually in writing to the Registrar any payment or considerations made to them in that particular year by the Scheme. Furthermore, the remuneration of the Trustees and Board Committee members shall also be disclosed to members of the Scheme and shall be reported on in the Discovery Health Medical Scheme Integrated Annual Report. The CMS and members shall also be provided with details of how the proposed Trustees' and Board Committee members' fees were determined, as well as the details of the independent advisers who provided advice to the Remuneration Committee on the structuring of Trustees' and Board Committee members' fees.

Remuneration payment procedures

All fees shall be paid directly to the Trustee into his/her bank account, the details of which are to be provided by the Trustee to the Scheme Secretary.

Tax will be deducted at the standard rate unless otherwise directed by the provision of a tax directive from the Trustee, or when advised to deduct additional tax by the Trustee.

Application of Trustee liability insurance

The Scheme must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.

For more information on the remuneration of Trustees see the Annual Financial Statements on **pages 106 – 107**.

Regulatory and industry **matters dealt with in 2015**

CIRCULAR 20 OF 2015:

Notice of intention to publish undesirable business practice declaration in terms of section 61 (2) of the Medical Schemes Act, 1998 (Act No 131 of 1998)

Circular 20 of 2015 was issued by the Council for Medical Schemes (CMS) on 13 March 2015 and notified medical schemes that the Registrar had published a notice in the Government Gazette of his intention to declare certain business practices undesirable, and requested written representations in response. The practices described in the Circular related to the manner of use of branding, logos and names of medical schemes. The CMS invited responses from the industry. The Scheme submitted representations to the CMS on 28 April 2015, and awaits feedback from the CMS.

CIRCULARS 29 AND 36 OF 2015:

Draft Undesirable Business Practice Declaration in terms of Section 61 (2) of the Medical Schemes Act, 1998 (Act No 131 of 1998)

Circular 29 of 2015 was issued by the CMS on 17 April 2015 and notified that the Registrar had published a notice in the Government Gazette of his intention to declare certain business practices undesirable. The practices discussed in the Circular relate to the election and voting processes followed by schemes. In response to requests from the industry, the CMS subsequently published Circular 36 of 2015 on 10 April 2015, granting an extension for all stakeholders to respond until 30 June 2015. The Scheme submitted representations to the CMS on 29 May 2015, and awaits a response from the CMS.

Competition Commission market inquiry into the private healthcare sector

An inquiry by the Competition Commission into the South African private healthcare sector to determine whether there are aspects of the market which distort, restrict or prevent competition is underway, with the final report expected in December 2016. The Scheme fully supports the inquiry.

CMS inspection

As per the CMS Annual Report 2013-2014, in December 2013 the CMS appointed an Inspector to conduct an investigation into the Trustee election process conducted in 2013. The Scheme cooperated fully with the Inspector during the process, which commenced in 2013 and continued into 2014. Following the Inspector's Report, the Scheme has submitted detailed representations to the CMS and continues to engage with the CMS on the matter.

The CMS' Circulars are available at **https://www.medicalschemes.com/Publications.aspx**.

Low cost benefit options

In 2012 the National Treasury published draft regulations for the long- and short-term insurance industry to provide for demarcation between health insurance policies and medical schemes (i.e. what constitutes insurance business and what constitutes the business of a medical scheme). In response, the CMS published Circular 54 of 2015 in September 2015, describing the minimum guidelines for the possible introduction of Low Cost Benefit Options by medical schemes, which could potentially expand access to private healthcare cover to people who could not previously afford private medical scheme cover.

In response, the Scheme submitted detailed benefit design options and proposed contributions to the CMS in September 2015. The CMS and the Department of Health have received various submissions relating to the proposed benefits to be offered by Low Cost Benefit Options, and the guidelines have subsequently been withdrawn until further notice as further analysis and consideration of the proposed benefits is required.

National Health Insurance (NHI)

The South African Constitution, in Chapter 2 the Bill of Rights, Section 27, provides that all citizens have the right to access to healthcare. In accordance with these principles the Department of Health published a Green Paper on National Health Insurance in 2011, and received comments from all stakeholders including the Scheme. The paper is based on the premise that a central NHI Fund will be established which will procure healthcare services from both the public and private sectors.

In December 2015 the amended White Paper was released. The Scheme is examining the White Paper and will be submitting detailed comments within the commentary period.

Scheme rules and non-disclosure

Each year, the Scheme Rules are amended to cater for changes to benefit options for the upcoming year and in response to legislative requirements where applicable. The Scheme Rules are required to be registered by the CMS.

The 2016 Scheme Rules were submitted to the CMS in September 2015. Scheme Rules 11 and 14.7 remain unregistered by the CMS as they require clarification based on interpretation of the specific provisions in the Act. The Scheme is engaging with the CMS to obtain this clarification.

The Scheme Rules are available to registered users at **https://www.discovery.co.za/portal/individual/dhms-rules**.

Performance

Our Principal Officer's review of the year

Discovery Health Medical Scheme continues to be the industry leader in the funding of evidence-based, cost-effective, quality healthcare and in supporting the enhancement of the healthcare system for Scheme members and stakeholders.

South Africa's economy grew by only 1.3% in 2015, down from 1.5% in 2014 and 2.2% in 2013, according to preliminary estimates of real gross domestic product (GDP) published by Stats SA. The Rand lost 35% of its value against the US Dollar in 2015 and consumers have had to limit spending as prices, including basic food and household products, climbed.

During 2015, the Scheme's total risk contribution income was R40.1 billion and total risk claims were R33.3 billion. After accounting for non-healthcare expenses and other operating expenses, the Scheme achieved a strong operating result of R507 million for 2015. Investment income (net of return on savings trust assets) was R762 million, contributing to a net surplus of R1.3 billion. Member reserves increased to a significant R12.9 billion, with a solvency ratio of 26% of total annual contribution income. This significant reserve level further enhances the claims-paying ability of the Scheme, which protects its members from the potentially devastating and unexpected expenses associated with healthcare, and is a source of great pride for us. In recognition of this ability to pay claims, independent credit rating agency Global Credit Ratings Co confirmed the Scheme's AA+ credit rating. This is the 15th consecutive year the Scheme has achieved this rating, the highest a medical scheme can attain in South Africa. This independent endorsement means our

During 2015, the Scheme's total risk contribution income was **R40.1 billion** and total risk claims were **R33.3 billion**.

members can rest assured that the Scheme is able to fund their healthcare expenses reliably and sustainably for the foreseeable future. To further emphasise the value that the Scheme provides to its members, the ten highest member claims in 2015 amounted to R43 million, and over 5 000 members each claimed more than R500 000 during the year. To put this into perspective, for every R1 of member contributions, R0.86 went towards the funding of member claims. Any surplus funds were transferred to member reserves, in accordance with the fundamental operating principle of a non-profit organisation.

Non-healthcare expenses continue to decline in line with the Scheme's strategic objectives. The Board, with the support of the Non-healthcare Expenses Committee, has maintained its strong focus on ensuring that non-healthcare expenses remain on a downward trajectory. Annual administration fee increases have been contained to consumer price inflation (CPI) minus 0.5% in 2015 and reduced to 7.79% of gross annual contribution income from 7.98% in 2014. Administration fees as a percentage of gross annual contribution income are now significantly below the industry average for open medical schemes.

Continuous innovation and the provision of quality healthcare at lower cost have supported the Scheme's consistently excellent membership growth, while the rest of the open scheme market has been shrinking. This has increased the Scheme's share of the open medical scheme market from 15.4% in 2000 to approximately 53% in 2015. The Scheme achieved net beneficiary growth of 2.16% in 2015 from an already high base to 2 691 852 beneficiaries (at 31 December 2015). In addition, an exceptionally low lapse rate of 5% indicates that members continue to find value in the Scheme.

Analysis has shown that the Scheme remains the most affordable across the entire spectrum of healthcare plans in the open medical scheme market on a like-for-like basis. On average, contributions are 14% lower, based on principal member contribution rates, than those of the next nine competitor medical schemes in the open medical scheme market.

The Vested® outsourcing business model which governs the relationship between the Scheme and its Administrator and Managed Care provider, Discovery Health (Pty) Ltd, continues to yield exceptional value for the Scheme and its members. This model has enabled an unmatched record of innovation, high levels of member satisfaction, more focused and sustainable clinical risk management solutions, continued membership growth, enhanced stakeholder relations and improved outsourcing governance. An independent review by Deloitte indicated that for every R1 spent on administration and managed care fees paid to Discovery Health in 2014, beneficiaries of the Scheme derived an additional R1.69 in value.

To achieve its purpose, the Scheme must manage its relationships with all of its stakeholders in a way that balances their expectations and protects the long-term sustainability of the Scheme, which is a constant challenge. The Scheme's approach is to engage on the basis that working towards a common purpose is paramount, notwithstanding the differing needs of stakeholders in some instances. The Scheme conducts all its interactions with stakeholders in good faith, with the common purpose of optimising value and ensuring access to affordable, quality healthcare for its members, now and in the future.

MILTON STREAK
PRINCIPAL OFFICER

Read more about how we engage with our stakeholders from **page 20** and more about Vested outsourcing and the Deloitte review on **pages 18 – 19**.

Discovery Health Medical Scheme performance

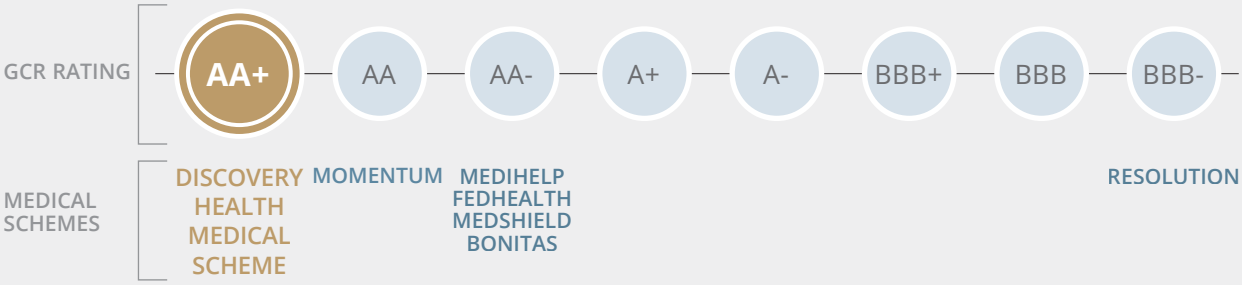
In a nutshell...

The Scheme generated a positive net healthcare result of R507 million for the year ended 31 December 2015 (2014: R753 million). The decline from 2014 was mainly attributable to the impact of medical inflation and increased utilisation of benefits. Despite turbulent investment markets, the Scheme was able to generate healthy investment income of R1 019 million (2014: R859 million) contributing to the net surplus for the year of R1 276 million (2014: R1 537 million).

The Scheme's solid financial performance increased members' funds to R12.9 billion (2014: R11.7 billion) with a solvency level of 25.98% (2014: 25.76%). The Scheme's financial strength and ability to pay claims was once again confirmed, with a credit rating of AA+, the highest possible rating in the industry, from independent credit rating agency, Global Credit Rating Co (GCR).

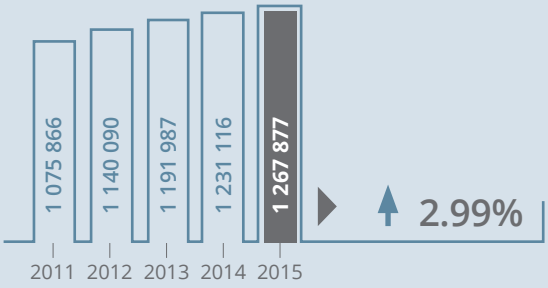
The Scheme's full set of financial results are set out in the **Annual Financial Statements** on **pages 82 – 151**.

DHMS maintains AA+ credit rating

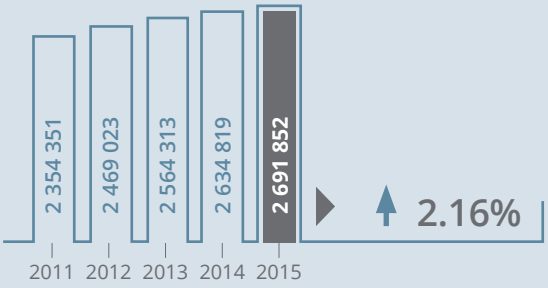


Source: Global Credit Rating Co.

Increase in Scheme principal members



Increase in Scheme lives



AA+
Independent credit rating for claims-paying ability
(2014: AA+)

25.98%
Statutory solvency level
(2014: 25.76%)

53%
Share of open scheme market
(2014: 53%)

5%
Annualised lapse rate
(2014: 4.5%)

3.24%
Average growth in principal members
(2014: 3.51%)

2.12
Average family size
(2014: 2.15)

2.62%
Managed care as % of gross contributions
(2014: 2.67%)

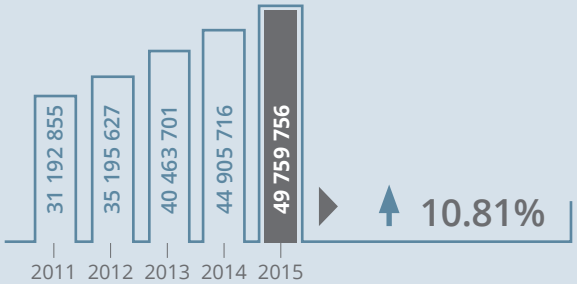
7.79%
Admin fees as % of gross contributions
(2014: 7.98%)

6.01%
Average return on investments
(2014: 8.21%)

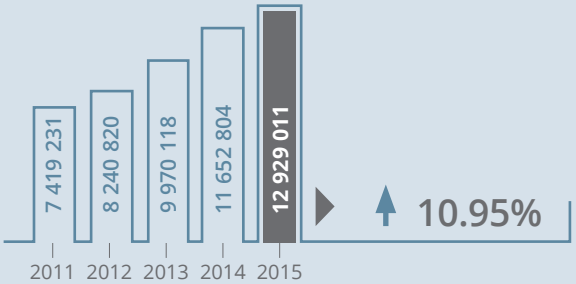
8.55%
Pensioner ratio
(2014: 8.17%)

33.86
Average age of beneficiaries at year end
(2014: 33.58)

Increase in gross contributions (R'000)



Growth in members' funds (R'000)



Discovery Health Medical Scheme performance *continued*

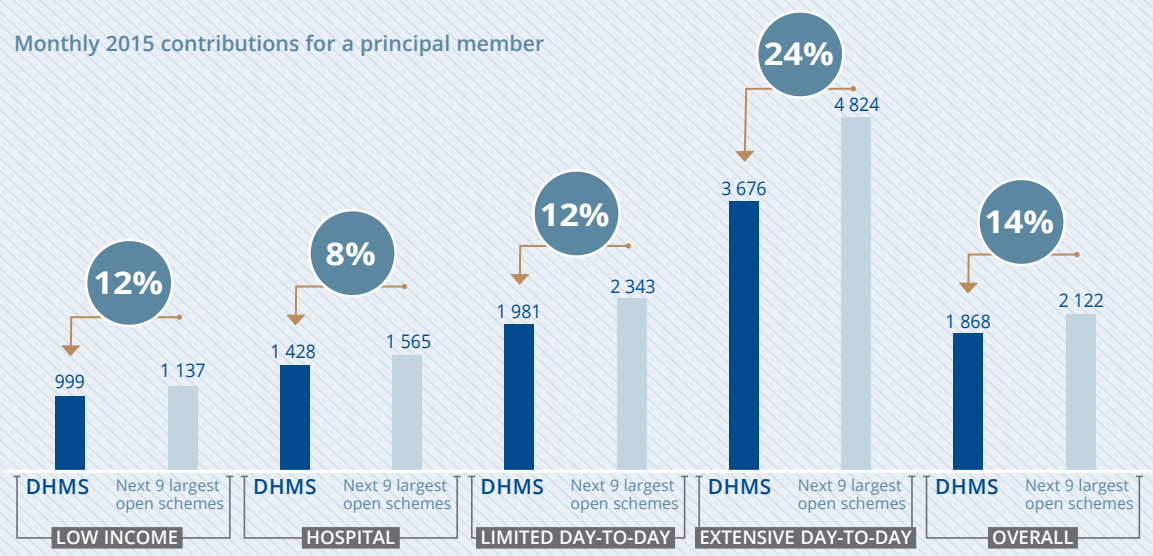
Gross contribution income

The Scheme continued to attract new members through its ability to provide benefit options that offer high value and broad choice at competitive rates.

15 Benefit plans

6 Network efficiency discount options*

Monthly 2015 contributions for a principal member

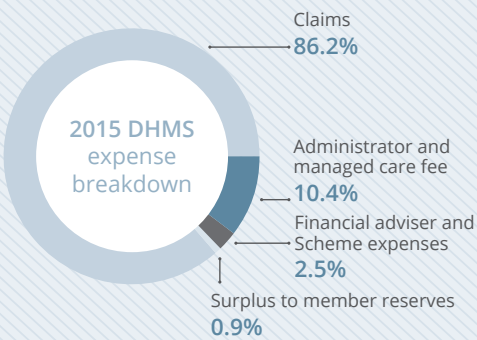


The Scheme's contributions are on average 14% lower (based on a principal member rate) than the next nine largest open schemes in 2015 due to its ability to contain the impact of medical inflation.

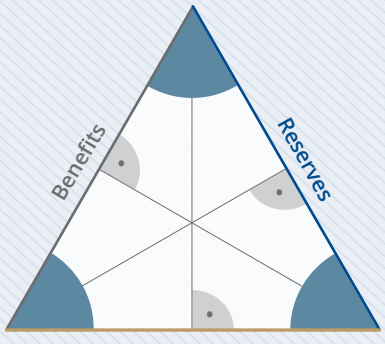
The Scheme's commitment to its members and its high levels of efficiency are evidenced by the fact that 87% of contributions received are used for members' direct benefit by funding claims and reserves (to meet regulatory solvency requirements) and in accordance with the fundamental operating principles of a non-profit organisation. The remainder of the contributions are used to fund activities for the support and benefit of members such as innovation, administration, managed care, financial advisers and the daily operations of the Scheme.

Maintaining the balance between keeping contributions competitive, providing quality and affordable healthcare to our members and ensuring we meet regulatory reserve requirements remains a continuous challenge.

87% of member contributions are for funding claims and reserves



Equilibrium is a function of contributions, reserves and benefits



Gross contribution income increased year-on-year by 10.81% to R49.8 billion (2014: R44.9 billion), driven by the 9.9% headline increase in 2015 contributions and growth in average membership of 3.24%. The most significant net membership growth was recorded in the mid to low tier options, where the Saver and KeyCare series recorded net membership growth of 22 389 and 14 046 respectively. The Comprehensive series experienced the largest decline in principal membership by 10 465.

EXECUTIVE SERIES
- Executive

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

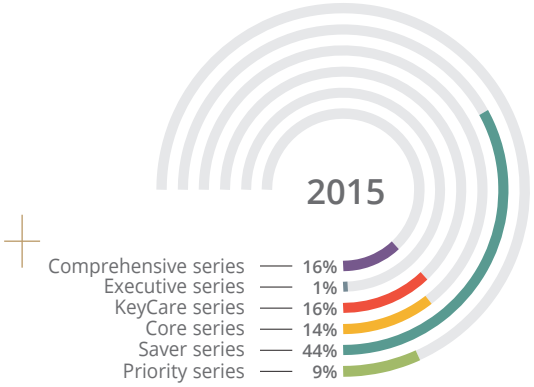
CORE SERIES
- Classic Core
- Essential Core
- Coastal Core
- Classic Delta* Core
- Essential Delta* Core

SAVER SERIES
- Classic Saver
- Essential Saver
- Coastal Saver
- Classic Delta* Saver
- Essential Delta* Saver

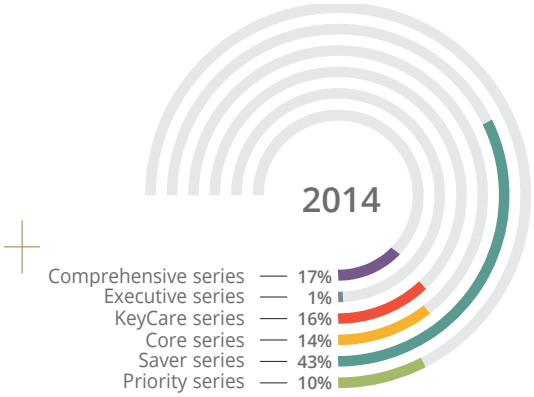
PRIORITY SERIES
- Classic Priority
- Essential Priority

KEYCARE SERIES
- KeyCare Plus
- KeyCare Core
- KeyCare Access

Distribution of Scheme beneficiaries on various plans



Total beneficiaries
2 691 852



Total beneficiaries
2 634 819

Colours refer to plan types depicted alongside.

For more information about these benefit plans, go to **https://www.discovery.co.za/portal/individual/medical-aid-plan-range**.

Discovery Health Medical Scheme performance *continued*

Net claims incurred

Net claims incurred increased by 12.53% year-on-year to R33.3 billion (2014: R29.6 billion).

One of the major concerns for medical schemes during 2015 has been the escalating cost of healthcare, with healthcare inflation consistently well above CPI. The drivers of healthcare inflation are tariff increases, higher consumption of healthcare services due to the increase in available services and new technological developments in healthcare (supply-induced demand), and deteriorating demographic beneficiary profiles (adverse selection, age, chronic and pensioner ratio). A summary of the composition of medical inflation (annualised over the period 2008 to 2015) is illustrated in the diagram alongside.

Despite these cost pressures, the Scheme managed through risk management and other innovative activities to contain the gross claims ratio (defined as relevant healthcare expenditure as percentage of risk contributions) to 86%, marginally up from 85% in 2014.

Gross administration expenditure

Gross administration expenditure consists of administration fees paid to the Administrator and other operational Scheme expenditure.

