Discovery
Health Medical Scheme

FOR THE BENEFIT OF OUR MEMBERS

INTEGRATED ANNUAL REPORT 2013

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The Discovery Health Medical Scheme has

GROWN TO BECOME THE LARGEST OPEN MEDICAL SCHEME IN SOUTH AFRICA COVERING 2.5 MILLION LIVES.

This distinction comes thanks to the ever-increasing number of people who decide to entrust their healthcare funding needs to us. It is humbling to know that the responsibility for ensuring the best possible health outcomes for so many people rests on our shoulders.

The Scheme is therefore accountable mainly to our members, but also to every other individual who interacts with us or our members in the course of providing or accessing care in the private healthcare system.

Being the biggest open medical scheme in the country comes with great responsibility. Our focus is always on finding ways to use the Scheme's scale not only to the benefit of all our members and stakeholders, but also to the benefit of greater society.

The Discovery Health Medical Scheme's Integrated Annual Report for 2013 aims

TO GIVE OUR PRIMARY STAKEHOLDERS A CLEAR VIEW

of not only the Scheme's operational performance, but also of key issues that affect the private healthcare industry as a whole.

Report scope and boundaries

This report covers the Scheme's performance for the period 1 January 2013 to 31 December 2013. We report on strategic and material information of relevance to the members of the Discovery Health Medical Scheme (the Scheme). The report also provides information on the Scheme's assessment of how Discovery Health (Pty) Ltd (Discovery Health) has managed its administration and managed care responsibilities in respect of the Scheme's mandates. In support of the Scheme's commitment to ensuring that our members receive the best administrative services in return for the contributions they pay, we commissioned an independent governance review, conducted by Deloitte Consulting (Pty) Ltd (Deloitte). The results of this report illustrated strong performance for both the Scheme and the Administrator.

You can access the full report at **www.discovery.co.za**

Report structure

The 2013 report has a new structure to include more graphical presentation of data to improve the readability of the report, while ensuring that the integrity of the written data remains intact and available for those who want to conduct deeper analysis. The report also includes more graphics compared to the previous one, along with cross-references to specific reviews and data found elsewhere in the report.

Reporting assurance

It is important that the information contained in this report is accurate and reliable. The Scheme wants to ensure that our members have access to precise, verified information and will continue in our efforts to ensure that the quality of information remains of the highest standard. The Board of Trustees is in agreement that the content of this report is relevant to the reader base, complies with the Scheme's legislated responsibility to provide detailed feedback on the various aspects of its operations and performance, and that it serves as a transparent, integrated source of information to all stakeholders. The Board is also satisfied that the Scheme has adequate resources to continue with its operations in the near future. The Scheme's Annual Financial Statements have therefore been prepared on the basis of the Scheme being a going concern.

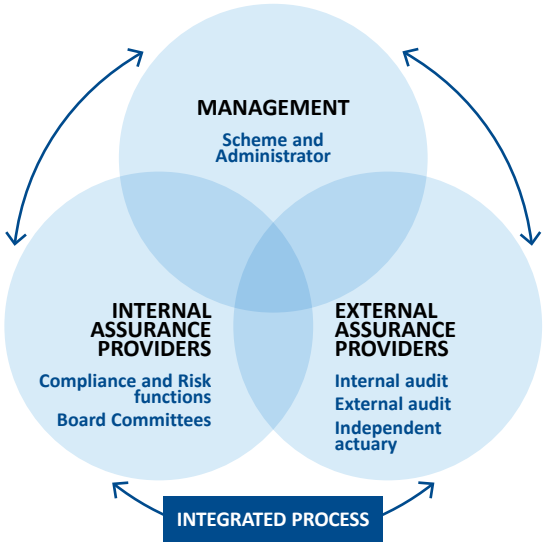
The Scheme's **Annual Financial Statements** can be found on page 47.

Combined assurance

Assurance providers are the internal and external people who provide information about the measures put in place to prevent risks from occurring and to reduce the risk impact where applicable. The process of combined assurance allows for a comprehensive view of the possible risks and opportunities within the Scheme, as well as visibility over what assurance is provided and by whom.

Each defined key activity relevant to the running of the Scheme is measured against the level of assurance that each of the different lines of defence within the Scheme can provide. The Board of Trustees uses this information to consider whether sufficient focus is placed on each key activity to ensure that it is operating effectively.

The Scheme uses a Combined Assurance model based on three lines of defence and is summarised as follows:



The Combined Assurance model is reviewed, maintained and updated regularly, to ensure that the model remains relevant and that it evolves according to the needs of the Scheme. The Board is confident that this model provides the most efficient way of identifying and responding to risks and opportunities when they arise, enabling a more proactive approach to the management of the Scheme's operations.

The Scheme has decided to apply this model as it represents best practice in terms of corporate governance requirements.

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.

Read more about the **Audit Committee** on page 23.

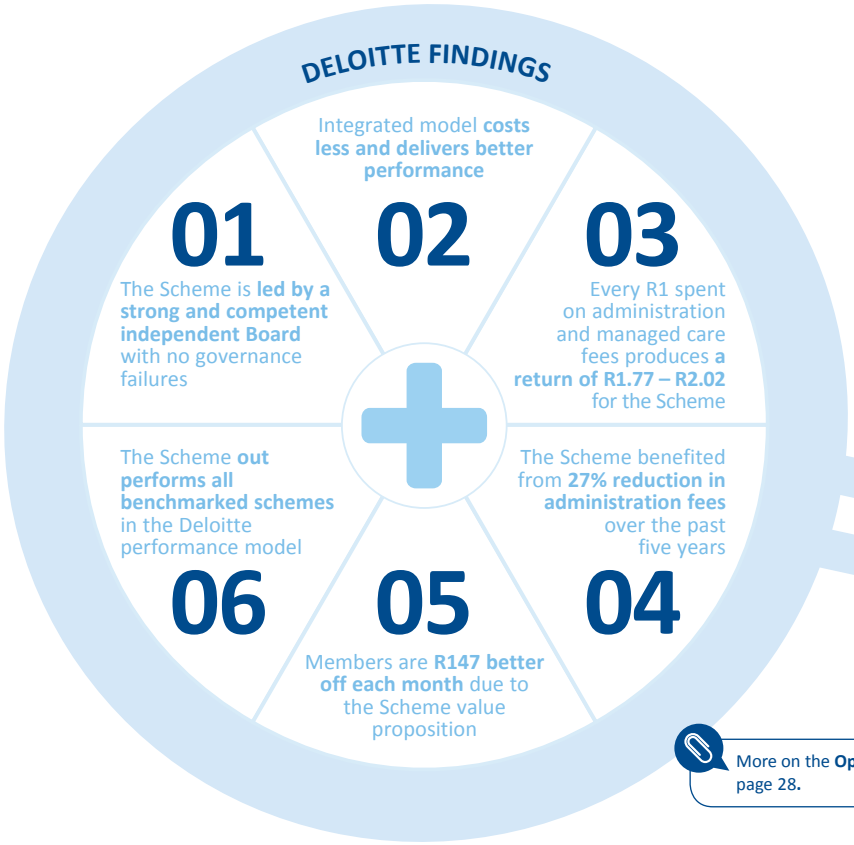
Details of fees paid to the external auditors for audit services are included in the Annual Financial Statements.

The Scheme has adopted a policy governing non-audit services that are provided by the external auditor. The fees have also been disclosed and agreed with the Audit Committee.

Independent operating model and governance review

In the 2012 Discovery Health Medical Scheme Annual Report we provided detail of an independent review commissioned by the Scheme. The review was conducted by Deloitte Consulting (Pty) Ltd and forms part of our ongoing efforts to ensure that the members of the Scheme obtain the best value for money in respect of administration and managed healthcare services provided by Discovery Health. The review also forms part of the fiduciary duties of the Board of Trustees. We agreed to provide feedback on the findings of the operating model and governance review of the Scheme, and this was presented to the Scheme and its stakeholders at the 2013 Annual General Meeting. This report contains extracts, commentary and feedback on the Scheme's progress regarding the implementation of the findings.

These are the main findings of the operating model and governance review of the Scheme:



More on the **Operating Model and Governance Review** on page 28.

Reference icons found in this report

To help you find and more easily absorb information in this report, we have used the following icons:

SCHEME'S OPERATING MODEL AND GOVERNANCE REVIEW AS REPORTED BY DELOITTE

IN THIS REPORT

ON OUR WEBSITE

ANNUAL FINANCIAL STATEMENTS

Important sources of information

For more information about the benefits of your chosen health plan you can refer to your benefit brochure or the Discovery website, **www.discovery.co.za**

A full version of the Scheme Rules, as approved by the Council for Medical Schemes is also available on the website, **www.discovery.co.za** (You have to be a registered website user to access the Scheme Rules).

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

A full version of the Discovery Health Medical Scheme Operating Model and Governance Review, performed by Deloitte, is available on our website, **www.discovery.co.za**

LEADERSHIP REVIEW // chairperson's report

2013 was another year of excellent performance for the Discovery Health Medical Scheme. Amidst the challenges of ongoing financial pressures faced by consumers, the Scheme continued to provide its members with certainty of access to quality private healthcare cover when they need it most. Membership grew by 3.9% to 2 564 313 lives and it is encouraging to see that once people join the Scheme, they tend to stay, as evidenced by the significantly low lapse rate of 4.15%. A continuous priority of the Discovery Health Medical Scheme is to ensure that its members have access to cost-effective quality private healthcare cover at competitive contribution rates for their healthcare needs, both now and into the future. Members of the Scheme can therefore rest assured that they belong to a medical scheme which uses its leadership position, scale and expertise to ensure that members and stakeholders benefit from its ability to effect positive change in the South African private healthcare system.

Globally, the cost of providing private healthcare cover is on a **CONTINUAL UPWARD TRAJECTORY,** with private healthcare cost inflation in South Africa outstripping Consumer Price Inflation (CPI) by approximately 3% to 4%.

Medical inflation is our enemy and if medical schemes do not apply sound cost management principles, the cost of private healthcare cover would become less affordable in future. Finding more innovative ways to limit the inflationary fee-for-service payment structures in a fragmented private healthcare system (where the Scheme pays per healthcare service rendered) by introducing more effective alternative reimbursement mechanisms (where healthcare providers are reimbursed to effectively manage patients' healthcare needs within an agreed payment structure) means that the Scheme would be able to keep costs under control without compromising the quality of care members receive. New healthcare technologies come at an ever-increasing cost. It is however vital that our members have access to new technologies and while the financial effect of funding these is significant, the Scheme works closely with its Administrator, Regulator, manufacturers and suppliers to ensure that we find ways for our members to access these new technologies, especially where they are proven to be life-saving.

DISCOVERY HEALTH MEDICAL SCHEME BOARD OF TRUSTEES

Michael van der Nest SC

BA (Law), LLB (Stellenbosch)
Chairperson

Noel Graves SC

BA, LLB (UCT)

Giles Waugh

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

The Oxford Healthcare Alliance's 3-4-50 Model asserts that 3 poor lifestyle choices (physical inactivity, poor nutrition and smoking), contribute to 4 of the world's most prevalent non-communicable diseases (cancer, diabetes, heart and lung disease). These diseases in turn lead to 50% of all deaths worldwide. The global healthcare funding industry has to deal with this increasing burden being placed on the healthcare system. In addition, people are also living longer, and the increase in disease prevalence means that countries and individuals have to pay more to access healthcare cover. Healthcare funders are continuously trying to understand how and why people make choices that have an adverse effect on their health. It is generally accepted by leaders in the healthcare funding industry that wellness programmes have become an integral part of the performance and sustainability of medical schemes. We have seen an increase in the application of behavioural science principles when it comes to balancing the principles of health and wellness. The challenge, however, is to offer an immediate benefit to the member who chooses to make a healthier lifestyle choice. Studies have repeatedly shown that offering a reward is the best way to drive positive behavioural changes. In this exciting field, members of the Discovery Health Medical Scheme have access to the world's leading science-based wellness programme, Vitality, offered by Discovery Vitality (Pty) Ltd. Internal analysis indicates that the Scheme's risk claims are lower by approximately R1.1 billion as a result of the positive impact of Vitality on wellness behaviour and improving the overall risk profile of the Scheme.

The Discovery Health Medical Scheme regularly engages with the Council for Medical Schemes, the National Department of Health and relevant industry bodies on issues impacting private healthcare funding and delivery in South Africa. The private healthcare system in South Africa is a national asset and the Scheme supports efforts by Discovery Health, and other stakeholders in building a better healthcare system, not only for Scheme members but for all South Africans. One current issue of concern in the private healthcare funding industry is the demarcation between medical scheme cover and "healthcare insurance" products available in the market. The proliferation of these "health insurance" products clearly doing the business of a medical scheme, is posing risks to the industry and members. The Board is evaluating its options to deal with this issue in the best interest of members and the Scheme.

The Board of Trustees is responsible for the stewardship of the Scheme. Best practice governance is a key objective and for this reason the Trustees maintain a strong focus on driving continuous innovation at all levels of strategy and operations, ensuring that members continue to receive maximum value for the contributions they pay. The Board's main strategic focus areas for 2014 are: to strengthen the Scheme's outsourcing business model and monitoring mechanisms; maintain the Scheme's industry leadership position and competitive advantage; provide benefit richness and contribution stability across the entire product range; further enhance member and provider service experience at every touch point in the healthcare system; facilitate the continuous improvement of quality of healthcare provided to our members and to focus on more refined stakeholder relations engagement strategies and plans.

We thank you for your continued trust in and support of the Discovery Health Medical Scheme. We undertake to continue making responsible decisions that are in the best interest of the many lives who are part of the Discovery Health Medical Scheme.

MICHAEL VAN DER NEST SC
CHAIRPERSON

Puke Maserumule

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

Prof Zephne van der Spuy

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

Daisy Naidoo

CA(SA), Masters of Accounting (Taxation)

LEADERSHIP REVIEW // principal officer's report

The Discovery Health Medical Scheme's robust performance continued in 2013 against a backdrop of ongoing economic pressure on consumers, rising healthcare costs, an increased burden of disease and intense public debate around healthcare issues. Despite ever-increasing complexities within the private healthcare system, the Discovery Health Medical Scheme continued to deliver on its core purpose of funding quality, cost-effective healthcare cover for all its members. Gross contribution income for 2013 exceeded R40 billion, with a strong net healthcare result of R860 million and a net surplus (including investment income) of R1.5 billion.

The Scheme experienced another period of strong membership growth, increasing principal membership by 4.55% off an already high base. Overall, the Scheme ended the year with 2 564 313 lives covered, an increase of 3.9%. In a community-rated regulatory environment, continuous membership growth is vital for the sustainability of medical schemes. The Scheme now covers 52% of the total number of lives covered in the open medical scheme market, further entrenching its position as the leading open medical scheme in South Africa.

Legislation requires the Scheme to maintain accumulated funds of 25% of gross annual contribution income. The Scheme's strong membership growth during 2013 continues to create short-term solvency pressure as new members join without any reserves, while the Scheme has to hold the full 25% solvency requirement from their date of joining. The Scheme ended 2013 with a solvency level of 24.3%, which is 1.3% above the business plan solvency trajectory agreed with the Council for Medical Schemes. The Scheme is projected to reach the statutory solvency level of 25% in 2015. Scheme reserves have increased to a substantial R9.9 billion at year end 2013, which is indicative of the significant financial strength and scale of the Discovery Health Medical Scheme.

Non-healthcare expenditure has continued its downward trajectory, being the Scheme's only cost component which has been reducing in real terms. While claims costs have increased by 17.9% over and above consumer price inflation over the past five years, administration and managed healthcare fees have had a deflationary effect of 3.6% over the same period.

During the 2013 financial year, the Scheme maintained its focus on providing Scheme members with the richest benefits and widest plan choices, while making access to affordable healthcare cover available to more people in the lower income market. The Scheme introduced two new Plans for 2013; the Classic Comprehensive Zero MSA Plan and the KeyCare Access Plan. The Classic Comprehensive Zero MSA Plan offers the same security of extensive private healthcare cover in hospital and for chronic medicine as Classic Comprehensive, but with the flexibility to self-fund day-to-day healthcare needs. KeyCare Access provides a new entry point for lower income earners. Ongoing market analysis has shown that the Discovery Health Medical Scheme remains the most affordable medical scheme choice across the entire spectrum of healthcare plans available in the open medical schemes market on a like for like basis – on average, contributions are 15% lower than those of competitor schemes.

Once members join, they tend to remain with the Scheme. The Scheme's lapse rate of 4.15%, the lowest in the industry, bears testimony to this. The Scheme has retained its AA+ credit rating for its claims paying ability from independent credit rating agency Global Credit Ratings Co. The Scheme has achieved this rating, the highest rating a medical scheme is able to receive in South Africa, for the 13th consecutive year.

The Scheme constantly reviews and assesses the performance of its administrator and managed healthcare provider, Discovery Health in order to ensure that the Scheme and its members receive the required value for fees paid. Following the Scheme's operating model and governance review, performed by Deloitte Consulting (Pty) Ltd, and presented to members at the 2013 AGM, the Scheme has implemented the key recommendations contained in the report – see page 28 for more detailed information. One of the key findings of the Scheme's operating model and governance review highlighted that an integrated operating model (where administration and managed healthcare are outsourced to the same provider) out-performs a fragmented model (where administration and managed healthcare are outsourced to different providers). An integrated operating model incurs on average 15% lower non-healthcare expenses than fragmented operating models. From an overall performance perspective, the integrated operating model results in a better performing scheme relative to the performance of a scheme that adopts a fragmented operating model. The Discovery Health Medical Scheme's operating model is built on innovation, active collaboration, best practice corporate governance, transparency and member engagement – a model that has served the Scheme well

During the 2013 financial year, the Scheme maintained its focus on providing Scheme members with
THE RICHEST BENEFITS AND WIDEST PLAN CHOICES,
while making access to affordable healthcare cover available to more people in the lower income market.

over an extended period and has effectively aligned the incentives of the Scheme and Discovery Health in an efficient manner.

The innovation, expertise and scale of the operations of the Scheme's administrator, are unparalleled in the industry. With over 46 000 calls answered each day and 3.9 million claims processed every month, the Scheme and Discovery Health have leveraged scale to develop a range of technological and service innovations, including smartphone and tablet applications for members and healthcare professionals. These applications enhance the quality of care for members and significantly improve the experience of members in the healthcare system. In an effort to manage diabetes more effectively, telemetric devices are made available to Scheme members who suffer from diabetes. This device assists both the patient and their treating doctor to manage the patient's disease more easily, with the help of readily available member-specific clinical information at the touch of a button. HealthID, a first-of-its-kind tablet application that allows doctors to see a consolidated view of members' medical and treatment history, was launched in 2012 and improved in 2013. Many doctors have attested to its efficiency in providing a platform for sharing clinical information that facilitates better coordination of care, improves patient outcomes, while at the same time streamlining administration processes for doctors.

Discovery Health has also invested significantly in a wide range of benefit and risk management assets and tools. These include a number of important healthcare provider assets within the private healthcare system. These capabilities and assets have succeeded in "bending the cost curve" and lowering the cost of healthcare for both Scheme members and the industry as a whole.

The Discovery Health Medical Scheme will continue its focus on ensuring best practice governance, product and service innovation, risk management strategies, the introduction of alternative reimbursement models and enhanced stakeholder engagement and relationship strategies. With the continued sustainability of the Scheme and the wellbeing of its members as top priority, the Discovery Health Medical Scheme Board of Trustees will ensure that members continue to receive significant value from the Scheme and Discovery Health for the foreseeable future.

MILTON STREAK
PRINCIPAL OFFICER

OVERVIEW //
about discovery health medical scheme

The Scheme is the
LARGEST OPEN MEDICAL SCHEME IN SOUTH AFRICA.

It is a not-for-profit entity governed by the Medical Schemes Act, No 131 of 1998, as amended, and by the Rules of the Discovery Health Medical Scheme. It is regulated by the Council for Medical Schemes.

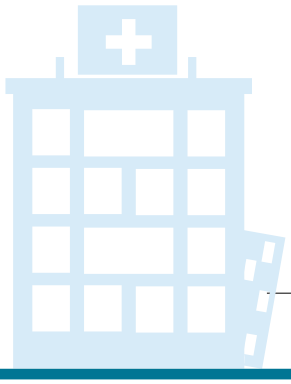
If you are reading this report as a member of the Discovery Health Medical Scheme, you are part of only 17% of the population of South Africa fortunate enough to have private healthcare cover. There are many reasons for this disparity between covered and non-covered individuals in our country. One is that in South Africa it is not compulsory to join a medical scheme as soon as you start working, unless your employer insists on membership. This means that there is a portion of the population who could buy private healthcare cover, but don't, for a variety of reasons. Another is that many households simply do not earn enough money to pay for day-to-day necessities in addition to private healthcare cover.

We feature a number of member experiences in this report that reflect the impact of the decision not only to prioritise private healthcare cover, but to choose cover with the Discovery Health Medical Scheme. Read the extraordinary stories of two **Members' Experiences** on page 12.

The Scheme belongs to its members and is governed by an independent Board of Trustees, elected by the members of the Scheme. When members pay their contributions every month, the Scheme pools the money and then ensures that the money is used wisely, so that we can pay for you and your family's healthcare needs not just now, but well into the future. The Board of Trustees oversees the business of the Scheme to ensure that the Scheme and the Administrator conducts its business in a way that benefits the Scheme and its members.

Read more about the Board of Trustees in the **Governance Review** on page 22.

97
Babies born to Scheme members



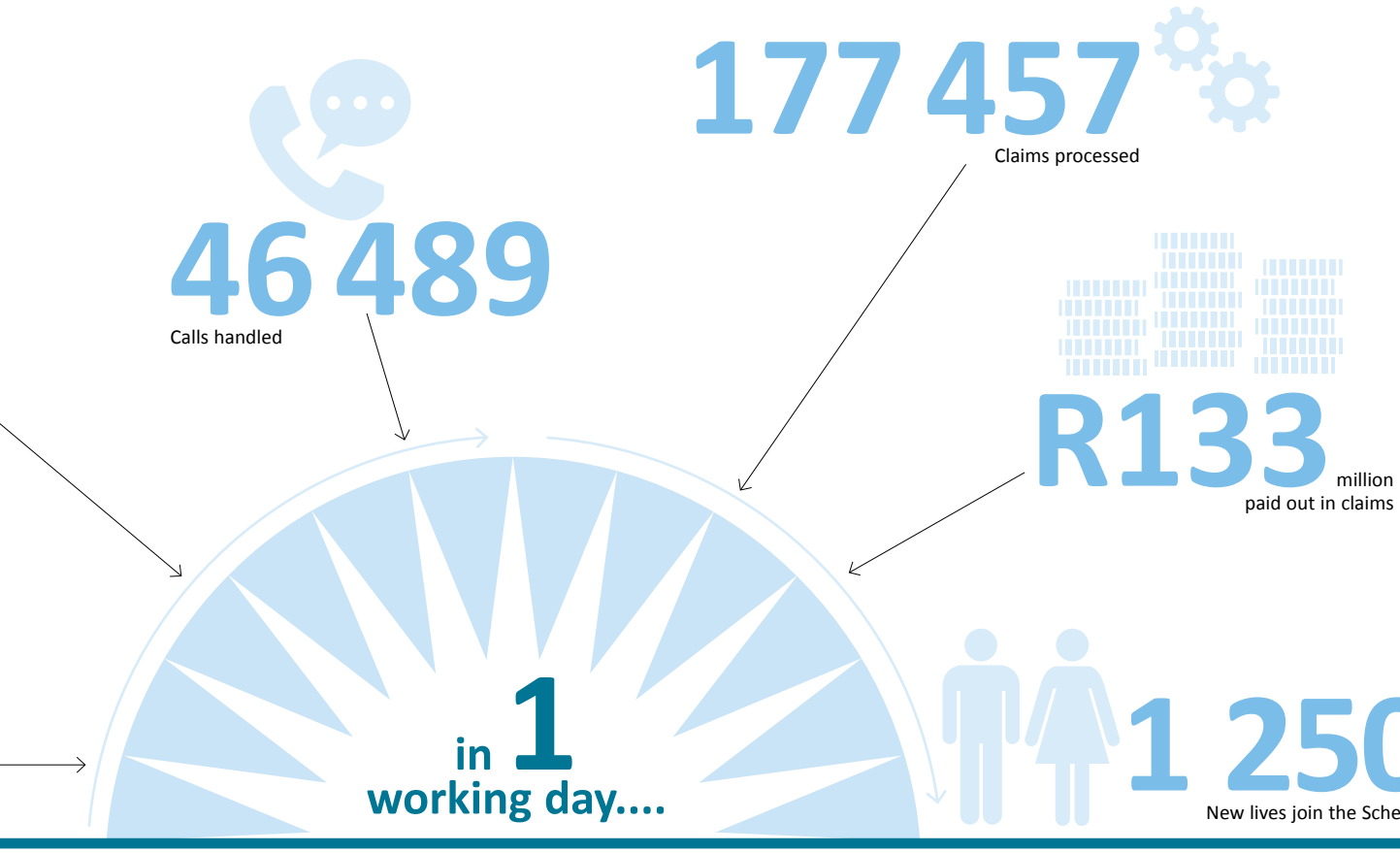
1 799
Hospital admissions authorised

HERE ARE SOME OF THE WAYS IN WHICH THE SCHEME'S SIZE HELPS IMPACT MEMBERS AND SOCIETY IN A POSITIVE WAY:

It helps thousands of families to afford the medicine and treatments they need to live a healthy and productive life. The Scheme helps members fund treatment and medicine that saves their lives. Without the backing of the Scheme they would not have been able to pay for these treatments and medicine.

Many members who need costly new innovations in medicines and technologies are only able to do so because the Scheme helps them fund these items.

HERE'S AN INTERESTING SNAPSHOT OF THE ACTIVITIES DISCOVERY HEALTH PERFORMS EVERY WORKING DAY



Discovery Health can negotiate better rates with GPs, specialists and hospitals, ensuring that members have greater access and more options in terms of the doctors and hospitals they go to, with the assurance of lower or no co-payments for healthcare services.

It enables Discovery Health to negotiate lower medicine prices, which benefit members and society as a whole. This is because Single Exit Price legislation determines the maximum mark-up that can be placed on the negotiated price of a drug. These prices, as negotiated by Discovery Health, must by law be applied to all medicines.

It eases the burden on the South African public healthcare system.

OVERVIEW //
questions our members often ask

WHY DO I NEED A MEDICAL AID?

A. *Medical aids (also called medical schemes) provide healthcare cover to their members. Schemes are governed by the Medical Schemes Act and are the only entities allowed by law to provide comprehensive healthcare cover. Few of us could afford the costs of long hospital stays or care for serious injuries, surgery, or chronic illnesses – for example, it costs R8 500 a night for a premature baby to stay in a private hospital's neonatal unit (some stay for five months), and that's just the bed, without any consultations, medicine or medical supplies. Medical schemes help us finance life's curved balls when we can't do it alone.*

The Discovery Health Medical Scheme's highest claim payment for 2013 was R4.9 million. The average monthly contribution per member for 2013 was R2 320 per month. In order for a claimant to pay off the value of this claim from their own pocket, at the same rate that their contribution is set and without any increases, it would take 177 years. With a financially sound medical scheme behind you, the pooled contributions go towards funding huge medical expenses like this one, without placing you in debt for the rest of your life.

Where do my contributions go?

A. *The major portion of your contribution is needed to cover in-hospital and emergency medical costs because this is the major risk area and the most expensive type of claims. On most plans, a portion of your contribution goes into a Medical Savings Account (MSA), which you control and use for out-of-hospital expenses like GP visits and medicine. 89% of your contribution is used to fund healthcare costs, with the remaining 11% paying for non-healthcare expenses like administration and managed healthcare.*

How do you calculate the contributions I should pay?

A. *The contribution you pay depends on the plan that you choose, the size of your family and whether you have children and (for some plans) your income. The contributions are the same for men and women but different for children and do not take into account whether a person is sick or healthy. To work out the contribution that will apply for the following year, the Scheme estimates the likely average cost of paying for each member's medical benefits as well as the cost of running the Scheme. The calculation takes into account that some plans offer richer benefits and therefore have higher contributions.*

The new contributions come into effect on 1 January of every year. The Scheme sends members letters and benefit brochures confirming their new contributions and also publishes the contributions on the Discovery website www.discovery.co.za

Q. What is the difference between Discovery Health Medical Scheme and Discovery Health (Pty) Ltd?

A. *The Scheme is a not-for-profit entity. It appoints an accredited administrator and managed healthcare provider.*

More information can be found in the **About Discovery Health Medical Scheme** section on page 8.

This administrator and managed healthcare provider is Discovery Health (Pty) Ltd (Discovery Health). All contributions that members pay to the Scheme are pooled into a collective fund which, by law, can only be used to pay claims related to healthcare services. Discovery Health takes care of all the administration activities needed to manage a scheme the size of the Discovery Health Medical Scheme, for example call centres, claims processing, operating systems and many more functions. Discovery Health also provides managed healthcare services as well as a package of other value-added services to members of the Scheme, all included in the cost of the administration and managed care fee.

More information on the services Discovery Health provides to the Scheme can be found in the **Integrated Performance Review** section on page 40.

Q. How do I choose the best plan for my family?

A. *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. It's important to re-assess your plan every year (before early December which is the cut-off for plan changes), as your needs change and so do the contributions and benefits. Typically your financial adviser would work out how much you spent on healthcare in the last year and check what you spent the most on (you can ask for a claims transaction history or view it online at www.discovery.co.za/Health/Ineedadocument). Your financial adviser would also ask whether the expenses you incurred are likely to be repeated in the new year and whether they are for in- or out-of-hospital procedures. They would also check if you had enough money in your Medical Savings Account to last the year. Think about the possible health risks that your family may face in the coming year. Now you and your financial adviser would look at a plan comparison to match your needs to the available plan options. It's important to consult a financial adviser who can provide financial advice with regards to the plan choice that best suits your needs. Visit www.discovery.co.za for more information on the different plans we offer.*

BABY STEPS

WHEN TANYA MOODLEY BEGAN EXPERIENCING ABDOMINAL PAIN 25 WEEKS INTO HER PREGNANCY SHE THOUGHT IT WAS JUST PART AND PARCEL OF NORMAL PREGNANCY.

"This was our first child and we were very excited from the beginning, we had wanted to have a child for a long time. It felt like a miracle from the start, but I was naïve about what was going to happen later on. In my mind it was all going to work out perfectly, I was going to have a normal birth and breastfeed without any problems. All the signs up to that point showed everything was well," says Tanya.

"But when the pain didn't go away and I started bleeding, I knew something was wrong," she says. Tanya and her husband, Davy, went to the hospital where her gynae did a physical exam and a scan and confirmed everything was in order. But the pain escalated through that night and her instincts told her all was not well.

"I woke up early the next morning but I was so weak I could hardly move. The pain was intense and I knew I was in labour, I knew the baby was coming," says Tanya.

When they reached the hospital, the baby was delivered straight away, with one push.

"I looked at the faces around me in the delivery room and I saw expressions of sorrow and regret. They looked at Davy, who was distraught and very emotional. The looks implied 'I'm so sorry for your loss'. I put my head up and I saw a tiny blue baby. We were overcome with sadness and anguish thinking that he had not survived, and seeing his little body lying still without any movement.

"Everyone was quiet, and the pause in conversation felt very long. Then out of the blue this sound came, like a gasp. Kyle had taken a breath. Our despair turned into hope."

Kyle had arrived 15 weeks early, weighing just 700 grams. "The doctors gave him a 10% chance of survival. He'd been starved of oxygen and we were warned of the possible complications that could arise in the days ahead like heart and lung conditions and brain bleeds. The first 48 hours were crucial. 'Don't get your hopes up, expect the worst,' they said.

"I cried so much when I saw him, he looked so tiny and underdeveloped. He had a drip in his head, and a feeding tube into his stomach and two other cords attached to his tiny little feet. Kyle's birth was a life-changing experience and it put things into perspective for us. I held onto my faith – not the stats and science – based on that first breath, which I believe was him saying, I'm here for a purpose, I am going to fight to live, I am going to hold onto hope, it's my time.

"From the beginning we knew we needed to prepare for complications. After a few weeks Kyle became very ill and the cardiologist picked up some problems. The first was the congenital heart disorder PDA (patent ductus arteriosus) where a connecting blood vessel that is open when the baby is in the womb so that blood bypasses the immature, non-functioning lungs fails to close at birth. In order to get blood oxygenated, Kyle had to have the gap closed surgically when he reached a kilogram in weight. Kyle was one month old and weighed 900 grams when this procedure was done. The second surgery, which was done when Kyle was seven months old and weighed 3kgs, was to open a chamber of the heart that was too small.

"The day we brought him home for the first time was the best day of our lives; our house finally became a home," they say.

Touched by the Moodley's story, the Discovery Health Concierge team reacted to their situation and founded the Premmie Concierge Project, which aims to assist and support parents of babies in the neonatal ICU and beyond.

"Discovery provided us with immense support during this time through the Health Concierge team. They constantly phoned to check in on us. They were always willing to assist, support and provide any information we required. In addition they emailed us a list of helpful links and articles. A pleasant and heart-warming surprise was when they sent us an information pack, which included a comprehensive book on dealing with a micro-premature baby," says Davy.

"We received personal care with Discovery, we felt we had somebody to partner with us in this journey. Discovery Health Medical Scheme covered all the costs of the Neonatal Intensive Care Unit (NICU) and surgeries from our hospital benefit. Hospital accounts are not something you want to worry about at a time when your newborn is living from day to day," says Davy.

Although he still has heart defects (atrial septal defect and pulmonary valve stenosis) and poor weight gain – Kyle, who has just celebrated his third birthday, is an energetic and fun-loving little boy. He loves playing with his toy cars, trucks and buses but his favourite pastimes are snuggling up to mommy, playing with daddy and chasing after his cat, Bizzy.

ALIVE IN ME

MADIMO MOKGOSI, A TEACHER'S ASSISTANT AT A PREP SCHOOL IN SANDTON, JOHANNESBURG, IS FOR ONCE FEELING HER AGE. SHE IS RECOVERING FROM A RECENT LIVER TRANSPLANT AND HAS NEVER FELT BETTER.

"I have so much energy, I feel like I am back in the world after a long absence," she says.

After being diagnosed with hepatitis autoimmune disease in her matric year, at age 18, Madimo felt tired all the time and constantly cold. "I couldn't go out or work, I had jaundice and blood clots were visible through the skin on my neck," she says.

In autoimmune hepatitis, the liver becomes inflamed as a result of an attack by the immune system. Although the exact cause of the illness isn't known, some other diseases, toxins and drugs may trigger it in susceptible people, especially women. Untreated it can lead to scarring of the liver (cirrhosis) and eventually liver failure.

Madimo was treated with medicine for two years, but she couldn't continue due to financial problems. "I thought things were under control, but I realised later that although the symptoms were 'in hiding' the condition of my liver was worsening."

Her situation became critical in April 2013. "I was in and out of hospital and I was told my only chance was a new liver. But I was aware that many people die waiting for organs."

In South Africa, the waiting list for donated organs is extremely long, with the demand far greater than the availability. Around 4 000 people are awaiting all types of organs at any given time, with only 500 receiving transplants per year.

Hope arrived in the form of Dr Jean Botha, head of liver transplantation at the Wits Donald Gordon Medical Centre, where Madimo is being treated. "Dr Botha looked at my dad and said: Two things are going to happen – it's either we get your daughter a liver or we buy her a coffin. And I am going to make sure that we don't put her in that coffin. I broke down and so did my dad," recalls Madimo.

Dr Botha is known for novel techniques in which he splits the liver of a patient's family member in order to transplant a portion into the patient. Because the liver can regenerate, after surgery both the donor's liver and the transplanted portion inside the recipient grow to full size.

Due to his weight, age and medical history, Madimo's father was not an appropriate donor. She lost her mom when she was 10, and so a sibling was the next logical option. "My younger brother, Barnard, is too young as he is under 21, but my sister, Tsholofelo, seemed the perfect candidate," says Madimo.

Tsholofelo immediately agreed to donate part of her liver to save her sister, notwithstanding the risks and the fact that she has a five-year-old daughter to care for. Authorisation for the procedure, and Discovery's approval to pay all of Tsholofelo's medical costs, was received within days.

But it wasn't to be. During routine tests, doctors discovered that Tsholofelo was anaemic and couldn't make the donation after all. Both women were devastated.

Madimo's condition continued to worsen and she seemed to be out of options.

Then, 10 days later, on 25 October 2013, Madimo received a phone call. "I will never forget those words. The voice on the other end said: 'We have found a liver for you and you need to be at the hospital as soon as possible.' A friend came to collect me and I was at the hospital in less than 10 minutes. I was sent straight into ICU to complete compatibility testing."

"A nurse came to us and said: 'Have you heard the good news? The liver is yours and we are operating in 30 minutes!' The procedure took six hours and Madimo has made good progress since the operation. "I am feeling so well and I am so grateful for the donation of the liver that saved my life, and for the love and support of my partner Prince and his family."

Just two months before her surgery Madimo was made permanent by her employers and joined Discovery Health Medical Scheme. "They were there for me from the first day till now, and without Discovery I probably wouldn't be alive," she says. Madimo also does not have to worry about paying for the expensive medication she has to take every month to stop her body from rejecting her new liver.

"In some cultures there is a saying: 'We want to bury our person in full.' This deters many people from becoming an organ donor, but we need more donors to save more lives. I was saved by someone I will never get to know, but I know that person lives on, as he is living in me."

OVERVIEW // business model

The Discovery Health Medical Scheme is governed on behalf of its members by an

INDEPENDENT BOARD OF TRUSTEES.

The business model implemented by the Scheme is based on best practice outsourcing principles.

This allows the Board to fulfil its duties to the benefit of all members of the Scheme. The Scheme can leverage Discovery Health's considerable knowledge, expertise, systems, innovations and value-added services while ensuring that the interests of the Scheme and its members are best served.

Board of Trustees

The Board is made up of independent, highly skilled, professional people, each with distinctive expertise in legal, clinical, financial, business and actuarial disciplines.

How the Scheme is administered

The Discovery Health Medical Scheme pays a fixed administration and managed healthcare fee to Discovery Health, a for-profit subsidiary of the JSE-listed Discovery Limited. The only income that Discovery Health earns from the Scheme is the fixed administration and managed healthcare fees, based on the number of members in the Scheme. The Administrator is accountable to the Scheme's independent Board of Trustees and is accredited by the regulatory body, the Council for Medical Schemes. Discovery Health is a dynamic, innovative and financially strong medical scheme administrator and managed healthcare organisation. The Administrator manages the key aspects of the operating environment of the Scheme, including the collection of contributions from members, the contractual and claims payment relationships with healthcare professionals and providers of all healthcare services and products.

Outsourced operating model

There are specific functions that are imperative to the successful day-to-day operations of the Scheme, which the Scheme outsources to Discovery Health. The relational and transactional governance elements are best executed through an integrated business model, which means that the Scheme can leverage Discovery Health's considerable knowledge and expertise, while ensuring that the interests of the members of the Scheme are best served through active collaboration.

DISCOVERY HEALTH MEDICAL SCHEME

Medical scheme/Not-for-profit entity/Pooling vehicle for members' funds/Governed by an independent Board of Trustees

BOARD OF TRUSTEES

- Clinical Governance Committee
- Risk Committee
- Remuneration Committee
- Product Committee
- Stakeholder Relations Committee
- Audit Committee
- Investment Committee
- Nomination Committee
- Non-Healthcare Expenses Committee

Scheme office

Administrator

Discovery Health (Pty) Ltd

Medical scheme administrator/Managed healthcare services/Part of Discovery Limited, a listed company on JSE

DISCOVERY HEALTH OPERATING MODEL

RISK | **IT AND SYSTEMS** | **GOVERNANCE**

Research and development → Marketing and distribution → Admin and servicing → Benefit management and care

42	170	290	3 800	4 000
actuaries	health professionals	analysts and statisticians	staff in 88 teams across 8 sites	financial advisers

VITALITY

- Health and wellness tools
- Disease management
- Preventive care
- Personal pathways

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

OVERVIEW //
strategy and key risks

The Scheme continues to make significant progress

IN DELIVERING ON ITS STRATEGIC FOCUS AREAS.

The continuously evolving healthcare landscape and the Scheme's role in the private healthcare industry in South Africa necessitate a regular review of strategy to ensure it remains focused, robust and relevant. The Board of Trustees meets annually to develop and scrutinise the strategic focus areas to ensure that the Scheme continues to create value for all stakeholders by containing healthcare and non-healthcare costs, enhancing benefits and strengthening the Scheme's long-term sustainability.

PERFORMANCE AGAINST OBJECTIVES SET IN 2012

We have outlined these as well as the Scheme's performance against these objectives during the 2013 benefit year.

Ensuring continuous best practice governance

The independent operating model and governance review conducted by Deloitte confirmed that the Scheme has a sound, robust governance model.

Non-healthcare expenditure has continued to decrease.

Trustees were elected at the Scheme's Annual General Meeting, in accordance with the Medical Schemes Act and the registered Rules of the Scheme.

An enhanced focus on bending the cost curve through innovation in risk management and the implementation of alternative reimbursement strategies

The following interventions contributed to a significantly improved financial outcome for the Scheme:

- Further investment in analytics and systems to identify fraud and abuse
- An improved loss ratio in the KeyCare Plans
- Alternative reimbursement arrangements with hospital groups
- Substantial Single Exit Price decreases and successful Drug Utilisation Reviews on several items
- Surgical inflation was contained well below CPI for the second consecutive year.

STRATEGIC PRIORITIES FOR 2014

The Scheme will focus on the following **key strategic objectives** during the 2014 benefit year

01 **Further enhance** the Scheme's outsourcing business model based on international outsourcing best practice principles

STRATEGIC RISK

02 **To maintain** the Scheme's industry leadership position and competitive advantage

FINANCIAL RISK
INSURANCE RISK

03 **Continue to provide** rich benefits and contribution stability across the product range

FINANCIAL RISK
INSURANCE RISK

The following considerations are applied when determining the Scheme's annual strategy:

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

Enhanced stakeholder engagement and relationship strategies

A Stakeholder Relations Committee was established to ensure that the Scheme's stakeholder relations strategy is effectively implemented.

An increased focus on product design to enhance the Scheme's competitive and product leadership position

The Scheme's wide range of plans suits the needs of its diverse membership base, with a price point which is on average 15% lower than the next 10 biggest open schemes, the highest rating in respect of claims paying ability (AA+) and the lowest lapse rates in the industry.

The key objectives for the 2013 benefit year were communicated in the Scheme's 2012 Integrated Annual Report.

You can find the 2012 Annual Report on our website **www.discovery.co.za.**

05 **Continue investment** in a unique and superior service experience for Scheme members and healthcare service providers at every touch point in the healthcare system

OPERATIONAL RISK
STRATEGIC RISK

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

STRATEGIC RISK
INSURANCE RISK
OPERATIONAL RISK

07 **Implement more refined** stakeholder relations engagement strategies and plans

STRATEGIC RISK

08 **Maintain overall focus** on best practice governance

STRATEGIC RISK
OPERATIONAL RISK

OVERVIEW //
key relationships

The Scheme is committed to transparent and

EFFECTIVE COMMUNICATION WITH OUR STAKEHOLDERS

in whatever forum we interact with them.

Engagement takes place through several channels and across a wide range of issues. Our stakeholder engagement principles remain the basic tenet upon which our approach to interactions is built:

Transparency and accountability

Inclusivity and responsiveness

Honesty and integrity

Complete, timely, relevant, accurate and accessible information.

The Scheme relies heavily on feedback from and interaction with our stakeholders, and we constantly work hard to improve and expand our interactions with them. We understand that successful interaction happens only when all parties are engaged and willing to work towards a common goal, even when they disagree on certain issues.

It is a constant challenge for the Scheme to manage the expectations of its different stakeholder groups, while ensuring that members' best interests as well as the long-term sustainability of the Scheme are not compromised. It requires a delicate balancing act for the Scheme to establish and maintain open lines of communication between parties who often do not agree on the way forward as it pertains to a particular aspect of healthcare delivery. This is not always easily achieved, but the Scheme remains committed to ensuring that these interactions continue in good faith, with the common purpose of ensuring that access to affordable, quality healthcare remains available to the members of the Scheme, both now and in the future.

Based on a recommendation arising from the Scheme's operating model and governance review that the Scheme should develop a stakeholder relations framework, the Scheme established a Stakeholder Relations Committee. This Committee has performed a stakeholder risk assessment that identified and prioritised the most important stakeholders. Engagement plans are drafted based on the level of interaction required with each specific stakeholder group. This Committee is chaired by the Chairman of the Board, Michael van der Nest SC.

The Scheme's plan to ensure more comprehensive stakeholder engagement during 2014 includes the following:

- Regular analysis and feedback from the Stakeholder Relations Committee to inform the Scheme's decision making regarding the needs of its stakeholders.
- The use of focus groups and other platforms of communication to ensure that stakeholders are able to provide regular feedback about the issues that concern them.
- A focus on enhancing communication to make the complexities of navigating the healthcare system easier to manage.

01 members

The most important stakeholders of the Scheme are the more than 2.5 million people to whom the Scheme provides healthcare cover. The Scheme communicates with its members through several channels. The main forum for the Scheme to engage directly with its members is the Annual General Meeting, where the Scheme reports to its members about its financial and operational performance during the preceding financial year. Members who attend the meeting also elect the Trustees of the Scheme for three-year terms in a transparent election process, and may vote on any motions submitted for discussion at the meeting.

During the year, the Scheme engages intensively with members through the following channels:

- **Call centres:** Discovery Health operates four service teams across the country, offering call centre access 24 hours per day, seven days a week. The Discovery Health service teams receive around 46 000 calls per day from Scheme members and other stakeholders. Regular member surveys and research help the Scheme to assess the level of service provided to members and to identify any areas in which service can be improved.
- **Walk-in centres:** There are five walk-in service centres around the country, which provide members with personalised service during office hours. During 2013, just over 65 000 members visited the walk-in centres.
- **Digital communication:** The Scheme also communicates with members through frequent electronic newsletters, electronic and paper claims statements, SMS messaging and through the Discovery website, as well as a smartphone application which allows members to interact extensively with the Scheme and with Discovery Health without making a phone call. Members can also engage with the Scheme on social media platforms such as Facebook and Twitter and a dedicated social media team assists members through this channel.

  Visit our Facebook page **www.facebook.com/DiscoveryHealthSA**
  Follow us on Twitter @Discovery_SA

- **Printed communication:** The Scheme interacts extensively with members throughout the year through the Discovery magazine, year-end benefit and plan materials, and regular communication about any changes to benefits.

02 interactions with regulatory, industry bodies and government

The regulatory body governing the medical schemes industry is the Council for Medical Schemes. Maintaining open lines of communication with the Council is a top priority for the Scheme.

Stakeholder engagement activities during the past year included

- Quarterly and ad hoc meetings with the Council for Medical Schemes on various regulatory matters impacting the Scheme and the industry.
- Discussions with the National Department of Health on issues impacting healthcare in South Africa and to contribute to strategic national healthcare development issues.
- Interacting with the Competition Commission on proposed scheme amalgamations in the industry.

03 Discovery Health (Pty) Ltd

The administrator and managed healthcare provider of the Scheme

The Scheme and Discovery Health, have a contractual relationship that directs all outsourced activities.

Read more about how this relationship is structured in the **How the Scheme is administered** section on page 14.

Discovery Health reports extensively to the Scheme's Board of Trustees, its Committees and the Scheme office on a regular basis. The Board can therefore ensure that Discovery Health is acting in members' best interests by meeting the strategic and statutory requirements as agreed upon. The Board also ensures that the contractual service levels are monitored and met and identifies any deviations from the contracted agreements.

The Trustees negotiate the administration and managed healthcare fees with Discovery Health every year.

The engagements between the Scheme and Discovery Health are frequent and centre around:

- Scheme performance and risk management
- 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 assessment and monitoring
- Combined Assurance
- Stakeholder relations.

04 healthcare intermediaries

The Scheme relies heavily on healthcare intermediaries to provide the necessary information and support services to the Scheme's members, especially those who join us for the first time. Around 7 000 independent and 400 Discovery financial advisers, supported by 250 business consultants countrywide, advise Scheme members on the best choice of healthcare plans to suit both their medical and financial needs. To assist them, Discovery Health hosts the Discovery Insights Series, a series of regular workshops on relevant industry topics. Discovery Health also provides a range of additional knowledge courses, product launches, supporting marketing material and tools, training material and support, ongoing communication through electronic newsletters and website articles, and continuous professional development days that form part of quarterly training.

Stakeholder engagement activities during the past year included:

- A comparative analysis of the 2012 open medical scheme financials presented to all major corporate financial advisers nationwide
- A comprehensive analysis of the South African medical schemes industry, including a report containing key industry insights, presented to all major corporate financial advisers nationwide
- 2014 Discovery Health Medical Scheme updates presented to more than 6 000 financial advisers in September 2013
- Post-launch training presented to financial adviser consultants and financial advisers at more than 30 sessions during October 2013
- Regular executive level engagements with key intermediaries to address any problems and to elicit valuable feedback.

05

doctors, professional societies and other healthcare providers

We believe that our country's healthcare professionals are a national asset.

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. Close to 90% of all consultations between these professionals and Scheme members are covered in full at the contracted rate. 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. Overall, these arrangements provide Scheme members with certainty of cover and a wide range of options to avoid co-payments, and they allow the Scheme to comply with Prescribed Minimum Benefit legislation in terms of the Medical Schemes Act.

Discovery Health and the Scheme further engage actively and continuously with the representatives of health professionals through their various professional societies. Regular meetings, workshops and thought leadership summits are held where pertinent issues affecting healthcare delivery in South Africa are examined. We also meet with representative bodies and societies on specific industry issues. We also engage continuously with the pharmaceutical industry to secure the best possible prices of medicines for Scheme members, thereby protecting the pool of funds from which members' claims are paid. Because of Single Exit Price (SEP) legislation, price negotiations with the pharmaceutical industry also benefit South Africans who are not members of the Scheme.

Stakeholder engagement activities during the past year included:

Healthcare professionals:

- Tariff negotiations, including alternative reimbursement models, with various disciplines, including pathology and radiology
- End-to-end management of an open tender process for pathology in specific hospitals
- Implementation of a new preferred provider network for allied professionals.

Hospitals:

- Tariff negotiations with all hospital groups
- Negotiated new alternative reimbursement contracts
- Strengthening accountability processes on healthcare quality
- Implementing a new renal dialysis network contract for the low-income plans, resulting in substantial savings for 2013.

Pharmaceutical suppliers:

- Engagement with approximately 90 pharmaceutical companies on more than 1 200 products to reduce medicine prices
- Working with retail pharmacies to increase the use of more cost-effective alternatives, including generics
- Commissioning research on benchmarking of international high-cost medicine prices
- Continued investigation of partnerships with pharmacy network chains for the procurement of high-cost drugs, discounted dispensing fees, formulary compliance and stock listing.

Surgical suppliers:

- New preferred supplier agreements for hip and knee prosthesis, resulting in substantial savings for the Scheme
- Engagement with suppliers for access to full product ranges, and in certain cases, specific product lines, at preferential rates
- Ongoing review and classification of new products
- Providing access to product and price arrangements for the low-income plans
- End-to-end management of open product tender processes for new suppliers.