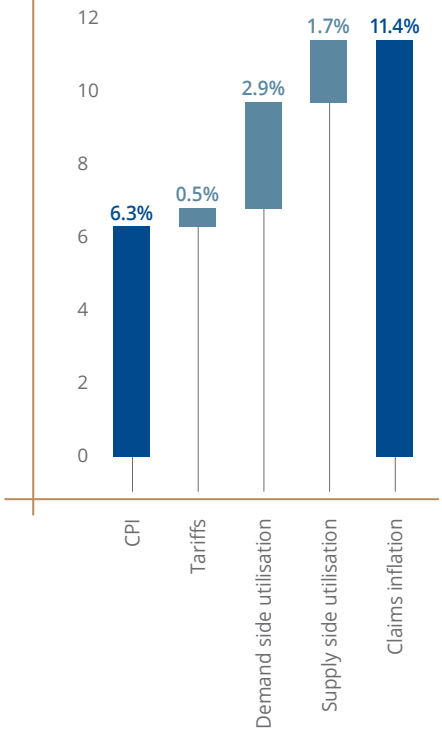
The most significant component of gross administration expenditure is administration fees paid to the Scheme's Administrator, Discovery Health. The gross increase in administration fees of 8.1% to R3.9 billion (2014: R3.6 billion) was attributable to the administration fee per member rate increase and growth in average Scheme membership of 3.24%.

Administration fee per average member per month (pampm) increased by 4.7% from R247.18 to R258.73. The rate increase was below CPI due to significant scale-related administration fee discounts negotiated for 2015.

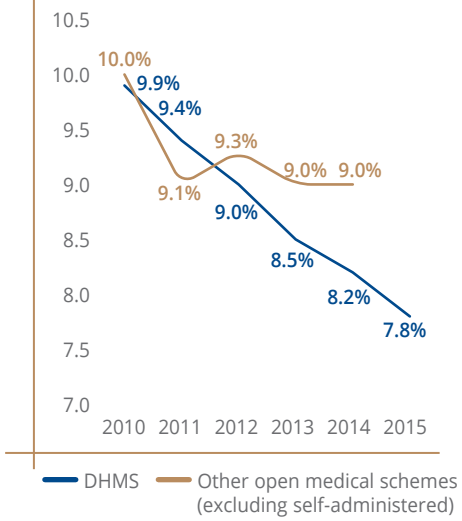
The graph alongside depicts the continued decrease in administration fees as a percentage of gross contribution income, compared to the average open scheme competitor.

A Scheme analysis of the Council for Medical Schemes (CMS) 2014/2015 annual report[1] shows that Discovery Health Medical Scheme ranks below the average gross administration expenditure per average beneficiary per month (pabpm) for open schemes (R119.80; R121.50 excluding the Scheme) at R118.40 for 2014. The open scheme year-on-year increase in gross administration expenditure pabpm was 5.2% (6.5% excluding the Scheme) compared to the Scheme's increase of 4% for 2014.

Average annualised inflation rate (2008 – 2015)



Administration fees as a percentage of gross contribution income



1 *CMS Annual Report (https://www.medicalschemes.com/Publications.aspx).*

Accredited managed care services costs

The increase in accredited managed care services costs of 8.71% to R1.3 billion (2014: R1.2 billion) was attributable to both the accredited managed care costs per member per month rate increase, and growth in average Scheme membership of 3.24%.

Managed care costs pampm increased, in line with CPI, by 5.30% from R82.80 to R87.19. Further, we saw a continued decline in managed care costs as a percentage of gross contribution income with the 2015 ratio at 2.62% (2014: 2.67%).

A Scheme analysis of the CMS 2014/2015 annual report shows that Discovery Health Medical Scheme had a managed care cost pabpm of R38.50 compared to the average of R35.40 among open schemes (average of R31.80 when the Scheme is excluded). Although the pabpm managed care costs may appear slightly more expensive relative to other open schemes, the 2014 claims cost savings of R122.45 per beneficiary per month realised through claims review processes, implemented protocols, price negotiations and drug utilisation reviews should be considered. This equates to a saving of R3.18 for every Rand paid in managed care costs – an exceptional return on investment of 217.6%.

Investment results

The Scheme manages its investment portfolio in a diversified manner with the aim of optimising investment returns within its approved risk appetite. Asset allocation is managed and monitored from an asset/liability perspective ensuring sufficient liquid funds available to meet claims and other liabilities as they fall due. Given the short-term nature of Scheme liabilities, a significant portion of Scheme assets are invested in money market and cash investments, with smaller allocations to bonds (local and foreign) and equities.

The 2015 year was one of the most challenging for global stock markets since the 2008 financial crisis. South Africa, along with other emerging markets, were impacted by the slowdown in the Chinese economy and the commodity sell-off. The FTSE/JSE All Share Index returned a mere 5.1% for 2015. The Rand depreciated 35% against the US Dollar with our bond market (All Bond Index) showing a negative 3.9% return for 2015.

Despite difficult market conditions, the Scheme managed an investment return of 6.01% for 2015 (2014: 8.21%).

Global benchmarking

In 2015, Deloitte was engaged to benchmark the Scheme against its international peer group. The study covered the period 2006 to 2013 across seven countries (South Africa, Australia, Brazil, Germany, India, the Netherlands and the USA). Data was obtained from the relevant regulatory authorities as well as Deloitte offices in these countries. Twenty of the world's largest insurers, including Discovery Health Medical Scheme and its five largest competitors in South Africa (by size), were included in this benchmarking exercise. The study involved the development of metrics that are a suitable measure of the performance of health insurers. These metrics cover financial strength, growth, sustainability, public perception and innovation, and were developed to translate appropriately across the different healthcare environments.

The study included 13 performance categories with key benchmarking categories as follows:

- Claims inflation;
- Premium inflation;
- Non-healthcare expense levels;
- Service levels; and
- Innovation.

German health insurers performed the best and achieved the highest scores. The overall average rankings over the period 2010 to 2013 were as follows: Germany first, South Africa second and Australia third.

At a more detailed level, insurer-specific comparisons identified DKV (ERGO), Central (Generali), Discovery Health Medical Scheme and United Healthcare Group as the top four performing health insurers respectively. The Scheme was ranked in the top three for three of the four years in the period 2010 to 2013, finishing as the joint top-ranked insurer in 2010 and 2012. The only exception was in 2011, when the Scheme ranked fifth.

When analysing the specific metrics for these high-performing insurers, it is evident that each has performed consistently in the following areas:

- Solvency and claims-paying ability;
- Operating results;
- Administration expenses;
- Growth in members and beneficiaries; and
- Public perception and innovative product offerings.

The Scheme ranked among the top three insurers throughout the review period, significantly outperforming local schemes, giving members the comfort that their Scheme is among the best globally.

Discovery Health Medical Scheme performance *continued*

Member disputes and appeals

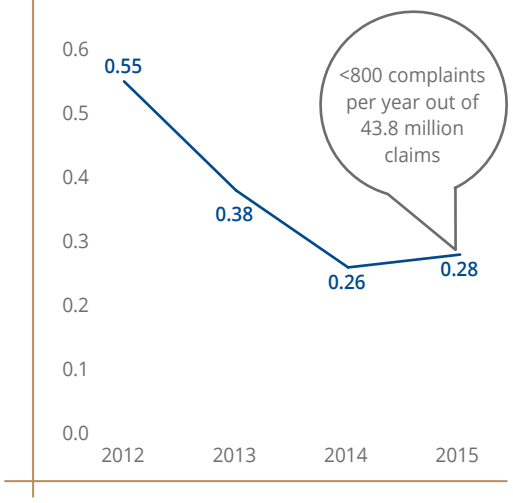
The Scheme places great importance on its members as its primary stakeholders. According to the Council for Medical Schemes 2014/2015 annual report, the Scheme has a low level of complaints per 1 000 beneficiaries (as shown alongside), and does not appear on the CMS' list of the ten schemes registering the highest number of complaints.

Members are able to lodge disputes with the Scheme or directly with the CMS. During 2015, 326 disputes were lodged with the Scheme, of which most were resolved before requiring a hearing. The Disputes Committee heard a total of 65 disputes, of which nine were carried over from 2014. A total of 14 disputes from 2015 were carried over to hearings in 2016.

During the same period, 738 complaints were lodged with the CMS in terms of Section 47 of the Medical Schemes Act (the Act). In 2015 there were in excess of 43 million claims made by members, resulting in a complaints per thousand beneficiaries ratio of 0.022.

Given the Scheme's approximately 53% market share (covering nearly 2.7 million beneficiaries), this is a source of great pride for the Scheme. The Scheme believes that its strong focus on its members as primary stakeholders is the driver of the continuing decrease in complaints, as shown alongside.

CMS complaints per 1 000 DHMS beneficiaries



See more about how to lodge complaints or disputes on **page 153**.

Solvency

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

At 31 December 2015, the Scheme's solvency level of 25.98% (2014: 25.76%) of gross annual contributions was R488 million (2014: R340 million) more than the statutory solvency requirement of 25%, and exceeded the business plan level of 25.4% by R289 million (2014: 24.3% by R655 million).

Calculation of regulatory capital requirement	31 Dec 2015 R'000	31 Dec 2014 R'000
Total members' funds	12 929 011	11 652 804
Less cumulative net gain on re-measurement of investments	–	(85 833)
Total net assets (Regulation 29)	12 929 011	11 566 971
Gross annual contributions	49 759 756	44 905 716
Solvency ratio	25.98%	25.76%
Average accumulated funds per member at year end	R10 360	R9 639

Prudent financial management

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

	31 Dec 2015 R'000	31 Dec 2014 R'000
Gross annual contributions	49 759 756	44 905 716
Total outstanding contributions – excluding December contributions	16 378	14 224
% outstanding	0.03%	0.03%

Due application of the Scheme Rules

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

Ensuring statutory and regulatory compliance

The Board is 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 applicable regulatory requirements.

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

Matters of non-compliance for the year ended 31 December 2015

The CMS issued Circular 11 of 2016 (the Circular) dealing with issues to be addressed in the audited financial statements of medical schemes. The Circular requires that all instances of non-compliance be disclosed in the audited financial statements, irrespective of whether the auditor considers them to be material or not.

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

Statutory scheme solvency

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

During 2015, the Scheme's solvency level dipped below 25% during January, February and November. The reason for the drop below 25% during January and February was attributable to the impact of annual contribution increases (schemes are required to hold reserves equal to annualised inflation-adjusted contributions from the first day of the financial year). Negative claims experience during November caused the solvency ratio to drop below 25%.

At 31 December 2015, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 25.98% (2014: 25.76%) which exceeds the statutory solvency requirement of 25% and the approved phase-in solvency level of 25.4%, as set out in the business plan submitted to the CMS.

Sustainability of benefit plans

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

For the year ended 31 December 2015 the following plans did not comply with Section 33 (2):

Benefit plan	Net healthcare result (R'000)	Net deficit (R'000)
Executive	(327 852)	(320 737)
Classic Comprehensive	(705 166)	(601 499)
Classic Comprehensive Zero MSA	(1 007)	(544)
Coastal Saver	(110 686)	(84)
KeyCare Plus	(529 518)	(394 861)

The performance of all benefit options is monitored on a continuous basis with a view to improving their financial outcomes, and we continually evaluate different strategies to address the deficits in these plans.

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

In addition, the Scheme updates the Registrar on both the Scheme and individual benefit option performance in its monthly management accounts and quarterly monitoring meetings.

Investment in employer groups and medical scheme administrators

Section 35 (8) (a) and (c) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide. CMS has granted DHMS exemption from these sections of the Act on 7 March 2013. On 10 March 2016 the Scheme received a letter from the CMS requesting the Scheme to renew its Section 35 (8) (c) exemption within 30 days. The Scheme will be submitting an application on 8 April 2016 requesting a renewal of its exemption from both Section 35 (8) (a) and (c) of the Act.

Discovery Health Medical Scheme performance *continued*

Matters of non-compliance for the year ended 31 December 2015 *continued*

Investments in other assets in territories outside South Africa

Our offshore bond managers utilise derivative instruments to aid with efficient portfolio construction and management, and to reduce the overall risk within our portfolios. The derivatives used are highly liquid and are either exchange traded or governed by International Swaps and Derivatives Association agreements. The derivative instruments are not used for speculation and there is no gearing or leverage applied. Investments in derivatives in territories outside the Republic of South Africa are, however, prohibited in terms of Category 7 (b) of Annexure B to the Regulations of the Medical Schemes Act 131 of 1998.

The Scheme submitted an exemption application to the CMS in 2014 requesting that the Scheme be permitted to invest in the offshore derivatives. The CMS granted the Scheme an exemption on 19 May 2015 to invest in offshore derivatives, subject to certain conditions, up until 31 December 2016. The Scheme will be submitting an application for an extension of the current exemption during August 2016.

Contributions received after due date

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

The Scheme does however employ robust credit control processes dealing with the collection of outstanding contributions, including the suspension of membership for non-payment.

Broker fees paid

In terms of Regulation 28 (5) of the Act, broker fees shall be paid on a monthly basis on receipt by a medical scheme of the relevant monthly contribution in accordance with the maximum amount payable per Regulation 28 (2), limited to one broker as required by Regulation 28 (8). In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible and represents less than 0.03% of the total broker fees paid for the year. The exceptions relate to transactions that do not occur frequently and Discovery Health has developed exception reporting to identify and correct these transactions, and has a well-established claw-back system to rectify commission overpayments.

Late joiner penalties

In terms of Regulation 13 of the Act, a medical scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties. Late joiner penalties depend on factors such as age and years of creditable medical scheme coverage.

In only a few cases (17), late joiner penalties were incorrectly applied to members due to data capturing errors. The Scheme is in the process of backdating corrections for the respective members.

Duplicate membership

Section 28 (b) (i) of the Act states that no person shall be admitted as a dependant of more than one member of a particular medical scheme. A few isolated cases (11) were noted where the same dependant was registered under two memberships. The majority of cases relate to child dependants being added by both parents on their own respective memberships, whether from birth or as result of a divorce. Actions have been taken to correct the duplications identified. Additional controls have been implemented to prevent re-occurrence, which include monthly exception reports of all duplicate memberships and ensuring that ID numbers are obtained during New Business and Administration processes.

Reserve accounts

Movements in reserve accounts are set out in the Statement of Changes in Funds and Reserves on page 84.

Outstanding claims

Movements in the outstanding claims provision are set out in Note 6 to the Annual Financial Statements on page 98.

Personal Medical Savings Accounts

The Personal Medical Savings Account (PMSA) enables members to manage day-to-day healthcare expenses. Members pay an agreed sum of 0%, 15% or 25% of the gross contributions, depending on their plan choice, into this savings account. The Scheme advances the full annual amount to members for immediate use, although members only contribute monthly. The PMSA provides a variety of benefits to members for medical expenses outside hospital, such as day-to-day medicines, visits to GPs and specialists, dental care and optometry.

The balance remaining in the PMSA 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 PMSA 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 are managed by two independent asset managers, Taquanta and Momentum. The average interest earned on these funds was 6.91% in 2015 (2014: 6.21%).

Going concern

The Board of Trustees is satisfied that the Scheme has adequate resources to continue its operations in the foreseeable future. Accordingly, the Scheme's financial statements have 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 and non-audit services are included in the Annual Financial Statements. The Scheme has a formal policy governing non-audit services. The fees have been disclosed and agreed with the Audit Committee.

Operational statistics per benefit plan

2015	EXECUTIVE	CLASSIC COMP	CLASSIC CORE	CLASSIC SAVER	CLASSIC PRIORITY	ESSENTIAL COMP
Number of members at the end of the accounting period	11 262	163 889	54 057	258 175	100 080	20 388
Number of beneficiaries at the end of the accounting period	25 149	376 774	115 775	565 252	230 166	40 810
Average number of members for the accounting period	11 468	167 127	53 274	255 914	101 008	20 783
Average number of beneficiaries for the accounting period	25 698	385 422	114 418	559 621	231 898	41 770
Average risk contributions per member per month (R')	6 037	4 800	2 759	2 633	3 308	4 182
Average risk contributions per beneficiary per month (R')	2 694	2 081	1 285	1 204	1 441	2 081
Average net claims incurred per member per month (R')	7 927	4 660	1 915	1 902	2 617	3 353
Average net claims incurred per beneficiary per month (R')	3 538	2 021	892	870	1 140	1 668
Average administration costs per member per month (R')	285	285	285	285	285	285
Average administration costs per beneficiary per month (R')	127	124	133	130	124	142
Average managed care: Management services per member per month (R')	87	87	87	87	87	87
Average managed care: Management services per beneficiary per month (R')	39	38	41	40	38	43
Average family size at 31 December	2.23	2.30	2.14	2.19	2.30	2.00
Loss ratio (%)	133%	99%	73%	76%	82%	83%
Total non-healthcare expenses as a percentage of risk contributions (%)	6%	8%	13%	14%	11%	9%
Average non-healthcare expenses per member per month	377	378	362	371	377	378
Average non-healthcare expenses per beneficiary per month	168	164	168	170	164	188
Average age of beneficiaries (years)	42.49	39.74	38.54	32.19	35.94	44.59
Pensioner ratio (beneficiaries over 65 years)	19%	15%	14%	6%	10%	24%
Average relevant healthcare expenses per member per month	8 043	4 774	2 002	1 989	2 704	3 464
Average relevant healthcare expenses per beneficiary per month	3 590	2 070	932	910	1 178	1 724
Net surplus/(deficit) per benefit plan	(320 737)	(601 499)	285 423	993 912	336 804	97 722

- *In line with Circular 56 of 2015, accredited managed care was reclassified from non-healthcare expenses to relevant healthcare expenses (refer note 12 to the Annual Financial Statements for further detail). Accordingly, comparative operational statistics were restated to allow for appropriate comparison.*

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 (%)	130%	99%	71%	75%	79%	82%
Total non-healthcare expenses as a percentage of risk contributions (%)	7%	8%	14%	15%	12%	9%
Average non-healthcare expenses per member per month	358	359	343	353	359	361
Average non-healthcare expenses per beneficiary per month	158	154	159	162	156	176
Average age of beneficiaries (years)	40.83	37.97	36.68	30.46	34.35	41.92
Pensioner ratio (beneficiaries over 65 years)	17%	13%	11%	5%	8%	20%
Average relevant healthcare expenses per member per month	7 104	4 336	1 787	1 790	2 367	3 169
Average relevant healthcare expenses per member per month	3 146	1 857	831	820	1 031	1 546
Net surplus/(deficit) per benefit plan	(276 655)	(508 405)	279 309	889 218	415 838	101 858

	ESSENTIAL CORE	ESSENTIAL SAVER	ESSENTIAL PRIORITY	COASTAL SAVER	COASTAL CORE	KEYCARE PLUS	KEYCARE CORE	KEYCARE ACCESS	CLASSIC COMP ZERO MSA	TOTAL
	35 434	97 816	8 344	181 052	87 022	229 510	14 854	5 241	753	**1 267 877**
	74 106	205 605	17 651	412 879	191 498	403 636	23 320	7 531	1 700	**2 691 852**
	33 075	93 255	8 444	179 275	85 046	219 615	14 083	4 913	751	**1 248 031**
	69 820	197 093	17 798	409 467	187 726	387 746	22 132	7 152	1 685	**2 659 445**
	2 192	2 203	2 990	2 224	2 136	1 443	1 219	872	4 805	**2 675**
	1 039	1 042	1 419	974	968	818	776	599	2 141	**1 255**
	1 457	1 355	1 843	1 820	1 679	1 396	541	444	4 406	**2 221**
	690	641	874	797	760	791	344	305	1 963	**1 042**
	285	285	285	285	285	153	82	98	285	**259**
	135	135	135	125	129	87	52	68	127	**121**
	87	87	87	87	87	87	87	87	87	**87**
	41	41	41	38	40	49	55	60	39	**41**
	2.09	2.10	2.12	2.28	2.20	1.76	1.57	1.44	2.26	**2.12**
	70%	65%	65%	86%	83%	99%	52%	64%	95%	**86%**
	16%	16%	12%	17%	17%	14%	11%	16%	8%	**13%**
	356	362	372	368	357	208	131	139	374	**338**
	169	171	177	161	162	118	83	95	167	**158**
	35.93	30.71	35.20	32.98	36.78	28.68	34.17	30.43	38.15	**33.86**
	10%	5%	10%	6%	11%	5%	10%	5%	12%	**9%**
	1 544	1 442	1 930	1 907	1 766	1 436	628	560	4 543	**2 304**
	731	682	916	835	800	813	400	385	2 024	**1 081**
	136 190	504 202	74 927	(84)	65 198	(394 861)	86 251	13 236	(544)	**1 267 140**

	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**
	70%	66%	64%	84%	80%	94%	65%	68%	93%	**85%**
	17%	17%	13%	17%	17%	15%	11%	17%	8%	**13%**
	337	345	353	350	337	199	123	128	355	**322**
	158	161	168	152	152	111	77	86	159	**150**
	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%	5%	8%	5%	8%	**8%**
	1 414	1 352	1 743	1 712	1 556	1 281	734	529	4 022	**2 116**
	665	629	830	746	703	716	463	353	1 798	**985**
	113 230	403 527	75 191	44 779	105 747	(172 747)	55 654	10 432	(168)	**1 536 808**

Discovery Health's initiatives for the Scheme

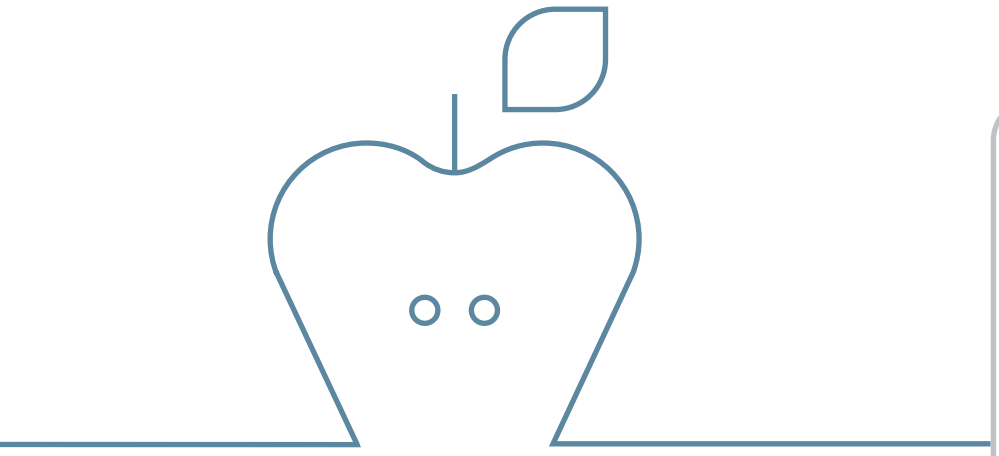
Discovery Health (Pty) Ltd has an unmatched record of innovation, which is supported by the business model of Vested® outsourcing used to optimise the relationship between Discovery Health Medical Scheme and Discovery Health.

Read more about Vested outsourcing and how the Scheme conducts its operations on **pages 18 – 19**.

Together, Discovery Health Medical Scheme and Discovery Health have an unmatched record of innovation, which is supported by the business model of Vested® outsourcing used to optimise the relationship between Discovery Health Medical Scheme and Discovery Health. Discovery Health pursues a variety of projects and initiatives on behalf of Discovery Health Medical Scheme to the benefit of its members, and according to the Vested-governed agreements between the organisations.

Discovery Health is a strong believer in an integrated, value-driven healthcare system, centred on the needs of the patient. Discovery Health's business model is designed to integrate all aspects of healthcare including wellness, quality of care and technology into a cohesive and sustainable healthcare system.

Key to enabling this vision is:



Improving health through wellness programmes such as Vitality.[1]

At the heart of Discovery Health's drive to make people healthier is the Vitality wellness programme. On behalf of the Scheme, Discovery Health will continue to leverage this programme to bring innovative solutions to market that help address health risks and make people healthier.

Better healthcare

through care coordination for Scheme members and better flow of information between health professionals throughout the healthcare system. Discovery Health has so far and will continue to develop unique technologies and programmes to support this approach. Some of the innovations in this area include HealthID, Personal Health Programmes, and Discovery HomeCare.

Lowering the cost of healthcare

through robust risk management strategies and an innovative product suite to meet Scheme members' benefit and affordability needs. This includes a move away from fee-for-service reimbursement to value-based contracting with providers. This type of contracting includes measures of quality of care and clinical outcomes. Discovery Health has already developed value-based contracts with doctors and is openly and actively engaging with the industry on identifying other means to reduce healthcare costs. On behalf of the Scheme, Discovery Health will also continue to grow and maintain provider networks based on efficiency, and implement measures to increase adoption of cost-effective generic medicines, and incorporating technology into the healthcare system.

Providing an intuitive and accessible system and benefits that enable personalised service and healthcare.

Mobile and digital technologies such as wearable technologies and big data are driving significant change in global healthcare systems by empowering members and their doctors to manage their health and their health plans, improve coordination, quality of care and enhance the overall experience. Staying abreast of these emerging technologies and the insights from the data is critical for new and unique product designs. A new and exciting focus for Discovery Health is the rapidly advancing field of genome sequencing which through a global partnership with Human Longevity Inc. aims to sequence the DNA of medical scheme members who undergo these tests, ultimately leading the way towards personalised medicine, personalised nutrition and personalised exercise.

1 *Vitality is a separate wellness product sold and administered by Discovery Vitality (Pty) Ltd. Registration number 1999/007736/07, an authorised financial services provider.*

Discovery Health's initiatives for the Scheme *continued*

In 2015, Discovery Health enhanced its model to ensure it continues to deliver quality healthcare in an environment of high medical inflation.

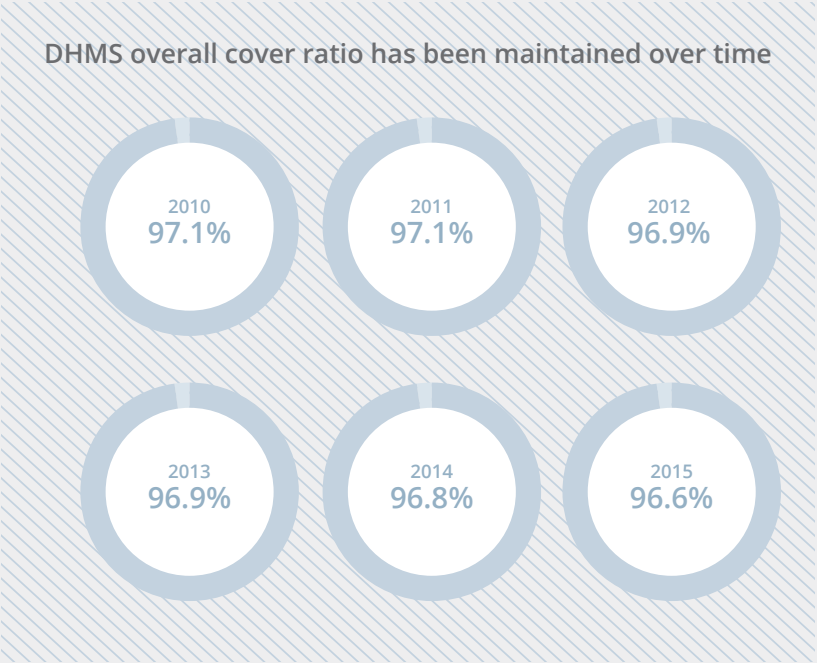
Impacting healthcare costs for members

Highest in-hospital claims reimbursement

Discovery Health has developed extensive provider networks for the Scheme which provide access for members to quality healthcare and protects them against co-payments. The extent to which members make use of full cover choices, available through these networks, is best shown as a cover ratio. The Scheme's members continue to enjoy exceptionally high levels of cover, averaging 96.6% in 2015.

The Scheme's cover ratios are the highest among the largest open medical schemes.[1]

1 *Overall cover ratios are based on the 2015 GCR South Africa Medical Schemes Statistical Bulletin (https://globalratings.net/).*



Southern Rx partnership

Discovery Health, through its wholly owned dispensing pharmacy Southern Rx Pharmacy, has reduced the cost of selected imported medicines for the South African healthcare industry, and to the benefit of the Scheme's members.

Read more about Southern Rx at **http://www.southernrx.co.za**.

Three Southern Rx exclusive biosimilar contracts

30% saving

Bosentas for pulmonary hypertension

Current cost: R18 509 monthly

Southern Rx negotiations

91% saving

Discovery HomeCare

Discovery HomeCare is a service provider that offers home-based care.

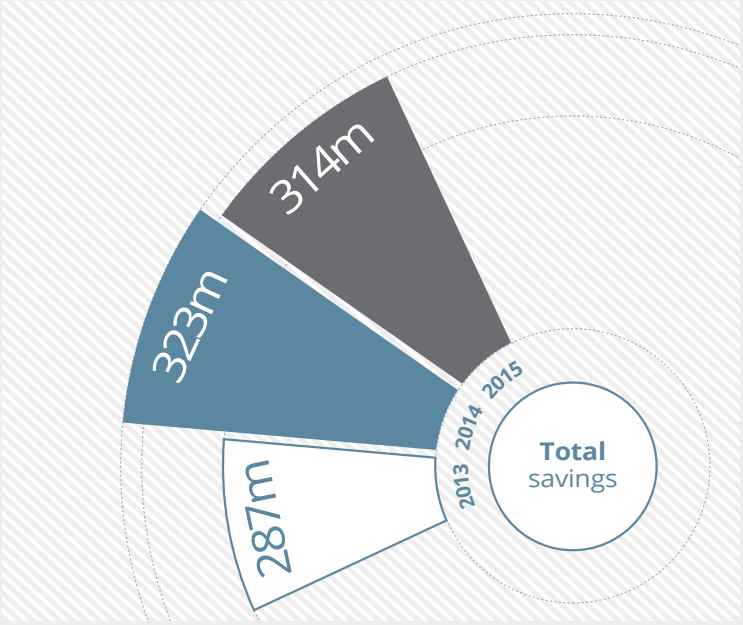
Read more about HomeCare on **page 23**.

Informa and Forensics

Money lost to fraud is a true lost opportunity for more investment in the genuine healthcare needs of medical scheme members, which could be used to enhance and prolong lives, and to reward healthcare professionals better for their precious and scarce skills.

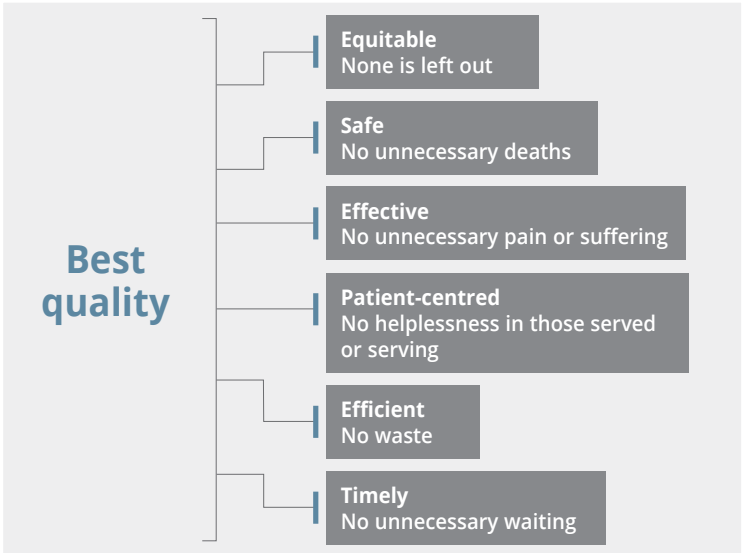
Discovery Health's Informa and Forensics department recovered approximately R314 million on behalf of the Scheme in 2015. The department has adopted and operates under the principles of Treating Customers Fairly, an outcomes-based regulatory and supervisory approach designed to ensure that specific, clearly articulated fairness outcomes for customers are delivered by regulated financial firms. The department's operations are evaluated as part of Discovery Health's accreditation by the CMS.

Find out more about Treating Customers Fairly at **https://www.fsb.co.za/feedback/pages/tcfhome.aspx**.



Access to superior quality of care

Discovery Health Medical Scheme and Discovery Health believe that everyone wants, and deserves, high-quality healthcare.



Discovery Health's initiatives for the Scheme *continued*

Access to superior quality of care *continued*

Recognising excellence in quality of care

Partnerships with healthcare professionals

Discovery Health is committed to providing access to quality and cost-effective private healthcare to the members of Discovery Health Medical Scheme. Discovery Health is also committed to working with the profession to achieve efficiencies in the healthcare system and enhance professional remuneration in a sustainable manner.

Discovery Health Medical Scheme continues to engage with healthcare professionals individually and through various professional bodies to form partnerships that enhance and support the quality of care provided to its members. Key engagements with healthcare professionals during 2015 are discussed below.

Read more about the Scheme and Discovery Health's engagement with healthcare professionals on **pages 25 – 26**.

Paediatric Governance Project

Since the launch of this project, there has been an improvement in the quality of care, a decrease in inappropriate admissions and an increase in paediatricians' remuneration. The impact of practice engagement has continued to demonstrate alignment with the typically high standard of practice around the country. Increases in clinical quality and associated savings continue to be realised. In addition to the quality of care benefits, additional savings from these activities are shared with paediatricians.

Physician Quality Network

In collaboration with the Faculty of Consulting Physicians of South Africa, physicians can enhance their income through this shared value initiative, which focuses on care delivery, governance and quality improvement.

Enhanced Recovery After Surgery (ERAS)

ERAS, a surgical pilot for colorectal surgery, is going well with over 60 patients having undergone the new model of surgical care with good outcomes. The focus is currently on refining the project criteria and measurement. The funding model will continue until the end of 2016 and will be evaluated for broader roll out thereafter. ERAS has the potential to reduce care time by 30% and may reduce surgical complications by 30% to 50%.

SASCI CAD Care Project

Discovery Health, in collaboration with the South African Society of Cardiovascular Intervention (SASCI), launched a care delivery programme to demonstrate that collaborative learning and data sharing can improve healthcare quality and cost outcomes for members diagnosed with coronary artery disease (CAD). Cardiologists who choose to participate benefit from access to more flexible funding and a more efficient benefit reimbursement process as well as enhanced professional remuneration.

Read more about healthcare professional partnerships on **page 26**.

Empowering members and supporting healthcare providers

Enhancing the Discovery Health Professional Zone to promote quality of care

Discovery Health's online portal for healthcare professionals, the Professional Zone, now has annual Practice Quality Reports to assist healthcare professionals to track the care they provide to members and benchmark against similar cases. This supports healthcare professionals in improving the care they provide to members.

HealthID

HealthID is the first electronic health record application of its kind in South Africa. It makes members' health records available to their doctors (once consent is given) and assists doctors in interacting with Discovery Health Medical Scheme.

HealthID has grown significantly in uptake and impact since it was launched in 2012, with over 6 150 registered doctors, 1 448 regular users and over 900 000 members providing consent for their records to be viewed by their doctors.

In 2015, HealthID was made available to healthcare professionals on the Discovery internet site and extended to support:

Personal Health Programmes – GPs can prescribe Personal Health Programmes for eligible chronic disease patients, with the ability to monitor health and track progress over time.

Advanced Illness Benefit (AIB) web – enhanced end of life management through HealthID.

Smart Plan – Discovery Health Medical Scheme's first digital health plan which empowers members and their doctor to manage their health and health plan electronically.

Kids Electronic Health Record – provides parents and doctors with a trusted source of health and wellness information for children under the age of 18, which includes doctor's visits, vaccinations, hospitalisations, medication and lifestyle activities.

Premier Practice – enhancement to metrics capture screen to ensure captured results are submitted to the Discovery Health Vault.

CIB Select – selected doctors on a managed network are able to edit chronic illness benefit decisions via HealthID.

Sick Note – gives doctors the ability to complete a sick note for a member.

HealthID functionality includes:

- **Electronic health record**
  Giving members peace of mind that their medical records are available when and where they are needed most.
- **Electronic medicine scripting**
  Makes members aware of potential co-payments and enables doctors to discuss available medicine options.
- **Consent**
  Gives members peace of mind that their personal information is protected and will only be viewed by their chosen doctors.
- **Electronic Chronic Illness Benefit**
  Reduces the risk of members' applications being delayed due to incomplete information.
- **Members' personal and benefit details**
  Members are assured that the healthcare professional they have been referred to has a comprehensive view of the referral information they need.
- **Pathology reports**
  Doctors can access pathology reports for their patients, lowering the costs associated with ordering multiple reports.
- **Electronic referrals**
  Members may be referred to another healthcare professional with automatic approval on select plans.
- **Call me feature**
  Members may request a call for any assistance required whether it be clinical, technical or administrative.

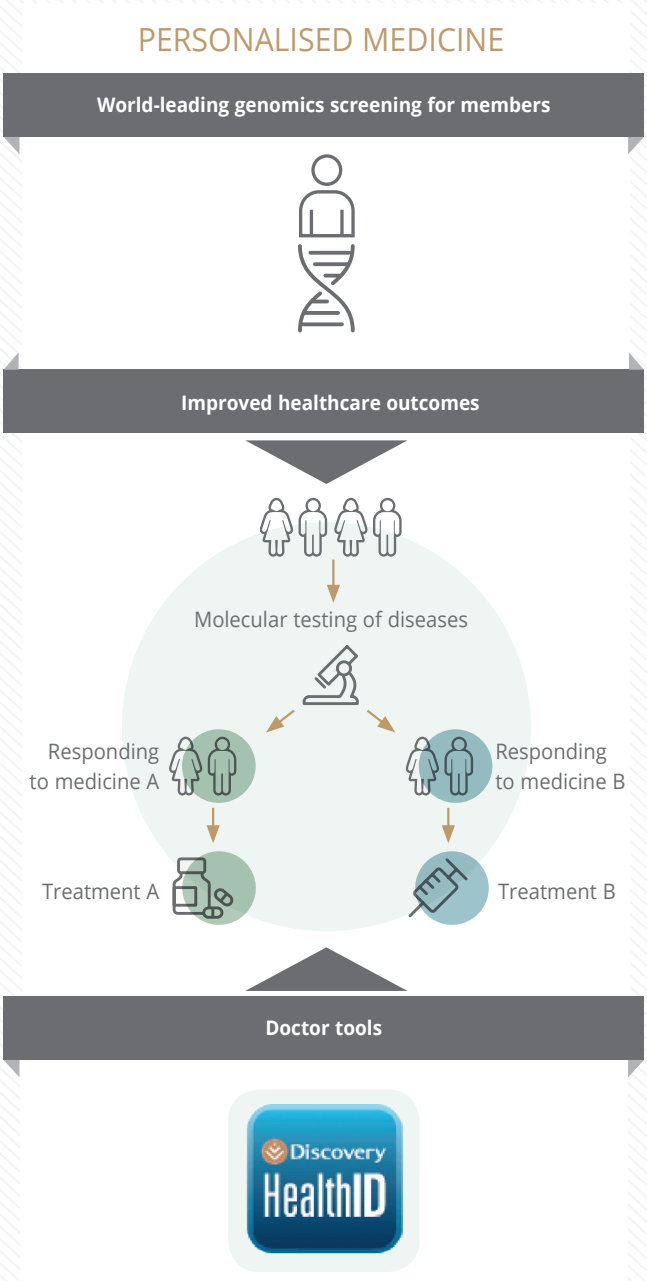
Discovery Health's initiatives for the Scheme *continued*

Personalised healthcare for improved outcomes

Discovery Health launched a partnership with Human Longevity Inc. (HLI) to enable Scheme members to have their genome sequenced.

Read more about personalised healthcare on **page 24**.

Delivering personalised healthcare and service journeys



Personal Health Programmes and Premier Practice

Discovery Personal Health Programmes integrate Discovery Health Medical Scheme screening benefits with the optional offerings of a separate wellness product offered through the world's leading science-based wellness programme, Vitality[1], to enhance the care of members with diabetes (type 1 and type 2), hypertension, hyperlipidaemia or ischaemic heart disease.

The Personal Health Programme:

- Guides members on what to do to improve their health.
- Facilitates monitoring throughout the programme by the member's Premier Practice GP, who is able to track and monitor their progress in real time by viewing health metrics such as fitness and blood glucose levels, weight management, nutrition and medication intake.
- Members can monitor their own progress at any time, through relevant alerts and reminders.
- If members also belong to Vitality, they earn points and unlock additional rewards to help them live well.
- GPs can sign up to become Premier Practice GPs with Discovery Health, which also allows them to participate in peer mentoring and ongoing professional development.

At the end of 2015, around 4 100 members were enrolled on Personal Health Programmes, with initial results showing a significant reduction in hospital admissions and specialist visits.

The GP Premier Practice initiative continues to grow with 1 300 doctors and 6 300 members actively engaged by November 2015. This initiative embodies the concepts of shared value with activity tracking demonstrating a positive impact on the health behaviour of members.

International second-opinion services

Since 2013, Discovery Health has enabled the treating specialists of Scheme members to obtain second opinions from the world-renowned Cleveland Clinic in the USA. This adds significantly to the quality of treatment for members with particularly complex medical needs.

From 1 January 2015, the Scheme funded 50% of the second-opinion fee from Cleveland Clinic where a second opinion was requested by the member's treating specialist.

Cleveland Clinic

Unique savings for Scheme members

Scheme members have exclusive access to value-added healthcare offers outside of the Scheme benefits that are not available to members of other open medical schemes. These include:

- 20% discount on frames and eyeglass lenses (excluding KeyCare members, at optometrists in the Discovery Health Optometry Network).
- Semen testing and preservation, and to cryogenically store their newborn baby's umbilical cord blood and tissue stem cells for potential future medical use at a discounted rate.

HealthyCompany: a comprehensive wellness solution for employers

Healthy employees mean less costs related to healthcare, higher productivity and lower absenteeism.

Read more about HealthyCompany on **page 28**.

1 *Vitality is a separate wellness product sold and administered by Discovery Vitality (Pty) Ltd. Registration number 1999/007736/07, an authorised financial services provider.*

Discovery Health's initiatives for the Scheme *continued*

Unique, superior service experience

Discovery Health on Call 24/7

This service provides convenient family doctor consultations when and where you need them.

Discovery Health Medical Scheme is uniquely placed to offer convenient virtual consultations to members through the Discovery Member App, and HealthID. In 2015 virtual consultations were made available to all members, which are paid from their available day-to-day benefits. In addition, members are able to book a doctor's appointment via the Discovery Member App for selected practices.

The Smart Plan and accessing networks through mobile technology

In 2015, Discovery Health Medical Scheme launched the Smart Plan, which embraces the dynamic world of digital technology, empowering members to manage their health plan and access healthcare professionals through their smart phone or other devices.

Discovery Health has had great success in setting up networks of healthcare professionals and hospitals, which translates into contribution savings for members.

The Smart Plan network of doctors engage with Discovery Health on the many digital platforms made available to them, which facilitates a smooth journey through the healthcare system for Smart Plan members. Through the Discovery Member App, members can choose their provider and book an appointment or a virtual consultation with participating doctors.

App – Claims QR Code

In 2015, the Discovery Member App was enhanced to enable members to submit their claims in two quick, easy and innovative ways:

- Take a photo of the claim by using the camera on their phone.
- Scan the QR code on the claim.

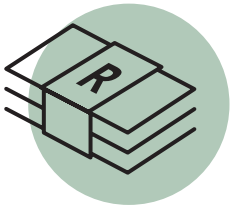
Every working day[1], on average, Discovery Health facilitated the following for Discovery Health Medical Scheme members in 2015:

A day in the life of Scheme operations

158
Babies born

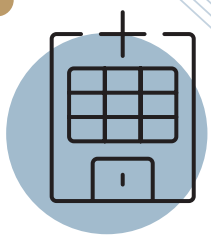
R1 422 574
savings through fraud and forensics investigations

1 516
new beneficiaries joined the Scheme



R169 million
paid out in claims

2 890
Hospital admissions authorised



1 Using 249 working days in a year.

Annual Financial Statements

Statement of Responsibility by the Board of Trustees

for the year ended 31 December 2015

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 2015, 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. The Annual Financial Statements have been prepared in accordance with International Financial Reporting Standards and the Medical Schemes Act 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 2016. 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 81. The Annual Financial Statements, which are presented on pages 82 to 151 were approved by the Board of Trustees on 7 April 2016 and are signed on its behalf by:

M VAN DER NEST, SC
CHAIRPERSON

N GRAVES, SC
TRUSTEE

M STREAK
PRINCIPAL OFFICER

Report of the Audit Committee

for the year ended 31 December 2015

We are pleased to present our report for the financial year ended 31 December 2015. 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 and has discharged the responsibilities contained therein.