INTEGRATED PERFORMANCE REVIEW //
governance review

This section details the roles and responsibilities of the Board of Trustees and its committees.

The Scheme is confident that with the level of skills, independence and governance displayed by the Board,

THE MEMBERS OF THE SCHEME CAN REST ASSURED

the affairs of the Scheme are being handled in the most professional way, to the absolute benefit of the members and stakeholders of the Scheme.

BOARD OF TRUSTEES

Over 50% of the Board's members are elected by members of the Scheme in a transparent election process.

The Board is made up of independent, highly skilled professionals, with distinctive expertise in various disciplines such as legal, clinical, financial, actuarial and business.

In order for the Board to fulfill its fiduciary duties effectively, additional Board committees have been established to optimally fulfill governance requirements. These committees all have written charters, clear reporting procedures and their performance is evaluated by the Board annually.

The Board committees are:

- Audit Committee
- Risk Committee
- Clinical Governance Committee
- Investment Committee
- Remuneration Committee
- Non-healthcare Expenses Committee
- Product Committee
- Nomination Committee
- Stakeholder Relations Committee.

The Board of Trustees has established a Disputes Committee in terms of the Scheme Rules and the Act, to assist with the adjudication and settlement of disputes between a complainant and the Scheme. A dispute is a complaint submitted by a complainant against a decision or ruling by the Scheme on any matter provided for in the Act, that the complainant is dissatisfied with. The Scheme annually appoints a panel consisting of up to nine persons (Scheme members or non-members), who constitute the pool of persons from amongst whom the Disputes Committee is constituted. Of these persons, at least one third must be persons with legal expertise and at least one third must have medical expertise. No more than one third may be non-members and none may be Trustees of the Scheme, a director of the Scheme's administrator or an employee of the Scheme or its administrator.

The Board and all its committees also perform annual peer and effectiveness reviews to address and strengthen governance processes. The absence of any instance of governance failures concerning the Scheme is due to the Board's continued focus on governance best practice. The Board of Trustees takes on a high degree of fiduciary responsibility and risk in overseeing a scheme with an annual contribution income in excess of R40 billion, members' reserve funds in excess of R9.9 billion and which operates in a highly regulated and complex environment.

The main role of the Board of Trustees includes:

- Assessing the strategy of the Scheme against the Scheme and Discovery Health's implementation thereof
- Ensuring the sustainability of the Scheme
- Determining whether Discovery Health's service delivery and managed care principles meets the needs of the Scheme's membership base
- Driving innovation and improvement on all levels of the Scheme's operation
- Ensuring that the Scheme Rules and stipulations of the Act as well as any other applicable laws are adhered to in the day-to-day running of the Scheme's affairs
- Commissioning periodic independent governance reviews to assess the effectiveness of the Board and its committees to ensure that the correct skills and expertise is represented on the Board
- Taking responsibility for the governance of risk and combined assurance as well as information technology (IT) governance
- Overseeing risk-based internal audit activities to ensure effectiveness
- Consider stakeholder perceptions and its impact on the Scheme's reputation.

The duties of the Board of Trustees are to:

- Act with due care, diligence, skill and good faith
- Ensure the proper and sound management of the Scheme
- Appoint, evaluate and delegate functions to the Principal Officer
- Oversee and direct the management of the Scheme's activities performed by the administrator and managed healthcare provider
- Apply sound business principles and ensure the financial soundness of the Scheme

- Address key issues and ensure that discussions on policy, strategy and performance are treated as critical, informed and constructive
- Ensure that proper control systems are employed by or on behalf of the Scheme
- Ensure that the Rules, operation and administration of the Scheme comply with the provisions of the Act, and all other applicable laws
- Take all reasonable steps to protect the confidentiality of medical records concerning the state of health of the Scheme's members
- Ensure that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and responsibilities in terms of the Rules of the Scheme.

During the 2013 financial year attendance at the Board of Trustees meetings was as follows:

Name	18 Feb 2013	19 Feb 2013	8 Apr 2013	13 Jun 2013	20 Aug 2013	3 Dec 2013
Mr M van der Nest SC	✓	✓	✓	✓	✓	✓
Mr P Maserumule[3]	✓	✓	✓	✓	✓	✓
Mr N Graves SC[3]	✓	✓	✓	x	✓	✓
Prof Z van der Spuy[3]	✓	✓	✓	✓	✓	✓
Mr G Waugh	✓	✓	✓	✓	✓	✓
Ms D Naidoo[2]	N/A	N/A	N/A	N/A	✓	✓
Dr N Sangweni[1]	✓	✓	✓	✓	✓	✓
Mr B Stott[4]	✓	✓	✓	✓	✓	✓

1 Term ended 20 June 2013, invitee to the Board of Trustees meetings thereafter
2 Elected 20 June 2013
3 Re-elected 20 June 2013
4 Term ended 20 June 2013. Chairman of the Audit and Risk Committees since July 2013

AUDIT COMMITTEE

The Audit Committee is established as determined by Section 36(10) to (13) of the Act and plays a pivotal role in the Scheme's corporate governance structure. The Committee is responsible for assisting the Board of Trustees in terms of the financial reporting, internal financial control systems, risk management, compliance with legislation and internal and external audit processes.

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

The responsibilities of the Audit Committee are to:

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

The members of the Committee may consult any expert or specialist to assist the committee in the execution of its duties. The external auditors and the Principal Officer of the Scheme, as well as the internal auditors of the administrator 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 Committee meets at least four times per year and schedules additional meetings if necessary. The external and internal auditors regularly meet with the Committee without the presence of the administrator's management. Scheme management regularly meets with the Committee without the auditors being present.

The report of the Committee is presented on page 49.

As at 31 December 2013, the Committee members were:

Mr Barry Stott	Independent Member – Chair
Mr Neil Novick	Independent Member
Mr Steven Green	Independent Member
Mr Don Eriksson	Independent Member
Mr Giles Waugh	Trustee
Ms Daisy Naidoo	Trustee

During the 2013 financial year, attendance at the Audit Committee meetings was as follows:

Name	13 Mar 2013	3 Apr 2013	24 Jul 2013	16 Aug 2013	28 Oct 2013
Mr B Stott[1]	✓	✓	✓	✓	✓
Mr D Eriksson[2]	✓	✓	✓	✓	✓
Mr N Novick	✓	✓	✓	✓	✓
Mr S Green	✓	✓	✓	✓	✓
Mr G Waugh	✓	✓	✓	✓	✓
Ms D Naidoo[3]	N/A	N/A	✓	✓	×

1 *Chairperson of the Committee since July 2013*
2 *Chairperson of the Committee for part of the year*
3 *Member of the Committee since July 2013*

RISK COMMITTEE

The Board of Trustees has established this Committee to ensure best practice governance. The Committee considers the risk management strategy, policy and plans for recommendation to the Board of Trustees for approval. The Committee also monitors the risk management process and its effectiveness as well as oversees the combined assurance model.

The Risk Committee members are appointed by the Board of Trustees on an annual basis, and consist of representatives from the Board of Trustees, independent members, and Scheme management.

Risk management

The Trustees are committed to operating under a best practice risk management framework that covers all its activities and contributes to the sustainability of the Scheme and the protection of its members.

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

The responsibilities of the Risk Management function are to:

- Provide tools, methodologies and standards to enable the Scheme Management to assess and manage their risks, which meet the risk management requirements of King III and other regulations
- Assist the Board of Trustees and Scheme Management in the understanding and active consideration of risks as a key part of decision making
- Provide risk assessment, monitoring and reporting, which provides a clear view on the risks faced by the Scheme and the actions the Scheme and administrator management need to take
- Build and develop risk management understanding and expertise across the Scheme and administrator.

Compliance management

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

The Scheme has a Compliance function which is independent of Scheme management, and its primary responsibility is to assist the Principal Officer and the Board of Trustees to discharge their responsibilities.

The responsibilities of the Compliance function can be summarised as follows:

- Management of regulatory change: Identification of changes in the regulatory environment and notification to relevant business operations to ensure that appropriate controls are implemented to address new requirements
- Provision of general guidance and support to the Scheme: Assisting Scheme management with the implementation of appropriate controls to monitor compliance to relevant regulatory obligations, to assist the Scheme with the management of any non-compliance
- Carry out a compliance monitoring programme: maintenance of a risk-based methodology to independently assess the appropriateness and efficiency of controls implemented to monitor and ensure compliance to regulatory obligations

- Management of regulatory relationships: Management of regulatory relationships with all applicable regulators, including implementation of controls to ensure:
  - A single point of entry for regulatory complaints and enquiries
  - That all regulatory returns are submitted on time
  - Ongoing contact with the regulators regarding regulatory and supervisory developments that may impact the operations of the Scheme.

As at 31 December 2013, the members were as follows:

Mr Barry Stott	Independent Member – Chair
Mr Neil Novick	Independent Member
Mr Steven Green	Independent Member
Mr Don Eriksson	Independent Member
Mr Giles Waugh	Trustee
Ms Daisy Naidoo	Trustee
Mr Milton Streak	Principal Officer: DHMS
Mr Shaun Osner	Chief Financial Officer: DHMS
Dr Buddy Modi	Clinical Executive: DHMS
Dr Stephen Rich	Clinical and Risk Executive: DHMS
Mr Calvin Hope	Governance Executive: DHMS

During the 2013 financial year, attendance at the Risk Committee meetings was as follows:

Name	13 Mar 2013	3 Apr 2013	24 Jul 2013	16 Aug 2013	28 Oct 2013
Mr B Stott[1]	✓	✓	✓	✓	✓
Mr D Eriksson[2]	✓	✓	✓	✓	✓
Mr S Green	✓	✓	✓	✓	✓
Ms D Naidoo[3]	N/A	N/A	✓	✓	✗
Mr N Novick	✓	✓	✓	✓	✓
Mr G Waugh	✓	✓	✓	✓	✓
Mr M Streak	✓	✓	✓	✓	✓
Dr S Rich	✓	✓	✓	✓	✓
Mr S Osner	✓	✓	✓	✓	✓
Mr C Hope	✓	✓	✓	✓	✓
Dr B Modi[4]	N/A	N/A	N/A	N/A	✓

1 *Chairperson of the Committee since July 2013*
2 *Chairperson of the Committee for part of the year*
3 *Member of the Committee since July 2013*
4 *Member of the Committee since October 2013*

CLINICAL GOVERNANCE COMMITTEE

The Board has established a Clinical Governance Committee, to ensure best practice governance.

The duties of the Committee are to:

- Ensure that the healthcare benefits, as prescribed by the Act and the Rules of the Discovery Health Medical Scheme, are upheld
- Ensure that the managed healthcare mandate of the Scheme to offer members the highest level of appropriate, affordable and quality care is complied with, taking into account the balance between cost-effective quality healthcare and effective clinical risk management
- Ensure that all members of the Scheme enjoy an acceptable quality of care experience, in keeping with the philosophy of continued quality improvement and meeting member expectations and needs.

The Scheme measures the quality of care members receive by using various structural, process and outcome measures. The Scheme also subscribes to Health Quality Assessment (HQA), which assesses process measures on behalf of the Scheme, relative to the rest of the medical scheme industry. The Clinical Governance Committee reviews these measures and recommends the appropriate course of action where necessary.

The Committee oversees various clinical projects implemented in line with these measures, as well as their outcomes. Furthermore, the Committee oversees clinical risk management for the Scheme, and monitors ex gratia requests, Council for Medical Scheme complaints, and disputes lodged by members or any other persons.

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

The Clinical Governance Committee comprises at least three members with the required expertise, at least one of whom should be a Trustee. The Board of Trustees may co-opt additional expertise to complement the Committee composition.

As at 31 December 2013, the members were as follows:

Prof Zephne van der Spuy	Trustee – Chair
Dr Nozipho Sangweni	Independent Member
Dr Buddy Modi	Clinical Executive: DHMS
Dr Stephen Rich	Clinical and Risk Executive: DHMS

During the 2013 financial year, attendance at the Clinical Governance Committee meetings was as follows:

Name	11 Mar 2013	17 Apr 2013	20 Aug 2013	2 Dec 2013
Prof Z van der Spuy	✓	✓	✓	✓
Dr N Sangweni	✓	✓	✓	✓
Dr S Rich	✓	✓	✓	✓
Dr B Modi[1]	N/A	N/A	N/A	✓

1 *Member of the Committee since October 2013*

INVESTMENT COMMITTEE

The Board has established an Investment Committee, to ensure best practice governance. The Committee is mandated to invest the Scheme's assets in line with the Act and the Scheme's approved investment policy. The investment objectives are to hold a diversified pool of assets, to maximise investment returns in the long term with minimal risk and to ensure sufficient liquidity for the Scheme to meet its liabilities, subject to any constraints imposed by legislation or the Scheme's Trustees. The Committee is advised by an independent asset consultant, which helps the Committee in formulating and monitoring an appropriate investment strategy for the Scheme's assets.

As at 31 December 2013, the members were as follows:

Mr Puke Maserumule	Trustee – Chair
Mr Noel Graves SC	Trustee
Ms Daisy Naidoo	Trustee
Mr Barry Stott	Independent Member

During the 2013 financial year, attendance at the Investment Committee meetings was as follows:

Name	20 Feb 2013	9 Apr 2013	10 Jun 2013	23 Jul 2013	20 Aug 2013	13 Nov 2013
Mr P Maserumule	✓	✓	✓	✓	✓	✓
Mr B Stott	✓	✓	✓	✓	✓	✓
Mr N Graves[1]	N/A	N/A	N/A	✓	✓	✓
Ms D Naidoo[1]	N/A	N/A	N/A	✓	✓	✓
Mr G Waugh[2]	✓	✓	✓	N/A	N/A	N/A

1 Member of the Committee since July 2013
2 Member of the Committee for part of the year, resigned from the Committee in July 2013

REMUNERATION COMMITTEE

The Board has established a Remuneration Committee, to ensure best practice governance.

The Remuneration Committee assists the Board of Trustees in terms of the Scheme's remuneration strategies and principles as well as its human resources policies. The Committee consists of two Trustees and one independent member.

The remuneration of the Discovery Health Medical Scheme Board of Trustees and its committees is benchmarked through independent review on a periodic basis. The Scheme's Remuneration Committee uses expert input and independent benchmarking surveys, based on remuneration structures for non-executive directors of large insurance and financial organisations in South Africa, as guidelines for its remuneration policy. The fees paid to the Trustees are considered appropriate considering these levels of responsibility and the skills and experience required. The Scheme's remuneration policy is available on www.discovery.co.za.

The responsibilities of the Remuneration Committee include:

- Assisting the Board of Trustees in its responsibility for setting and administering remuneration policies in the Scheme's long term interest
- Ensuring that the Scheme's employees are remunerated fairly and equitably taking into account external market trends and benchmarks
- Recommendations to the Board of Trustees on trustee and committee remuneration to ensure that it is sufficient to attract and retain the required skills and expertise.

As at 31 December 2013, the members were as follows:

Mr Don Eriksson	Independent Member – Chair
Mr Michael van der Nest SC	Trustee
Mr Noel Graves SC	Trustee

During the 2013 financial year, attendance at the Remuneration Committee meetings was as follows:

Name	4 Jul 2013	5 Nov 2013
Mr D Eriksson	✓	✓
Mr M van der Nest SC	✓	✓
Mr N Graves SC[1]	N/A	×

1 Member of the committee since July 2013

NON-HEALTHCARE EXPENSES COMMITTEE

The Board has established a Non-healthcare Expenses Committee, to ensure best practice governance.

The responsibilities of the Non-healthcare Expenses Committee are to:

- Review and recommend the proposed administration and managed care fees to the Board of Trustees for consideration and approval
- Review the Scheme's service level agreements with the administrator and assist the Board of Trustees to ensure that these have been complied with
- Monitor the value the Scheme and its members receive from the administrator.

As at 31 December 2013, the members were:

Mr Noel Graves SC	Trustee – Chair
Mr Michael van der Nest SC	Trustee
Mr Giles Waugh	Trustee
Mr Milton Streak	Principal Officer: DHMS

During the 2013 financial year, attendance at the Non-healthcare Expenses Committee meetings was as follows:

Name	25 Jul 2013	14 Aug 2013	28 Nov 2013
Mr N Graves SC	✓	✓	✓
Mr G Waugh	✓	✓	✓
Mr M van der Nest SC	×	✓	✓
Mr M Streak	✓	✓	✓

PRODUCT COMMITTEE

The Board has established a Product Committee, to ensure best practice governance.

The responsibilities of the Product Committee are to:

- Evaluate and review the Scheme's benefit design strategies on an annual basis
- Evaluate benefits based on clinical best practice and financial sustainability, as well as members' best interests (fairness principles) and communication best practice principles
- Recommend benefit amendments to the Board of Trustees for approval.

As at 31 December 2013, the Committee members were:

Mr Giles Waugh	Trustee – Chair
Prof Zephne van der Spuy	Trustee
Mr Noel Graves SC	Trustee
Dr Nozipho Sangweni	Independent Member
Mr Milton Streak	Principal Officer: DHMS

During the 2013 financial year, attendance at the Product Committee meetings was as follows:

Name	3 Jul 2013	23 Jul 2013	12 Aug 2013	2 Dec 2013
Mr G Waugh	✓	✓	✓	✓
Dr N Sangweni	✓	×	✓	✓
Prof Z van der Spuy[1]	N/A	N/A	✓	✓
Mr N Graves SC[1]	N/A	N/A	✓	✓
Mr M Streak	✓	✓	✓	✓

1 Member of the Committee since July 2013

STAKEHOLDER RELATIONS COMMITTEE

The Stakeholder Relations Committee was established during the current year by the Board of Trustees as a recommendation from the operating model and governance review. This Committee is responsible for identifying important stakeholders, their legitimate interests and expectations. The Committee needs to ensure that the Scheme's strategic objectives tie in with the needs of its major stakeholders and maintain and improve the very important interactions between the Scheme and its stakeholders.

As at 31 December 2013, the Committee members were:

Mr Michael van der Nest SC	Trustee – Chair
Mr Puke Maserumule	Trustee
Mr Dave King	Independent Member
Mr Milton Streak	Principal Officer: DHMS

The first meeting of the newly-constituted Stakeholder Relations Committee was held on 25 February 2014.

INTEGRATED PERFORMANCE REVIEW //

independent operating model and governance review

FINDINGS AND IMPLEMENTATION OF RECOMMENDATIONS

The primary objective of the Board's operating model and governance review was to critically assess the Scheme's transactional and relational governance systems and processes.

Main focus areas:

RELATIONAL GOVERNANCE

The effectiveness of the Board's governance role and responsibilities in the outsourcing and oversight of the Scheme's administration and managed healthcare services.

TRANSACTIONAL GOVERNANCE

Review the value received for the administration and managed healthcare fees paid.

REVIEW OF THE OPERATING MODEL

Assess whether the current operating model is in the best interest of the Scheme and its members.

Operating model and governance review findings

Positive *Recommendation* *Failure*

RELATIONAL GOVERNANCE

- The Scheme is fully compliant with the Act
- The Scheme is led by a competent and independent Board
- The balance of power is maintained by the Trustees
- The Scheme office is experienced and highly competent
- Information provided by Discovery Health is detailed and of high quality
- Assurance model to be improved
- Stakeholder engagement model to be enhanced
- Oversight capacity of Scheme office to be enhanced
- Continuously align contracts and SLA with Discovery Health
- None

TRANSACTIONAL GOVERNANCE

- The Scheme receives significant value-for-money from Discovery Health
- Members benefit from scale, skills and experience of Discovery Health
- Fees paid to Discovery Health not a significant outlier to peers
- The Scheme benefits from economies of scale
- The Scheme outperforms all peers in Deloitte Performance Model
- Continued evaluation of benefits of economies of scale
- Continued evaluation of non-healthcare expenses (NHE)
- Continued evaluation of value-for-money outcomes
- None

OPERATING MODEL

- Integrated operating model incurs on average 15% lower NHE than fragmented model
- Integrated operating model results in better scheme performance than fragmented model
- Maintain integrated operating model
- None

Review approach

Deloitte was provided with access to a wide range of information:

- Presentations, site visits, interviews and discussions
- Publicly available information (e.g. Council for Medical Schemes) and confidential information.

Independence and review:

- Deloitte team members are independent from both the Scheme and Discovery Health
- Team members had a varied skills set, e.g. actuarial, clinical, risk management, legal, governance and economics
- A Deloitte Risk and Reputation Leader continuously assessed and ensured that independence was maintained
- Over 5 100 professional hours were used by 20+ members of the Deloitte Team (local and international) over a period of nine months
- An independent actuary conducted an assessment of the performance model.

Scheme actions

Improve **assurance model**

Dedicated compliance manager	Assigned 2012
Dedicated risk manager	Implemented 2013
Revised risk management process	Implemented 2013
Independent audit of risk management process	Implemented 2013
Revised Combined Assurance Framework	Implemented 2013

Enhance **stakeholder engagement**

Enhance framework and strategy	Implemented 2013
Independent communications consultant	Appointed 2013
Enhanced marketing reporting	Implemented 2013
Establish Stakeholder Relations Committee	Established 2013

Enhance **oversight capacity** of Scheme office

Succession planning	Ongoing
Assessment of resource requirements	Completed 2012
Appointment of Chief Financial Officer	Appointed 2012
Appointment of Chief Risk Officer	Appointed 1 January 2014

Administration and Managed Care **contracts**

Align with outsourcing best practice	Negotiation in progress
Align service level agreements	Negotiation in progress

Evaluation of economies of scale	Ongoing; Annual
Evaluation of non-healthcare expenses	Ongoing; Annual
Value-for-money analysis	Ongoing; Annual

Continue to enhance operating model through active collaboration with Discovery Health	Ongoing
Continue to align operating model with outsourcing best practice	Ongoing
Maintain balance of power through best practice governance structures	Ongoing

The Discovery Health Medical Scheme

CONTINUED TO DELIVER ON ITS CORE PURPOSE

of funding evidence-based, cost-effective, quality healthcare and supporting the enhancement of the healthcare system for Scheme members and stakeholders.

This objective is underpinned by sound financial management, best practice governance and effective risk management efforts, ensuring long term sustainability, as is evidenced by the strong financial performance for the year under review.

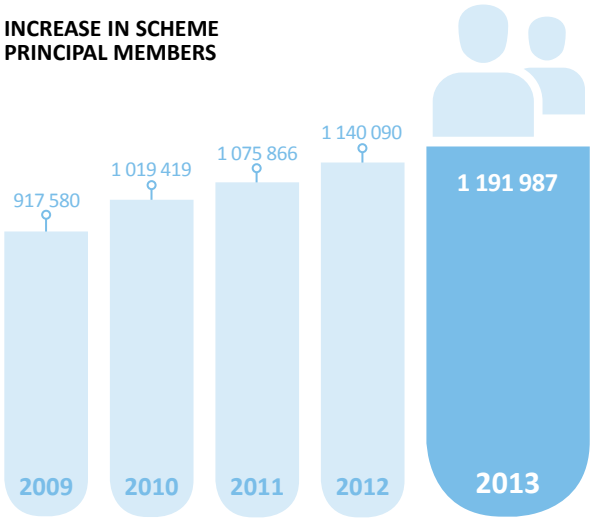
The net healthcare result increased from R187 million in 2012 to R860 million for the year ended 31 December 2013. The investment income of R682 million contributed to a substantial net surplus for the year ended 31 December 2013 of R1.5 billion. The Scheme's strong financial performance increased members' funds to over R9.9 billion, with the Scheme's investments and cash exceeding R10.4 billion at the end of the financial year. The Scheme's high level of financial strength and claims payment ability was once again confirmed through a credit rating of AA+, the highest possible rating in the industry, by an independent credit rating agency, Global Credit Rating Co.

In an environment where the majority of open medical schemes are shrinking, the Scheme continues to attract and retain members with a net growth in lives of 3.9% from an already high base.

At 31 December 2013, the Scheme provided cover to 2 564 313 lives. The ability of the Scheme to retain members is demonstrated by an extremely low lapse rate for 2013 of 4.15%.

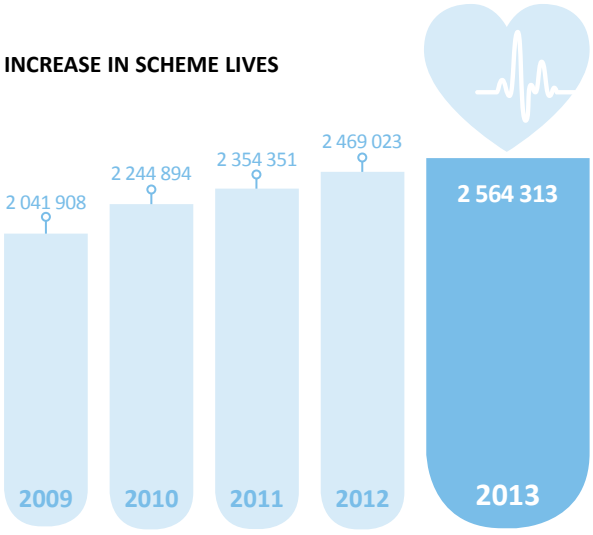
The detailed results of the Scheme are set out in the **Annual Financial Statements** on pages 47 to 113.