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 Committee met five times during 2015.

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. Internal Audit and the external auditor are also afforded the opportunity to meet with the Committee, after each meeting, without the Administrator present.

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 2015. 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 per 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.

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

Committee member		Qualifications	4 Mar	11 Mar	21 Jul	20 Aug	21 Oct
Independent member/Chair	Mr Barry Stott	CA(SA)	✓	✓	✓	✓	✓
Trustees	Ms Daisy Naidoo	CA(SA), Masters of Accounting (Taxation)	✓	✓	✓	✓	✓
	Mr Giles Waugh	FIA, FASSA	✓	✓	✓	✓	✓
Independent members	Mr Neil Novick[1]	CA(SA)	✓	✓	✓	✓	✓
	Mr Steven Green	BSc (Hons)	✓	✓	✓	✓	✓
	Mr Don Eriksson[2]	CA(SA)	✓	×			
	Mr Dave King[3]	BSc (Hons), MBA			×	✓	✓

1 Mr Neil Novick resigned 31 December 2015.

2 Mr Don Eriksson resigned 1 July 2015.

3 Mr Dave King a member since 1 July 2015.

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. Corlia Volschenk was approved by the Council for Medical Schemes as the statutory auditor of the Scheme for the financial period 1 January 2015 to 31 December 2015 in accordance with Section 36 (2) of the Medical Schemes Act 131 of 1998 on 27 August 2015.

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 Scheme 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 2015.

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. Fees in respect of audit and non-audit services are reflected in note 15 to the Annual Financial Statements.

Report of the Audit Committee *continued*

for the year ended 31 December 2015

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, the Medical Schemes Act 131 of 1998 and circulars issued by the Council for Medical Schemes.

Internal financial controls

The Committee is responsible for assessing the Scheme's system of internal financial and accounting control. In this regard the Committee has, among other things, evaluated the adequacy and effectiveness of the Scheme's systems of internal control and made appropriate recommendations to the Board of Trustees. This included a formal documented review by the Internal Audit function of 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.

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

** *High Assurance – The existing control framework provides a high level of assurance that the Annual Financial Statements are fairly presented.*

Evaluation of the expertise and experience of the Chief Financial Officer and Finance function

The Committee satisfied itself with respect to the expertise and experience of the Scheme's Chief Financial Officer. The Committee further 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.

Ethics and compliance

The Committee is responsible for reviewing any major breach of the relevant Scheme charters, codes and relevant legal, regulatory and other obligations. The Committee is satisfied that there has been no material breach of these standards or material non-compliance with laws and regulations, except for the matters of non-compliance with the Act as detailed in Note 34 to 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 2015 as well as the budget for the year ending 31 December 2016. The Committee took note of the positive solvency and liquidity position of the Scheme. The Scheme members' funds exceed R12.9 billion, with cash and investments exceeding R13.5 billion.

On the basis of this review and taking note of the current net surplus of R1.3 billion, the Committee considers that:

- The Scheme's assets currently exceeds its liabilities; and
- 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 2015 and, based on the information provided to the Committee, considers (except for the matters of non-compliance with the Act as detailed in Note 34 to the Annual Financial Statements) 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
7 April 2016

Independent Auditor's Report

for the year ended 31 December 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 pages 82 to 151 which comprise the Statement of Financial Position at 31 December 2015, 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 2015, 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 instances 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 34 of the financial statements; and

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% at the end of January, February and November 2015. However, at 31 December 2015, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 25.98% which exceeds the statutory solvency requirement of 25%, as disclosed in note 34 of the financial statements.

PricewaterhouseCoopers Inc.
DIRECTOR: CORLIA VOLSCHENK
Registered Auditor

7 April 2016

Sunninghill

Statement of Financial Position

as at 31 December 2015

R'000	Notes	2015	2014
ASSETS			
Non-current assets		**1 071**	1 511
Long-term Employee Benefit Plan asset	27	**1 071**	1 511
Current assets		**18 897 501**	16 785 039
Financial assets at fair value through profit or loss	2	**11 399 332**	9 474 520
Derivative financial instruments	7	**–**	22 700
Trade and other receivables	3	**1 632 586**	1 604 550
Cash and cash equivalents			
– Personal Medical Savings Account trust assets	4	**3 667 456**	3 188 789
– Medical Scheme assets	5	**2 198 127**	2 494 480
Total assets		**18 898 572**	16 786 550
FUNDS AND LIABILITIES			
Members' funds		**12 929 011**	11 652 804
Accumulated funds		**12 929 011**	11 652 804
Current liabilities		**5 969 561**	5 133 746
Outstanding claims provision	6	**985 087**	845 795
Derivative financial instruments	7	**65 210**	5 969
Personal Medical Savings Account trust liabilities	8	**3 736 659**	3 250 743
Trade and other payables	9	**1 182 605**	1 031 239
Total funds and liabilities		**18 898 572**	16 786 550

Statement of Comprehensive Income

for the year ended 31 December 2015

R'000	Notes	2015	Restated 2014
Risk contribution income	10	**40 066 741**	36 111 000
Relevant healthcare expenditure*		**(34 503 627)**	(30 692 168)
Net claims incurred	11	**(33 255 417)**	(29 552 978)
Claims incurred	11	**(33 326 153)**	(29 652 737)
Third-party claims recoveries	11	**70 736**	99 759
Accredited managed healthcare services (no risk transfer)*	12	**(1 305 790)**	(1 201 155)
Net income on risk transfer arrangements	13	**57 580**	61 965
Risk transfer arrangement fees		**(344 093)**	(325 975)
Recoveries from risk transfer arrangements		**401 673**	387 940
Gross healthcare result*		**5 563 114**	5 418 832
Broker service fees	14	**(982 874)**	(918 871)
Expenses for administration	27	**(3 874 896)**	(3 585 641)
Other operating expenses	15	**(198 387)**	(161 129)
Net healthcare result		**506 957**	753 191
Other income		**1 033 020**	983 126
Investment income	21	**1 018 998**	859 112
Net gains on financial assets at fair value through profit or loss	22	**6 504**	116 457
Sundry income	23	**7 518**	7 557
Other expenditure		**(263 837)**	(199 509)
Expenses for asset management services rendered		**(31 578)**	(17 704)
Interest paid	24	**(232 259)**	(181 805)
Net surplus for the year		**1 276 140**	1 536 808
Other comprehensive income		**–**	–
Total comprehensive income for the year		**1 276 140**	1 536 808

* *See Note 12 to the Annual Financial Statements for explanatory note on change of disclosure.*

Statement of Changes in Funds and Reserves

for the year ended 31 December 2015

R'000	Notes	2015 Accumulated funds	2014 Accumulated funds
Balance at beginning of the year		**11 652 804**	9 970 118
Total comprehensive income for the year		**1 276 140**	1 536 808
Reserves transferred from other medical schemes	25	**67**	145 878
Total member funds end of the year		**12 929 011**	11 652 804

Statement of Cash Flows

for the year ended 31 December 2015

R'000	Notes	2015	2014
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows from operations before working capital changes	29	**555 793**	799 556
Working capital changes:			
Increase in trade and other receivables	29.1	**(99 229)**	(160 458)
Increase in outstanding claims provision		**139 292**	33 605
Increase in Personal Medical Savings Accounts		**485 916**	474 023
Increase in trade and other payables	29.2	**151 366**	15 689
Cash generated by operations		**1 233 138**	1 162 415
Purchases of financial instruments	29.3	**(6 176 902)**	(3 448 243)
Proceeds from sale of financial instruments	29.4	**4 339 081**	1 737 654
Cash transferred from other medical schemes		**67**	104 624
Interest received	21	**981 460**	835 728
Dividend income	21	**37 729**	23 617
Interest paid	24	**(232 259)**	(181 805)
Net cash flows from operating activities		**182 314**	233 990
NET INCREASE IN CASH AND CASH EQUIVALENTS		**182 314**	233 990
Cash and cash equivalents at beginning of year		**5 683 269**	5 449 279
CASH AND CASH EQUIVALENTS AT END OF YEAR		**5 865 583**	5 683 269
Cash and cash equivalents comprise:			
Personal Medical Savings Accounts trust assets	4	**3 667 456**	3 188 789
Medical Scheme assets	5	**2 198 127**	2 494 480
		5 865 583	5 683 269

Accounting policies

for the year ended 31 December 2015

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 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 7 April 2016.

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, except for changes required by the mandatory adoption of new and revised IFRS, discussed in the table below.

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 33.

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; and
- 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 2015 and relevant to the Scheme:

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

Standard	Scope	Effective date
IFRS 13 (Amendment): Fair value measurement	When IFRS 13 was published, paragraphs B5.4.12 of IFRS 9 and AG79 of IAS 39 were deleted as consequential amendments. This led to a concern that entities no longer had the ability to measure short-term receivables and payables at invoice amounts where the impact of not discounting is immaterial. 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. The standard is further amended to clarify that the portfolio exception in IFRS 13, which allows an entity to measure the fair value of a group of financial assets and financial liabilities on a net basis, applies to all contracts (including non-financial contracts) within the scope of IAS 39 or IFRS 9.	1 July 2014
IAS 24 (Amendment): Related parties	The standard is amended 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

Accounting policies *continued*

1 | Basis of preparation *continued*

New standards, amendments and interpretations effective in 2015 and not relevant to the Scheme:

Standard	Scope	Effective date
IFRS 1 (Amendment): 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	This amendment amends the definition of 'market condition' and 'vesting conditions' and the definitions of 'performance condition' and 'service condition' are added.	1 July 2014
IFRS 3 (Amendment): Business combinations	The standard is amended to clarify the measurement requirements for all contingent consideration assets and liabilities. The standard is also amended to clarify that IFRS 3 does not apply to the accounting for formation of a joint arrangement.	1 July 2014
IFRS 8 (Amendment): Operating segments	The standard is amended to require disclosure of the judgements made by management in aggregating operating segments.	1 July 2014
IAS 16 (Amendment): Property, plant and equipment and IAS 38 (Amendment): Intangible assets	Both standards are amended to clarify how the gross carrying amount and the accumulated depreciation are treated where an entity uses the revaluation model. The carrying amount of the asset is restated to the revalued amount. The split between gross carrying amount and accumulated depreciation is treated in one of the following ways: ▪ Either the gross carrying amount is restated in a manner consistent with the revaluation of the carrying amount, and the accumulated depreciation is adjusted to equal the difference between the gross carrying amount and the carrying amount after taking into account accumulated impairment losses, or ▪ The accumulated depreciation is eliminated against the gross carrying amount.	1 July 2014
IAS 40 (Amendment): Investment property	The standard is amended to clarify that IAS 40 and IFRS 3 are not mutually exclusive. The guidance in IAS 40 assists preparers to distinguish between investment property and owner-occupied property. Prepares also need to refer to the guidance in IFRS 3 to determine whether the acquisition of an investment property is a business combination.	1 July 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 (Amendment): Financial instruments	A finalised version of IFRS 9 has been issued which replaces IAS 39 Financial Instruments: Recognition and Measurement. The completed standard provides guidance on classification, measurement, impairment, hedge accounting and derecognition. This standard introduces new requirements for the classification and measurement of financial assets by introducing a fair value through other comprehensive income category for certain debt instruments. It also introduces a new single impairment model applicable to all financial instruments as well as an expected credit loss model which will result in earlier recognition of losses. No changes were introduced for the classification and measurement of financial liabilities, except for the recognition of changes in own credit risk in other comprehensive income for liabilities designated at fair value through profit or loss. The amendments also align hedge accounting more closely with an entity's risk management. The revised standard establishes a more principles-based approach to hedge accounting and addresses inconsistencies and weaknesses in the current model in IAS 39.	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 from 1 January 2013.	1 January 2018
IAS 1 (Amendment): Presentation of financial statements	The amendments clarify guidance on materiality and aggregation, the presentation of subtotals, the structure of financial statements and the disclosure of accounting policies.	1 January 2016

Accounting policies *continued*

1 | Basis of preparation *continued*

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

Standard	Scope	Effective date
IFRS 5 (Amendment): Non-current assets held for sale and discontinued operations	This is an amendment to the changes in methods of disposal. Assets (or disposal groups) are generally disposed of either through sale or through distribution to owners. The amendment to IFRS 5 clarifies that changing from one of these disposal methods to the other should not be considered to be a new plan of disposal, rather it is a continuation of the original plan. There is therefore no interruption of the application of the requirements in IFRS 5. The amendment also clarifies that changing the disposal method does not change the date of classification.	1 January 2016
Amendment to IAS 7 – Cash flow statements	In January 2016, the International Accounting Standards Board (IASB) issued an amendment to IAS 7 introducing additional disclosure that will enable users of financial statements to evaluate changes in liabilities arising from financing activities. The amendment responds to requests from investors for information that helps them better understand changes in an entity's debt. The amendment will affect every entity preparing IFRS financial statements. However, the information required should be readily available. Preparers should consider how best to present the additional information to explain the changes in liabilities arising from financing activities.	1 January 2017
IFRS 7 (Amendment): Financial instruments; disclosure	Servicing contracts – The amendment clarifies that a servicing contract that includes a fee can constitute continuing involvement in a financial asset. An entity must assess the nature of the fee and arrangement against the guidance for continuing involvement in paragraphs IFRS 7.B30 and IFRS 7.42C in order to assess whether the disclosures are required. Applicability of the offsetting disclosures to condensed interim financial statements – The amendment removes the phrase 'and interim periods within those annual periods' from paragraph 44R, clarifying that these IFRS 7 disclosures are not required in the condensed interim financial report. However IAS 34 requires an entity to disclose an explanation of events and transactions that are significant to an understanding of the changes in financial position and performance of the entity since the end of the last annual reporting period.	1 January 2016
IFRS 10 (Amendment): Consolidated financial statements and IAS 28 (Amendment): Investments in associates and joint ventures	This amendment eliminates the inconsistency between IFRS 10 and IAS 28. If the non-monetary assets sold or contributed to an associate or joint venture constitute a 'business', then the full gain or loss will be recognised by the investor. A partial gain or loss is recognised when a transaction involves assets that do not constitute a business, even if these assets are housed in a subsidiary. The amendment also clarifies the application of the consolidation exception for investment entities and their subsidiaries.	1 January 2016
IFRS 11 (Amendment): Joint arrangements	This amendment adds new guidance on how to account for the acquisition of an interest in a joint operation that constitutes a business. The amendments specify the appropriate accounting treatment for such acquisitions.	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

1 | Basis of preparation *continued*

Standard	Scope	Effective date
IFRS 15 (Standard): Revenue from contracts with customers	This standard establishes a single, comprehensive revenue recognition model for all contracts with customers to achieve greater consistency in the recognition and presentation of revenue. Revenue is recognised based on the satisfaction of performance obligations, which occurs when control of good or service transfers to a customer.	1 January 2018
IFRS 16 (Standard): Leases	This standard introduces a single lessee accounting model and requires lessees to recognise assets and liabilities arising from all leases (with limited exceptions) with a term of more than 12 months in the Statement of Financial Position. The model reflects that, at the start of a lease, the lessee obtains the right to use an asset for a period of time and has an obligation to pay for that right. A lessee measures lease liabilities at the present value of future lease payments. A lessee measures lease assets, initially at the same amount as lease liabilities, and also includes costs directly related to entering into the lease. IFRS 16 supersedes IAS 17, 'Leases', IFRIC 4, 'Determining whether an Arrangement contains a Lease', SIC 15, 'Operating Leases – Incentives' and SIC 27, 'Evaluating the Substance of Transactions Involving the Legal Form of a Lease'.	1 January 2019
IAS 16 (Amendment): Property, plant and equipment and IAS 38 (Amendment): Intangible assets	This amendment clarifies that the use of revenue-based methods to calculate the depreciation of an asset is not appropriate because revenue generated by an activity that includes the use of an asset generally reflects factors other than the consumption of the economic benefits embodied in the asset. The amendment also clarifies that revenue is generally presumed to be an inappropriate basis for measuring the consumption of the economic benefits embodied in an intangible asset.	1 January 2016
IAS 16 (Amendment): Property, plant and equipment and IAS 41 (Amendment): Agriculture	This amendment to IAS 16 has scoped in bearer plants, but not the produce on bearer plants. It further explains that a bearer plant not yet in the location and condition necessary to bear produce is treated as a self-constructed asset. The amendment to IAS 41 has adjusted the definition of a bearer plant, includes examples of non-bearer plants and removes current examples of bearer plants from IAS 41.	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. When there is no deep market for high-quality corporate bonds in that currency, government bond rates must be used.	1 January 2016
IAS 27 (Amendment): Separate financial statements	This amendment restores the option to use the equity method to account for investments in subsidiaries, joint ventures and associates in an entity's separate financial statements.	1 January 2016
IAS 34 (Amendment): Interim Financial Reporting	The amendment states that the interim disclosures must either be in the interim financial statements or incorporated by cross-reference between the interim financial statements and wherever they are included within the greater interim financial report. Other information within the interim financial report must be available to users on the same terms as the interim financial statements and at the same time.	1 January 2016
IAS 38 (Amendment): Intangible Assets	Clarifies the use of revenue-based methods to calculate depreciation of an asset.	1 January 2016

Accounting policies *continued*

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.

3 Financial assets

Financial assets at fair value through profit or loss

The Scheme recognises a financial asset at fair value through profit or loss 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 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.

Trade and other 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 measurable 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 which 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.

Accounting policies *continued*

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 31.

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.

14 Relevant healthcare expenditure

Relevant healthcare expenditure consists of net claims incurred, accredited managed healthcare services (no risk transfer) and net income or expense from risk transfer arrangements.

14.1 Claims incurred

Gross claims incurred comprises of 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 which 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 are 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.

Accounting policies *continued*

14 Relevant healthcare expenditure *continued*

14.3 Accredited managed healthcare services (no risk transfer)

Accredited managed healthcare services (no risk transfer) 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 and are expensed as incurred.

During the year under review, the Council for Medical Schemes (CMS) issued Circular 56 of 2015 which informed the industry that CMS had reviewed the classification of managed care services as defined in the Act and concluded that all accreditable managed care services should be included as part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of medical schemes.

Fees for Accredited managed healthcare services (no transfer of risk) in the Statement of Comprehensive Income no longer form part of non-healthcare expenditure, and are included as part of Relevant healthcare expenditure. This change represents a re-classification and only impacts the gross healthcare result and neither the net healthcare result nor comprehensive income of previously presented results.

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.

16 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.

17 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.

18 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 on the "last day to trade" for listed shares and on the "date of declaration" for unlisted shares.

19 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 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.

20 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.

21 Employee benefits

Pension obligations

All employees of the Scheme are members of defined contribution plans. Defined contribution plans are plans under which the Scheme pays fixed contributions to separate legal entities.

The Scheme has no legal or constructive obligation to pay further contributions if the plans do 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 plans 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 benefits

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.

21 | Employee benefits *continued*

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.

22 | 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.

23 | 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.
- Accredited Managed healthcare 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.

24 | 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. Disclosure of these investments has been made in Note 32 to the Annual Financial Statements. The objectives include achieving medium- to long-term capital growth and the investment strategy does not include the use of leverage.

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'.

Notes to the Annual Financial Statements

for the year ended 31 December 2015

R'000	2015	2014
1 Accounting policies		
The accounting policies of the Scheme are set out on pages 85 – 95.		
2 Financial assets at fair value through profit or loss		
The Scheme's financial assets at fair value through profit or loss have been summarised as follows:		
Current assets	**11 399 332**	9 474 520
– Offshore bonds	**1 335 137**	1 089 600
– Equities	**1 415 647**	1 026 342
– Yield-enhanced bonds	**3 058 012**	996 091
– Inflation-linked bonds	**464 574**	343 737
– Money market instruments	**5 125 962**	6 018 750
	11 399 332	9 474 520
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	**9 474 520**	7 607 085
Acquisitions	**6 176 902**	3 447 332
Disposals	**(4 465 329)**	(1 745 608)
Net gains on revaluation of financial assets at fair value through profit or loss (Note 22)	**213 239**	165 712
At the end of the year	**11 399 332**	9 474 520
A register of investments is available for inspection at the registered office of the Scheme.		
3 Trade and other receivables		
Insurance receivables		
Contribution receivables	**1 386 504**	1 392 667
Contributions outstanding	**1 396 137**	1 399 772
Less: Provision for impairment	**(9 633)**	(7 105)
Member and service provider claims receivables	**70 316**	58 181
Amount due	**278 845**	235 639
Less: Provision for impairment	**(208 529)**	(177 458)
Other risk transfer arrangements	**7 520**	2 684
Recoveries due from other risk transfer arrangements	**5 051**	179
Share of outstanding claims provision (Note 6)	**2 469**	2 505
Broker fee receivables	**111**	68
Amounts due from brokers	**895**	668
Less: Provision for impairment	**(784)**	(600)
Other insurance receivables	**60 869**	30 056
Total receivables arising from insurance contracts	**1 525 320**	1 483 656

R'000	2015	2014
3 Trade and other receivables *continued*		
Loans and receivables		
Balance due by related party	**12 024**	9 557
Discovery Third Party Recovery Services (Pty) Ltd (Note 27)	**12 024**	9 557
Sundry accounts receivable	**93 797**	110 142
Interest receivable	**1 445**	1 195
Total receivables arising from loans and receivables	**107 266**	120 894
	1 632 586	1 604 550

At 31 December 2015 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	**1 594 575**	1 309 747
Net additional Investments	**120 220**	193 859
Interest Income	**118 267**	91 645
Fair value adjustments	**(75)**	(676)
Balance at the end of the year	**1 832 987**	1 594 575
PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO (Managed by Taquanta Asset Managers (Pty) Ltd)		
Balance at beginning of the year	**1 594 214**	1 309 558
Net additional Investments	**127 524**	198 056
Interest Income	**112 731**	86 818
Fair value adjustments	**–**	(218)
Balance at the end of the year	**1 834 469**	1 594 214
Total Personal Medical Savings Account trust assets	**3 667 456**	3 188 789

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 (Note 8) is reconciled monthly and arises from timing of cash flows to and from the portfolios. For the year under review the average rate earned on the Personal Medical Savings Account trust assets was 6.91% (2014: 6.21%).

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

R'000	2015	2014
5 Cash and cash equivalents – medical scheme assets		
Call accounts	**–**	208 000
Current accounts	**842 123**	406 068
Money market instruments	**1 356 004**	1 880 412
	2 198 127	2 494 480
At 31 December 2015 cash and cash equivalents are carried at fair value.		
6 Outstanding claims provision		
Outstanding claims provision – not covered by risk transfer arrangements	**982 618**	843 290
Outstanding claims provision – covered by risk transfer arrangements	**2 469**	2 505
	985 087	845 795
Analysis of movement in outstanding claims		
Balance at beginning of the year	**845 795**	812 190
Payments in respect of prior year	**(872 043)**	(806 779)
(Under)/over provision in prior year (Note 11)	**(26 248)**	5 411
Outstanding claims provision raised in current year	**1 011 335**	840 384
Not covered by risk transfer arrangements	**1 008 866**	837 879
Covered by risk transfer arrangements (Note 3)	**2 469**	2 505
Balance at end of the year	**985 087**	845 795
Analysis of outstanding claims provision		
Estimated gross claims	**1 059 065**	899 168
Less:		
Estimated recoveries from savings plan accounts (Note 8)	**(73 978)**	(53 373)
Balance at end of the year	**985 087**	845 795

R'000	2015	2014
7 Derivative financial instruments		
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments	–	22 700
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments	**(65 210)**	(5 969)
Derivative financial (liability)/asset at the end of the year	**(65 210)**	16 731
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
Derivative financial asset/(liability) at the beginning of the year	**16 731**	(23 435)
Net realised losses on derivative financial instruments (Note 29.4)	**126 248**	89 419
Realised gains on derivative financial instruments	**(36 137)**	–
– Equity portfolio derivatives	**(2 852)**	–
– Zero-cost equity collar	**(785)**	–
– Zero-cost currency collar	**(32 500)**	–
Realised losses on derivative financial instruments	**162 385**	89 419
– Equity portfolio derivatives	**–**	2 430
– Bond portfolio derivatives	**–**	413
– Zero-cost currency collars	**162 385**	86 576
Net fair value losses on derivative financial instruments (Note 22)	**(208 189)**	(49 254)
Gain on revaluation of derivative financial instruments to fair value	**8 823**	7 697
– Equity portfolio derivatives	**8 823**	–
– Zero-cost equity collars	**–**	2 258
– Zero-cost currency collars	**–**	5 439
Loss on revaluation of derivative financial instruments to fair value	**(217 012)**	(56 950)
– Equity portfolio derivatives	**(5 738)**	(1 967)
– Zero-cost equity collar	**(63 629)**	(31 748)
– Zero-cost currency collar	**(147 645)**	(21 522)
– Bond portfolio derivatives	**–**	(1 713)
Derivative financial (liability)/asset at the end of the year	**(65 210)**	16 731

Derivative Instruments

The Trustees approved a strategy to protect the value of the Scheme's investments by entering into zero-cost equity collars which protects the Scheme's equity portfolios against a fall in equity markets and zero-cost currency collars to protect the Scheme's offshore bond portfolios against Rand appreciation.

The Scheme's equity managers entered into All Shareholder Index (ALSI) and SWIX 40 futures contracts to generate an equity-related return on cash held in the equity portfolios.

The Scheme's bond managers entered into bond futures to hedge the bond portfolios 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 32).

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

R'000	2015	2014
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	**3 250 743**	2 776 720
Add:		
Personal Medical Savings Accounts contributions received or receivable	**9 693 015**	8 794 716
For the current year (Note 10)	**9 693 015**	8 794 716
Interest on Personal Medical Savings Accounts (Note 24)	**232 141**	181 687
Transfers received from other medical schemes	**19 815**	14 231
Less:		
Claims paid to or on behalf of members (Note 11)	**(9 199 956)**	(8 301 351)
Refunds on death or resignation	**(259 099)**	(215 260)
Balance due to members on Personal Medical Savings Accounts held in trust at the end of the year	**3 736 659**	3 250 743
It is estimated that claims to be paid out of members' Personal Medical Savings Accounts in respect of claims incurred in 2015 but not reported will amount to approximately R73 978 313 (2014: R53 373 459) (Note 6).		
As at 31 December 2015 the carrying amount of the members' Personal Medical Savings Accounts were deemed to be equal to their fair values, which is the amount payable on demand. The amounts were not discounted, due to the demand feature.		
Interest is allocated on these Personal Medical Savings Account balances monthly in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes. The Scheme does not charge interest on negative (overdrawn) Personal Medical Savings Account balances.		
9 Trade and other payables		
Insurance payables		
Contributions received in advance	**119 036**	101 162
Premium refunds due to employers	**1 494**	173
Reported claims not yet paid	**506 752**	334 519
Balance at the beginning of the year	**334 519**	470 518
Movement for the year	**172 233**	(135 999)
Broker fee creditors	**87 618**	87 973
Accredited brokers	**87 618**	87 973
Other insurance liabilities	**4**	16
Total liabilities arising from insurance contracts	**714 904**	523 843
Financial liabilities		
Balance due to related parties	**437 982**	368 555
Discovery Health (Pty) Ltd (Note 27)	**437 982**	368 555
Unallocated funds	**11 727**	2 724
Total accruals	**17 992**	136 117
General accruals	**17 992**	136 101
Leave pay provision	**–**	16
Total arising from financial liabilities	**467 701**	507 396
	1 182 605	1 031 239
At 31 December 2015 the carrying amounts of insurance and other payables approximate their fair values due to the short-term maturities of these liabilities.		

R'000	2015	2014
10 Risk contribution income		
Gross contribution per registered Scheme Rules	**49 759 756**	44 905 716
Less:		
Personal Medical Savings Account contributions (Note 8)	**(9 693 015)**	(8 794 716)
Risk contribution income per Statement of Comprehensive Income	**40 066 741**	36 111 000
11 Net claims incurred		
Current year claims per registered Scheme Rules	**42 386 817**	37 920 483
Claims not covered by risk transfer arrangements	**41 985 144**	37 532 543
Claims covered by risk transfer arrangements (Note 13)	**401 673**	387 940
Movement in outstanding claims provision	**139 292**	33 605
Under/(over) provision in prior year (Note 6)	**26 248**	(5 411)
Adjustment for current year	**113 044**	39 016
	42 526 109	37 954 088
Less:		
Claims charged to members' Personal Medical Savings Accounts (Note 8)	**(9 199 956)**	(8 301 351)
Claims incurred	**33 326 153**	29 652 737
Third-party claim recoveries	**(70 736)**	(99 759)
	33 255 417	29 552 978

Risk transfer arrangements

During 2015 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 2015 benefit year that were not part of this risk transfer agreement 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 2015 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.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

11 Net claims incurred *continued*

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 are 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:

   - PLPM 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 PLPM costs by the number of members exposed for the period on this programme.

R'000	2015	Restated 2014
12 Accredited managed healthcare services (no risk transfer)		
The accredited managed healthcare services (no risk transfer) have been grouped into the following categories of services.		
Discovery Health (Pty) Ltd		
Active Disease Risk Management Services and Disease Risk Management Support Services	**420 464**	386 773
Hospital Benefit Management Services	**390 431**	359 146
Managed Care Network Management Services and Risk Management Services	**363 010**	333 922
Pharmacy Benefit Management Services	**131 885**	121 314
	1 305 790	1 201 155

During the year under review, the Council for Medical Schemes (CMS) issued Circular 56 of 2015 which informed the industry that CMS had reviewed the classification of managed care services as defined in the Act and concluded that all accreditable managed care services should be included as part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of medical schemes. Fees for Accredited managed healthcare services (no transfer of risk) in the Statement of Comprehensive Income no longer form part of non-healthcare expenditure, and are included as part of Relevant healthcare expenditure. This change represents a re-classification and only impacts the gross healthcare result and neither the net healthcare result nor comprehensive income of previously presented results.

R'000	2014

12 | Accredited managed healthcare services (no risk transfer) *continued*

Managed care services for 2014 were presented as follows:

Discovery Health (Pty) Ltd	
Clinical protocols/disease management	210 203
Hospital management	624 602
Pharmaceutical benefit management	180 174
Provider networks	186 176
	1 201 155

As set out below, the categories of service have been updated to conform to Circular 13 of 2014. The comparative disclosure has been updated accordingly.

Previous category naming convention	Category naming convention per Circular 13 of 2014
Disease Management/Clinical Protocols	Active Disease Risk Management Services and Disease Risk Management Support Services
Hospital Management	Hospital Benefit Management Services
Pharmaceutical Benefit Management	Pharmacy Benefit Management Services
Provider Networks	Managed Care Network Management and Risk Management Services

R'000	2015	2014

13 | Net income on risk transfer arrangements

The Scheme operated the following risk transfer arrangements during the year:

Other risk transfer arrangements:		
Capitation fees paid	**(344 093)**	(325 975)
Recoveries under risk transfer arrangements	**401 673**	387 940
	57 580	61 965

14 | Broker service fees

Brokers' fees	**982 874**	918 871
	982 874	918 871

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

R'000	2015	2014
15 Other operating expenses		
Association fees	**240**	240
Audit fees	**5 432**	5 078
Audit services for the year ended 2015	**2 015**	–
Audit services for the year ended 2014	**2 550**	2 099
Audit services for the year ended 2013	**–**	2 201
Other services	**867**	778
Audit and Risk Committees fees (Note 16)	**1 246**	998
Bank charges	**10 379**	9 880
Clinical Governance Committee fees	**74**	121
Council for Medical Schemes	**38 202**	33 151
Custodian fees	**–**	11
Debt collecting fees	**3 222**	3 250
Dispute Committee fees	**478**	426
Fidelity Guarantee Insurance	**224**	212
General meeting costs	**3 218**	1 993
Investment Committee fees	**125**	121
Investment reporting fees	**2 571**	2 412
Legal fees	**542**	1 704
Net impairment losses (Note 17)	**71 193**	55 962
Nomination Committee fees (Note 18)	**132**	–
Other expenses	**20 732**	15 858
Principal Officer fees – Remuneration	**5 126**	4 816
Principal Officer fees – Unvested Long-term Employee Benefit	**1 502**	1 116
Printing, postage and stationery	**550**	409
Product Committee fees	**66**	109
Professional fees	**10 877**	5 701
Remuneration Committee fees	**68**	15
Scheme office costs	**4 538**	3 691
Staff costs (Note 19)	**13 279**	9 893
Sundry amounts written off	**192**	22
Stakeholder Relations Committee fees	**142**	223
Trustees' remuneration and consideration expenses (Note 20)	**4 037**	3 717
	198 387	161 129

16 Audit and risk committee fees

B Stott – Independent member (Chairperson)[1]	**594**	446
D Eriksson – Independent member[2]	**99**	182
N Novick – Independent member [4]	**229**	191
S Green – Independent member	**219**	179
D King – Independent member[3]	**105**	–
	1 246	998

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 20.

1 *Ex officio member of the Board of Trustees, as Audit and Risk Committee Chairperson.*

2 *Resigned 1 July 2015.*

3 *Newly appointed as at 1 July 2015.*

4 *Resigned 31 December 2015.*

R'000	2015	2014
17 Net impairment losses		
Insurance and other receivables		
Contributions that are not collectable	**2 527**	1 371
Movement in provision	**2 527**	1 371
Members' and service providers' portions that are not recoverable	**61 005**	54 086
Movement in provision	**61 005**	54 086
Amounts due by brokers that are not recoverable	**184**	173
Movement in provision	**184**	173
Amounts due by forensic debtors that are not recoverable	**–**	(1)
Movement in provision	**–**	(1)
Receivables written off	**7 505**	379
Less:		
Previously written off receivables recovered	**(28)**	(46)
	71 193	55 962
18 Nomination committee fees		
P Goss – Independent member (Chairperson)	**44**	–
T Wixley – Independent member	**44**	–
R Shough – Independent member	**44**	–
	132	–
The Nomination Committee was established on 6 November 2015.		
19 Staff costs		
Salaries and bonuses	**11 837**	8 850
Pension costs – defined contribution plans	**745**	501
Medical and other benefits	**499**	448
Long-term Employee Benefit service cost	**394**	–
(Decrease)/increase in leave pay accrual	**(196)**	94
	13 279	9 893
Number of employees at 31 December	**11**	9

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

20 Trustees' remuneration and consideration expenses

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

		Committee fees			
31 December 2015	Services as Trustee R'000	Audit and Risk Committees R'000	Investment Committee R'000	Clinical Governance Committee R'000	Product Committee R'000
M van der Nest, SC (Chairperson)	**602**	**–**	**–**	**–**	**–**
P Maserumule	**314**	**–**	**155**	**–**	**–**
N Graves, SC	**336**	**–**	**115**	**–**	**79**
Z van der Spuy	**324**	**–**	**–**	**122**	**79**
G Waugh	**306**	**211**	**–**	**–**	**102**
D Naidoo	**336**	**219**	**124**	**–**	**–**
Total	**2 218**	**430**	**394**	**122**	**260**

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

	Committee fees				
	Non-healthcare Expenditure Committee R'000	Remuneration Committee R'000	Stakeholder Relations Committee R'000	Trustee Travel R'000	Total R'000
	–	53	91	–	746
	–	–	71	–	540
	101	53	–	–	684
	–	–	–	86	611
	79	–	–	–	698
	79	–	–	–	758
	259	106	162	86	4 037

	Committee fees				
	Non-healthcare Expenditure Committee R'000	Remuneration Committee R'000	Stakeholder Relations Committee R'000	Trustee Travel R'000	Total R'000
	30	10	144	–	616
	–	–	114	–	525
	189	10	–	–	689
	–	–	–	94	618
	126	–	–	–	664
	96	–	–	–	604
	441	20	258	94	3 717

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

R'000	2015	2014
21 Investment income		
Financial assets at fair value through profit or loss:	**971 034**	812 261
Dividend income	**37 729**	23 617
Interest income	**933 305**	788 644
Cash and cash equivalents interest income	**47 964**	46 851
Investment income per Statement of Comprehensive Income	**1 018 998**	859 112
The Scheme's total interest income is summarised below.		
Financial assets not at fair value through profit or loss:	**48 155**	47 084
Interest received from Administrator (Note 23)	**191**	233
Cash and cash equivalents interest income	**47 964**	46 851
Financial assets at fair value through profit or loss:		
Interest income	**933 305**	788 644
Total interest income	**981 460**	835 728
22 Net gains/(losses) on financial assets at fair value through profit or loss		
Net fair value gains on financial assets at fair value through profit or loss:	**213 239**	165 712
Fair value gains on financial assets at fair value through profit or loss:	**315 387**	265 620
– Equities	**23 368**	83 707
– Money market instruments	**671**	–
– Offshore bonds	**290 923**	177 118
– Inflation-linked bonds	**425**	2 753
– Yield-enhanced bonds	**–**	2 042
Fair value losses on financial assets at fair value through profit or loss :	**(102 148)**	(99 908)
– Equities	**(58 738)**	–
– Money market instruments	**(539)**	(39 102)
– Offshore bonds	**(32 099)**	(56 787)
– Inflation-linked bonds	**(5 918)**	–
– Yield-enhanced bonds	**(4 854)**	(4 019)
Net fair value losses on derivative financial instruments:	**(208 189)**	(49 254)
Fair value gains on derivative financial instruments:	**8 823**	7 697
Fair value losses on derivative financial instruments:	**(217 012)**	(56 950)
Net fair value gains/(losses) on cash and cash equivalents	**1 454**	–
	6 504	116 457

R'000	2015	2014
23 Sundry income		
Interest received from Administrator (Note 21)	**191**	233
Prescribed amounts written back	**3 678**	5 966
Stale cheques written back	**3 649**	1 358
	7 518	7 557
24 Interest paid		
Financial assets not at fair value through profit or loss:		
Interest on Personal Medical Savings Accounts (Note 8)	**232 141**	181 687
Interest paid to Administrator (Note 27)	**118**	118
	232 259	181 805
25 Reserves transferred from other medical schemes		
Movement in and reserves transferred from amalgamated schemes during the year under review		
Nampak SA Medical Scheme*	**–**	(3 290)
IBM South Africa Medical Scheme*	**–**	(1 851)
Edcon Medical Scheme*	**–**	9
Altron Medical Scheme	**198**	49 435
PG Bison Medical Scheme	**(131)**	16 890
Afrox Medical Scheme	**–**	84 685
	67	145 878

* *The effective date of these amalgamations was prior to 2014 and there have been no movements in these reserves during the year under review. The transactions recorded in 2014 are movements in reserves subsequent to the amalgamation date relating to contributions, claims and operating expenses adjustments.*

26 Amalgamations

No amalgamations took place during the current year. Three amalgamations were effective during 2014 and the details of these transactions are presented below.

Altron Medical Aid

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 is recognised as a result of this transaction.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

R'000	2015	2014
26 Amalgamations *continued*		
Altron Medical Aid *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's MAS members' interest)	–	40 990
Net recognised values of Altron's MAS 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	–	(941)
General accruals	–	(662)
Personal Medical Savings Accounts	–	(28 454)
Goodwill	–	–
Movement subsequent to amalgamation	**198**	8 445
Closing balance	**198**	49 435

Movements subsequent to the amalgamation date relate to contributions, claims and operating expenses adjustments.

R'000	2015	2014
26 Amalgamations *continued*		
Altron Medical Aid *continued*		
As a result of the amalgamation, the Scheme acquired the following receivables information which is set out below.		
Fair value of receivables acquired:	–	1 085
Insurance receivables	–	1 079
Contribution debtors	–	1 018
Members 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)
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	–	(941)
General accruals	–	(662)
Personal Medical Savings Accounts	–	(28 454)
	–	40 990

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

26 Amalgamations *continued*

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 is recognised as a result of this transaction.

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:

R'000	2015	2014
Reserves effectively transferred: (Acquisition date fair value of Afrox's MAS members' interest)	–	82 907
Net recognised values of Afrox's MAS 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	–	–
Movement subsequent to amalgamation	–	1 779
Closing balance	–	84 685

Movements subsequent to the amalgamation date relate to contributions, claims and operating expenses adjustments.

R'000	2015	2014
26 Amalgamations *continued*		
Afrox Medical Aid Society *continued*		
As a result of the amalgamation, the Scheme acquired the following receivables information 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 debtors	–	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 debtors	–	(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 debtors	–	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

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

26 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 is recognised as a result of this transaction.

R'000	2015	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's MAS members' interest)	–	17 535
Net recognised values of PG Bison's MAS 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	–	–
Movement subsequent to amalgamation	**(131)**	(644)
Closing balance	**(131)**	16 890

Movements subsequent to the amalgamation date relate to contributions, claims and operating expenses adjustments.

26 Amalgamations *continued*

PG Bison Medical Aid Society *continued*

As a result of the amalgamation, the Scheme acquired the following receivables information which is set out below.

R'000	2015	2014
Fair value of receivables acquired:	–	56
Insurance receivables	–	56
Contribution debtors	–	77
Provision for impairment	–	(21)
Gross contractual amounts receivable:	–	77
Insurance receivables	–	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 debtors	–	(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

27 Related party transactions

The Scheme is governed 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 non-executive Board of Trustees and the executive officers of the Scheme. The disclosure deals with full-time executive officers who are compensated on a salary basis, and non-executive Board of Trustees who are compensated on a fee basis.

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, specialist pharmaceutical services through Southern RX Distributors (Pty) Ltd and home-based care through Grove Nursing Services (Pty) Ltd, all wholly-owned subsidiaries of Discovery Health (Pty) Ltd.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

27 Related party transactions *continued*

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 which includes Trustees and Executive Officers:

R'000	2015	2014
Statement of Comprehensive Income transactions		
Compensation		
Short-term employee benefits	**(21 704)**	(21 578)
Unvested long-term employee benefits	**(1 502)**	(1 117)
Contributions and claims		
Gross contributions received	**795**	788
Claims paid from the Scheme	**(252)**	(778)
Claims paid from the Personal Medical Savings Account	**(202)**	(138)
Statement of Financial Position transactions		
Long-term Employee Benefit Plan asset	**1 071**	1 511
Plan asset	**5 136**	3 483
Plan liability	**(4 065)**	(1 972)
Contribution debtors	**17**	20
Personal Medical Savings Account balances	**(28)**	(38)
Trustee remuneration payable	**(58)**	–

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

Transactions	Nature of transactions and their terms and conditions
Compensation	This constitutes remuneration and consideration paid to Trustees' and Executive officers' short-term employee benefits and unvested long-term employee benefits.
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.
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 as applicable to other members.

R'000	2015	2014
27 Related party transactions *continued*		
Transactions with entities that have significant influence over the Scheme		
Discovery Health (Pty) Ltd – Administrator		
Statement of Comprehensive Income transactions		
Administration fees paid	**(3 874 896)**	(3 585 641)
Interest received on monthly balances (Note 23)	**191**	233
Interest paid on monthly balances (Note 24)	**(118)**	(118)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd (Note 9)*	**(327 895)**	(266 988)
Discovery Health (Pty) Ltd – Managed care organisation		
Statement of Comprehensive Income transactions		
Accredited managed healthcare services (no risk transfer) (Note 12)	**(1 305 790)**	(1 201 155)
Statement of Financial Position transactions		
Balance (due to) Discovery Health (Pty) Ltd at year end (Note 9)*	**(110 087)**	(101 567)
Discovery Third Party Recovery Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Third-party collection fees	**(17 695)**	(13 970)
Statement of Financial Position transactions		
Balance due to the Scheme at year end (Note 3)	**12 024**	9 557
Southern RX Distributors (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(71 392)**	(4 661)
Statement of Financial Position transactions		
Claims due to provider	**(1 168)**	–
Discovery Wellness Experience		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(12 306)**	(3 043)
Grove Nursing Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Claims paid from the Scheme	**(3 686)**	–
Statement of Financial Position transactions		
Claims due from provider	**1**	–

* *Total amount due to Discovery Health (Pty) Ltd for the current financial year is R438 million (2014: R369 million), disclosed in Note 9.*

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

27 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 shall 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 a prime-linked rate and is due within 30 days.