INCREASE IN SCHEME PRINCIPAL MEMBERS



up 4.55%

INCREASE IN SCHEME LIVES



up 3.9%

AA+
Independent credit rating for claims paying ability

24.30%
Statutory solvency level

4.15%
Annualised lapse rate

4.55%
Average growth in principal members

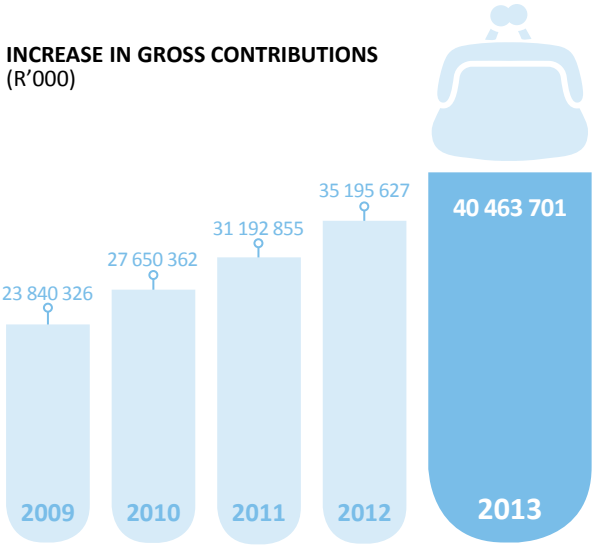
8.59%
Average return on investments

2.2
Average family size

8.26%
Admin fees as % of gross contributions

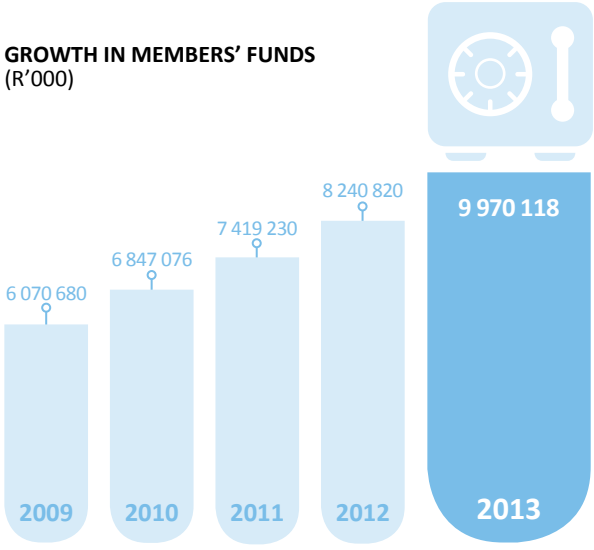
2.72%
Managed care fees as % of gross contributions

INCREASE IN GROSS CONTRIBUTIONS
(R'000)



up 14.97%

GROWTH IN MEMBERS' FUNDS
(R'000)



up 20.98%

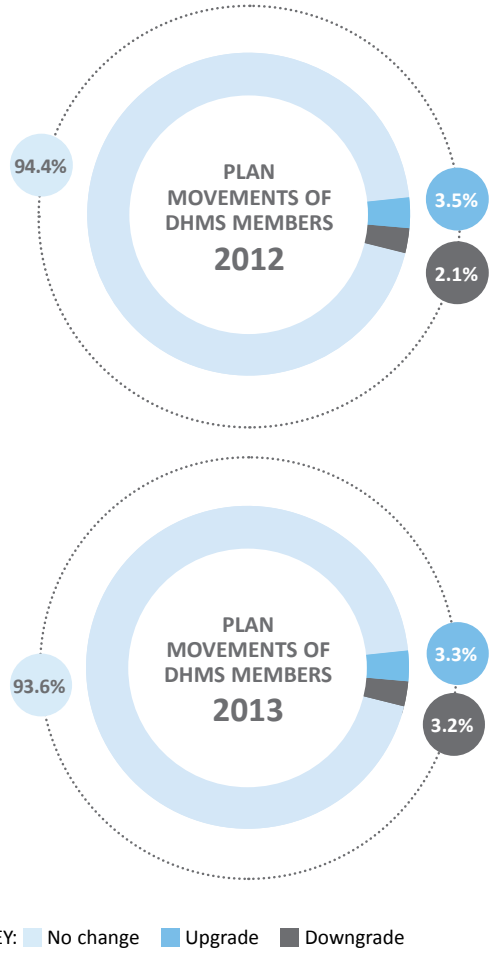
IN 2013 THE SCHEME OFFERED

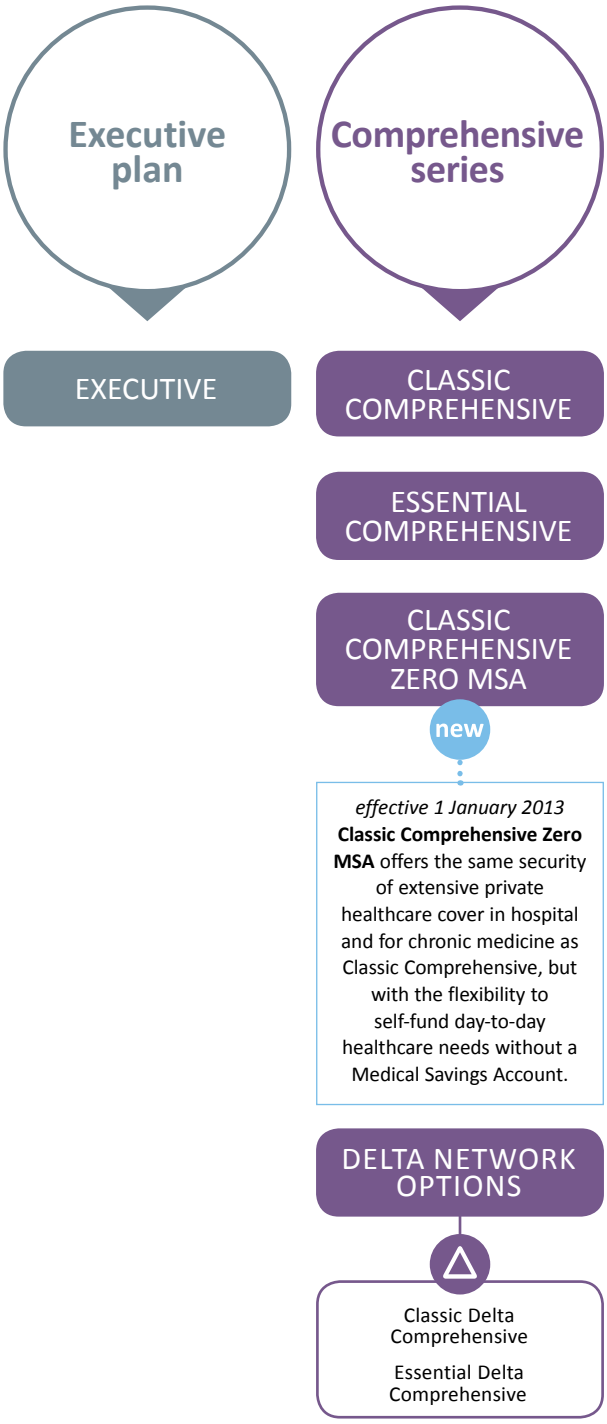
15 BENEFIT PLANS AND 6 NETWORK OPTIONS TO MEMBERS

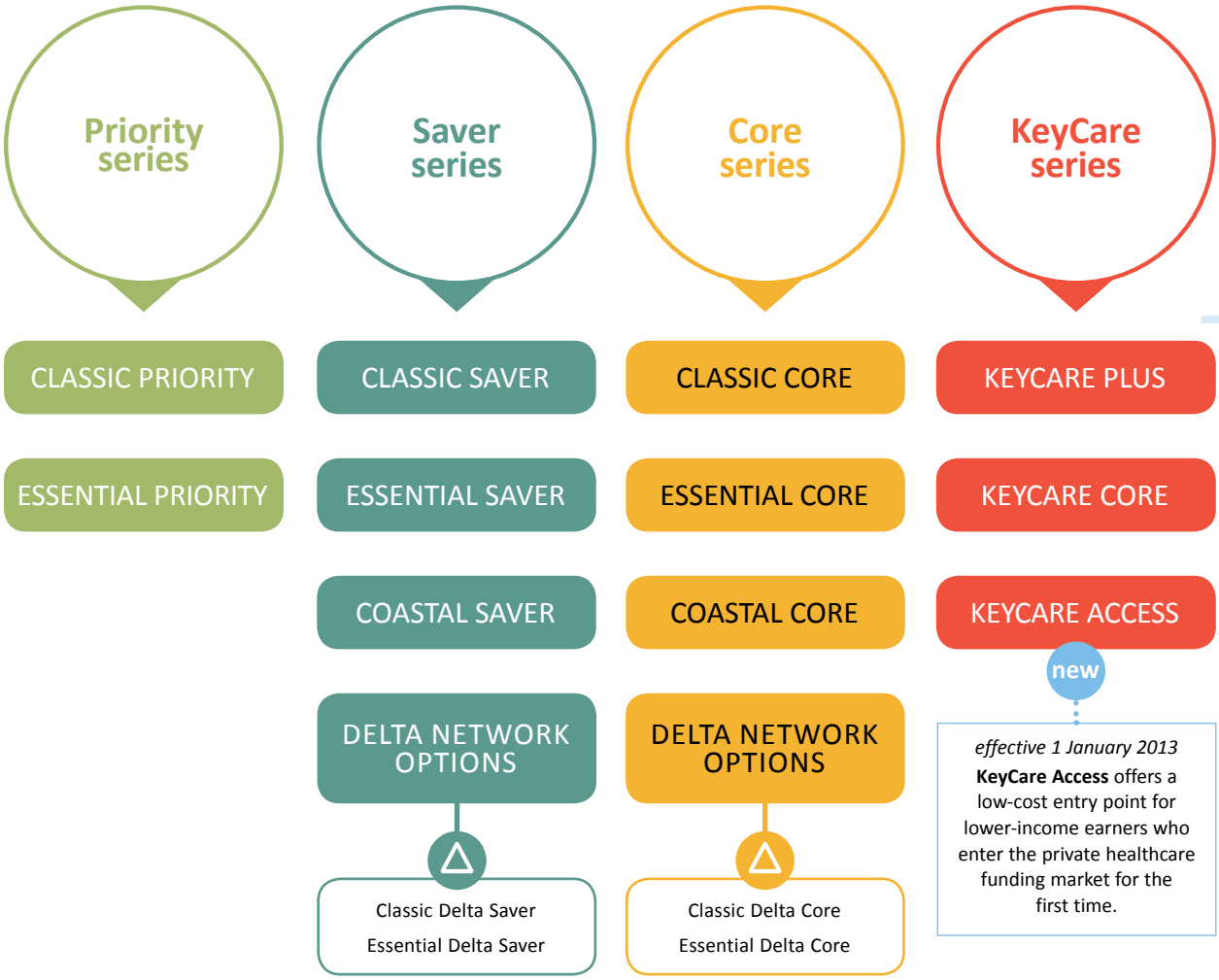
The Scheme continues to offer the widest range of well-priced plans and the richest benefits compared to its peers. Stability in both contribution increases and benefit design has been of key importance in a volatile environment.

CONSISTENT PATTERN OF STABILITY IN PLAN MOVEMENTS

The combination of richest benefits and competitive pricing is the reason why the vast majority of Scheme members remain on their chosen plan option.







PLANS

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

KEY FINANCIAL METRICS

R9.9billion
Members' funds (2012: R8.2 billion)

R40.46billion
Gross contribution income (2012: R35.19 billion)

R32.5billion
Risk contribution income (2012: R28.23 billion)

2.56million
Membership (lives) (2012: 2.47 million)

8.59%
Average return on investments (2012: 7.92%)

24.30%
Solvency ratio (2012: 23.41%)

SOLVENCY

The Scheme is required to maintain accumulated funds of 25% of gross annual contributions for the accounting period under review in terms of Regulation 29(2) of the Medical Schemes Act, No 131 of 1998, as amended ("the Act"). As required by Regulation 29(4) of the Act, the Scheme has informed the Council for Medical Schemes that the solvency level is below the required statutory solvency level of 25%.

Calculation of regulatory capital requirement

	2013 R'000	2012 R'000
Total members' funds per Statement of Financial Position	**9 970 118**	8 240 820
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**(136 666)**	–
Accumulated funds per Regulation 29	**9 833 452**	8 240 820
Gross contribution income	**40 463 701**	35 195 627
Solvency margin = Accumulated funds/gross contribution income x 100	**24.30%**	23.41%

The Scheme has submitted a business plan to the Council for Medical Schemes in terms of Regulation 29(4) of the Act. The business plan provides for the Scheme increasing the statutory reserves to the required level of 25% by 31 December 2015. The business plan takes into account several assumptions such as membership growth, investment returns and medical inflation. The Council for Medical Schemes has approved the business plan.

As at 31 December 2013 the Scheme's regulatory capital level of 24.30% was R282 million less than the statutory capital requirement of 25%, but exceeded the business plan level of 23.00% by R527 million.

The approved phase-in solvency levels are as follows:

Year ended	Solvency level (Target)	Solvency level (Actual)
31 December 2013	23.00%	24.30%
31 December 2014	24.30%	–
31 December 2015	25.40%	–

R2 451
Average net contributions per member per month (2012: R2 116)

R2 046
Average net claims per member per month (2012: R1 739)

R8 170
Average accumulated funds per member at year end (2012: R7 228)

33.28
Average age at year-end (2012: 32.95)

7.76%
Pensioner ratio at year-end (2012: 7.36%)

PRUDENT FINANCIAL MANAGEMENT

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

Year ended	December 2013 R'000	December 2012 R'000	December 2011 R'000
Gross contributions	**40 463 701**	35 195 627	31 192 855
Total outstanding contributions – excluding December contributions	**10 172**	5 986	8 304
% Outstanding	**0.03%**	0.02%	0.03%

DUE APPLICATION OF THE SCHEME RULES

The Trustees keep a constant check on appropriate and consistent application of Scheme Rules in relation to beneficiary entitlement and healthcare provider reimbursements. This check is very important, given the large and diverse membership base of the Scheme.

ENSURING STATUTORY AND REGULATORY COMPLIANCE

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

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

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

MATTERS OF NON-COMPLIANCE FOR THE YEAR ENDED 31 DECEMBER 2013

During the year, the Scheme did not comply with the following sections and regulations of the Act:

Statutory Scheme Solvency

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

The Scheme has submitted a business plan to the Council for Medical Schemes in terms of Regulation 29(4) to the Act. The business plan provides that the Scheme will increase the statutory reserves to the required level of 25% by 31 December 2015. The business plan takes into account several assumptions such as membership growth, investment returns and medical inflation. The Council for Medical Schemes has approved the business plan with phase-in solvency levels as set out below.

At 31 December 2013, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 24.30% (2012: 23.41%), which is R282 million less than the statutory requirement of 25%, but exceeded the business plan level of 23.00% by R527 million.

Year ended	Solvency level (Target)	Solvency level (Actual)
31 December 2012	22.30%	23.41%
31 December 2013	23.00%	24.30%
31 December 2014	24.30%	–
31 December 2015	25.40%	–

Sustainability of benefit plans

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

At 31 December 2013 the following benefit plans did not comply with Section 33(2):

Plans	Net underwriting deficit R'000	Net (deficit)/ surplus R'000
Executive	(257 289)	(248 234)
Classic Comprehensive	(521 739)	(384 241)
Classic Comprehensive Zero MSA	(1 809)	(1 537)
Coastal Saver	(62 750)	60 216
KeyCare Plus	(210 918)	(89 838)

Investments in employer groups

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

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

Broker fees paid before contributions are received

In terms of Regulation 28(5) of the Act, the Scheme broker fees must be paid monthly and on receipt by the Scheme of the relevant monthly contribution. In some instances brokers were compensated prior to receipt of the relevant monthly contributions.

RESERVE ACCOUNTS

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

OUTSTANDING CLAIMS

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

PERSONAL MEDICAL SAVINGS ACCOUNT

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

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

The Scheme's liability to members in respect of the savings account is reflected as a current liability in the Annual Financial Statements (Note 8) and is repayable in terms of Regulation 10 of the Act.

In accordance with the Council for Medical Schemes' requirements, the PMSA assets have been invested separately to the Scheme's assets and are managed by two independent asset managers. The Scheme received an extension for the implementation of Circular 38 of 2011 and Circular 5 of 2012 to 31 December 2013. During 2012 the Scheme calculated additional interest due to members and raised a provision of R80 million. The provision was increased by R6 million during 2013. Subsequent to year end the Scheme has allocated the additional 2012 interest to all members.

GOING CONCERN

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

AUDITOR INDEPENDENCE

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

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

OPERATIONAL STATISTICS

	2013					
	Executive	Classic Comp	Classic Comp Zero MSA	Classic Core	Classic Saver	Classic Priority
Number of members at the end of the accounting period	**11 799**	**178 842**	**520**	**52 601**	**225 984**	**103 192**
Number of beneficiaries at the end of the accounting period	**26 964**	**421 848**	**1 173**	**113 169**	**494 169**	**237 210**
Average number of members for the accounting period	**11 955**	**181 512**	**459**	**51 300**	**219 959**	**103 333**
Average number of beneficiaries for the accounting period	**27 420**	**428 857**	**1 042**	**110 892**	**480 197**	**236 795**
Average risk contributions per member per month (R')	**5 056**	**4 063**	**3 918**	**2 324**	**2 206**	**2 751**
Average risk contributions per beneficiary per month (R')	**2 204**	**1 719**	**1 726**	**1 075**	**1 011**	**1 200**
Average net claims incurred per member per month (R')	**6 394**	**3 847**	**3 805**	**1 524**	**1 563**	**2 082**
Average net claims incurred per beneficiary per month (R')	**2 788**	**1 628**	**1 676**	**705**	**716**	**909**
Average administration costs per member per month (R')	**263**	**263**	**263**	**263**	**263**	**263**
Average administration costs per beneficiary per month (R')	**115**	**111**	**116**	**122**	**120**	**115**
Average managed care: Management services per beneficiary per month (R')	**34**	**33**	**35**	**36**	**36**	**34**
Beneficiaries per member at 31 December	**2.29**	**2.36**	**2.27**	**2.16**	**2.18**	**2.29**
Dependants per member at 31 December	**1.29**	**1.36**	**1.27**	**1.16**	**1.18**	**1.29**
Relevant healthcare expenditure as a percentage of risk contributions (%)	**127**	**95**	**98**	**66**	**71**	**76**
Non-healthcare expenditure as a percentage of risk contributions (%)	**8**	**10**	**11**	**18**	**19**	**15**

OPERATIONAL STATISTICS

	2012				
	Executive	Classic Comp	Classic Core	Classic Saver	Classic Priority
Number of members at the end of the accounting period	11 964	184 153	50 892	203 537	100 772
Number of beneficiaries at the end of the accounting period	27 644	438 966	110 043	441 050	232 561
Average number of members for the accounting period	12 092	186 101	49 578	197 034	100 132
Average number of beneficiaries for the accounting period	28 003	444 176	107 538	428 802	230 195
Average risk contributions per member per month (R')	4 541	3 655	2 129	2 015	2 462
Average risk contributions per beneficiary per month (R')	1 961	1 531	982	926	1 071
Average net claims incurred per member per month (R')	5 949	3 538	1 391	1 398	1 875
Average net claims incurred per beneficiary per month (R')	2 569	1 482	641	643	815
Average administration costs per member per month (R')	255	255	255	255	255
Average administration costs per beneficiary per month (R')	110	107	118	117	111
Average managed care: Management services per beneficiary per month (R')	32	31	34	34	32
Beneficiaries per member at 31 December	2.32	2.39	2.17	2.18	2.30
Dependants per member at 31 December	1.32	1.39	1.17	1.18	1.30
Relevant healthcare expenditure as a percentage of risk contributions (%)	131	97	65	69	76
Non-healthcare expenditure as a percentage of risk contributions (%)	9	11	18	20	17

2013

Essential Comp	Essential Core	Essential Saver	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	KeyCare Access	Total
24 966	**28 721**	**78 912**	**9 963**	**164 114**	**79 508**	**211 779**	**15 233**	**5 853**	**1 191 987**
51 961	**60 773**	**170 402**	**20 971**	**377 795**	**176 353**	**378 568**	**24 063**	**8 894**	**2 564 313**
25 469	**26 881**	**75 100**	**9 487**	**161 962**	**76 912**	**203 589**	**14 366**	**5 624**	**1 167 906**
53 283	**57 233**	**162 848**	**19 966**	**373 042**	**170 952**	**365 960**	**22 684**	**8 571**	**2 519 743**
3 576	**1 859**	**1 906**	**2 488**	**1 866**	**1 791**	**1 249**	**1 028**	**684**	**2 451**
1 709	**873**	**879**	**1 182**	**810**	**806**	**695**	**651**	**449**	**1 133**
2 767	**1 231**	**1 138**	**1 549**	**1 468**	**1 308**	**1 106**	**509**	**396**	**2 046**
1 323	**578**	**525**	**736**	**637**	**589**	**615**	**323**	**260**	**934**
263	**263**	**263**	**263**	**263**	**263**	**140**	**74**	**89**	**231**
126	**124**	**121**	**125**	**114**	**118**	**78**	**47**	**58**	**107**
38	**37**	**36**	**37**	**34**	**34**	**44**	**50**	**52**	**38**
2.09	**2.13**	**2.17**	**2.10**	**2.30**	**2.30**	**1.80**	**1.58**	**1.52**	**2.10**
1.09	**1.13**	**1.17**	**1.10**	**1.30**	**1.30**	**0.80**	**0.58**	**0.52**	**1.10**
78	**66**	**60**	**62**	**79**	**73**	**86**	**50**	**61**	**80**
12	**22**	**21**	**17**	**22**	**22**	**21**	**19**	**29**	**17**

2012

Essential Comp	Essential Core	Essential Saver	Essential Priority	Coastal Saver	Coastal Core	KeyCare Plus	KeyCare Core	Total
27 873	25 770	70 606	9 704	156 447	75 018	209 230	15 124	**1 140 090**
59 076	54 981	154 137	20 442	361 272	166 807	378 054	23 990	**2 469 023**
28 184	24 055	67 869	9 403	153 237	72 313	197 123	14 316	**1 111 438**
59 704	51 573	148 564	19 756	354 608	161 112	357 700	22 735	**2 414 467**
3 224	1 710	1 759	2 212	1 674	1 605	1 065	926	**2 116**
1 522	797	804	1 053	723	720	587	583	**974**
2 446	1 116	1 058	1 358	1 282	1 213	1 008	494	**1 739**
1 154	521	483	647	554	545	556	311	**801**
255	255	255	255	255	255	133	70	**231**
121	119	117	122	110	115	73	44	**106**
35	35	34	35.00	32.00	33.00	41.00	47.00	**34.00**
2.12	2.14	2.19	2.10	2.31	2.23	1.81	1.59	**2.17**
1.12	1.14	1.19	1.10	1.31	1.23	0.81	0.59	**1.17**
76	65	60	61	77	76	91	53	**82**
13	23	22	18	24	24	23	19	**18**

INTEGRATED PERFORMANCE REVIEW //

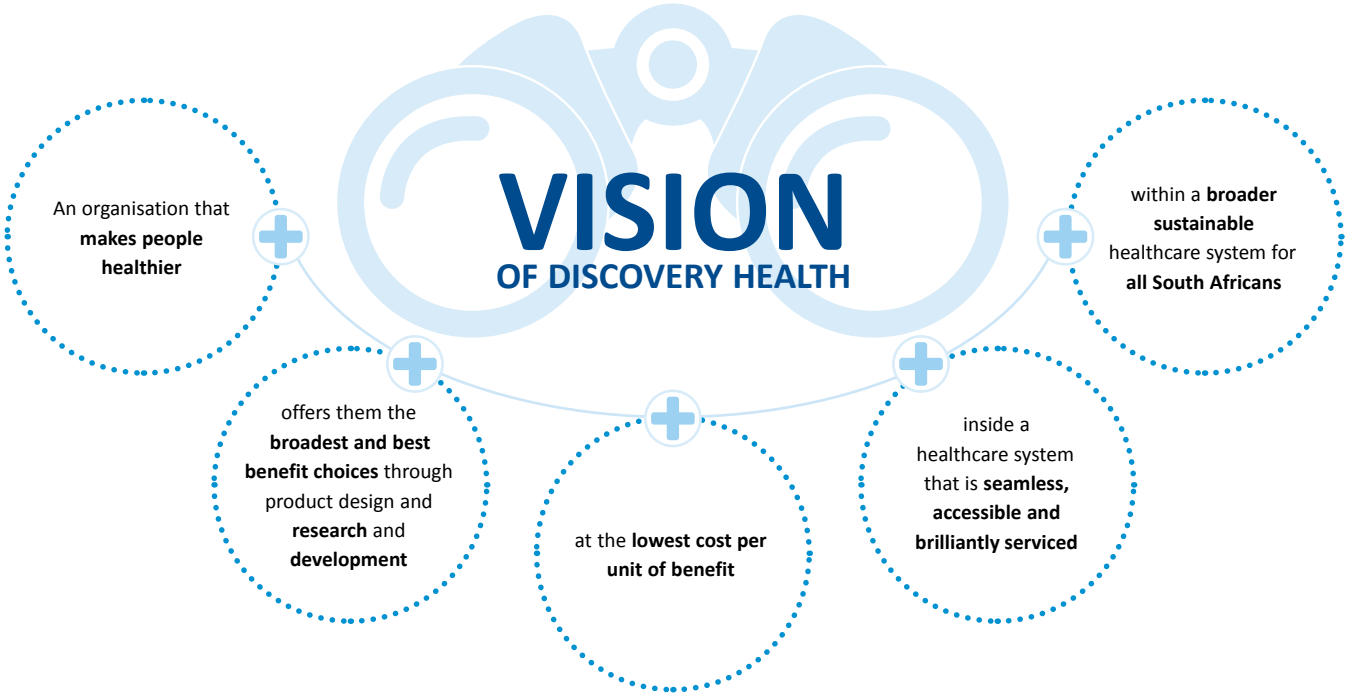
operating review: Discovery Health (Pty) Ltd

Discovery Health (Pty) Ltd aims to support the Scheme in

MAINTAINING THE DELICATE EQUILIBRIUM BETWEEN MEMBER CONTRIBUTIONS, RESERVES AND BENEFITS,

without any trade-offs.

In addition, the ongoing balance of cost, quality and access remain a central focus for the Administrator, Discovery Health (Pty) Ltd (Discovery Health). Discovery Health improves the quality of care provided to members of the Scheme, adding significant value for members, as well as for all other users of private healthcare services in South Africa. This includes structural and process interventions focusing on systematic improvement in the coordination of care between providers in the private healthcare system, as well as the improvement of healthcare quality and efficiency. The vision of Discovery Health is to be:



An integrated operating model ensures that the Scheme has a significant amount of assurance that continuity in terms of the implementation of the Scheme's strategic focus is being maintained. In a fragmented business model, where a scheme obtains elements of their administration from various service providers, the chances of misalignment between the scheme and its service providers is significantly higher.

We believe that it is due to the efficiency of this integrated business model that the Scheme outperforms all its competitors in every area.

Discovery Health's intervention helps the Scheme to contain costs by lowering the impact of medical inflation by approximately 3.6% per annum

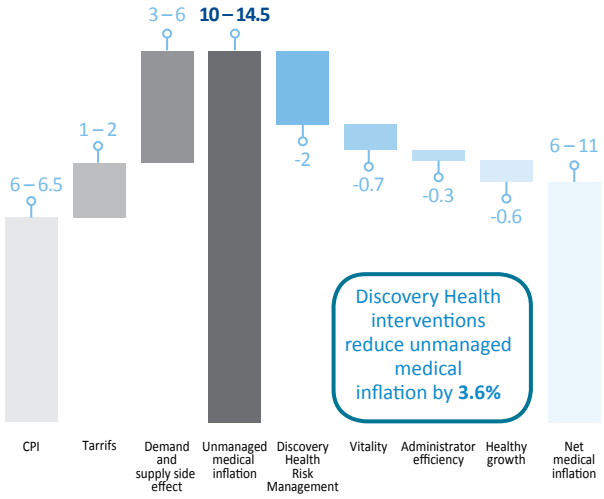
Medical inflation in South Africa is generally driven by the following factors:

Consumer Price Inflation Index (CPI)	6.0 – 6.5%
Tariffs	1.0 – 2.0%
Demand and supply side effect	3.0 – 6.0%

Unmanaged medical inflation exceeds CPI by 5 – 7% ranging between 10 and 14.5%

CONTRIBUTORS TO MEDICAL INFLATION IN SA (%)

IMPACT OF DISCOVERY HEALTH INTERVENTIONS ON MEDICAL INFLATION (%)



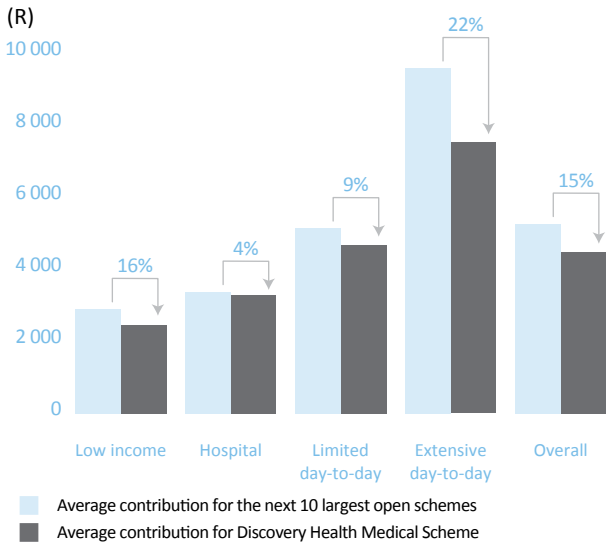
Effect of containing medical inflation during 2013 on the 2014 contribution increase

The components of the 2014 contribution increases, taking the main inflation drivers into account, are as follows:

Driver	Inflation %	Comments
Tariff for hospitals, healthcare professionals and medicines	CPI ± 1%	Tariff increases remain close to CPI for 2014
Demographic and utilisation changes	3 – 5%	Demand and supply-side effects such as ageing membership and advances in medical technology
Admin and managed care fees	minus 0.3%	Discovery Health administration and managed care costs are deflationary, reflecting the on-going economies of scale derived by Discovery Health in reducing the overall contribution increase
Overall medical inflation	7.7 – 12.2%	**Uniform contribution increase of 8.9%**

In the current financial climate when value for money is top of mind for consumers, it is important that the Scheme is able to provide plan options offering high value and a broad spectrum of choice at a competitive rate. The Scheme's contributions are on average 15% lower than the next 10 largest open medical schemes, due in large part to Discovery Health's ability to contain the impact of medical inflation.

AVERAGE 2014 CONTRIBUTION FOR A FAMILY OF FOUR



Innovative risk management principles

Over the past 20 years, Discovery Health has developed a unique and successful health risk management operating model to manage healthcare funding efficiently and cost-effectively to ensure the sustainability of the Discovery Health Medical Scheme. The successful implementation of this model leads to lower claims inflation experienced by the Scheme.

Risk management assets:

Hospital and health professional networks.

Discovery Health negotiates network arrangements with a wide range of healthcare service providers to assist the Scheme in benefit and risk management. Network arrangements mean that the same high quality of care is provided to members, but at a cost effective rate.

The Designated Service Provider network coverage offered by Discovery Health is unique in the South African industry because it provides access to a wide spectrum of private sector service providers. Members can consult with these providers, who are paid at fully contracted rates, without the worry of additional co-payments. Close to 90% of all Discovery Health Medical Scheme member interactions with GPs and specialists now happen in a network or within a payment arrangement.

The Discovery Health hospital networks, such as the KeyCare network and the Delta network, are on average at least 10% more cost-effective than the average.

The KeyCare Day Surgery network has had a marked impact on cost for the Scheme. This network, which was introduced in 2011, provides affordable healthcare cover to a broader segment of the community in an appropriate setting. KeyCare members need to have procedures on the day surgery procedures list performed at a day surgery facility. This in turn leads to savings to the KeyCare plan range, which helps keep contribution increases within an affordable range.

Risk-sharing reimbursement arrangements with hospitals and healthcare professionals

Aside from the network arrangements in place with specific hospitals, Discovery Health has also been able to consistently negotiate the lowest tariffs in the market with all the major hospital groups. Discovery Health works closely with hospital groups to reach agreement on the implementation of alternative reimbursement models. As a result, around 90% of hospital admissions for Discovery Health Medical Scheme members are covered in full as part of an alternative reimbursement model. The introduction of these reimbursement models means that there is a shift away from a fee-for-service payment model, globally viewed as a driver of high healthcare costs. The success of the alternative reimbursement models is evident in the fact that the Scheme's total spend on hospital admissions is below industry norms.

In 2013 Discovery Health negotiated alternative reimbursement models with pathologists, physiotherapists and blood transfusion centres, resulting in a saving to the Scheme of R57 million.

Forensics and fraud management

Healthcare funders both locally and abroad face a constant challenge in the form of escalating costs due to fraud and benefit abuse. Discovery Health helps the Scheme curb the adverse effect of these activities by employing a wide range of sophisticated software and other analytic tools. A dedicated forensic investigative unit works with actuarial, statistical and clinical teams to investigate every suspected case thoroughly and institute swift action where appropriate. In 2013 savings worth R284 million were made, translating to a direct cost saving for the Scheme and its members.

A refined, multi-faceted health analytic system

Discovery Health employs a large team of some of the country's best actuaries, analysts, statisticians and clinical professionals. These individuals use their skills and knowledge, along with a sophisticated health analytic system made up of risk adjustment tools and software assets to improve the quality of care for members of the Scheme and to eliminate inefficiencies. Health analytics is a critical skill and asset for healthcare funders as it enables them to better manage risk over the long term. It is estimated that good risk management saves the Discovery Health Medical Scheme approximately R3.3 billion per year – or 10% of total claims.

Health analytics also enables data analysis and interpretation of a range of issues that impact the quality and cost of healthcare.

Reducing the cost impact of fragmented care through the Care Coordination Programme

The Discovery Health Care Coordination Programme is available to Scheme members with the highest clinical needs. The programme enables Scheme members to be discharged from hospital to a participating care facility where they can regain their health. A registered nurse, called a care coordinator, assists members and their families throughout the process. Members who are discharged from hospital continue to receive education and care at home and in their communities for as long as they need it – all with the view of keeping them as healthy and strong as possible to prevent multiple hospital admissions. The range of services includes rehabilitation, disease education, psychosocial support and nursing services. There are currently 15 facilities involved in the programme in the five regions it covers. The programme was initially launched in the Western Cape and Gauteng and was recently expanded to KwaZulu-Natal and the Free State. A total of 3 489 Discovery Health Medical Scheme members were enrolled on the programme as at 31 March 2014.

The Scheme and its members receive world-class service and access to unique value-added services

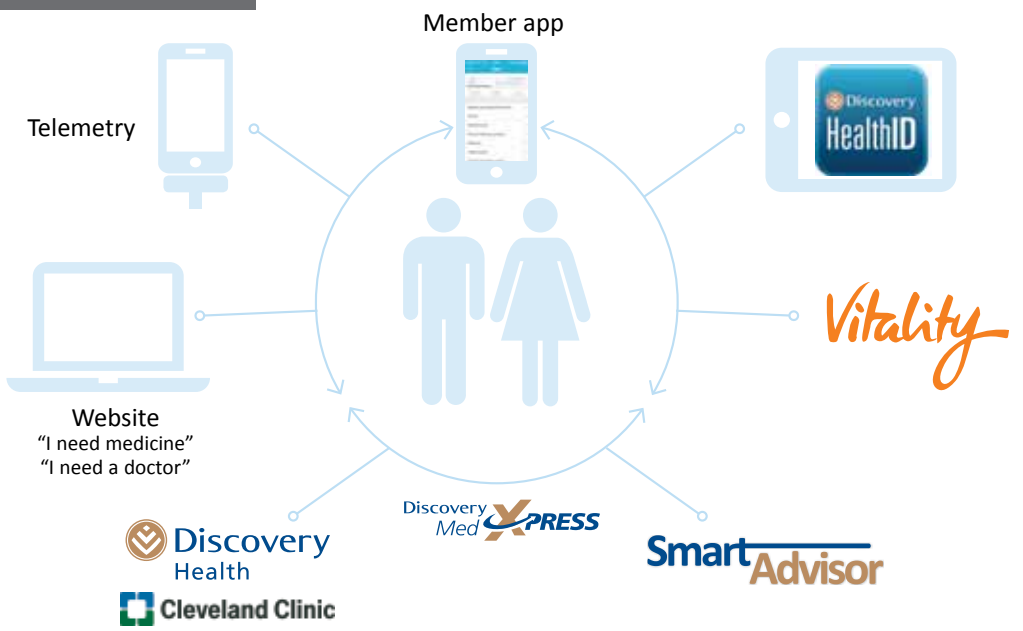
A highly-rated industry infrastructure

With an unparalleled scale of operations, Discovery Health continues to offer the Scheme and its members the best service levels as rated by the members of the Scheme. 400 000 members were surveyed in 2013. These members rated Discovery Health's service on average as 8.89 out of 10. The Scheme continues to work with Discovery Health on ways to meet the reasonable expectations of members who are not satisfied with the service they receive.

Ongoing innovation in product design and value-added services

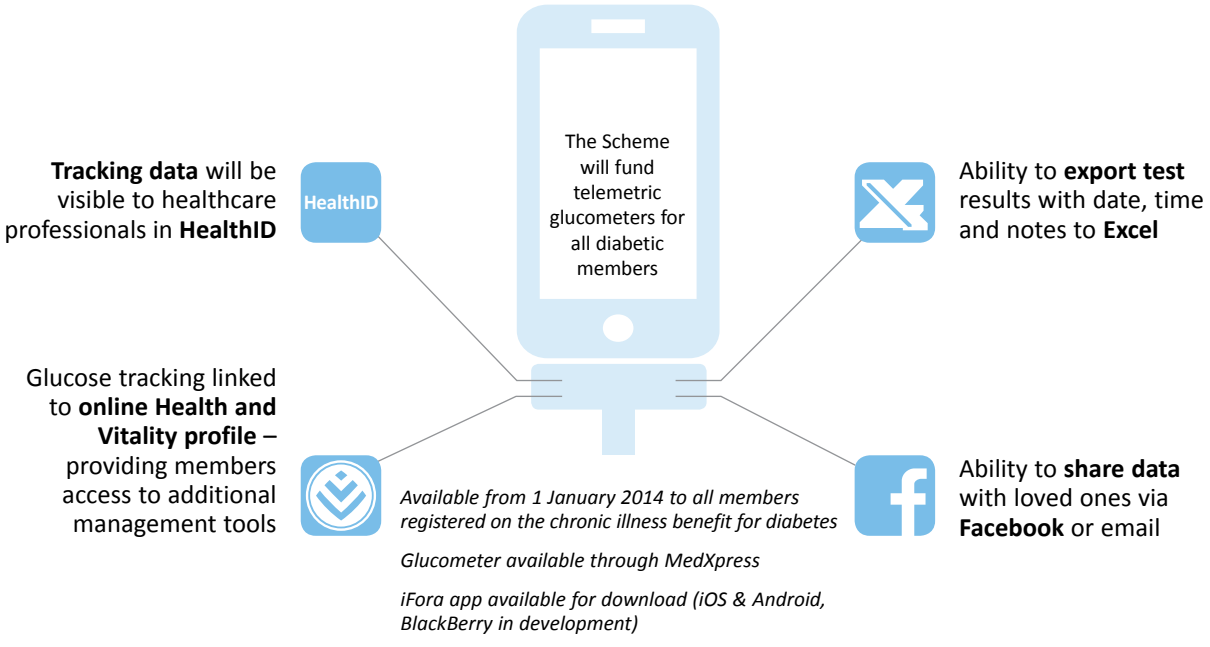
In a continuous effort to simplify access for members, Discovery Health is using the power of technology and digitising the healthcare environment through some revolutionary innovations. These include smartphone and tablet applications for both healthcare professionals and members (providing real-time access to information when and where doctors or members need it), telemetry and other devices (providing improved accuracy of data to doctors and to increase awareness among members), and tablet applications for financial advisers.

DIGITAL ECOSYSTEM FOR MEMBERS



Discovery Health is constantly looking for new ways to enhance this digital ecosystem, and in 2014 diabetic members are able to use telemetric glucometers to keep their doctor updated with their monitoring data in near real-time.

PROVIDING TELEMETRY DEVICES FOR DIABETICS



Discovery Health has negotiated discounts unique to members of the Discovery Health Medical Scheme across a variety of services.

EXCLUSIVE DISCOUNTS FOR DISCOVERY HEALTH MEDICAL SCHEME MEMBERS

MedSaver	ChroniCare	Optometry	Stem cell cryogenics
SAVE UP TO **25%** on the purchase of schedule 1 and 2 medicines	SAVE UP TO **25%** on ChroniCare products at Dis-Chem pharmacies	SAVE UP TO **20%** on frames and lenses through our optometry network	SAVE UP TO **25%** on umbilical cord blood and tissue stem cell cryogenics with Netcells Biosciences

ACCESS TO CONSULTATION WITH EXPERTS FROM THE GLOBALLY RENOWNED CLEVELAND CLINIC

Discovery Health Medical Scheme patients and their doctors now have access to second medical opinions from international healthcare experts. South Africa has some of the best medical practitioners who are at the forefront of medicine. Discovery Health supports every effort from local doctors who wish to collaborate with their international peers in an effort to reach the best possible clinical outcomes for their patients. To facilitate this process, Discovery Health has developed the Cleveland Clinic MyConsult online medical second opinion programme.

Cleveland Clinic

ANNUAL FINANCIAL STATEMENTS 2013//

The Discovery Health Medical Scheme's high level of financial strength and claims paying ability is confirmed by

A CREDIT RATING OF AA+, NET SURPLUS FOR THE YEAR OF R1.5 BILLION AND MEMBERS' FUNDS EXCEEDING R9.9 BILLION.

ANNUAL FINANCIAL STATEMENTS //

statement of responsibility by the board of trustees

FOR THE YEAR ENDED 31 DECEMBER 2013

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 the Discovery Health Medical Scheme (the Scheme). The Annual Financial Statements comprise the Statement of Financial Position at 31 December 2013, the Statement of Comprehensive Income, the Statement of Changes in Funds and Reserves and Statement of Cash Flows for the year ended, and the Notes to the Annual Financial Statements. The Annual Financial Statements have been prepared in accordance with International Financial Reporting Standards and the Medical Schemes Act, No 131 of 1998, as amended, ("the Act") and include amounts based on judgements and reasonable estimates.

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

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

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

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

The Board of Trustees has reviewed the Scheme's budget for the year ending 31 December 2014. 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 51.

The Annual Financial Statements which are presented on pages 52 to 113 were approved by the Board of Trustees on 15 April 2014 and are signed on its behalf by:

M VAN DER NEST SC
CHAIRPERSON

N GRAVES SC
TRUSTEE

M STREAK
PRINCIPAL OFFICER

ANNUAL FINANCIAL STATEMENTS // report of the audit committee

FOR THE YEAR ENDED 31 DECEMBER 2013

WE ARE PLEASED TO PRESENT OUR REPORT

for the financial year ended 31 December 2013. 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 executive officers of the Scheme and representatives of the Administrator attend meetings or parts of meetings by invitation. Internal Audit and the External Auditor attend meetings or parts of meetings by invitation and meet with the Committee after each meeting without the Administrator present.

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

Committee member	Qualifications	Number of meetings held during the financial year	Number of meetings attended
Mr B Stott[1] (Chairperson)	CA(SA)	5	5
Mr N Novick	CA(SA)	5	5
Mr S Green	BSc (Hons)	5	5
Mr D Eriksson[2]	CA(SA)	5	5
Mr G Waugh (Trustee)	FIA, FASSA	5	5
Ms D Naidoo[3] (Trustee)	CA(SA), Masters of Accounting (Taxation)	5	2

1 *Chairperson of the Committee since July 2013*
2 *Chairperson of the Committee for part of the year*
3 *A member of the Committee since July 2013*

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 2013. 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.

External Auditor appointment and independence

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

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

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

The Committee, following consultation with the Scheme's executive officers, approved the engagement letter, terms, audit plan, budgeted audit fees and representation letter for the year ended 31 December 2013.

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

Financial statements and accounting practices

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

report of the audit committee

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, amongst 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 *High Assurance** can be placed on the adequacy and effectiveness of the Scheme's internal financial controls, relative to the fair presentation of the Annual Financial Statements.

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

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

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

Whistle blowing

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

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 following two matters of material non-compliance with the Act.

- Note 33 of the Annual Financial Statements indicates that the Scheme did not comply with Regulation 29(2) of the Act. The accumulated funds required of 25% of gross annual contributions had not been met at 31 December 2013. The ratio of accumulated funds expressed as a percentage of gross annual contributions was 24.30%. The Scheme has notified the Council for Medical Schemes and submitted a business plan detailing the period over which the Scheme will increase the reserves to meet the required solvency ratio of 25%. This business plan has been approved by the Council for Medical Schemes. The required solvency level as set out in the business plan as at 31 December 2013 is 23.00%.
- Note 33 also details the disclosure in respect of five of the Scheme's 15 benefit plans which were not self-sustaining as at 31 December 2013 as required by section 33(2) of the Act.

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 2013 as well as the budget for the year ending 31 December 2014. The Committee took note of the positive solvency and liquidity position of the Scheme. The Scheme members' funds exceed R9.9 billion, with cash and investments exceeding R10.4 billion.

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

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

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

Opinion

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

The Committee has evaluated the Scheme's Annual Financial Statements for the year ended 31 December 2013 and, based on the information provided to the Committee, considers (except for the matters mentioned above) that the Scheme complies, in all material respects, with the requirements of the Act and International Financial Reporting Standards.

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

MR B STOTT
CHAIRPERSON: AUDIT COMMITTEE
15 April 2014

ANNUAL FINANCIAL STATEMENTS // independent auditor's report

FOR THE YEAR ENDED 31 DECEMBER 2013

To the members of Discovery Health Medical Scheme

We have audited the Annual Financial Statements of Discovery Health Medical Scheme set out on pages 52 to 113, which comprise the Statement of Financial Position as at 31 December 2013, 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 Annual Financial Statements

Discovery Health Medical Scheme's Trustees are responsible for the preparation and fair presentation of these Annual Financial Statements in accordance with International Financial Reporting Standards and in the manner required by the Medical Schemes Act, No 131 of 1998, as amended, and for such internal control as the Trustees determine is necessary to enable the preparation of Annual Financial Statements that are free from material misstatements, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these Annual 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 whether the Annual Financial Statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the Annual Financial Statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the Annual 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 Annual 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 Annual 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, the Annual Financial Statements present fairly, in all material respects, the financial position of Discovery Health Medical Scheme as at 31 December 2013, and its financial performance and its cash flows for the year then ended in accordance with International Financial Reporting Standards and in the manner required by the Medical Schemes Act, No 131 of 1998, as amended.

Report on other legal and regulatory requirements

As required by the Council for Medical Schemes, we report on instances of non-compliance with the Medical Schemes Act, No 131 of 1998, as amended.

We draw attention to Note 33 to the Annual Financial Statements which indicates the areas of non-compliance of Discovery Health Medical Scheme with the Medical Schemes Act, No 131 of 1998, as amended. We draw attention to the following instances of non-compliance which we consider to be material:

The Scheme did not comply with Regulation 29(2) of the Medical Schemes Act, No 131 of 1998, as amended. The required 25% accumulated funds ratio had not been met as at 31 December 2013. The ratio of accumulated funds, expressed as a percentage of gross contributions was 24.3% as at 31 December 2013.

Furthermore we draw attention to the detailed disclosure in Note 33 of the Annual Financial Statements where some of the benefit plans were not self-supporting during 2013 as required by Section 33(2) of the Medical Schemes Act, No 131 of 1998, as amended.

PricewaterhouseCoopers Inc
DIRECTOR: CORLIA VOLSCHENK
Registered Auditor
Sunninghill

15 April 2014

ANNUAL FINANCIAL STATEMENTS // statement of financial position

AS AT 31 DECEMBER 2013

R'000	Notes	2013	2012
ASSETS			
Non-current assets		**1 717**	–
Long Term Employee Benefit Plan asset	26	**1 717**	–
		14 571 535	12 108 480
Current assets			
Financial assets at fair value through profit or loss	2	**7 607 085**	6 968 790
Derivative financial instruments	7	**17 250**	–
Trade and other receivables	3	**1 497 921**	1 459 601
Cash and cash equivalents			
– Personal Medical Savings Account trust assets	4	**2 619 305**	2 260 141
– Medical Scheme assets	5	**2 829 974**	1 419 948
Total assets		**14 573 252**	12 108 480
FUNDS AND LIABILITIES			
Members' funds		**9 970 118**	8 240 820
Accumulated funds		**9 970 118**	8 240 820
Current liabilities		**4 603 134**	3 867 660
Outstanding claims provision	6	**812 190**	768 675
Derivative financial instruments	7	**40 685**	32 673
Personal Medical Savings Account trust liabilities	8	**2 776 720**	2 291 580
Trade and other payables	9	**973 539**	774 732
Total funds and liabilities		**14 573 252**	12 108 480

ANNUAL FINANCIAL STATEMENTS // statement of comprehensive income

FOR THE YEAR ENDED 31 DECEMBER 2013

R'000	Notes	2013	2012
Risk contribution income	10	**32 509 819**	28 225 777
Relevant healthcare expenditure		**(26 230 531)**	(23 093 400)
Net claims incurred	11	**(26 285 077)**	(23 194 642)
Claims incurred		**(26 310 242)**	(23 332 148)
Third party claim recoveries		**25 165**	137 506
Net income on risk transfer arrangements	12	**54 546**	101 242
Risk transfer arrangement fees		**(297 760)**	(263 898)
Recoveries from risk transfer arrangements		**352 306**	365 140
Gross healthcare result		**6 279 288**	5 132 377
Managed care: management services	13	**(1 101 009)**	(991 216)
Broker service fees	14	**(825 263)**	(755 803)
Expenses for administration		**(3 340 754)**	(3 084 814)
Other operating expenses	15	**(152 486)**	(113 365)
Net healthcare result		**859 776**	187 179
Other income		**824 297**	719 388
Investment income	20	**682 482**	617 289
Net gains on financial assets at fair value through profit or loss	21	**135 990**	96 067
Sundry income	22	**5 825**	6 032
Other expenditure		**(149 573)**	(117 777)
Expenses for asset management services rendered		**(12 619)**	(13 701)
Interest paid	23	**(136 954)**	(104 076)
Net surplus for the year		**1 534 500**	788 790
Other comprehensive income		**–**	–
Total comprehensive income for the year		**1 534 500**	788 790

ANNUAL FINANCIAL STATEMENTS // statement of changes in funds and reserves

FOR THE YEAR ENDED 31 DECEMBER 2013

R'000	Note	2013 Accumulated funds	2012 Accumulated funds
Balance at beginning of the year		**8 240 820**	7 419 231
Total comprehensive income for the year		**1 534 500**	788 790
Reserves transferred from other medical schemes	24	**194 798**	32 799
Balance at end of the year		**9 970 118**	8 240 820

ANNUAL FINANCIAL STATEMENTS // statement of cash flows

FOR THE YEAR ENDED 31 DECEMBER 2013

R'000	Notes	2013	2012
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows from operations before working capital changes	28	**906 936**	224 977
Working capital changes:			
Increase in trade and other receivables		**(68 704)**	(186 861)
Increase in outstanding claims provision		**43 515**	200 830
Increase in Personal Medical Savings Accounts		**485 140**	360 989
Increase in trade and other payables		**136 248**	114 169
Cash generated by operations		**1 503 135**	714 104
Purchases of financial instruments		**(1 655 782)**	(1 938 983)
Proceeds from sale of financial instruments		**1 335 595**	3 132 216
Cash transferred from other medical schemes		**40 624**	32 799
Interest received	20	**667 924**	600 265
Dividend income	20	**14 648**	17 124
Interest paid	23	**(136 954)**	(104 076)
Net cash flows from operating activities		**1 769 190**	2 453 449
CASH FLOWS FROM FINANCING ACTIVITIES			
Payments out of members' trust funds		**–**	(11)
Net cash flows from financing activities		**–**	(11)
NET INCREASE IN CASH AND CASH EQUIVALENTS		**1 769 190**	2 453 438
Cash and cash equivalents at beginning of year		**3 680 089**	1 226 651
CASH AND CASH EQUIVALENTS AT END OF YEAR		**5 449 279**	3 680 089
Cash and cash equivalents comprise of:			
Personal Medical Savings Accounts trust assets	4	**2 619 305**	2 260 141
Medical Scheme assets	5	**2 829 974**	1 419 948
		5 449 279	3 680 089

ANNUAL FINANCIAL STATEMENTS // accounting policies

FOR THE YEAR ENDED 31 DECEMBER 2013

GENERAL INFORMATION

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

The Scheme is an open medical scheme registered in terms of the Medical Schemes Act No 131 of 1998, as amended, ("the Act") and is domiciled in South Africa. During April 2014 the Scheme was awarded AA+ for its claims-paying ability – the highest rating in the industry – by independent credit rating agency Global Credit Ratings for the 13th consecutive year.