The administration fees are an all-inclusive fee, 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.

The main categories of service provided can be broken down as follows:

- Member and provider servicing;
- Marketing and advertising;
- Financial and actuarial services; and
- Governance, risk, compliance and internal audit.

Managed healthcare agreements

Managed healthcare means clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

Accredited managed healthcare services (no risk transfer)

Managed healthcare 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.

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 shall 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 a prime-linked rate and is due within 30 days.

27 Related party transactions *continued*

Transactions with entities that have significant influence over the Scheme *continued*

The accredited services provided by the managed care organisation include:

- Active Disease Risk Management Services and Disease Risk Management Support Services
- Hospital Benefit Management Services
- Managed Care Network Management Services and Risk Managed Services
- Pharmacy Benefit Management Services

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 2015 to 31 December 2015 for the amount of R12 million (2014: R9.6 million) (Note 3).

Specialist Pharmaceutical Services

The Scheme is contracted with Southern RX Pharmacy, 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 experiences through lifestyle and health assessments to Scheme members with the use of information technology and on-site medical evaluations of key health indicators.

Home-based Nursing Services

The Scheme is contracted with Grove Nursing services also known as Discovery HomeCare services, a wholly owned subsidiary of Discovery Health (Pty) Ltd, to provide home-based care to members of the Scheme in the comfort of their home.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

28 | Surplus/(deficit) from operations per benefit plan

2015	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	**830 871**	**9 626 771**	**43 280**	**1 763 910**	**8 085 165**	**4 009 464**	**1 043 009**	**2 465 336**
Net claims incurred	(1 090 864)	(9 345 184)	(39 684)	(1 224 311)	(5 841 078)	(3 172 290)	(836 214)	(1 516 002)
Claims incurred	(1 091 535)	(9 355 078)	(39 725)	(1 227 405)	(5 855 182)	(3 178 190)	(837 513)	(1 521 065)
Third-party claim recoveries	671	9 894	41	3 094	14 104	5 900	1 299	5 063
Net income/(expense) on risk transfer arrangements	(4 040)	(54 034)	(450)	–	–	–	(5 941)	–
Risk transfer arrangement fees	(9 876)	(126 167)	(916)	–	–	–	(13 327)	–
Recoveries from risk transfer arrangements	5 836	72 133	466	–	–	–	7 386	–
Accredited managed healthcare services (no risk transfer)*	(11 999)	(174 863)	(785)	(55 739)	(267 757)	(105 682)	(21 745)	(97 571)
Relevant healthcare expenditure*	**(1 106 903)**	**(9 574 081)**	**(40 919)**	**(1 280 050)**	**(6 108 835)**	**(3 277 972)**	**(863 900)**	**(1 613 573)**
Gross healthcare result*	**(276 032)**	**52 690**	**2 361**	**483 860**	**1 976 330**	**731 492**	**179 109**	**851 763**
Broker service fees	(10 775)	(159 699)	(682)	(40 608)	(224 310)	(95 695)	(19 802)	(70 895)
Expenses for administration	(39 226)	(571 646)	(2 567)	(182 213)	(875 309)	(345 486)	(71 177)	(318 954)
Other operating expenses	(1 819)	(26 511)	(119)	(8 465)	(40 677)	(16 035)	(3 297)	(14 852)
Net healthcare result	**(327 852)**	**(705 166)**	**(1 007)**	**252 574**	**836 034**	**274 276**	**84 833**	**447 062**
Investment income	10 405	151 633	473	33 587	232 309	91 660	18 856	84 714
Net fair value gains on financial assets at fair value through profit or loss	106	1 529	6	294	1 481	800	188	154
Sundry income	69	1 002	3	321	1 542	606	124	564
Other income	**10 580**	**154 164**	**482**	**34 202**	**235 332**	**93 066**	**19 168**	**85 432**
Expenses for asset management services rendered	(288)	(4 189)	(19)	(1 348)	(6 461)	(2 539)	(521)	(2 380)
Interest paid	(3 177)	(46 308)		(5)	(70 993)	(27 999)	(5 758)	(25 912)
Other expenditure	**(3 465)**	**(50 497)**	**(19)**	**(1 353)**	**(77 454)**	**(30 538)**	**(6 279)**	**(28 292)**
Net surplus/(deficit) for the year	**(320 737)**	**(601 499)**	**(544)**	**285 423**	**993 912**	**336 804**	**97 722**	**504 202**

* *See Note 12 to the Annual Financial Statements for explanatory note on change of disclosure.*

28 | Surplus/(deficit) from operations per benefit plan *continued*

2015	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	**870 164**	**302 973**	**4 784 988**	**2 179 506**	**3 803 900**	**205 967**	**51 437**	**40 066 741**
Net claims incurred	(578 249)	(186 734)	(3 915 586)	(1 713 148)	(3 678 423)	(91 452)	(26 198)	(33 255 417)
Claims incurred	(580 074)	(187 273)	(3 925 543)	(1 717 962)	(3 690 793)	(92 312)	(26 503)	(33 326 153)
Third-party claim recoveries	1 825	539	9 957	4 814	12 370	860	305	70 736
Net income/(expense) on risk transfer arrangements	–	–	–	–	123 748	–	(1 703)	57 580
Risk transfer arrangement fees	–	–	–	–	(190 971)	–	(2 836)	(344 093)
Recoveries from risk transfer arrangements	–	–	–	–	314 719	–	1 133	401 673
Accredited managed healthcare services (no risk transfer)*	(34 605)	(8 835)	(187 572)	(88 982)	(229 779)	(14 735)	(5 141)	(1 305 790)
Relevant healthcare expenditure*	**(612 854)**	**(195 569)**	**(4 103 158)**	**(1 802 130)**	**(3 784 454)**	**(106 187)**	**(33 042)**	**(34 503 627)**
Gross healthcare result*	**257 310**	**107 404**	**681 830**	**377 376**	**19 446**	**99 780**	**18 395**	**5 563 114**
Broker service fees	(22 914)	(7 483)	(150 846)	(60 125)	(111 395)	(6 056)	(1 589)	(982 874)
Expenses for administration	(113 121)	(28 882)	(613 181)	(290 883)	(402 605)	(13 849)	(5 797)	(3 874 896)
Other operating expenses	(5 271)	(1 340)	(28 489)	(13 523)	(34 964)	(2 243)	(782)	(198 387)
Net healthcare result	**116 004**	**69 699**	**(110 686)**	**12 845**	**(529 518)**	**77 632**	**10 227**	**506 957**
Investment income	20 861	7 662	162 740	53 623	138 494	8 882	3 099	1 018 998
Net fair value gains on financial assets at fair value through profit or loss	(23)	68	1 045	381	456	13	6	6 504
Sundry income	201	51	1 079	513	1 328	85	30	7 518
Other income	**21 039**	**7 781**	**164 864**	**54 517**	**140 278**	**8 980**	**3 135**	**1 033 020**
Expenses for asset management services rendered	(850)	(212)	(4 529)	(2 156)	(5 600)	(360)	(126)	(31 578)
Interest paid	(3)	(2 341)	(49 733)	(8)	(21)	(1)	(0)	(232 259)
Other expenditure	**(853)**	**(2 553)**	**(54 262)**	**(2 164)**	**(5 621)**	**(361)**	**(126)**	**(263 837)**
Net surplus/(deficit) for the year	**136 190**	**74 927**	**(84)**	**65 198**	**(394 861)**	**86 251**	**13 236**	**1 276 140**

* *See Note 12 to the Annual Financial Statements for explanatory note on change of disclosure.*

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

28 | Surplus/(deficit) from operations per benefit plan *continued*

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	(998 895)	(8 924 731)	(32 213)	(1 076 578)	(4 929 334)	(2 831 958)	(847 292)	(1 275 217)
Claims incurred	(999 841)	(8 938 683)	(32 270)	(1 080 942)	(4 949 226)	(2 840 279)	(849 124)	(1 282 358)
Third-party claim recoveries	946	13 952	57	4 364	19 892	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	–
Accredited managed healthcare services (no risk transfer)*	(11 789)	(173 985)	(680)	(52 293)	(239 130)	(102 665)	(22 786)	(83 217)
Relevant healthcare expenditure*	**(1 011 405)**	**(9 111 686)**	**(33 044)**	**(1 128 871)**	**(5 168 464)**	**(2 934 623)**	**(871 942)**	**(1 358 434)**
Gross healthcare result*	**(233 459)**	**132 665**	**2 308**	**461 569**	**1 753 542**	**793 295**	**186 364**	**695 804**
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)**	**(606)**	**245 194**	**733 263**	**348 772**	**86 957**	**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	23 118	10 088	2 258	7 865
Sundry income	75	1 108	1	329	1 501	649	144	517
Other income	**10 515**	**155 196**	**450**	**34 889**	**213 009**	**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)**	**(168)**	**279 309**	**889 218**	**415 838**	**101 858**	**403 527**

* *See Note 12 to the Annual Financial Statements for explanatory note on change of disclosure.*

28 | 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)	(186 716)	(3 336 836)	(1 433 200)	(3 066 175)	(110 487)	(25 672)	(29 552 978)
Claims incurred	(480 248)	(187 476)	(3 350 879)	(1 439 989)	(3 083 621)	(111 699)	(26 102)	(29 652 737)
Third-party claim 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
Accredited managed healthcare services (no risk transfer)*	(29 722)	(9 310)	(169 592)	(80 528)	(206 354)	(14 055)	(5 049)	(1 201 155)
Relevant healthcare expenditure*	**(507 396)**	**(196 026)**	**(3 506 428)**	**(1 513 728)**	**(3 193 355)**	**(124 542)**	**(32 224)**	**(30 692 168)**
Gross healthcare result*	**214 806**	**108 749**	**650 786**	**381 038**	**189 093**	**67 301**	**14 971**	**5 418 832**
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**	**69 110**	**(65 876)**	**53 251**	**(307 249)**	**46 500**	**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 losses on financial assets at fair value through profit or loss	2 819	911	16 465	7 745	19 832	1 338	485	116 457
Sundry income	186	59	1 067	505	1 296	88	32	7 557
Other income	**19 792**	**8 300**	**151 109**	**53 689**	**137 562**	**9 363**	**3 368**	**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**	**75 191**	**44 779**	**105 747**	**(172 747)**	**55 654**	**10 432**	**1 536 808**

* *See Note 12 to the Annual Financial Statements for explanatory note on change of disclosure.*

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

R'000	2015	2014
29 Cash flows from operations before working capital changes		
Net surplus for the year	**1 276 140**	1 536 808
Adjustments for:		
Impairment losses	**71 193**	55 629
Interest received (Note 21)	**(981 460)**	(835 728)
Dividend income (Note 21)	**(37 729)**	(23 617)
Interest paid (Note 24)	**232 259**	181 805
Unvested long-term employee benefits	**1 894**	1 116
Net gains on financial assets at fair value through profit or loss (Note 22)	**(6 504)**	(116 457)
	555 793	799 556
Reconciliation of movements in the cash flow statement		
29.1 Increase in trade and other receivables	**(99 229)**	(160 458)
Opening balance	**1 604 550**	1 497 921
Closing balance	**(1 632 586)**	(1 604 550)
Amalgamations	**–**	1 800
Impairment losses	**(71 193)**	(55 629)
29.2 Increase in trade and other payables	**151 366**	15 689
Opening balance	**(1 031 239)**	(973 539)
Closing balance	**1 182 605**	1 031 239
Amalgamations	**–**	(42 011)
29.3 Purchases of financial instruments	**(6 176 902)**	(3 448 243)
Financial assets at fair value (Note 2)	**(6 176 902)**	(3 447 332)
Restricted equity fund	**–**	(911)
29.4 Proceeds from sale of financial instruments	**4 339 081**	1 737 654
Financial assets at fair value (Note 2)	**4 465 329**	1 745 608
Derivative financial instruments (Note 7)	**(126 248)**	(89 419)
Financial instruments from amalgamated schemes	**–**	81 465

30 Events after the reporting period

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

31 | 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

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. The day-to-day benefits include both the Personal Medical Savings Account (PMSA) and an insurance risk element. This includes the Insured Network Benefit and Above Threshold Benefit (ATB). The Scheme does not carry risk for PMSA benefits.

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.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

31 | Insurance risk management report *continued*

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

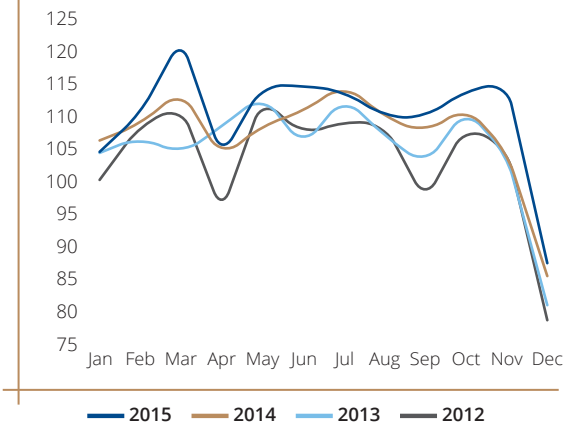
Hospital benefit risk

The main factors impacting 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.

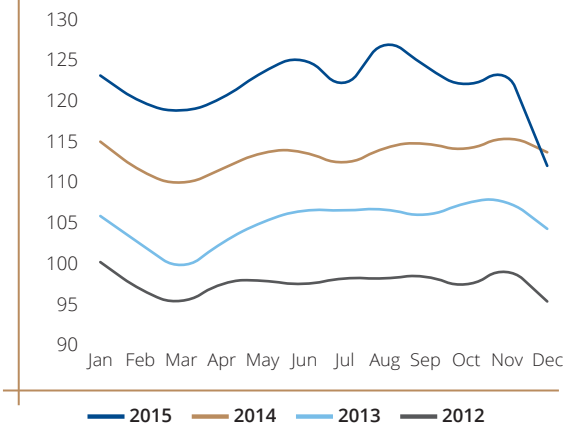
An increase in the admission rate is often linked to increases in the number of beneficiaries at older ages. The increase in cost per event is driven by annual tariff and other cost increases. An increased cost per event can also be caused by an increased case-mix, severity of admissions and the introduction 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 2012.

Hospital Admission Rate
(Indexed to Jan 2012 = 100)



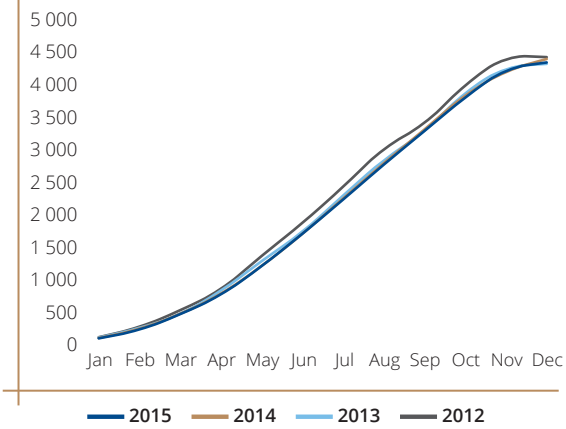
Total Cost Per Event
(Indexed to Jan 2012 = 100)



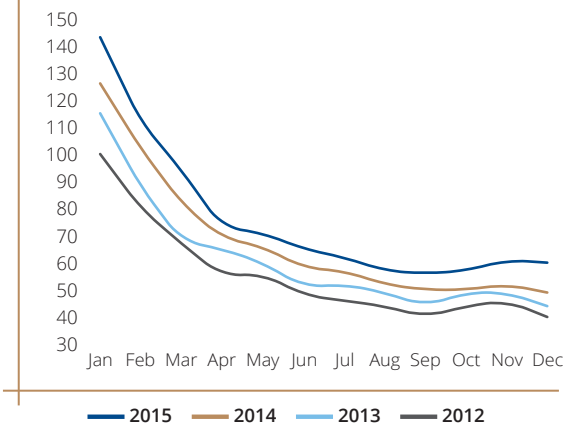
Day-to-day benefits risk

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.

Claimants Per 1 000 Beneficiaries From Above Threshold Benefits (Indexed to Jan 2012 = 100)



Cost Per ATB Claimant
(Indexed to Jan 2012 = 100)



31 | Insurance risk management report *continued*

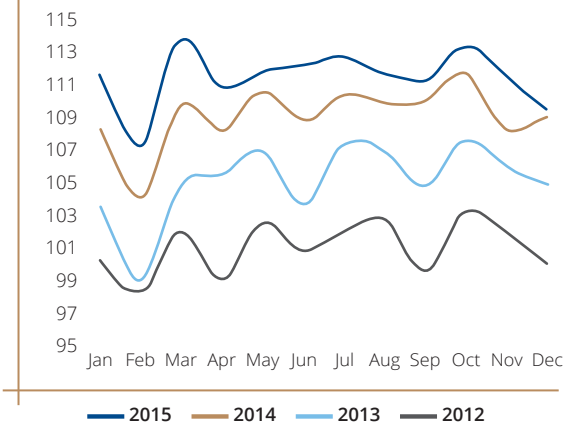
Chronic benefits risk

The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant respectively.

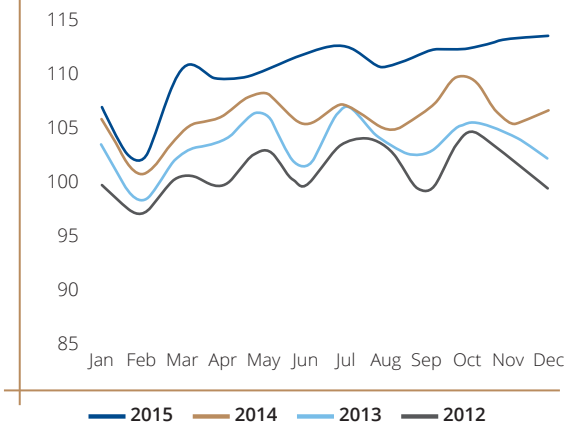
Higher increases in chronic claimants are linked to increases in the number of beneficiaries at older ages. In addition, changes relating to the eligibility for chronic benefits will also impact costs. An increase in the number of items per claimant will drive up the costs of chronic claims per claimant. Increases in the regulated prices for chronic medication, the Single Exit Price, and increases in dispensing fees 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 2012.

Chronic Claimants Per 1 000 Beneficiaries
(Indexed to Jan 2012 = 100)



Chronic Cost Per Claimant
(Indexed to Jan 2012 = 100)



Risk management

The Scheme has various initiatives that are used to manage the risk 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.
- 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 an Advanced Illness Benefit Programme dedicated to managing care during the end of life stage for patients that are terminally ill.
- 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, Drug Utilisation Review, Performance-based Reimbursement contracts with certain pharmacies and the MedXpress Programme, 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.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

31 Insurance risk management report *continued*

Concentration of insurance risk

As the largest open medical scheme by membership in South Africa, the Scheme is not subject to a significant degree of concentration risk. The Scheme also offers a wide range of benefit plans which 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 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, checks the quality of care provided and has access to data on the underlying fee-for-service claims which 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 2015 outstanding claims provision was made in accordance with Advisory Practice Note 304 of the Actuarial Society. 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 changes.
- External influences.
- The demographic profile of the Scheme.

31 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 December 2015 in respect of treatment dates during 2015, the recommended provision for outstanding claims as at December 2015 is R985 million (2014: R846 million).

R'000	2015	2014
The total claims incurred (including the provision for outstanding claims) for the most significant claims categories are as follows:		
Total estimate of incurred claims		
In-hospital claims incurred	**24 063 065**	21 091 639
Chronic claims incurred	**2 052 610**	1 886 367
Out-of-hospital risk claims incurred	**7 033 552**	6 411 385

The table below outlines the sensitivity of total incurred claims estimates to slower claims processing. If processing is slower than expected, a larger claims provision for unprocessed claims will be required. It should be noted that this is a deterministic approach with no correlations between the key variables.

R'000	Change in variable %	Impact on outstanding claims provision 2015	Impact on outstanding claims provision 2014
In-hospital claims incurred	1% increase in claims costs	240 631	210 916
Chronic claims incurred	1% increase in claims costs	20 526	18 864
Out-of-hospital risk claims incurred	1% increase in claims costs	70 336	64 114

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 98% 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 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.

32 Financial risk management report

Overview

The Scheme is exposed to financial risk through its financial assets, insurance 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.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

32 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 the Scheme's in-house legal counsel.
- An independent valuation is performed by a third party.

Personal Medical Savings Account trust assets

These portfolios have been established to manage members' Personal Medical Savings Account balances in portfolios which 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 primary risks affecting 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
31 December 2015				
Investments	**11 399 332**			
Offshore bonds	**1 335 137**	✓		✓
Equities	**1 415 647**		✓	
Yield-enhanced bonds	**3 058 012**			✓
Inflation-linked bonds	**464 574**			✓
Money market instruments	**5 125 962**			✓
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 12% (2014: 11%) of its investable assets in offshore bond portfolios (reference currency is the US Dollar). At 31 December 2015 this equates to R1.3 billion (2014: R1.1 billion) (Note 2). Derivative financial instruments are utilised by bond managers within these portfolios to manage various currency exposures.

32 | Financial risk management report *continued*

Currency risk *continued*

Currency derivatives financial instrument (zero-cost currency collars)

The Scheme entered into zero-cost currency collar arrangements with South African banks to hedge exposure to changes in the Rand/US Dollar rate with respect to its offshore bond portfolios. The current contracts expire during 2016 and were entered into with the cap at R15.55 to the US Dollar for the one contract and R16.27 to the US Dollar for the second. The spot level (the floor) was entered into at R14.32 to the US Dollar for the one contract and at R14.90 to the US Dollar for the second.