These Annual Financial Statements were authorised for issue by the Board of Trustees on 15 April 2014.

1 BASIS OF PREPARATION

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

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

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

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

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

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

New standards, amendments and interpretations effective in 2013 and relevant to the Scheme:

Standard	Scope	Effective date
IFRS 7 (Amendment): Financial Instruments: Disclosures	This amendment requires entities to disclose gross amounts subject to right of set-off, amounts set off in accordance with accounting standards followed, and the related net credit exposure.	1 January 2013
IFRS 12: Disclosures of interest in other entities	This standard includes the disclosure requirements for all forms of interests in other entities, including joint arrangements, associates, special purpose vehicles and other off balance sheet vehicles.	1 January 2013
IFRS 13 (New Standard): Fair value measurement	This standard replaces the fair value measurement guidance contained in individual IFRSs with a single source of fair value measurement guidance. It defines fair value, establishes a framework for measuring fair value and sets out disclosure requirements for fair value measurement. It explains how to measure fair value when required or permitted by other IFRSs.	1 January 2013
IAS 19 (Amendment): Employee benefits	The amendment makes significant changes to the recognition and measurement of defined benefit pension expenses, termination benefits, the definition of short-term and other employee benefits and to the disclosures for all employee benefits.	1 January 2013

1 BASIS OF PREPARATION (continued)

New standards, amendments and interpretations effective in 2013 and not relevant to the Scheme:

Standard	Scope	Effective date
IFRS 1 (Amendment): First time adoption	Exception to the retrospective application of IFRS for first-time adopters.	1 January 2013
IFRS 1 (Amendment): First time adoption	Clarify options for users where repeated application of IFRS 1 is required.	1 January 2013
IFRS 1 (Amendment): First time adoption	Borrowing cost amendments.	1 January 2013
IFRS 10: Consolidated financial statements	Amendments to the transition guidance of IFRS 10. Assess control at the date of initial application.	1 January 2013
IFRS 11: Joint arrangements	Joint arrangements – joint ventures and joint operations. Amendments to the transition guidance of IFRS 11.	1 January 2013
IAS 16 (Amendment): Property, plant and equipment	Amendment to recognition and classification of servicing equipment.	1 January 2013
IAS 27 (Revised 2011): Separate financial statements	Consequential amendments resulting from the issue of IFRS 10, 11 and 12.	1 January 2013
IAS 28 (Revised 2011): Associates and joint ventures	Investments in associates.	1 January 2013
IAS 32 (Amendment): Financial instruments: Presentation	Clarify the tax effect of distribution to holders of equity instruments.	1 January 2013
IAS 34 (Amendment): Interim financial reporting	Interim financial reporting.	1 January 2013
IFRIC 20: Stripping costs in the production phase of a surface mine	Stripping costs in the production phase of surface mining.	1 January 2013

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

Standard	Scope	Effective date
IFRS 9: Financial instruments (2009)	This standard introduces new requirements for the classification and measurement of financial assets. All recognised financial assets that are currently within the scope of IAS 39 will be measured at either amortised cost or fair value.	1 January 2015
IFRS 9: Financial instruments (2010)	The standard has been updated to include guidance on financial liabilities and the derecognition of financial instruments.	1 January 2015
IAS 32 (Amendment): Financial instruments: Presentation	The amendment clarifies some of the requirements for offsetting financial assets and financial liabilities on the statement of financial position.	1 January 2014

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

Standard	Scope	Effective date
IFRS 10: Consolidated financial statements	Exception to the principle that all subsidiaries should be consolidated.	1 January 2014
IFRS 12: Disclosures of interest in other entities	Disclosures required from an investment entity.	1 January 2014
IAS 27: Consolidated and separate financial statements	Requirement to account for interests in investment entities.	1 January 2014
IAS 36 (Amendment): Impairment of assets	Disclosure of information about the recoverable amount of impaired assets.	1 January 2014
IAS 39 (Amendment): Financial instruments	Amendment to provide relief from discontinuing hedge accounting.	1 January 2014

2 CLASSIFICATION, RECOGNITION, PRESENTATION AND DERECOGNITION OF FINANCIAL INSTRUMENTS

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

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

Offsetting financial instruments

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

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

Derecognition of financial assets and liabilities

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

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

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

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

3 FINANCIAL ASSETS

Financial assets at fair value through profit or loss

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

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

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

Loans and receivables

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

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

4 FOREIGN CURRENCY TRANSLATION

Functional and presentation currency

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 is 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; and
- Balances with banks.

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

7 IMPAIRMENT OF FINANCIAL ASSETS

Financial assets carried at amortised cost

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

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

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

The Scheme first assesses whether objective evidence of impairment exists, individually for financial assets that are individually significant, such as service provider debtors. In the case of assets 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.

8 MEMBERS' FUNDS

The funds represent the accumulated funds of the Scheme. The funds are mainly held as statutory reserves in lieu of 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 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 registered Scheme 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 deduction of Personal Medical Savings Account contributions. Risk contributions are earned from the date of attachment of insurance risk, over the indemnity period on a straight-line basis. The earned portion of risk contributions received is recognised as revenue.

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

14 RELEVANT HEALTHCARE EXPENDITURE

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

14.1 Claims incurred

Gross claims incurred 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.

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 MANAGED CARE: MANAGEMENT SERVICES FEES

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

17 BROKER SERVICE FEES

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

18 EXPENSES FOR ADMINISTRATION AND OTHER OPERATING EXPENSES

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

19 INVESTMENT INCOME

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

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

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

20 REIMBURSEMENTS FROM THE ROAD ACCIDENT FUND

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

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

21 UNALLOCATED FUNDS

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

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

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

22 EMPLOYEE BENEFITS

Pension obligations

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

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

Other post-employment obligations

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

Other long term employee benefit

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

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

Leave pay accrual

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

Bonuses

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

23 INCOME TAX

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

24 ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT PLANS

The following items are directly allocated to benefit plans:

- Contribution income;
- Claims incurred;
- Risk transfer arrangement fees;
- Managed care: management service fees;
- Expenses for administration; and
- 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 options 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 option;
- 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 apportioned based on the number of members per benefit plan.

25 STRUCTURED ENTITIES

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

- Restricted activities
- A narrow and well-defined objective, such as to provide investment opportunities for investors by passing on risks and rewards associated with the assets of the structured entity to investors;
- Insufficient equity to permit the structured entity to finance its activities without subordinated financial support; and
- 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 investment schemes ("funds") are investments in unconsolidated structured entities.
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 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.'

FOR THE YEAR ENDED 31 DECEMBER 2013

R'000	2013	2012
1 ACCOUNTING POLICIES		
The accounting policies of the Scheme are set out on pages 55 to 62.		
2 FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS		
The Scheme's financial assets are summarised by measurement category as follows:		
Financial assets at fair value through profit or loss	**7 607 085**	6 968 790
Loans and receivables (Note 3)	**100 207**	163 765
Total financial assets	**7 707 292**	7 132 555
The details of assets in each of the categories are detailed below.		
Financial assets held at fair value through profit or loss		
Current assets	**7 607 085**	6 968 790
– Offshore bonds	**967 571**	422 942
– Listed equities	**706 870**	472 567
– Yield enhanced bonds	**879 120**	850 412
– Money market instruments	**5 053 524**	5 222 869
	7 607 085	6 968 790
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
At the beginning of the year	**6 968 790**	8 012 078
Acquisitions	**1 605 375**	1 939 565
Disposals	**(1 140 869)**	(3 124 263)
Gain on revaluation of investments to fair value	**173 789**	141 410
At the end of the year	**7 607 085**	6 968 790
A register of investments is available for inspection at the registered office of the Scheme.		
Section 35(8)(a) 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. Due to the large number of the Scheme's employers being listed on the JSE, investments were made in certain of its employers listed on the JSE. The Council for Medical Schemes has granted the Scheme an exemption from this section of the Act.		
3 TRADE AND OTHER RECEIVABLES		
Insurance receivables		
Contribution receivables	**1 316 364**	1 189 794
Contributions outstanding	**1 322 098**	1 193 672
Less: Provision for impairment	**(5 734)**	(3 878)
Member and service provider claims receivables	**52 922**	53 795
Amount due	**224 878**	205 303
Less: Provision for impairment	**(171 956)**	(151 508)
Other risk transfer arrangements	**2 601**	3 208
Recoveries due from other risk transfer arrangements	**111**	81
Less: Provision for impairment	**–**	–
Share of outstanding claims provision (Note 6)	**2 490**	3 127
Broker fee receivables	**144**	190
Amounts due from brokers	**570**	532
Less: Provision for impairment	**(426)**	(342)
Other insurance receivables	**25 683**	48 849
Total receivables arising from insurance contracts	**1 397 714**	1 295 836

R'000	2013	2012
3 TRADE AND OTHER RECEIVABLES (continued)		
Loans and receivables		
Balance due by related party	**13 191**	19 800
Discovery Third Party Recovery Services (Pty) Ltd	**13 191**	19 800
Sundry accounts receivable	**85 661**	142 491
Interest receivable	**1 355**	1 474
Total receivables arising from loans and receivables	**100 207**	163 765
	1 497 921	1 459 601

At 31 December 2013 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.

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

4 CASH AND CASH EQUIVALENTS – PERSONAL MEDICAL SAVINGS ACCOUNTS		
(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	**1 129 982**	–
Additional Investments	**112 676**	1 128 127
Interest Income	**66 856**	1 880
Fair value adjustments	**233**	(25)
Balance at the end of the year	**1 309 747**	1 129 982
PERSONAL MEDICAL SAVINGS ACCOUNT TRUST PORTFOLIO (Managed by Taquanta Asset Managers (Pty) Ltd)		
Balance at beginning of the year	**1 130 159**	–
Additional Investments	**116 543**	1 128 577
Interest Income	**62 856**	1 582
Fair value adjustments	**–**	–
Balance at the end of the year	**1 309 558**	1 130 159
Total Personal Medical Savings Account Trust Assets	**2 619 305**	2 260 141

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. The difference between total Personal Medical Savings Account trust assets and Personal Medical Savings Account trust liabilities arises from timing of cash flows to or from the portfolios.

Details relating to these portfolios is provided under Note 31.

5 CASH AND CASH EQUIVALENTS – MEDICAL SCHEME ASSETS		
Call accounts	**499 654**	510 000
Current accounts	**367 252**	300 861
Money market instruments	**1 963 068**	609 087
	2 829 974	1 419 948

At 31 December 2013 the carrying amounts of cash and cash equivalents approximate their fair values due to the short-term maturities of these assets.

R'000	2013	2012
6 OUTSTANDING CLAIMS PROVISION		
Outstanding claims provision – not covered by risk transfer arrangements	**809 700**	765 548
Outstanding claims provision – covered by risk transfer arrangements (Note 3)	**2 490**	3 127
	812 190	768 675
Analysis of movement in outstanding claims		
Balance at beginning of the year	**768 675**	567 845
Payments in respect of prior year	**(784 317)**	(619 353)
Under provision in prior year (Note 11)	**(15 642)**	(51 508)
Adjustment for current year	**827 832**	820 183
Covered by risk transfer arrangements	**2 490**	3 127
Not covered by risk transfer arrangements	**825 342**	817 056
Balance at end of the year	**812 190**	768 675
Analysis of outstanding claims provision		
Estimated gross claims	**882 067**	812 328
Less:		
Estimated recoveries from savings plan accounts (Note 8)	**(69 877)**	(43 653)
Balance at end of the year	**812 190**	768 675
7 DERIVATIVE FINANCIAL INSTRUMENTS		
Financial assets held at fair value through profit or loss		
Current assets		
– Derivative financial instruments held for trading	**17 250**	–
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments held for trading	**(40 685)**	(32 673)
Derivative financial liability at the end of the year	**(23 435)**	(32 673)
Reconciliation of the balance at beginning of the year to the balance at the end of the year:		
Derivative financial (liability)/asset at the beginning of the year	**(32 673)**	21 206
Additions to derivative financial instruments:	**47 966**	–
– Zero cost equity collar	**37 289**	–
– Zero cost currency collar	**10 677**	–
Realised gain on derivative financial instruments	**(797)**	(7 953)
Realised gains on revaluation of derivative financial instruments	**(3 643)**	(4 302)
– Equity portfolio derivatives	**(3 643)**	(3 033)
– Bond portfolio derivative	**–**	(1 269)
Realised losses on revaluation of derivative financial instruments	**2 846**	3 205
– Equity portfolio derivatives	**1 132**	256
– Bond portfolio derivatives	**1 714**	2 949
Realised gain on foreign exchange currency	**–**	(6 856)
– Zero cost currency collar	**–**	(6 856)

R'000	2013	2012
7 DERIVATIVE FINANCIAL INSTRUMENTS (continued)		
Net loss on revaluation of derivative financial instruments:	**(37 930)**	(45 926)
Gain on revaluation of derivative financial instruments	**16 465**	4 066
– Equity portfolio derivatives	**–**	4 066
– Zero cost equity collar	**15 949**	–
– Bond portfolio derivatives	**516**	–
Losses on revaluation of derivative financial instruments	**(54 395)**	(49 991)
– Equity portfolio derivatives	**(2 991)**	–
– Zero cost equity collar	**(9 072)**	(34 745)
– Zero cost currency collar	**(42 332)**	(9 802)
– Bond portfolio derivatives	**–**	(5 444)
Derivative financial liability at the end of the year	**(23 435)**	(32 673)

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 and zero cost currency collars to protect the Scheme's offshore bond portfolios.

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

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

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

8 PERSONAL MEDICAL SAVINGS ACCOUNT TRUST LIABILITIES (Personal Medical Savings Account trust monies managed by the Scheme on behalf of its members)		
Balance on Personal Medical Savings Accounts at the beginning of the year	**2 291 580**	1 930 591
Add:		
Personal Medical Savings Accounts contributions received or receivable	**7 953 882**	6 969 850
For the current year (Note 10)	**7 953 882**	6 969 850
Interest on Personal Medical Savings Accounts (Note 23)	**136 673**	104 076
Transfers received from other medical schemes	**17 883**	17 211
Less:		
Claims paid to or on behalf of members (Note 11)	**(7 445 345)**	(6 581 347)
Refunds on death or resignation	**(177 953)**	(148 801)
Balance due to members on Personal Medical Savings Accounts held in trust at the end of the year	**2 776 720**	2 291 580

It is estimated that claims to be paid out of members' Personal Medical Savings Accounts in respect of claims incurred in 2013 but not recorded will amount to approximately R69 876 504 (2012 – R43 652 635) (Note 6).

As at 31 December 2013 the carrying amount of the members' Personal Medical Savings Accounts were deemed to be equal to their fair values, which is the amount payable on demand. The amounts were not discounted, due to the demand feature.

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

R'000	2013	2012
9 TRADE AND OTHER PAYABLES		
Insurance payables		
Contributions received in advance	**72 833**	52 584
Contribution refunds due to employers	**197**	131
Reported claims not yet paid		
Balance at the beginning of the year	**351 682**	319 265
Movement for the year	**118 836**	32 417
Balance at the end of the year	**470 518**	351 682
Broker fee creditors	**73 292**	67 496
Accredited brokers	**73 292**	67 496
Other insurance liabilities	**20**	7
Total liabilities arising from insurance contracts	**616 860**	471 900
Financial liabilities		
Balance due to related parties	**327 313**	284 030
Discovery Health (Pty) Ltd	**327 313**	284 030
Unallocated funds	**25 253**	5 169
Total accruals	**4 113**	13 633
General accruals	**4 006**	13 429
Leave pay provision	**107**	204
Total arising from financial liabilities	**356 679**	302 832
	973 539	774 732
At 31 December 2013 the carrying amounts of insurance and other payables approximate their fair values due to the short term maturities of these liabilities.		
10 RISK CONTRIBUTION INCOME		
Gross contributions per registered Scheme Rules	**40 463 701**	35 195 627
Less:		
Personal Medical Savings Account contributions (Note 8)	**(7 953 882)**	(6 969 850)
Risk contribution income per Statement of Comprehensive Income	**32 509 819**	28 225 777
11 NET CLAIMS INCURRED		
Current year claims per registered Scheme Rules	**33 712 072**	29 712 665
Claims not covered by risk transfer arrangements	**33 359 766**	29 347 526
Claims covered by risk transfer arrangements (Note 12)	**352 306**	365 139
Movement in outstanding claims provision	**43 515**	200 830
Under provision in prior year (Note 6)	**15 642**	51 508
Adjustment for current year	**27 873**	149 322
	33 755 587	29 913 495
Less:		
Claims charged to members' Personal Medical Savings Accounts (Note 8)	**(7 445 345)**	(6 581 347)
Claims incurred	**26 310 242**	23 332 148
Third party claim recoveries	**(25 165)**	(137 506)
	26 285 077	23 194 642

11 NET CLAIMS INCURRED (continued)

Risk transfer arrangements

During 2013 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 2013 benefit year was used as the basis for determining the claims under this arrangement. These claim amounts are adjusted to include a provision for outstanding claims and then converted to a Per Life Per Month (PLPM) rate using the membership on the KeyCare Plus and KeyCare Access plans.

   In order to determine the value of claims under this arrangement, the average 2013 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 procedures codes was isolated. Using claims data linked to this group, the overall PLPM cost of dental services on all plans excluding KeyCare Plus and KeyCare Access was estimated. These claim amounts are adjusted to include a provision for outstanding claims. Generally, the claims experience on KeyCare Plus and KeyCare Access is different to that of other Scheme plans as KeyCare Plus and KeyCare Access is aimed at a specific target market and the benefits are restricted. To allow for this, the overall PLPM is adjusted by the ratio of KeyCare Plus and KeyCare Access claims experience to the other benefit plans offered by the Scheme. The value of claims under this arrangement is determined by multiplying the PLPM rate by the lives exposure for KeyCare Plus and KeyCare Access.

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

   Members have a choice of using this managed care organisation for their diabetes-related treatment 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:
   - Per Life Per Month estimates were calculated for consultations, procedures, medicine and hospital admissions to the extent that these services were covered under this risk transfer arrangement for the Executive and Comprehensive plan members who have not elected this provider
   - The expected fee-for-service cost was calculated by multiplying the calculated Per Life Per Month costs by the number of members exposed for the period on this programme.

R'000	2013	2012
12 NET INCOME ON RISK TRANSFER ARRANGEMENTS		
The Scheme operated the following risk transfer arrangements during the year:		
Other risk transfer arrangements:		
Capitation fees paid	**(297 760)**	(263 898)
Recoveries under risk transfer arrangements	**352 306**	365 140
Claims incurred in respect of related risk transfer arrangements	**264 949**	288 461
Recoveries received	**87 357**	76 679
	54 546	101 242

R'000	2013	2012
13 MANAGED CARE: MANAGEMENT SERVICES		
The managed care: management services have been grouped into the following categories of services.		
Discovery Health (Pty) Ltd		
Clinical Protocols/Disease Management	**192 678**	173 462
Hospital Management	**572 524**	515 434
Pharmaceutical Benefit Management	**165 151**	148 682
Provider Networks	**170 656**	153 638
	1 101 009	991 216
14 BROKER SERVICE FEES		
Brokers' fees	**825 263**	755 803
	825 263	755 803
In terms of Regulation 28(5) of the Act, the Scheme broker fees shall be paid on a monthly basis and upon receipt by the Scheme of the relevant monthly contribution. In some instances brokers were compensated prior to receipt of the relevant monthly contribution.		
15 OTHER OPERATING EXPENSES		
Association fees	**4 635**	32
Audit fees	**4 774**	4 004
Audit services for the year ended 2013	**1 828**	–
Audit services for the year ended 2012	**2 027**	1 658
Audit services for the year ended 2011	**–**	1 932
Other services	**919**	414
Audit and Risk Committees fees (Note 16)	**924**	729
Audit and Risk Committees training	**–**	9
Bank charges	**8 275**	6 957
Clinical Governance Committee fees	**57**	–
Council for Medical Schemes	**29 642**	26 209
Custodian fees	**6**	295
Debt collecting fees	**2 037**	1 936
Dispute Committee fees	**285**	362
General meeting costs	**2 269**	278
Investment Committee fees	**69**	–
Investment reporting fees	**1 438**	884
Legal fees	**1 994**	1 852
Net impairment losses (Note 17)	**53 320**	45 465
Other expenses	**11 650**	10 246
Principal Officer – Remuneration	**4 544**	4 029
Principal Officer – Unvested Long Term Employee Benefit	**855**	–
Scheme office costs	**3 010**	1 784
Printing postage and stationery	**368**	170
Professional fees	**13 602**	2 654
Staff costs (Note 18)	**5 540**	2 607
Sundry amounts written off	**14**	46
Trustees' remuneration and consideration expenses (Note 19)	**3 178**	2 817
	152 486	113 365

R'000	2013	2012
16 AUDIT AND RISK COMMITTEES FEES		
B Stott – Independent Member (Chairperson)[1]	**223**	–
D Eriksson – Independent Member[2]	**304**	384
N Novick – Independent Member	**211**	185
S Green – Independent Member	**186**	160
	924	729

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

1 Chairperson of the Committee since July 2013
2 Chairperson of the Committee for part of the year

17 NET IMPAIRMENT LOSSES		
Insurance and other receivables		
Contributions that are not collectable	**1 856**	(2 244)
Movement in provision	**1 856**	(2 244)
Members' and service providers' portions that are not recoverable	**48 710**	47 763
Movement in provision	**48 710**	47 763
Amounts due by brokers that are not recoverable	**85**	48
Movement in provision	**85**	48
Amounts due by forensic debtors that are not recoverable	**2 538**	–
Movement in provision	**2 538**	–
Receivables written off	**308**	213
Less:		
Previously written off receivables recovered	**(177)**	(315)
	53 320	45 465
18 STAFF COSTS		
Salaries and bonuses	**5 024**	2 326
Pension costs – defined contribution plans	**276**	101
Medical and other benefits	**317**	35
(Decrease)/increase in leave pay accrual	**(77)**	145
	5 540	2 607

19 TRUSTEES REMUNERATION AND CONSIDERATION EXPENSES

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

31 December 2013	Services as Trustee R'000	Committee fees: Audit and Risk Committees R'000	Investment Committee R'000	Clinical Governance Committee R'000	Non-Healthcare Expenses Committee R'000	Product Committee R'000	Nomination Committee R'000	Governance Review Committee R'000	Trustee travel R'000	Total R'000
M van der Nest (Chairperson)	**461**	**–**	**–**	**–**	**6**	**–**	**24**	**12**	**–**	**503**
P Maserumule[1]	**241**	**–**	**206**	**–**	**–**	**–**	**–**	**–**	**–**	**447**
N Sangweni[2]	**160**	**–**	**–**	**86**	**–**	**–**	**–**	**–**	**–**	**246**
B Stott[2]	**137**	**57**	**69**	**–**	**–**	**–**	**–**	**30**	**–**	**293**
N Graves[1]	**241**	**–**	**69**	**–**	**14**	**11**	**–**	**30**	**–**	**365**
Z van der Spuy[1]	**253**	**–**	**–**	**143**	**–**	**17**	**–**	**–**	**106**	**519**
G Waugh	**262**	**131**	**80**	**–**	**14**	**23**	**13**	**23**	**–**	**546**
D Naidoo[3]	**127**	**63**	**69**		**–**	**–**	**–**	**–**	**–**	**259**
Total	**1 882**	**251**	**493**	**229**	**34**	**51**	**37**	**95**	**106**	**3 178**

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

31 December 2012	Services as Trustee R'000	Committee fees: Audit and Risk Committees R'000	Investment Committee R'000	Clinical Governance Committee R'000	Non-Healthcare Expenses Committee R'000	Product Committee R'000	Nomination Committee R'000	Governance Review Committee R'000	Trustee travel R'000	Total R'000
M van der Nest (Chairperson)	406	–	–	–	–	–	–	11	–	417
P Maserumule	206	–	144	–	–	–	–	–	–	350
N Sangweni	225	–	–	160	–	25	–	–	–	410
B Stott	238	117	96	–	14	–	–	18	–	483
N Graves	226	–	–	–	14	–	–	26	–	266
Z van der Spuy	227	–	–	106	–	–	–	–	52	385
G Waugh	228	117	96	–	14	25	–	26	–	506
Total	**1 756**	**234**	**336**	**266**	**42**	**50**	**–**	**81**	**52**	**2 817**

R'000	2013	2012
20 INVESTMENT INCOME		
Financial assets at fair value through profit or loss:	**640 217**	561 729
Dividend income	**14 648**	17 124
Interest income	**625 569**	544 606
Cash and cash equivalents interest income	**42 265**	55 560
Investment income per Statement of Comprehensive Income	**682 482**	617 289
The Scheme's total interest income is summarised below.		
Financial assets not at fair value through profit or loss:	**42 355**	55 660
Interest received from Administrator (Note 22)	**90**	100
Cash and cash equivalents interest income	**42 265**	55 560
Financial assets at fair value through profit or loss:		
Interest income	**625 569**	544 606
Total interest income	**667 924**	600 265

R'000	2013	2012
21 NET GAINS/(LOSSES) ON FINANCIAL ASSETS AT FAIR VALUE THROUGH PROFIT OR LOSS		
Net foreign exchange gains/(losses) on financial assets at fair value through profit or loss:	**218 855**	(11 543)
– Offshore bonds	**218 855**	(11 543)
Net fair value gains on financial assets at fair value through profit or loss including derivatives:	**117 746**	157 601
– Listed equities	**65 910**	39 624
– Derivatives held for trading	**16 465**	4 066
– Money market instruments	**1 656**	1 050
– Offshore bonds	**33 554**	96 833
– Yield enhanced bonds	**161**	16 028
Net fair value losses on financial assets at fair value through profit or loss including derivatives:	**(200 611)**	(49 991)
– Derivatives held for trading	**(54 395)**	(49 991)
– Offshore bonds	**(140 526)**	–
– Yield enhanced bonds	**(5 690)**	–
	135 990	96 067
22 SUNDRY INCOME		
Interest received from Administrator	**90**	100
Prescribed amounts written back	**2 504**	1 419
Stale cheques written back	**3 231**	4 513
	5 825	6 032
23 INTEREST PAID		
Financial assets not at fair value through profit or loss:		
Interest on Personal Medical Savings Accounts (Note 8)	**136 673**	104 076
Interest paid to Administrator	**281**	–
	136 954	104 076
24 RESERVES TRANSFERRED FROM OTHER MEDICAL SCHEMES		
Reserves transferred from other schemes		
Nampak SA Medical Scheme	**162 984**	–
IBM South Africa Medical Scheme	**28 284**	–
Umed Medical Scheme	**1 568**	(46)
Afrisam Medical Scheme	**363**	(8)
Edcon Medical Scheme	**1 599**	32 853
	194 798	32 799

25 AMALGAMATIONS

AMALGAMATIONS EFFECTIVE DURING 2013

Nampak SA Medical Scheme

An amalgamation between the Scheme and Nampak SA Medical Scheme ("Nampak MAS") was confirmed during the 2012 financial year and effective from 1 March 2013.