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

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 have 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 on offshores bonds of R67 million (2014: R54 million) and a 15% depreciation in the Rand would result in a gain of R200 million (2014: R163 million). A 5% appreciation in the Rand would result in a loss of R67 million (2014: R54 million) and a 15% appreciation in the Rand would result in a loss of R200 million (2014: 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 Scheme's equity investments amounted to R1.4 billion (2014: R1 billion) (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 are 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 instrument (zero-cost equity collars)

The Scheme entered into zero-cost equity collar arrangements to hedge approximately 100% of the exposure to changes in market prices for investments in the equity portfolios. The contracts provide downside protection of up to 15% 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 14% and 17% above the pre-determined level. These contracts expire during 2016.

The fair value of these contracts have been included in financial assets and financial liabilities. 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 R73 million (2014: R55 million) and a 15% increase would result in a gain of R218 million (2014: R164 million). A 5% decrease would result in a loss of R73 million (2014: R55 million) and a decrease of 15% would result in a loss of R218 million (2014: 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 the year, the equity hedge collar will dampen the price increase on the equities in the portfolios. The Scheme may not therefore experience the full market escalation – this is the cost of the downside protection.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

32 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 bond managers have made use of bond futures and other derivative instruments within these portfolios to manage duration risk.

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 2015	0 – 3 months R'000	3 – 12 months R'000	> 12 months R'000	Total R'000
Cash and cash equivalents	**2 198 127**	**–**	**–**	**2 198 127**
Money market instruments carried at fair value through profit or loss	**–**	**5 125 962**	**–**	**5 125 962**
Yield-enhanced bonds carried at fair value through profit or loss	**–**	**3 058 012**	**–**	**3 058 012**
Inflation-linked bonds carried at fair value through profit or loss	**–**	**464 574**	**–**	**464 574**
Offshore bonds carried at fair value through profit or loss	**–**	**1 335 137**	**–**	**1 335 137**

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

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

%	2015	2014
Money market instruments carried at fair value through profit or loss	**6.09**	5.86
Cash and cash equivalents	**5.85**	5.33

The weighted average interest rate on short-term bank deposits (namely call account deposits) was 5.95% (2014: 5.71%). These deposits have an average maturity of 25 days (2014: 25 days).

Interest rate risk sensitivity analysis

A 1% increase in local interest rates would result in a loss of R91 million (2014: R41 million), and a 2% increase would result in a loss of R183 million (2014: R83 million). A 1% decrease in local interest rates would result in a gain of R91 million (2014: R41 million) and a 2% decrease would result in a gain of R183 million (2014: R83 million). This impact would be recognised in net surplus. The sensitivity is based on the assumption that local interest rates had increased or decreased by 1% or 2%, with all other variables held constant.

A 1% increase in foreign interest rates would result in a loss of R66 million (2014: R47 million) and a 2% increase would result in a loss of R133 million (2014: R94 million). A 1% decrease in foreign interest rates would result in a gain of R66 million (2014: R47 million) and a decrease of 2% would result in a gain of R133 million (2014: R94 million). This impact would be recognised in net surplus. The sensitivity is based on the assumption that foreign interest rates had increased or decreased by 1% or 2%, 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 which have not been provided for. At 31 December 2015 the Scheme did not consider there to be any significant concentration of legal risk that had not been provided for.

32 | Financial risk management report *continued*

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 oversees that the funds are invested 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.

Breakdown of investments

The investments are split between the following in the Annual Financial Statements:

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

R'000	Segregated Funds	Collective Investment Schemes	Policy of Insurance	Total
31 December 2015				
Investments	**10 064 195**	**716 812**	**618 325**	**11 399 332**
Offshore bonds	**–**	**716 812**	**618 325**	**1 335 137**
Equities	**1 415 647**	**–**	**–**	**1 415 647**
Yield-enhanced bonds	**3 058 012**	**–**	**–**	**3 058 012**
Inflation-linked bonds	**464 574**	**–**	**–**	**464 574**
Money market instruments	**5 125 962**	**–**	**–**	**5 125 962**
Cash and cash equivalents	**842 123**	**1 356 004**	**–**	**2 198 127**
	10 906 318	**2 072 816**	**618 325**	**13 597 459**
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	727 773	1 766 707	–	2 494 480
	9 112 693	2 331 028	525 279	11 969 000

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 (benchmark) return.

For the first portfolio the weighted modified duration of the portfolio shall not exceed 180 days. The weighted term to maturity of the portfolio shall not exceed two 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 45% (2014: 64%) of the Scheme's financial assets at fair value through profit or loss.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

32 Financial risk management report *continued*

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 27% (2014: 10%) of the Scheme's financial assets at fair value through profit or loss.

Offshore portfolio

The Scheme has two offshore portfolios each 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 12% (2014: 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 are measured against the JSE Bond Exchange and Actuarial Society of South Africa (JSE BEASSA IGOV) Index.

These portfolios comprise approximately 4% (2014: 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 of the portfolios is measured against the benchmark, which is the FTSE/JSE Shareholder Weighted Index (SWIX).

These portfolios comprise approximately 12% (2014: 11%) of the Scheme's Financial assets at fair value through profit or loss.

32 | Financial risk management report *continued*

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

For the year ended 31 December 2015	Financial assets and liabilities at fair value through profit and loss: Designated upon initial recognition R'000	Financial assets and liabilities at fair value through profit and loss: Classified as held for trading R'000	Loans and receivables R'000	Insurance receivables and (payables) R'000	Financial liabilities at amortised cost R'000	Total carrying amount R'000	Fair value amount R'000
Investments							
– Offshore bond portfolio	**1 335 137**	**–**	**–**	**–**	**–**	**1 335 137**	**1 335 137**
– Listed equities	**1 415 647**	**–**	**–**	**–**	**–**	**1 415 647**	**1 415 647**
– Yield-enhanced bond portfolio	**3 058 012**	**–**	**–**	**–**	**–**	**3 058 012**	**3 058 012**
– Inflation-linked bond portfolio	**464 574**	**–**	**–**	**–**	**–**	**464 574**	**464 574**
– Money market portfolios	**5 125 962**	**–**	**–**	**–**	**–**	**5 125 962**	**5 125 962**
Cash and cash equivalents:							
Medical Scheme assets	**–**	**–**	**2 198 127**	**–**	**–**	**2 198 127**	**2 198 127**
Personal Medical Savings Account trust assets			**3 667 456**			**3 667 456**	**3 667 456**
Trade and other receivables	**–**	**–**	**107 266**	**1 525 320**	**–**	**1 632 586**	**1 632 586**
Personal Medical Savings Accounts	**–**	**–**	**(3 736 659)**		**–**	**(3 736 659)**	**(3 736 659)**
Trade and other payables	**–**	**–**	**–**	**(714 904)**	**(467 701)**	**(1 182 605)**	**(1 182 605)**
Derivatives held for trading							
– Zero-cost collars	**–**	**(65 210)**	**–**	**–**	**–**	**(65 210)**	**(65 210)**
	11 399 332	**(65 210)**	**2 236 190**	**810 416**	**(467 701)**	**13 913 027**	**13 913 027**

For the year ended 31 December 2014	Financial assets and liabilities at fair value through profit and loss: Designated upon initial recognition R'000	Financial assets and liabilities at fair value through profit and loss: Classified as held for trading R'000	Loans and receivables R'000	Insurance receivables and (payables) R'000	Financial liabilities at amortised cost R'000	Total carrying amount R'000	Fair value amount R'000
Investments							
– Offshore bond portfolio	1 089 600	–	–	–	–	1 089 600	1 089 600
– Listed equities	1 026 342	–	–	–	–	1 026 342	1 026 342
– Yield-enhanced bond portfolio	996 091	–	–	–	–	996 091	996 091
– Inflation-linked bond portfolio	343 737	–	–	–	–	343 737	343 737
– Money market portfolios	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)	(1 031 238)	(1 031 238)
Derivatives held for trading							
– Zero-cost collars	–	22 700	–	–	–	22 700	22 700
– Other	–	(5 969)	–	–	–	(5 969)	(5 969)
	9 474 520	16 731	2 553 420	959 813	(507 396)	12 497 088	12 497 088

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

32 Financial risk management report *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 through its trade and other receivables, investments and cash.

Trade and other receivables

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.

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 highlights insurance receivables within trade and other receivables which are due and past due (by number of days).

	Total member and service provider claims receivables			
R'000	Active member claims receivables	Withdrawn member claims receivables	Service provider claims receivables	Total
31 December 2015				
Not past due	**1 239**	**4 217**	**8 796**	**14 252**
Past due 0 – 30 days	**2 330**	**6 583**	**2 119**	**11 032**
Past due 31 – 60 days	**4 023**	**7 653**	**(5 731)**	**5 945**
Past due 61 – 90 days	**1 904**	**6 598**	**6 834**	**15 336**
Past due 91 – 120 days	**2 321**	**9 872**	**(1 112)**	**11 081**
Past due 121 – 150 days	**3 015**	**9 977**	**(5 904)**	**7 088**
151 days to more than one year	**24 476**	**183 021**	**6 614**	**214 111**
Gross receivables	**39 308**	**227 921**	**11 616**	**278 845**
Provision for impairments	**(22 196)**	**(178 471)**	**(7 862)**	**(208 529)**
Trade and other receivables neither past due nor impaired	**17 112**	**49 450**	**3 754**	**70 316**
31 December 2014				
Not past due	–	–	–	–
Past due 0 – 30 days	1 544	3 163	12 347	17 054
Past due 31 – 60 days	1 857	4 730	(4 499)	2 088
Past due 61 – 90 days	1 710	5 999	(4 071)	3 638
Past due 91 – 120 days	2 110	7 562	8 761	18 433
Past due 121 – 150 days	1 911	6 466	(3 838)	4 539
151 days to more than one year	31 193	151 015	7 679	189 887
Gross receivables	**40 325**	**178 935**	**16 379**	**235 639**
Provision for impairments	(18 358)	(145 308)	(13 792)	(177 458)
Trade and other receivables neither past due nor impaired	21 967	33 627	2 587	58 181

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.

Contribution receivables	Other risk transfer arrangements	Broker fee receivables	Other insurance receivables	Loans and receivables	Total
1 379 759	**7 520**	**11 394**	**60 869**	**107 266**	**1 581 060**
9 595	**–**	**317**	**–**	**–**	**20 944**
4 514	**–**	**(242)**	**–**	**–**	**10 217**
6 261	**–**	**(22)**	**–**	**–**	**21 575**
(3 992)	**–**	**(441)**	**–**	**–**	**6 648**
–	**–**	**11**	**–**	**–**	**7 099**
–	**–**	**(10 122)**	**–**	**–**	**203 989**
1 396 137	**7 520**	**895**	**60 869**	**107 266**	**1 851 532**
(9 633)	**–**	**(784)**	**–**	**–**	**(218 946)**
1 386 504	**7 520**	**111**	**60 869**	**107 266**	**1 632 586**
1 385 549	2 684	–	30 056	120 894	1 539 183
15 937	–	91	–	–	33 082
(5 202)	–	164	–	–	(2 950)
808	–	(150)	–	–	4 296
2 680	–	97	–	–	21 210
–	–	14	–	–	4 553
–	–	452	–	–	190 339
1 399 772	**2 684**	**668**	**30 056**	**120 894**	**1 789 713**
(7 105)	–	(600)	–	–	(185 163)
1 392 667	2 684	68	30 056	120 894	1 604 550

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

32 Financial risk management report *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; and
- 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 receivables	Member and service provider claims receivables	Other risk transfer arrangements	Broker fee receivables	Total
Balance as at 1 January 2014	5 735	171 955	–	427	178 117
Increase in provision for impairment	1 371	54 086	–	173	55 630
Amounts utilised during the year	–	(48 583)	–	–	(48 583)
Balance as at 31 December 2014	7 106	177 458	–	600	185 164
Balance as at 1 January 2015	**7 106**	**177 458**	**–**	**600**	**185 164**
Increase/(decrease) in provision for impairment	**2 527**	**61 005**	**–**	**184**	**63 716**
Amounts utilised during the year	**–**	**(29 934)**	**–**	**–**	**(29 934)**
Balance as at 31 December 2015	**9 633**	**208 529**	**–**	**784**	**218 946**

32 Financial risk management report *continued*

Credit quality

Trade and other receivables

The credit quality of trade and other receivables that are neither past due nor impaired as presented on pages 136 – 137 can be assessed by reference to historical information about counterparty default.

Contribution debtors

The Scheme collected over 98% (2014: 97%) of outstanding debt in January 2016. Therefore we can establish that the credit quality of contribution debtors is high. Consequently, no additional disclosure of the credit quality is provided.

Active member claims debtors

A provision for impairment covering 56% (2014: 46%) of the debtors has been raised and the Trustees are satisfied that this is adequate.

Withdrawn member claims debtors

These amounts are due from members that have withdrawn from the Scheme. A provision for impairment covering 78% (2014: 81%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Other insurance receivables and loans and receivables

These debtors mainly comprise 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 thus no further analysis has been performed on these receivables.

Financial assets held at fair value through profit or loss, cash and cash equivalents and derivative financial instruments

The Scheme's credit risk exposures as at 31 December were as follows:

R'000	2015	2014
Financial assets held at fair value through profit or loss		
Non-current assets		
Current assets		
– Offshore bonds	**1 335 137**	1 089 600
– Yield-enhanced bonds	**3 058 012**	996 091
– Inflation-linked bonds	**464 574**	343 737
– Money market instruments	**5 125 962**	6 018 750
– Cash and cash equivalents	**2 198 127**	2 494 480
– Derivative financial instruments	**–**	22 700
	12 181 812	10 965 358

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

32 Financial risk management report *continued*

Exposure to credit risk

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.

Cash and cash equivalents comprise cash deposits with 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 pages 142 to 143.

Derivative counterparties are limited to high credit quality financial institutions.

During the year under review, the Scheme developed a Credit Risk Policy in conjunction with its investment consultant. The purpose of the policy is to guide the Scheme with respect to credit risk identification, measurement, monitoring and management in its oversight capacity. The policy provides for limits based on parameters such as:

- Instrument and counterparty exposure;
- Credit ratings;
- Geographical exposure;
- Industry exposure; and
- Expected loss.

Compliance with the limits are regularly monitored with a quarterly report back presented to the Scheme's Investment Committee.

The Scheme has assessed whether the above 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.

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.

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 indicators 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.

32 | Financial risk management report *continued*

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.

At 31 December 2015 2.8% (2014: 1.9%) 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.

At 31 December 2015 0.6% (2014: 0.5%) 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.

At 31 December 2015 0.5% (2014: 1.2%) 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.

At 31 December 2015 2.6% (2014: 2%) of the Scheme's financial assets at fair value through profit or loss invested in instruments with this credit rating.

CC: Very high levels of credit risk

Default of some kind appears probable.

At 31 December 2015 0.1% (2014: 0%) of the Scheme's financial assets at fair value through profit or loss invested in instruments with this credit rating.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

32 Financial risk management report *continued*

The following table discloses the Scheme's asset credit ratings using official credit ratings. The Scheme's credit risk policy limits investments in non-investment grade instruments to a maximum of 10% after considering official credit ratings and asset manager assigned internal credit ratings, where official ratings are not available. Less than 4% (at 31 December 2015) of assets at fair value through profit or loss were invested in non-investment grade instruments after consideration of asset manager-assigned internal credit ratings.

		Short-term rating		Long-term rating	
R'000	Total	F1+	F1	Govt	AAA
2015					
At fair value through profit or loss:	**9 983 685**	**856 196**	**10 142**	**592 441**	**1 400 390**
– Offshore bond portfolio	**1 335 137**	**11 766**	**10 110**	**62 487**	**208 689**
– Yield-enhanced bond portfolio	**3 058 012**	**16 323**	**32**	**205 127**	**549 463**
– Inflation-linked bond portfolio	**464 574**	**(31 702)**	**–**	**318 724**	**1 015**
– Money market portfolios	**5 125 962**	**859 809**	**–**	**6 103**	**641 223**
Cash and cash equivalents	**2 198 127**	**1 370 052**	**–**	**–**	**40 756**
Total	**12 181 812**	**2 226 248**	**10 142**	**592 441**	**1 441 146**
2014					
At fair value through profit or loss:	8 449 795	1 067 938	55 931	392 088	857 137
– Offshore bond portfolio	1 089 600	93 410	4 307	47 858	197 532
– Yield-enhanced bond portfolio	996 091	13 584	1	52 348	169 879
– Inflation-linked bond portfolio	343 737	7 524	–	189 329	–
– Money market portfolios	6 020 367	953 420	51 623	102 553	489 726
Cash and cash equivalents	2 492 863	604 793	80 007	–	7 275
Total*	10 942 660	1 672 731	135 938	392 088	864 412

* *Excludes derivative financial assets.*

At the reporting date the credit ratings shown are the most conservative of Moody's, Fitch and S&P and have been provided in a Fitch format.

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.

	Long-term rating						
	AA+ to AA-	A+ to A-	BBB- to BBB+	BB- to BB+	B- to B+	CCC+ to CCC-	CC+	Not rated
1 959 844	**3 879 452**	**346 423**	**116 706**	**55 001**	**290 665**	**7 525**	**468 900**
217 671	**307 201**	**218 849**	**116 706**	**55 001**	**9 645**	**7 525**	**109 487**
1 058 456	**740 692**	**127 165**	**–**	**–**	**35 339**	**–**	**325 415**
15 271	**161 266**	**–**	**–**	**–**	**–**	**–**	**–**
668 446	**2 670 293**	**409**	**–**	**–**	**245 681**	**–**	**33 998**
528 382	**203 198**	**3**	**–**	**–**	**20 468**	**–**	**35 268**
2 488 226	**4 082 650**	**346 426**	**116 706**	**55 001**	**311 133**	**7 525**	**504 168**
1 134 454	4 126 724	128 044	50 189	194 431	188 351	–	254 508
193 049	247 077	52 753	48 857	102 235	9 462	–	93 060
214 164	265 751	18 156	1 332	91 688	7 740	–	161 448
–	146 884	–	–	–	–	–	–
727 241	3 467 012	57 135	–	508	171 149	–	–
677 843	1 067 612	2 512	–	–	26 207	–	26 614
1 812 297	5 194 336	130 556	50 189	194 431	214 558	–	281 122

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

32 Financial risk management report *continued*

Credit risk *continued*

Credit quality *continued*

The exposure to investments in unconsolidated structured entities is disclosed in the following table:

Name and Description	2015 R'000	Authorised programme/ market size	% of authorised programme size/market size	Fair value hierarchy	Debt ranking	Credit ranking	Underlying assets
Asset-backed commercial paper	5 086	R25.3 billion	0.02%	Level 1 – 100%	Senior secured – 0.01% Secured – 99.99%	F1+: 100%	Instalment sales agreements Corporate loans Credit card receivables Bonds Equipment leases
Residential mortgage-backed securitisations	429 092	R69.4 billion	0.62%	Level 1 – 97.06% Level 2 – 2.94%	Senior secured – 26.24% Secured – 72.44% Senior unsecured – 1.32%	A to AAA: 93.17% BBB: 1.67% F1+: 2.22% Not rated: 2.94%	Prime home loans
Asset-backed securitisations	233 452	R28.2 billion	0.83%	Level 1 – 79.69% Level 2 – 20.31%	Senior secured – 16.89% Secured – 79.69% Senior Unsecured – 3.42%	A to AAA: 79.01% BBB: 0.39% CCC: 2.17% Not Rated: 18.43%	Vehicle loans Corporate loans Unsecured loans Equipment Leases
Commercial mortgage-backed securitisations	10 242	R2.5 billion	0.41%	Level 1 – 100%	Senior secured	AA to AAA: 100%	Commercial property
Collateralised loan obligations	64 033	R33.5 billion	0.19%	Level 1 – 100%	Senior secured – 0.01% Secured – 59.41% Unsecured – 40.58%	AA to AAA: 100%	Vehicle loans
Collective investment schemes	8 135	R52.8 billion	0.02%	Level 2		AA+	ABSA Money Market Fund
	1 317 999	R14 billion	9.42%	Level 2		AA+	Nedgroup Investments Money Market Class C2
	1 325	R12.6 billion	0.01%	Level 2		AA–	Nedgroup Investments Core Income Fund Class C2
	751	R9.2 billion	0.01%	Level 2		AA+	Momentum Money Market Fund B6
	4 818	R26.4 billion	0.02%	Level 2		AA+	Standard Bank Corporate Money Market Fund
	1 421	R13.7 billion	0.01%	Level 2		AA+	Investec Corporate Money Market Fund
	716 812	R4.5 billion	0.02%	Level 2		A	Investec Global Strategic Income Fund

Credit risk *continued*

Credit quality *continued*

Name and description	2014 R'000	Authorised programme/ market size	% of authorised programme size/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 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	AA 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 98% (R1.5 billion) (2014: 95% – R1.2 billion) 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.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

32 Financial risk management report *continued*

Liquidity risk *continued*

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

R'000	Less than 1 year	Between 1 and 2 years	Between 2 and 5 years
As at 31 December 2015			
Personal Medical Savings Accounts (Note 8)	**3 736 659**	**–**	**–**
Trade and other payables (Note 9)	**467 701**	**–**	**–**
	4 204 360	**–**	**–**
As at 31 December 2014			
Personal Medical Savings Accounts (Note 8)	**3 250 743**	**–**	**–**
Trade and other payables (Note 9)	**507 396**	**–**	**–**
	3 758 139	**–**	**–**

Fair value estimation

Financial instruments

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.

Personal Medical Savings Accounts

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 enrolls in another benefit plan or medical scheme without a savings account or does not enroll 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.

32 | Financial risk management report *continued*

Fair value hierarchy for financial assets measured at fair value

Assets measured at fair value

R'000	Fair value measurement at end of the year using: R'000	Level 1	Level 2	Level 3
2015				
Financial assets at fair value through profit or loss:				
Offshore bonds	**1 335 137**	**–**	**1 335 137**	**–**
Equities	**1 415 647**	**1 413 048**	**2 599**	**–**
Yield-enhanced bonds	**3 058 012**	**1 477 038**	**1 545 635**	**35 339**
Inflation-linked bonds	**464 574**	**454 127**	**10 447**	**–**
Money market instruments	**5 125 962**	**2 334 946**	**2 545 335**	**245 681**
	11 399 332	**5 679 159**	**5 439 153**	**281 020**
2014*				
Financial assets at fair value through profit or loss:				
Offshore bonds	1 089 600	–	1 089 600	–
Equities	1 026 342	1 024 646	1 696	–
Yield-enhanced bonds	996 091	717 827	278 264	–
Inflation-linked bonds	343 737	314 042	29 695	–
Money market instruments	6 018 750	2 183 721	3 835 029	–
	9 474 520	4 240 236	5 234 284	–

* *The fair value hierarchy has been presented per asset class (previously at an instrument level i.e. equities, government bonds, corporate bonds, money market instruments and other investments) to align to the presentation of financial assets at fair value through profit or loss elsewhere in these financial statements. The 2014 fair value hierarchy was accordingly updated.*

During the year under review investments in African Bank to the value of R281 million were classified under level 3 as a result of no trading activity in these instruments due to the curatorship. The valuation was determined using a discounted cash flow methodology based on information available in the market and incorporates certain assumptions applicable to these instruments. The discount rate was determined by adding a premium to comparative rates of similar institutions operating in the unsecured lending market. African Bank was classified under level 2 in the previous reporting period.

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.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

32 Financial risk management report *continued*

Fair value hierarchy for financial assets measured at fair value *continued*

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

Description	Fair value as at 31 December 2015	Fair value as at 31 December 2014	Valuation techniques	Observable input
Financial assets at fair value through profit or loss:				
Unlisted:				
Debt securities	**2 891 219**	1 397 559	Reference to listed benchmark bond	Risk-free yield to maturity curve risk-free zero curve
Money market securities	**2 547 934**	3 836 725	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
	5 439 153	5 234 284		

R'000	2015	2014
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 annual 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.		
Total members' funds per Statement of Financial Position	**12 929 011**	11 652 804
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**–**	(85 833)
Accumulated funds per Regulation 29	**12 929 011**	11 566 971
Gross annual contribution income	**49 759 756**	44 905 716
Solvency margin = Accumulated funds/gross annual contribution income x 100	**25.98%**	**25.76%**

At 31 December 2015, the Scheme's regulatory capital level of 25.98% (2014: 25.76%) was R488 million (2014: R341 million) more than the statutory capital requirement of 25%.

33 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 31.

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 32 and judgements relating to the impairment of assets are set out under Note 7 of the accounting policies.

34 Non-compliance matters

The CMS issued Circular 11 of 2016 (the Circular) dealing with issues to be addressed in the audited financial statements of medical schemes. The Circular requires that all instances of non-compliance be disclosed in the audited financial statements, irrespective of whether the auditor considers them to be material or not.

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

Statutory scheme solvency

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

During 2015, DHMS' solvency level dipped below 25% during January, February and November. The reason for the drop below 25% during January and February was attributable to the impact of annual contribution increases (schemes are required to hold reserves equal to annualised inflation-adjusted contributions from day one of the financial year). Negative claims experience during November caused the solvency ratio to drop below 25%.

At 31 December 2015, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 25.98% (2014: 25.76%) which exceeds the statutory solvency requirement of 25% and the approved phase-in solvency level of 25.4%, as set out in the business plan submitted to the Council for Medical Schemes.

Sustainability of benefit plans

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

For the year ended 31 December 2015 the following plans did not comply with Section 33 (2):

	Net healthcare result R'000	Net deficit R'000
Benefit plan		
Executive	**(327 852)**	**(320 737)**
Classic Comprehensive	**(705 166)**	**(601 499)**
Classic Comprehensive Zero MSA	**(1 007)**	**(544)**
Coastal Saver	**(110 686)**	**(84)**
KeyCare Plus	**(529 518)**	**(394 861)**

The performance of all benefit options is monitored on a continuous basis with a view to improving their financial outcomes, and we continually evaluate different strategies to address the deficits in these plans.

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

In addition, it updates the Registrar on both Scheme and individual benefit option performance in its monthly management accounts and quarterly monitoring meetings.

Investment in employer groups and medical scheme administrators

Section 35 (8) (a) and (c) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the Scheme, or any administrator or any arrangement associated with the Scheme. The Scheme has investments in certain employer groups and companies associated with medical scheme administration within its diversified investment portfolio. This situation occurs industry-wide. CMS has granted DHMS exemption from these sections of the Act on 7 March 2013. On 10 March 2016 the Scheme received a letter from the CMS requesting the Scheme to renew its Section 35 (8) (c) exemption within 30 days. The Scheme will be submitting an application on 8 April 2016 requesting a renewal of its exemption from both Section 35 (8) (a) and (c) of the Act.

Notes to the Annual Financial Statements *continued*

for the year ended 31 December 2015

34 Non-compliance matters *continued*

Investments in other assets in territories outside South Africa

Our offshore bond managers utilise derivative instruments to aid with efficient portfolio construction and management and to reduce the overall risk within our portfolios. The derivatives used are highly liquid and are either exchange traded or governed by International Swaps and Derivatives Association agreements. The derivative instruments are not used for speculation and there is no gearing or leverage applied. Investments in derivatives in territories outside the Republic of South Africa are however prohibited in terms of Category 7 (b) of Annexure B to the Regulations of the Medical Schemes Act 131 of 1998.

The Scheme submitted an exemption application to the CMS in 2014 requesting that the Scheme be permitted to invest in the offshore derivatives. The CMS granted DHMS an exemption on 19 May 2015 to invest in offshore derivatives, subject to certain conditions, up until 31 December 2016. The Scheme will be submitting an application for an extension of the current exemption during August 2016.

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. It is important to note that DHMS has no control over the timely payment of contributions to DHMS. The legal obligation resides with the members/employers to pay contributions within the prescribed period.

The Scheme however employs robust credit control processes dealing with the collection of outstanding contributions, including the suspension of membership for non-payment.

Broker fees paid

In terms of Regulation 28 (5) of the Act, broker fees shall be paid on a monthly basis upon receipt by a medical scheme of the relevant monthly contribution in accordance with the maximum amount payable per Regulation 28 (2) limited to one broker as required by Regulation 28 (8). In some instances brokers were compensated prior to receipt of the relevant monthly contribution, the amount paid was more than the prescribed amount and more than one broker per member was paid. In the instances where brokers were paid above the prescribed amount or more than one broker was paid, the value is negligible and represents less than 0.03% of the total broker fees paid for the year. The exceptions relate to transactions that do not occur frequently and the Administrator has developed exception reporting to identify and correct these transactions. Furthermore, the Administrator has a well-established claw-back system to rectify commission overpayments.

34 | Non-compliance matters *continued*

▪ Late joiner penalties

In terms of Regulation 13 of the Act, a medical scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties. Late joiner penalties depend on factors such as age and years of creditable medical scheme coverage.

In only a few cases (17) late joiner penalties were incorrectly applied to members due to data capturing errors. The Scheme is in the process of backdating corrections for the respective members.

▪ Duplicate membership

Section 28 (b) (i) of the Act states that no person shall be admitted as a dependant of more than one member of a particular medical scheme. A few isolated cases (11) were noted where the same dependant was registered under two memberships. The majority of cases relate to child dependants being added by both parents on their own respective memberships, whether from birth or as result of a divorce. Actions have been taken to correct the duplications identified. Additional controls have been implemented to prevent re-occurrence which include monthly exception reports of all duplicate memberships and ensuring that ID numbers are obtained during New Business and Administration processes.

Information **toolkit**

Principal Officer contact details

Email **principalofficer@discovery.co.za** or call **+27 11 529 2888** and ask for the Principal Officer of Discovery Health Medical Scheme.

Council for Medical Schemes contact details

DHMS is regulated by the Council for Medical Schemes (CMS). The CMS can be contacted telephonically on **0861 123 267** or via email on **information@medicalschemes.com.** The CMS is physically located at Block A, Eco Glades 2 Office Park, 420 Witch Hazel Avenue, Eco Park, Centurion, 0157.

Want to choose the best plan for you and your family

Choosing a plan for your family can be confusing, given the amount of information you have to consider. It is best to speak to your financial adviser, who will help you make the right decision based on your unique needs. It's also important to re-assess your plan every year before the annual cut-off date for plan changes, as your needs change and so do the contributions and benefits.

Financial advisers must be registered with the Financial Services Board and accredited by the Council for Medical Schemes. The Scheme pays the financial advisers' commission.

WHO TO CONTACT WHEN YOU:

Have any queries about your health plan

Email **healthinfo@discovery.co.za** or call **0860 99 88 77 (+27 11 541 1222 when overseas)**. Remember to put your membership number in the subject line of the email.

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. You will need to be logged into the website to find the information you need.

Want to find information about how we cover certain procedures

www.discovery.co.za/portal/individual/what-we-cover. You will need to be logged into the website to find the information you need.

Want to find a doctor where you won't have to pay a co-payment

www.discovery.co.za/portal/individual/maps-new. You will need to be logged into the website to find the information you need.

Want to get pre-authorisation for hospital stays, or find out about going to hospital

www.discovery.co.za/portal/individual/going-to-hospital. You will need to be logged into the website to apply for authorisation.

Need a document, for example, a tax certificate or membership certificate

www.discovery.co.za/portal/individual/find-a-document. You will need to be logged into the website to find the information you need.

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

IF YOU WANT TO REPORT FRAUD AND UNETHICAL BEHAVIOUR

Discovery Health provides a fraud hotline on behalf of the Scheme, and investigates possible instances of fraud. If you even slightly suspect someone of committing fraud, report all information to the fraud hotline.

You may remain anonymous if you prefer:

- **Toll-free phone: 0800 004500**
- **Toll-free fax: 0800 007788**
- **Email: discovery@tip-offs.com**
- **Post: Freepost DN298, Umhlanga Rocks 4320.**

Or email our fraud department at **forensics@discovery.co.za** directly to investigate the matter. Discovery Health may reward you up to 10% of the monies recovered, as a result of reporting suspected fraud.

WHEN YOU WANT TO SUBMIT A COMPLAINT OR COMPLIMENT, OR LODGE A DISPUTE

Email **healthinfo@discovery.co.za.** Remember to include your Discovery Health Medical Scheme membership number. Alternately, use the contact form on **www.discovery.co.za.**

When you to escalate a complaint to which you haven't received a satisfactory answer

Email **healthinfo@discovery.co.za.** Remember to include your Discovery Health Medical Scheme membership number, and specify in your email that you would like a Client Relationship Manager to contact you. If you have reference numbers from previous emails, please include these as well.

Want to contact the Principal Officer regarding a complaint escalation

Email **principalofficer@discovery.co.za** or call **+27 11 529 2888** and ask for the Principal Officer of Discovery Health Medical Scheme.

When you want to lodge a formal dispute

Email **mydispute@discovery.co.za** or call **+27 11 529 2888** and ask to speak to a member of the Disputes team.

When you want to submit a complaint to the Council for Medical Schemes

You can contact the CMS at any stage of the complaints process but are encouraged to follow the steps above to resolve your complaint before contacting the CMS directly. Email **complaints@medicalschemes.com** or call CMS Customer Care on **0861 123 267.**

INVESTMENT MANAGERS

ABAX INVESTMENTS (PTY) LTD
Coronation House, The Oval
1 Oakdale Road
Newlands, 7700
PO Box 23851
Claremont, 7735

ALLAN GRAY INVESTMENTS (PTY) LTD
1 Silo Square
V&A Waterfront
Cape Town, 8001
PO Box 51318
V&A Waterfront
Cape Town, 8002

ELECTUS FUND MANAGERS (PTY) LTD
Ground Floor
Great Westerford Building
240 Main Road
Rondebosch, 7700
PO Box 23540
Cape Town, 8000

FUTUREGROWTH ASSET MANAGEMENT (PTY) LTD
3rd Floor, Great Westerford Building
240 Main Road
Rondebosch, 7700
Private Bag X6
Newlands, 7725

INVESTEC ASSET MANAGEMENT (PTY) LTD
36 Hans Strijdom Avenue
Foreshore
Cape Town, 8001
PO Box 1826
Cape Town, 8000

100 Grayston Drive
Sandown
Sandton, 2196
PO Box 785700
Sandton, 2146

MOMENTUM ASSET MANAGEMENT (PTY) LTD
13th Floor, Tower 2
102 Rivonia Road
Sandton, 2196
PO Box 9959
Sandton, 2146

TAQUANTA ASSET MANAGERS (PTY) LTD
7th Floor, Newlands Terraces Boundary Road
Newlands
Cape Town, 7700
PO Box 23540
Claremont, 7735

ADMINISTRATOR AND MANAGED CARE PROVIDER
Discovery Health (Pty) Ltd
16 Fredman Drive
Sandton, 2196
PO Box 786722
Sandton, 2146

AUDITORS
PricewaterhouseCoopers Incorporated
2 Eglin Road
Sunninghill, 2157
Private Bag X36
Sunninghill, 2157

PRINCIPAL BANKERS
FNB Corporate
4 First Place, FNB Bank City
Cnr Pritchard & Simmonds Streets
Johannesburg, 2011
PO Box 7791
Johannesburg, 2000

Glossary

This glossary contains definitions of some of the terms used in this Report, as well as some additional terms which may be of interest to readers. The list of terms is not exhaustive. See more terms at https://www.discovery.co.za/portal/individual/important-concepts.

Administration	Basic medical scheme administration services include the collection of contributions, member and provider support services and the processing and paying of claims; Discovery Health (Pty) Ltd provides DHMS with a broad range of additional administration services, such as research and development activities, actuarial and business analytics, benefit design, fraud and forensics investigation, and marketing and communication services.
Board of Trustees	The Board oversees the affairs of the Scheme in the best interest of its members and stakeholders. Trustees are highly skilled individuals who offer their knowledge and experience to the Scheme. They may be elected or appointed, but at any time at least 50% of the Board must be elected by Scheme members.
Board Committees	The Board delegates some of its work to various Board Committees equipped with the necessary specialist skills. These Committees may consist of Trustees and/or additional independent members. All Committees report back to the Board and make recommendations in line with their respective mandates.
Brokers	See financial advisers.
Claims paying ability	Claims paying ability refers to how many times the Scheme is able to cover its monthly claims expense with its liquid investments.
Claims provision	See incurred but not reported (IBNR).
Council for Medical Schemes	The Council for Medical Schemes (CMS) is a statutory body responsible for regulating the medical schemes industry in South Africa: it administers and enforces the Medical Schemes Act 131 of 1998, as amended.
Deloitte	Deloitte Southern Africa is a leading professional services firm in Africa, providing audit, consulting, corporate finance, taxation services and risk advisory services. DHMS contracts Deloitte to provide ad-hoc professional services. (Source: http://www.deloitte.com/za/en.html).
Dependant	A member or person admitted as a dependant of a member. Beneficiaries of the Scheme include all members and their dependants.
Designated Service Provider (DSP)	The hospitals and healthcare providers and professionals with whom Discovery Health Medical Scheme has contracted to provide healthcare services to members. DSPs have a payment arrangement with Discovery Health Medical Scheme to provide treatment or services at an agreed rate and without any co-payments required by members.
Discovery Limited	An international organisation made up of companies like Discovery Health, Discovery Life, Discovery Vitality, Discovery Card and Discovery Insure. Discovery was named by Fortune Magazine as one of the 51 companies globally that have made a sizeable impact on major global, social or environmental problems as part of their competitive strategy and in 2015 received the Geneva Forum for Health Award, that recognises advances and contributions to healthcare systems. DHMS members have the option to join Discovery Vitality to take advantage of their wellness programmes as a complement to their medical insurance.
Discovery Health (Pty) Ltd	Discovery Health (Pty) Ltd has been appointed by the Board of Trustees to provide administration and managed care services to the Scheme.
Discovery Health Medical Scheme (DHMS or the Scheme)	Discovery Health Medical Scheme is a registered medical scheme, and like all other medical schemes in South Africa is a non-profit entity. The Scheme pools all members' contributions in order to fund members' claims. Any surplus funds are transferred to Scheme reserves for the benefit of members. The Scheme exists to serve its members' interests through enabling the sustainable provision of high-quality and affordable healthcare to all of its members.

Discovery Health Medical Scheme Rules (Scheme Rules or the Rules)	The Rules of the Scheme are registered by the Registrar for Medical Schemes in terms of the Medical Schemes Act 131 of 1998, as amended, including the benefit plan and schedules. Together with the Act, the Rules dictate how Discovery Health Medical Scheme operates.
Discovery Vitality	Discovery Vitality is a voluntary science-based wellness programme that encourages its members to get healthier by rewarding them for making healthy choices in support of wellness. Vitality is a separate wellness product sold and administered by Discovery Vitality (Pty) Ltd. Registration number 1999/007736/07, an authorised financial services provider.
Financial advisers (brokers)	Financial advisers (commonly also referred to as "brokers") provide members with independent advice about their health plan options based on individual medical and affordability needs. Financial advisers must be registered with the Financial Services Board and accredited by the Council for Medical Schemes. The Scheme pays contracted financial advisers a legislated commission.
Global Credit Ratings	GCR rates the full spectrum of security classes and accords both International Scale and National Scale credit ratings, and together with its international affiliates, rates almost 3 000 organisations and debt issues – spanning four continents. (Source: https://globalratings.net/). GCR has issued DHMS with the highest possible credit rating in the medical scheme industry of AA+, confirming its financial strength and claims-paying ability.
Healthcare providers	Healthcare providers are the health professionals who deliver healthcare services for example, doctors, nurses, dentists, specialists, hospitals, pharmacies and managed care organisations.
Incurred but not reported (IBNR)	The incurred but not reported (IBNR) (or "outstanding claims provision") is the total amount of payments due by the Scheme (in terms of its Rules) to healthcare providers for claims incurred (healthcare services provided/medicine supplied) by its members and/or their dependants, but which have not been lodged/reported to the Scheme by the period end. The IBNR is an estimate and the Scheme makes use of various actuarial methods to reasonably predict such amounts at the period end. Further detail has been provided under note 31 (Insurance Risk Management Report).
King Code of Governance for South Africa 2009 (King III)	The King Report on Corporate Governance is a code of corporate governance in South Africa issued by the King Committee on Corporate Governance. The code is non-legislative and is based on principles and practices.
Managed care	Managed care is the provision of appropriate, affordable, quality healthcare services through rules-based, clinical and disease management programmes.
Material matters	In integrated reporting, these are Issues that impact on the Scheme's ability to create value. They are determined by considering their effect on the organisation's strategy, governance, performance or prospects. An understanding of the perspectives of key stakeholders is critical to identifying relevant matters.
Medical Schemes Act 131 of 1998, as amended (MSA or the Act)	The Medical Schemes Act regulates all registered schemes. Discovery Health Medical Scheme operates according to the Act[1].
Member	A person who is admitted as a member in terms of the Rules of the Scheme, but does not include a dependant.
Networks and network providers	Some health plans, benefits and healthcare services require members to use the Scheme's network providers. By using these providers, the Scheme is able to keep member contributions as affordable as possible while at the same time ensuring full cover.

1 *See https://www.medicalschemes.com/Content.aspx?130.*

Glossary *continued*

Non-healthcare expenses	The sum of non-healthcare fees paid to the Administrator, financial adviser commissions (acquisition costs) and other management expenses (which include advertising expenditure, staff costs, bad debts, impairments, etc). Schemes are obligated to exercise a high degree of control over non-healthcare expenditure, as these can place additional pressure on their net healthcare performances, particularly in high-claiming years.
Open (unrestricted) scheme	A medical scheme which anyone can join, subject to the rules of the scheme (see restricted (closed) scheme).
Prescribed Minimum Benefit conditions	In terms of the Medical Schemes Act 131 of 1998 and its regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of: ▪ Any life-threatening emergency medical condition; ▪ A defined set of 270 diagnosis and treatment pairs; and ▪ 27 chronic conditions. These conditions and their treatments are known as the Prescribed Minimum Benefits (PMB). All medical schemes in South Africa have to include the Prescribed Minimum Benefits in the health plans they offer to their members. There are, however, certain requirements that a member must meet before they can benefit from the Prescribed Minimum Benefits. The three requirements are: 1. The condition must be part of the list of defined PMB conditions; 2. The treatment needed must match the treatments in the defined benefits on the PMB list; and 3. Members must use the scheme's designated healthcare service providers, unless in an emergency, or may be required to make a co-payment.
PwC	PricewaterhouseCoopers is a multinational professional services network. It is the largest professional services firm in the world, and is one of the Big Four auditors, along with Deloitte, EY and KPMG. PwC Southern Africa provides industry-focused assurance, advisory and tax services to public, private and government clients in all markets. PwC is DHMS' external auditors (Source: http://www.pwc.co.za/).
Restricted (closed) scheme	A medical scheme to which membership is restricted, based on employment by a particular employer or in a particular profession, trade or industry (see open (unrestricted) scheme).
Scheme Rules	See Discovery Health Medical Scheme Rules.
Solvency	The Medical Schemes Act of 1998 requires that each scheme retain a buffer of cash reserves to utilise against higher than expected claims resulting from random industry variations, including unexpected changes in membership profile, very large individual claims, and multiple claims arising from a catastrophic event or an epidemic. The minimum required solvency level to be maintained by a medical scheme is 25% of gross annual contributions.
Vested® outsourcing	Vested® is a business model, methodology, mindset and movement for creating highly collaborative business relationships that enable true win-win relationships in which both parties are equally committed to each other's success. When applied, a Vested® approach fosters an environment that sparks innovation, resulting in improved service, reduced costs and value that didn't exist before – for both parties. Vested® is based on award-winning research conducted by the University of Tennessee's College of Business Administration. (Source: http://www.vestedway.com/).

Discovery Health Medical Scheme

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

Discovery
Health Medical Scheme