Nampak 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 Nampak (Pty) Ltd, 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 Nampak MAS voted that the amalgamation of Nampak MAS with the Scheme would be in the best interest of Nampak MAS members.

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

No goodwill will be recognised as a result of this transaction.

R'000	2013	
25 AMALGAMATIONS (continued)		
AMALGAMATIONS EFFECTIVE DURING 2013 (continued)		
Nampak SA Medical Scheme (continued)		
The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:		
Reserves effectively transferred:		
(Acquisition date fair value of Nampak MAS's members' interest)		**162 664**
Net recognised values of Nampak MAS's identifiable assets and liabilities:		**162 664**
Non-current assets	**184 744**	
Available-for-sale financial assets	**184 744**	
Current assets	**29 545**	
Cash and cash equivalents	**14 204**	
Contribution receivables	**14 877**	
Member and service provider claims receivables	**222**	
Savings plan account advances	**364**	
Provision for impairment losses	**(164)**	
Interest receivable	**42**	
Current liabilities	**(51 625)**	
Outstanding claims provision	**(7 838)**	
Unallocated funds	**(17 478)**	
General accruals	**(213)**	
Personal Medical Savings Accounts	**(26 096)**	
Goodwill		**–**
As a result of the amalgamation, the Scheme acquired the following receivables information of which is set out below.		
Fair value of receivables acquired:		
Insurance receivables	**15 299**	
Contribution debtors	**14 877**	
Members claims debtors	**128**	
Service provider claims debtors	**94**	
Savings plan account advances	**364**	
Provision for impairment	**(164)**	
Loans and receivables	**42**	
Interest receivable	**42**	
Gross contractual amounts receivable:	**15 505**	
Insurance receivables	**15 463**	
Contribution debtors	**14 877**	
Member claims debtors	**128**	
Service provider claims debtors	**94**	
Savings plan account advances	**364**	
Loans and receivables	**42**	
Interest receivable	**42**	
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	**(164)**	
Contribution debtors	**(24)**	
Member and service provider claims debtors	**(138)**	
Savings account advances	**(2)**	

R'000	2013
25 AMALGAMATIONS (continued)	
AMALGAMATIONS EFFECTIVE DURING 2013 (continued)	
Nampak SA Medical Scheme (continued)	
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.	
Non-current assets	**184 744**
Available-for-sale financial assets	**184 744**
Current assets	**29 709**
Cash and cash equivalents	**14 204**
Contribution debtors	**14 877**
Member claims debtors	**128**
Service provider claims debtors	**94**
Savings plan account advances	**364**
Interest receivable	**42**
Current liabilities	**(51 625)**
Outstanding claims provision	**(7 838)**
Unallocated funds	**(17 478)**
General accruals	**(213)**
Personal Medical Savings Accounts	**(26 096)**
	162 828

IBM South Africa Medical Scheme

An amalgamation between the Scheme and IBM South Africa Medical Aid Scheme ("IBM MAS") was confirmed and effective from 1 July 2013.

IBM 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 IBM South Africa, 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 IBM MAS voted that the amalgamation of IBM MAS with the Scheme would be in the best interest of IBM MAS members.

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

No goodwill will be recognised as a result of this transaction.

R'000		2013
25 AMALGAMATIONS (continued)		
AMALGAMATIONS EFFECTIVE DURING 2013 (continued)		
IBM South Africa Medical Scheme (continued)		
The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:		
Reserves effectively transferred: (Acquisition date fair value of IBM MAS's members' interest)		**27 870**
Net recognised values of IBM MAS's identifiable assets and liabilities:		**27 870**
Non-current assets	**5 654**	
Available for sale investments	**5 654**	
Current assets	**33 887**	
Cash and cash equivalents	**26 422**	
Contribution receivables	**4 787**	
Member and service provider claims receivables	**2 729**	
Provision for Impairment losses	**(157)**	
Interest receivable	**50**	
Other accounts receivable	**56**	
Current liabilities	**(11 671)**	
Outstanding claims provision	**(1 999)**	
Reported claims not yet paid	**(1 357)**	
Unallocated funds	**(945)**	
General accruals	**(993)**	
Personal Medical Savings Accounts	**(6 377)**	
Goodwill		**–**
As a result of the amalgamation, the Scheme acquired the following receivables information of which is set out below.		
Fair value of receivables acquired:	**7 465**	
Insurance receivables	**7 415**	
Contribution debtors	**4 787**	
Members claims debtors	**2 355**	
Service provider claims debtors	**374**	
Provision for impairment	**(157)**	
Other accounts receivable	**56**	
Loans and receivables	**50**	
Interest receivable	**50**	
Gross contractual amounts receivable:	**7 622**	
Insurance receivables	**7 572**	
Contribution debtors	**4 787**	
Member claims debtors	**2 355**	
Service provider claims debtors	**374**	
Other accounts receivable	**56**	
Loans and receivables	**50**	
Interest receivable	**50**	
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	**(157)**	
Member claims debtors	**(32)**	
Service provider claims debtors	**(125)**	

R'000	2013
25 AMALGAMATIONS (continued)	
AMALGAMATIONS EFFECTIVE DURING 2013 (continued)	
IBM South Africa Medical Scheme (continued)	
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.	
Non-current assets	**5 654**
Available for sale investments	**5 654**
Current assets	**33 887**
Cash and cash equivalents	**26 422**
Contribution debtors	**4 787**
Member claim debtors	**2 323**
Service provider claim debtors	**249**
Interest receivable	**50**
Other accounts receivable	**56**
Current liabilities	**(11 671)**
Outstanding claims provision	**(1 999)**
Reported claims not yet paid	**(1 357)**
Unallocated funds	**(945)**
General accruals	**(993)**
Personal medical savings accounts	**(6 377)**
	27 870

AMALGAMATIONS CONFIRMED DURING 2013 BUT EFFECTIVE IN 2014

Altron Medical Aid Scheme

An amalgamation between the Scheme and Altron Medical Aid Scheme ("Altron MAS") has been confirmed during the year under review and will be effective from 1 January 2014.

The effective date of the amalgamation is post the reporting date of the Scheme, but before the financial statements are authorised for issue (Note 29).

IFRS 3 (Business combinations) requires that information relating to this amalgamation be disclosed in the current reporting period and these disclosures are provided below.

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 Altron MAS members.

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

No goodwill will be recognised as a result of this transaction.

R'000	2013	
25 AMALGAMATIONS (continued)		
AMALGAMATIONS CONFIRMED DURING 2013 BUT EFFECTIVE IN 2014 (continued)		
Altron Medical Aid Scheme (continued)		
The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:		
Reserves effectively transferred:		
(Acquisition date fair value of Altron MAS's members' interest)		**40 987**
Net recognised values of Altron MAS's identifiable assets and liabilities:		**40 987**
Current assets	**77 961**	
Cash and cash equivalents	**76 878**	
Contribution receivables	**1 017**	
Member and service provider claims receivables	**811**	
Provision for impairment	**(772)**	
Interest receivable	**6**	
Other accounts receivable	**21**	
Current liabilities	**(36 974)**	
Outstanding claims provision	**(4 200)**	
Reported claims not yet paid	**(2 516)**	
Unallocated funds	**(200)**	
Discovery Health (Pty) Ltd	**(942)**	
General accruals	**(662)**	
Personal Medical Savings Accounts	**(28 454)**	
Goodwill		**–**
As a result of the amalgamation, the Scheme acquired the following receivables information of which is set out below.		
Fair value of receivables acquired:	**1 083**	
Insurance receivables	**1 077**	
Contribution debtors	**1 017**	
Member claims debtors	**532**	
Service provider claims debtors	**279**	
Other accounts receivable	**21**	
Provision for impairment	**(772)**	
Loans and receivables	**6**	
Interest receivable	**6**	
Gross contractual amounts receivable:	**1 855**	
Insurance receivables	**1 849**	
Contribution debtors	**1 017**	
Member claims debtors	**532**	
Service provider claims 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 claims debtors	**(478)**	
Service provider claims debtors	**(245)**	

R'000	2013
25 AMALGAMATIONS (continued)	
AMALGAMATIONS CONFIRMED DURING 2013 BUT EFFECTIVE IN 2014 (continued)	
Altron Medical Aid Scheme (continued)	
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.	
Current assets	**77 961**
Cash and cash equivalents	**76 878**
Contribution debtors	**968**
Member claims debtors	**54**
Service provider claims debtors	**34**
Interest receivable	**6**
Other accounts receivable	**21**
Current liabilities	**(36 974)**
Outstanding claims provision	**(4 200)**
Reported claims not yet paid	**(2 516)**
Unallocated funds	**(200)**
Discovery Health (Pty) Ltd	**(942)**
General accruals	**(662)**
Personal Medical Savings Accounts	**(28 454)**
	40 987

AMALGAMATIONS PROPOSED DURING 2013 AND CONFIRMED IN 2014

Afrox Medical Aid Society

An amalgamation between the Scheme and Afrox Medical Aid Society ("Afrox MAS") has been proposed during the year under review and confirmed on 2 April 2014. The amalgamation will be effective from 1 May 2014.

The effective date of the amalgamation is post the reporting date of the Scheme, but before the financial statements are authorised for issue (Note 29).

IFRS 3 (Business combinations) requires that information relating to this amalgamation be disclosed in the current reporting period and these disclosures are provided below.

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 to the Act.

No goodwill will be recognised as a result of this transaction.

R'000	2013	
25 AMALGAMATIONS (continued)		
AMALGAMATIONS PROPOSED DURING 2013 AND CONFIRMED IN 2014 (continued)		
Afrox Medical Aid Society (continued)		
The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:		
Reserves effectively transferred:		**94 692**
(Acquisition date fair value of Afrox MAS's members' interest)		
Net recognised values of Afrox MAS's identifiable assets and liabilities:		**94 692**
Non-current assets	**91 417**	
Available-for-sale financial assets	**91 417**	
Current assets	**7 947**	
Cash and cash equivalents	**896**	
Contribution receivables	**7 046**	
Member and service provider claims receivables	**114**	
Provision for impairment	**(122)**	
Interest receivable	**7**	
Other accounts receivable	**6**	
Current liabilities	**(4 672)**	
Outstanding claims provision	**(4 264)**	
General accruals	**(408)**	
Goodwill		**–**
As a result of the amalgamation, the Scheme acquired the following receivables information of which is set out below.		
Fair value of receivables acquired:	**7 051**	
Insurance receivables	**7 044**	
Contribution debtors	**7 046**	
Member and service provider claims debtors	**114**	
Other accounts receivable	**6**	
Provision for impairment	**(122)**	
Loans and receivables	**7**	
Interest receivable	**7**	
Gross contractual amounts receivable:	**7 173**	
Insurance receivables	**7 166**	
Contribution debtors	**7 046**	
Member and service provider claims debtors	**114**	
Other accounts receivable	**6**	
Loans and receivables	**7**	
Interest receivable	**7**	
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	**(122)**	
Contribution debtors	**(120)**	
Member and service provider claims debtors	**(2)**	

R'000	2013
25 AMALGAMATIONS (continued)	
AMALGAMATIONS PROPOSED DURING 2013 AND CONFIRMED IN 2014 (continued)	
Afrox Medical Aid Society (continued)	
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.	
Non-current assets	**91 417**
Available-for-sale financial assets	**91 417**
Current assets	**7 947**
Cash and cash equivalents	**896**
Contribution debtors	**6 927**
Member and service provider claims debtors	**112**
Interest receivable	**7**
Other accounts receivable	**6**
Current liabilities	**(4 672)**
Outstanding claims provision	**(4 264)**
General accruals	**(408)**
	94 692

PG Bison Medical Aid Society

An amalgamation between the Scheme and PG Bison Medical Aid Society ("PG Bison MAS") has been proposed during the year under review and confirmed on 2 April 2014. The amalgamation will be effective from 1 May 2014.

The effective date of the amalgamation is post the reporting date of the Scheme, but before the financial statements are authorised for issue (Note 29).

IFRS 3 (Business combinations) requires that information relating to this amalgamation be disclosed in the current reporting period and these disclosures are provided below.

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 any franchised or associated companies, 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 to the Act.

No goodwill will be recognised as a result of this transaction.

R'000		2013
25 AMALGAMATIONS (continued)		
AMALGAMATIONS PROPOSED DURING 2013 AND CONFIRMED IN 2014 (continued)		
PG Bison Medical Aid Society (continued)		
The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of assets and liabilities was:		
Reserves effectively transferred:		
(Acquisition date fair value of PG Bison MAS's members' interest)		**20 301**
Net recognised values of PG Bison MAS's identifiable assets and liabilities:		**20 301**
Current assets	**21 783**	
Cash and cash equivalents	**21 140**	
Contribution receivables	**544**	
Member and service provider claims receivables	**147**	
Provision for impairment	**(48)**	
Current liabilities	**(1 482)**	
Outstanding claims provision	**(580)**	
Reported claims not yet paid	**(116)**	
General accruals	**(786)**	
Goodwill		**–**
As a result of the amalgamation, the Scheme acquired the following receivables information of which is set out below.		
Fair value of receivables acquired:	**643**	
Insurance receivables	**643**	
Contribution debtors	**544**	
Members and service provider claims debtors	**147**	
Provision for impairment	**(48)**	
Gross contractual amounts receivable:	**691**	
Insurance receivables	**691**	
Contribution debtors	**544**	
Members and service provider claims debtors	**147**	
Best estimate at the acquisition date of the contractual cash flows not expected to be collected are:		
Insurance receivables	**(48)**	
Contribution debtors	**(11)**	
Members and service provider claims debtors	**(37)**	

R'000	2013
25 AMALGAMATIONS (continued)	
AMALGAMATIONS PROPOSED DURING 2013 AND CONFIRMED IN 2014 (continued)	
PG Bison Medical Aid Society (continued)	
The amounts recognised as of the acquisition date for each major class of assets acquired and liabilities assumed.	
Current assets	**21 783**
Cash and cash equivalents	**21 140**
Contribution debtors	**533**
Members and service provider claims debtors	**110**
Current liabilities	**(1 482)**
Outstanding claims provision	**(580)**
Reported claims not yet paid	**(116)**
General accruals	**(786)**
	20 301

26 RELATED PARTY TRANSACTIONS

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

Key management personnel and their close family members

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

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

Parties with significant influence over the Scheme

Administrator:

Discovery Health (Pty) Ltd has significant influence over the Scheme, as Discovery Health (Pty) Ltd participates in the Scheme's financial and operating policy decisions, but does not control the Scheme. Discovery Health (Pty) Ltd provides administration, managed care services and third party collection services, through Discovery Third Party Recovery Services (Pty) Ltd, a wholly-owned subsidiary of Discovery Health (Pty) Ltd.

R'000	2013	2012
26 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:		
Statement of Comprehensive Income transactions		
Compensation		
Short term employee benefits	**(11 279)**	(8 064)
Unvested Long Term Employee Benefit	**(855)**	–
Contributions and claims		
Gross contributions received	**582**	384
Claims paid from the Scheme	**(133)**	(138)
Claims paid from the Personal Medical Savings Accounts	**(122)**	(96)
Statement of Financial Position transactions		
Long Term Employee Benefit Plan Asset	**1 717**	–
Contribution debtors	**24**	8
Amounts due to executive officers	**(38)**	(203)
Personal Medical Savings Account balances	**(22)**	4
Trustee remuneration payable	**–**	(69)

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

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

R'000	2013	2012
26 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	**(3 340 754)**	(3 084 814)
Interest received on monthly balances (Note 22)	**90**	100
Interest paid on monthly balances (Note 23)	**(281)**	–
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 9)	**(234 114)**	(191 876)
Discovery Health (Pty) Ltd – Managed care organisation		
Statement of Comprehensive Income transactions		
Managed care fees paid	**(1 101 009)**	(991 216)
Managed care: management services	**(1 101 009)**	(991 216)
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd at year end (Note 9)	**(93 199)**	(92 154)
Discovery Third Party Recovery Services (Pty) Ltd		
Statement of Comprehensive Income transactions		
Third party collection fees	**(10 420)**	(9 922)
Statement of Financial Position transactions		
Balance due to the Scheme at year end (Note 3)	**13 191**	**19 800**

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 Prime less 4.5% and is due within 30 days.

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

Managed care agreements

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

Managed care: management services

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

The managed care agreement is in accordance with instructions given by the Board of Trustees. The agreement is automatically renewed each year unless notification of termination is received or following the cancellation of Discovery Health (Pty) Ltd's accreditation or the issue of a lawful directive to this effect by the Council for Medical Schemes in terms of the Act. The Scheme and Discovery Health (Pty) Ltd 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 Prime less 4.5% and is due within 30 days.

26 RELATED PARTY TRANSACTIONS (continued)

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

The services provided by the managed care organisation include:

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

Third party collection services

The Scheme has contracted with Discovery Third Party Recovery Services (Pty) Ltd ("DTPRS"), 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 2013 to 31 December 2013 for the amount of R13.1 million to DTPRS.

Guarantees

At 31 December 2011, Discovery Health (Pty) Ltd guaranteed the recoverability of certain member claims receivables to the value of R10.9 million as well as certain forensic claims recoveries to the value of R100 million. The guarantees were payable on 31 December 2012. By 31 December 2012, the majority of the guaranteed receivables had been recovered. Due to the forensic recoveries process, the Trustees had agreed to extend the settlement of the guarantees to 30 June 2013, and the outstanding balance accrued interest.

The guarantees receivable from Discovery Health (Pty) Ltd were fully recovered by 31 July 2013.

27 SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT PLAN

2013	Executive R'000	Classic Comp R'000	Classic Comp Zero MSA R'000	Classic Core R'000	Classic Saver R'000	Classic Priority R'000	Essential Comp R'000	Essential Saver R'000
Risk contribution income	**725 245**	**8 848 843**	**21 583**	**1 430 897**	**5 823 541**	**3 411 256**	**1 092 932**	**1 717 538**
Net claims incurred	(917 240)	(8 379 890)	(20 957)	(938 323)	(4 124 240)	(2 581 702)	(845 673)	(1 026 019)
Claims incurred	(918 283)	(8 388 490)	(20 974)	(939 181)	(4 128 039)	(2 584 185)	(846 392)	(1 027 111)
Third party claim recoveries	1 043	8 600	17	858	3 799	2 483	719	1 092
Net income/(expense) on risk transfer arrangements	(2 095)	(29 193)	(94)	–	–	–	(3 513)	–
Risk transfer arrangement fees	(8 596)	(109 498)	(318)	–	–	–	(12 110)	–
Recoveries from risk transfer arrangements	6 501	80 305	224	–	–	–	8 597	–
Relevant healthcare expenditure	**(919 334)**	**(8 409 083)**	**(21 052)**	**(938 323)**	**(4 124 240)**	**(2 581 702)**	**(849 186)**	**(1 026 019)**
Gross healthcare result	**(194 089)**	**439 760**	**532**	**492 574**	**1 699 301**	**829 554**	**243 746**	**691 519**
Managed care: management services	(11 270)	(171 115)	(433)	(48 361)	(207 361)	(97 414)	(24 010)	(70 798)
Broker service fees	(10 482)	(160 983)	(394)	(34 983)	(171 137)	(87 337)	(22 315)	(51 122)
Expenses for administration	(37 728)	(572 848)	(1 448)	(161 893)	(694 148)	(326 109)	(80 381)	(236 993)
Other operating expenses	(1 557)	(23 654)	(60)	(6 700)	(28 742)	(13 475)	(3 316)	(9 825)
Net healthcare result	**(255 126)**	**(488 840)**	**(1 803)**	**240 637**	**597 913**	**305 219**	**113 724**	**322 781**
Investment income	7 618	115 720	217	24 234	140 429	65 911	16 232	48 027
Net gains on financial assets at fair value through profit or loss	1 378	20 868	55	5 977	25 669	11 941	2 925	8 807
Sundry income	59	910	–	256	1 096	516	126	374
Other income	**9 055**	**137 498**	**272**	**30 467**	**167 194**	**78 368**	**19 283**	**57 208**
Expenses for asset management services rendered	(129)	(1 963)	(3)	(554)	(2 379)	(1 115)	(272)	(813)
Interest paid	(2 034)	(30 936)	(3)	(273)	(37 687)	(17 643)	(4 335)	(12 942)
Other expenditure	**(2 163)**	**(32 899)**	**(6)**	**(827)**	**(40 066)**	**(18 758)**	**(4 607)**	**(13 755)**
Net surplus/(deficit) for the year	**(248 234)**	**(384 241)**	**(1 537)**	**270 277**	**725 041**	**364 829**	**128 400**	**366 234**

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

2013	Essential Core R'000	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	KeyCare Plus R'000	KeyCare Core R'000	KeyCare Access R'000	TOTAL R'000
Risk contribution income	**599 515**	**283 261**	**3 626 695**	**1 653 286**	**3 051 870**	**177 169**	**46 188**	**32 509 819**
Net claims incurred	(397 237)	(176 399)	(2 853 740)	(1 207 339)	(2 701 813)	(87 800)	(26 705)	(26 285 077)
Claims incurred	(397 666)	(176 511)	(2 856 230)	(1 208 428)	(2 704 105)	(87 906)	(26 741)	(26 310 242)
Third party claim recoveries	429	112	2 490	1 089	2 292	106	36	25 165
Net income/(expense) on risk transfer arrangements	–	–	–	–	91 091	–	(1 650)	54 546
Risk transfer arrangement fees	–	–	–	–	(164 128)	–	(3 110)	(297 760)
Recoveries from risk transfer arrangements	–	–	–	–	255 219	–	1 460	352 306
Relevant healthcare expenditure	**(397 237)**	**(176 399)**	**(2 853 740)**	**(1 207 339)**	**(2 610 722)**	**(87 800)**	**(28 355)**	**(26 230 531)**
Gross healthcare result	**202 278**	**106 862**	**772 955**	**445 947**	**441 148**	**89 368**	**17 833**	**6 279 288**
Managed care: management services	(25 341)	(8 944)	(152 685)	(72 506)	(191 927)	(13 543)	(5 301)	(1 101 009)
Broker service fees	(16 175)	(7 263)	(121 298)	(46 885)	(88 348)	(5 146)	(1 396)	(825 263)
Expenses for administration	(84 826)	(29 939)	(511 129)	(242 718)	(341 887)	(12 729)	(5 978)	(3 340 754)
Other operating expenses	(3 519)	(1 230)	(21 140)	(10 049)	(26 605)	(1 879)	(735)	(152 486)
Net healthcare result	**72 417**	**59 486**	**(33 297)**	**73 789**	**(207 619)**	**56 072**	**4 423**	**859 776**
Investment income	12 703	6 062	103 359	36 337	96 187	6 789	2 657	682 482
Net gains on financial assets at fair value through profit or loss	3 181	1 154	18 799	8 995	23 878	1 698	665	135 990
Sundry income	134	47	809	383	1 015	72	28	5 825
Other income	**16 018**	**7 263**	**122 967**	**45 715**	**121 080**	**8 559**	**3 350**	**824 297**
Expenses for asset management services rendered	(291)	(103)	(1 750)	(831)	(2 200)	(155)	(61)	(12 619)
Interest paid	(149)	(1 629)	(27 704)	(413)	(1 099)	(78)	(29)	(136 954)
Other expenditure	**(440)**	**(1 732)**	**(29 454)**	**(1 244)**	**(3 299)**	**(233)**	**(90)**	**(149 573)**
Net surplus/(deficit) for the year	**87 995**	**65 017**	**60 216**	**118 260**	**(89 838)**	**64 398**	**7 683**	**1 534 500**

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

2012	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	**658 921**	**8 161 363**	**1 266 663**	**4 764 994**	**2 958 447**	**1 090 378**	**1 432 565**	**493 523**
Net claims incurred	(863 146)	(7 900 665)	(827 445)	(3 306 324)	(2 252 527)	(827 094)	(861 277)	(322 205)
Claims incurred	(868 702)	(7 951 688)	(832 137)	(3 324 314)	(2 266 031)	(831 873)	(865 999)	(324 151)
Third party claim recoveries	5 556	51 023	4 692	17 990	13 504	4 779	4 722	1 946
Net income/(expense) on risk transfer arrangements	68	(1 873)	–	–	–	(459)	–	–
Risk transfer arrangement fees	(7 687)	(97 281)	–	–	–	(10 678)	–	–
Recoveries from risk transfer arrangements	7 755	95 408	–	–	–	10 219	–	–
Relevant healthcare expenditure	**(863 078)**	**(7 902 538)**	**(827 445)**	**(3 306 324)**	**(2 252 527)**	**827 553**	**(861 277)**	**(322 205)**
Gross healthcare result	**(204 157)**	**258 824**	**439 218**	**1 458 620**	**705 920**	**262 825**	**571 288**	**171 318**
Managed care: management services	(10 784)	(165 971)	(44 215)	(175 722)	(89 301)	(25 135)	(60 528)	(21 453)
Broker service fees	(10 400)	(162 492)	(32 176)	(149 214)	(81 778)	(24 306)	(44 985)	(13 632)
Expenses for administration	(37 053)	(570 279)	(151 918)	(603 750)	(306 832)	(86 366)	(207 960)	(73 706)
Other operating expenses	(1 231)	(18 942)	(5 057)	(20 101)	(10 203)	(2 869)	(6 930)	(2 460)
Net healthcare result	**(263 625)**	**(658 860)**	**205 852**	**509 833**	**217 806**	**124 149**	**250 885**	**60 067**
Investment income	6 718	103 396	27 537	109 429	55 624	15 659	37 689	13 355
Net gains on financial assets at fair value through profit or loss	1 062	16 328	4 275	17 023	8 725	2 471	5 831	2 036
Sundry income	66	1 012	269	1 069	544	152	368	130
Other income	**7 846**	**120 736**	**32 081**	**127 521**	**64 893**	**18 282**	**43 888**	**15 521**
Expenses for asset management services rendered	(148)	(2 283)	(611)	(2 430)	(1 231)	(345)	(838)	(298)
Interest paid	(1 114)	(17 136)	(4 633)	(18 477)	(9 295)	(2 592)	(6 402)	(2 291)
Other expenditure	**(1 262)**	**(19 419)**	**(5 244)**	**(20 907)**	**(10 526)**	**(2 937)**	**(7 240)**	**(2 589)**
Net surplus/(deficit) for the year	**(257 041)**	**(557 543)**	**232 689**	**616 447**	**272 173**	**139 494**	**287 533**	**72 999**

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

2012	Essential Priority R'000	Coastal Saver R'000	Coastal Core R'000	KeyCare Plus R'000	KeyCare Core R'000	Discontinued Plan R'000	TOTAL R'000
Risk contribution income	**249 616**	**3 078 094**	**1 392 639**	**2 518 958**	**159 045**	**622**	**28 225 777**
Net claims incurred	(153 276)	(2 358 159)	(1 052 906)	(2 385 097)	(84 848)	327	(23 194 642)
Claims incurred	(154 165)	(2 370 967)	(1 059 057)	(2 398 091)	(85 300)	327	(23 332 148)
Third party claim recoveries	889	12 808	6 151	12 994	452	–	137 506
Net income/(expense) on risk transfer arrangements	–	–	–	103 506	–	–	101 242
Risk transfer arrangement fees	–	–	–	(148 252)	–	–	(263 898)
Recoveries from risk transfer arrangements	–	–	–	251 758	–	–	365 140
Relevant healthcare expenditure	**(153 276)**	**(2 358 159)**	**(1 052 906)**	**(2 281 591)**	**(84 848)**	**327**	**(23 093 400)**
Gross healthcare result	**96 340**	**719 935**	**339 733**	**237 367**	**74 197**	**949**	**5 132 377**
Managed care: management services	(8 386)	(136 662)	(64 491)	(175 801)	(12 767)	–	(991 216)
Broker service fees	(6 891)	(109 593)	(40 859)	(74 764)	(4 711)	(2)	(755 803)
Expenses for administration	(28 812)	(469 552)	(221 579)	(315 006)	(12 001)	–	(3 084 814)
Other operating expenses	(960)	(15 627)	(7 382)	(20 141)	(1 462)	–	(113 365)
Net healthcare result	**51 291**	**(11 499)**	**5 422**	**(348 345)**	**43 256**	**947**	**187 179**
Investment income	5 222	85 110	40 159	109 442	7 949	–	617 289
Net gains on financial assets at fair value through profit or loss	810	13 277	6 216	16 793	1 220	–	96 067
Sundry income	51	832	392	1 069	78	–	6 032
Other income	**6 083**	**99 219**	**46 767**	**127 304**	**9 247**	**–**	**719 388**
Expenses for asset management services rendered	(116)	(1 888)	(893)	(2 443)	(177)	–	(13 701)
Interest paid	(883)	(14 332)	(6 796)	(18 768)	(1 357)	–	(104 076)
Other expenditure	**(999)**	**(16 220)**	**(7 689)**	**(21 211)**	**(1 534)**	**–**	**(117 777)**
Net surplus/(deficit) for the year	**56 375**	**71 500**	**44 500**	**(242 252)**	**50 969**	**947**	**788 790**

R'000	2013	2012
28 CASH FLOWS FROM OPERATIONS BEFORE WORKING CAPITAL CHANGES		
Net surplus for the year	**1 534 500**	788 790
Adjustments for:		
Impairment losses	**53 189**	45 567
Interest received	**(667 924)**	(600 265)
Dividend income	**(14 648)**	(17 124)
Interest paid	**136 954**	104 076
Net gains on financial assets at fair value through profit or loss	**(135 135)**	(96 067)
	906 936	224 977

29 EVENTS AFTER THE REPORTING PERIOD

Subsequent to the reporting date, the Scheme amalgamated with Altron Medical Aid Scheme effective from 1 January 2014. All assets and liabilities have been accounted for at fair value and transferred to, or are under the control of the Scheme.

An amalgamation with Afrox Medical Aid Society was proposed during 2013 and the exposition documents presented to the Registrar in terms of Section 63(4) of the Act. The amalgamation was confirmed on 2 April 2014 and is effective from 1 May 2014.

An amalgamation with PG Bison Medical Aid Society was proposed during 2013 and the exposition documents presented to the Registrar in terms of Section 63(4) of the Act. The amalgamation was confirmed on 2 April 2014 and is effective from 1 May 2014.

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

30 INSURANCE RISK MANAGEMENT REPORT

Nature and extent of risks arising from insurance contracts

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

This section summarises these risks and the way 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 the actual number and size of events during any year may vary from those estimated using established techniques. As such, the Scheme is exposed to the uncertainty surrounding the occurrence, timing and severity of claims under the contract.

For a portfolio of insurance contracts where the theory of probability is applied to pricing and provisioning, the principal risk that the Scheme faces under its insurance contracts is that the actual claim payments exceed the carrying amount of the insurance liabilities. This could occur because the frequency and severity of claims are greater than estimated. As insurance events are random, the actual number and amount of claims will vary from year to year from the level established using statistical techniques.

Experience shows that the larger the portfolio of insurance contracts, the smaller the variability of the actual outcome will be relative to expected levels. This is because an adverse movement in one subset of the portfolio is more likely to be offset by a favourable outcome in another subset.

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

The Scheme offers members a range of benefit plans reflecting the Scheme's underlying philosophy to offer choice, make members healthier and to enhance and protect their lives. The 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.

Chronic Illness Benefit

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 and AIDS, high blood pressure, cholesterol and asthma.

Day-to-day benefits

The day-to-day benefits include both the Personal Medical Savings Account (PMSA) and an insurance risk element – the Insured Network Benefit and Above Threshold Benefit. 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.

30 INSURANCE RISK MANAGEMENT REPORT (continued)

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

Hospital benefit risk

Frequency and severity of claims

The frequency and severity of claims can be affected by several factors. The two most significant factors are changes in the admission rate for a given burden of disease and changes in the burden of disease overall for those admitted.

The introduction of new hospital-based technologies could also increase frequency and severity of claims.

Initiatives used by the Scheme to manage the risk associated with admission rate include:

- The development of protocols around various high cost conditions, such as lower back surgery
- The "See Your Doctor First" initiative which requires members to see their doctor prior to an elective admission
- The amendment to the pre-authorisation length of stay benchmarks
- The work of the Clinical Policy Unit, which evaluates the effectiveness of new technologies and recommends whether the Scheme should cover these technologies or not
- Increased statistical and actuarial investigations and techniques to detect, manage and prevent fraud and over-servicing
- 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 Care Coordination Programme (CCP). This is a dedicated unit to ensure direct coordination of care from medical providers to beneficiaries that are exposed to conditions that would generate multiple admissions if not managed
- The establishment of a new disease management unit dedicated to managing high risk beneficiaries with complex diseases and
- The focus on high loss ratio employer groups in order to seek opportunities that integrate Corporate Wellness Programmes and Risk Management and aligning incentives.

Another factor that impacts on admission rates is a shifting membership distribution between plans. The actions the Scheme can take are limited by the legislative requirement of open enrolment. Nevertheless, the Scheme has developed advanced risk attribution models that quantify the likely cost impact of demographic movements and advanced tools to monitor changes in disease profile. These models and tools help the Scheme to take corrective action shortly after such trends emerge by, for instance, implementing new managed care policies where appropriate.

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 cost of claims results from an increase in the frequency and/or severity of claims.

An increase in the admission rate is often linked to increases in the number of beneficiaries at older ages. An increased cost per event can be caused by an increased case-mix or severity of admissions.

30 INSURANCE RISK MANAGEMENT REPORT (continued)

Chronic Illness Benefit (CIB) risk

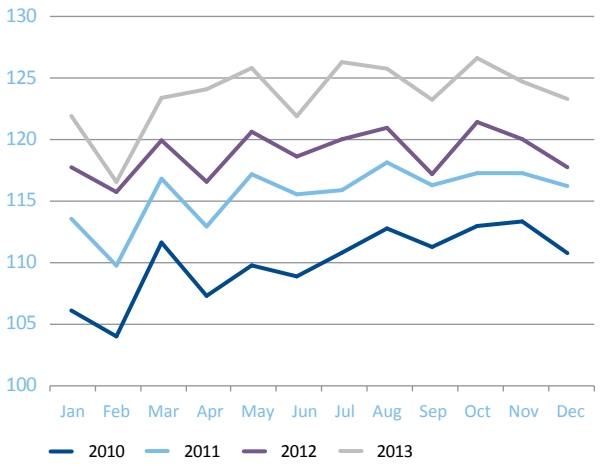
Frequency and severity of claims

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

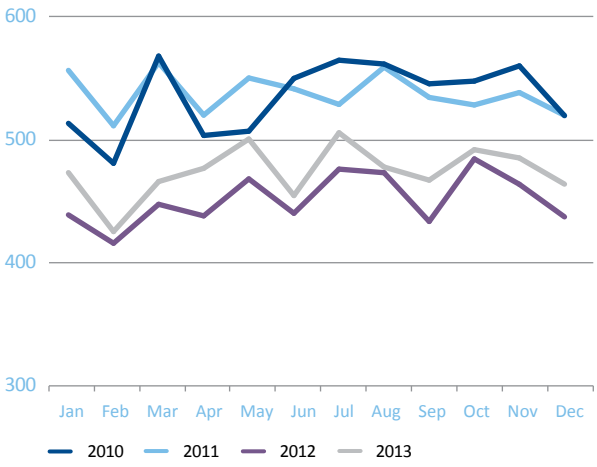
Higher increases in claimants are often linked to increases in the number of beneficiaries at older ages. The timing of increases in the Single Exit Price regulations for medication also has an impact on costs per claim. Any changes in the rules or Regulations relating to Prescribed Minimum Benefits for chronic conditions would also impact either positively or negatively on the costs. Increases in the number of items per claimant drives up the cost of chronic claims per claimant.

The following graphs indicate changes in the number of claimants and cost per claimant over the past four years.

CHRONIC CLAIMANTS PER 1 000 BENEFICIARIES



CHRONIC COST PER CLAIMANT



The Scheme manages and mitigates the risks associated with CIB benefits through an extensive managed care programme, involving detailed drug policy interventions, medicine protocols and benefit rules, all of which comply with the Regulations on Prescribed Minimum Benefits. Much of the work of the Clinical Policy Unit mentioned above also focuses on new drugs.

The mix between the various chronic conditions impacts the frequency and severity of claims.

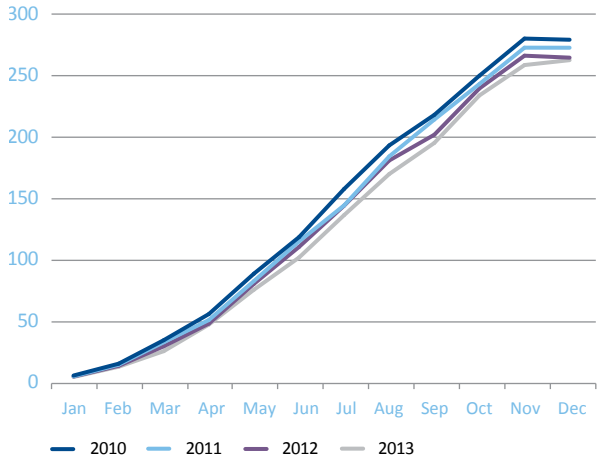
30 INSURANCE RISK MANAGEMENT REPORT (continued)

Day-to-day benefit risk

Frequency and severity of claims

The following graph indicates changes in the number of claimants over the past four years.

CLAIMANTS PER 1 000 BENEFICIARIES FOR THE ABOVE THRESHOLD BENEFIT



Concentration of insurance risk

As the largest open medical scheme in South Africa, the Scheme is not subject to a significant degree of concentration risk. The Scheme offers a wide range of benefit plans 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 plan.

All contracts are negotiated and renewed annually. The Scheme has the right to change the terms and conditions of each contract at renewal. Contracts can be terminated at any time during the year, subject to three months' written notice.

Risk transfer arrangements

The Scheme has four risk transfer agreements with service providers to cover specific risks. 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

According to the terms of the agreements, the suppliers provide certain minimum benefits to Scheme members, as and when required by the members. The Scheme does, however, remain liable to its members if any supplier fails to meet the obligations it assumes.

When selecting a supplier, the Scheme considers 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.

30 INSURANCE RISK MANAGEMENT REPORT (continued)

Concentration of insurance risk (continued)

Liquidity risk

The Scheme has not presented a maturity analysis showing the remaining contractual maturities of its insurance contracts. The Scheme presents information around the estimated timing of its insurance liabilities recognised at year end.

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

Risk management objectives and policies for mitigating insurance risk

The Scheme manages its insurance risk through benefit limits and sub-limits, application of clinical protocols, approval procedures for transactions that exceed set limits, pricing guidelines, pre-authorisation and case management, service provider profiling, and the regular monitoring of demographic and claims trends through advanced actuarial and clinical risk models.

The Scheme uses several methods to assess and monitor insurance risk exposure both for individual types of risks insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing, as well as statistical techniques such as generalised linear modeling, bootstrapping, cluster analysis and decision trees. The theory of probability and best actuarial practice is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and/or severity of claims is greater than expected.

The following factors affect the frequency and severity of claims:

- Fee-for-service provider reimbursement combined with a third-party payer creates the incentive for overservicing of members. The Scheme uses alternative reimbursement arrangements to mitigate this risk and also peer-review service providers, network arrangements and statistical trend analyses.
- The demographic profile of the membership base i.e. older, sicker members require more frequent and more intense treatment than younger, healthier members. This risk is managed through the regular updating of internal risk management models that assess the impact of any changes to the Scheme's demographic profile.
- Technological advances in healthcare generally increases the cost of treatment. This may be due to either the increased price of the new technology or the increased quantity of treatment. This risk is mitigated through a rigorous health technology assessment process in the Clinical Policy Unit which determines whether the technology is cost-effective and whether it should be funded.
- The price of covered services affects the severity of claims. This risk is mitigated by the Scheme's Rules, which specify the maximum rate at which each treatment is funded. The Scheme also manages this risk through annual tariff agreements with most provider groups.

Outstanding claims provision

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.

There are some sources of uncertainty that need to be considered in the estimate of the liability that the Scheme will ultimately have for claims made under insurance contracts prior to the effective date of the financial statements.

The estimation of the December 2013 outstanding claims provision was made in accordance with Advisory Practice Note 304 of the Actuarial Society of South Africa. In accordance with this note, the following factors are checked to determine whether they would have any impact on the outstanding claims provision estimate:

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

It was found that all of the above factors are adequately taken into account in the calculation methodology.

Based on the processing patterns and claims development up to the end of February 2014 in respect of treatment dates during 2013, the recommended provision for outstanding claims as at 31 December 2013 is R812 million.

30 INSURANCE RISK MANAGEMENT REPORT (continued)

Assumptions and the process used to determine the assumptions

The risks associated with the Scheme's insurance contracts are complex and subject to a number of variables that complicate quantitative sensitivity analysis.

The process used to determine the assumptions is intended to result in best estimates of the most likely or expected outcome. However, ultimate liabilities will vary as a result of subsequent developments. The sources of data used as inputs for the assumptions are internal, using detailed studies that are carried out monthly. There is emphasis on current trends, and where there is insufficient information to make a reliable best estimate of claims development, assumptions are used.

The claims provision is based on information currently available. The cost of outstanding claims is estimated using the chain ladder method. Run-off triangles are used as it takes time after the treatment date until the full extent of the claims to be paid is known. This method extrapolates the development of paid and incurred claims for each benefit month based on observed development of earlier months i.e. the method assumes that the recent historic claims development pattern will occur again over the run-off period. The outstanding claims provision is calculated based on claim processing patterns over the previous months. Owing to differences in reporting lags and claim processing patterns (caused by differences in the underlying insurance contracts, claim complexity, the volume of claims, the different rates of claim submission, the individual severity of claims and claim reporting lags), risk claims are grouped into in-hospital, chronic, above threshold benefits and out-of-hospital claim categories, and the claims development pattern is assessed separately for each category.

The reasonableness of the outstanding claims provision is reviewed at the time of its calculation. Using current and historic development factors, the provision is back-tested to ensure that it is reasonable and adequate. Any significant deviations provide an indication that the provision may need to be increased or decreased accordingly.

A run-off triangle is constructed showing, for each treatment month, the cumulative claims paid in each development month. The percentage increase in the cumulative claims paid from one development month to the next, i.e. the claims development factors, can then be used to calculate claims payments for future development months.

The calculation methodology assumes that the claim processing patterns will remain unchanged from month to month. The chain ladder estimate of outstanding claims is adjusted, among others, for the following factors:

- Known changes to the claims development pattern, for example as a result of changes in the method of submission (manual/electronic), are allowed for by adjusting the claim development factors on the basis of patterns evident from the most recent processing months
- Known changes to the hospital admission rate are allowed for by adjusting the claim development factors on the basis of changes in the proportion of members obtaining a hospital authorisation
- The seasonality of the claims experience
- External influences, for example the potential impact of medicine pricing legislation.

The number of hospital admissions authorised through the pre-authorisation process and the expected increase in the Per Life Per Month cost for the most recent benefit years for the "in-hospital", "chronic" and "above threshold" categories of claims are also considered. Since approximately 95% of claims are paid within three months of the date of service, no allowance for discounting of claims costs is made.

Outstanding claims provisions are estimated at a gross level and an adjustment is made to cater for risk transfer arrangements by reducing the outstanding claims provision by the amount of the expected claims incurred under these risk transfer arrangements.

Changes in assumptions and sensitivities to changes in key variables

There has been no material change in the assumptions or the calculation methodology over the period.

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

Where variables are considered to be immaterial, no impact has been assessed for insignificant changes to these variables. Particular variables may not be considered material at present. However, should the materiality level of an individual variable change, assessment of changes to that variable in the future may be required.

An analysis of the sensitivities around various scenarios for the general medical insurance business provides an indication of the adequacy of the Scheme's estimation process. The Scheme believes that the liability for claims reported in the Statement of Financial Position is adequate. However, it recognises that the process of estimation is based upon certain variables and assumptions which could differ when claims arise.

30 INSURANCE RISK MANAGEMENT REPORT (continued)

Changes in assumptions and sensitivities to changes in key variables (continued)

R'000	2013	2012
The total estimate of incurred claims and the provision for outstanding claims is as follows:		
Total estimate of incurred claims		
In-hospital claims incurred	**18 592 142**	16 259 043
Chronic claims incurred	**1 721 699**	1 551 849
Out-of-hospital risk claims incurred	**5 748 318**	5 191 964

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

	Change in variable %	Impact on outstanding claims provision 2013 R'000	Impact on outstanding claims provision 2012 R'000
In-hospital claims incurred	1% increase in claims costs	**185 921**	162 590
Chronic claims incurred	1% increase in claims costs	**17 216**	15 518
Out-of-hospital risk claims incurred	1% increase in claims costs	**57 483**	51 920

The Scheme is most vulnerable to changes in membership distribution and changes in the underlying rate of inflation which drives a number of assumptions.

Underwriting risk

Underwriting risk is the risk that the actual exposure of the Scheme in respect of outstanding claims will exceed the best estimates of such outstanding claims. Actuaries have been consulted in setting these estimates at year end, including the estimate for those claims outstanding at year end, which had not yet been reported.

Sensitivity of the Scheme's profit and loss and reserves to changes in variables that have a material effect on them

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

One of the sensitivity tests performed in arriving at the estimate is to calculate the chain ladder on treatment-to-paid run-off patterns over the last 12 months and compare it to a number of treatment-to-paid patterns scenarios. These include the treatment-to-paid patterns over the last three and the last six months. Other reasonability checks are also performed, namely checks against the expected loss ratio taking into account the seasonality of claims, checks of pre-authorisation statistics relating to hospital admissions, as well as known hospital admission rates and consideration of the number of working days in recent months.

31 FINANCIAL RISK MANAGEMENT REPORT

Overview

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

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

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

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

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 strategic and operating matters in respect of the investment of Scheme funds and meets at least quarterly.
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly.
- An external asset consulting company has been appointed to assist in formulating the investment strategy and to provide ongoing reporting and monitoring of the asset managers.
- Asset management agreements and mandates are concluded and reviewed by an external legal advisor.

Information on the enhancements to the risk management process is provided under the price and currency risk sections below.

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 has 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 Accounts. 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 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 13% of its investments and cash in offshore bond portfolios. At 31 December 2013 this equates to R968 million (2012: R423 million) (Note 2).

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Currency derivative financial instrument (zero-cost currency collars)

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

The Scheme entered into zero cost currency collar arrangements with South African banks to hedge exposure to changes in foreign currency for investments in the offshore bond portfolios. The contracts expire during 2014 and were entered into with the cap ranging between R10.33 and R11.83 to the US Dollar. The spot levels (the floor) were entered into at levels ranging between R9.60 and R10.06 to the US Dollar.

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 Net surplus (Note 7).

Currency risk sensitivity analysis

A 5% depreciation in the Rand would result in a gain of R48 million and a 15% depreciation in the Rand would result in a gain of R145 million. A 5% appreciation in the Rand would result in a loss of R48 million and a 15% appreciation in the Rand would result in a loss of R145 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 to the value of R707 million (2012: R473 million) (Note 2).

The Scheme manages the price risk arising from investments in equity securities, through the diversification of its investment portfolio's. Diversification of the portfolio's are performed by asset managers in accordance with the mandates 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 exposure to changes in market prices for investments in the equity portfolios. The contracts provide downside protection of up to 20% (the floor) after a reduction in equity prices of 5%. To achieve this, the Scheme agreed to forego upside benefit from an increase in equity prices above a pre-determined level (the cap). The cap for these contracts range between 11% and 13% above the pre-determined level. These contracts expire during 2014.

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

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

- If the index level is higher than the 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.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Equity price risk sensitivity analysis

A 5% increase in the price of equities within the equity portfolios would result in a gain of R37 million and a 15% increase would result in a gain of R112 million. A 5% decrease would result in a loss of R37 million and a decrease of 15% would result in a loss of R112 million. This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that equity prices had increased or decreased by 5% or 15%, with all other variables held constant. The analysis is performed without taking into account the effect of the equity hedges.

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

Interest rate risk

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

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

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

As at 31 December 2012	0 – 3 Months R'000	3 – 12 Months R'000	> 12 Months R'000	Total R'000
Cash and cash equivalents	1 419 948	–	–	1 419 948
Money market instruments carried at fair value through profit or loss	–	5 222 869	–	5 222 869
Yield enhanced bonds carried at fair value through profit or loss	–	850 412	–	850 412
Offshore bonds carried at fair value through profit or loss	–	–	422 942	422 942

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

%	2013	2012
Money market instruments carried at fair value through profit or loss	**6.62**	7.03
Cash and cash equivalents	**4.76**	4.75

The weighted average effective interest rate on short term bank deposits (namely call account deposits) was 5.02%. (2012 – 5.05%). These deposits have an average maturity of 28 days (2012 – 17 days).

Interest rate risk sensitivity analysis

A 5% increase in local interest rates would result in a loss of R3 million and a 15% increase would result in a loss of R9 million. A 5% decrease in local interest rates would result in a gain of R3 million and a decrease of 15% would result in a gain of R9 million. This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that local interest rates had increased or decreased by 5% or 15%, with all other variables held constant.

A 5% increase in foreign interest rates would result in a loss of R2 million and a 15% increase would result in a loss of R4 million. A 5% decrease in foreign interest rates would result in a gain of R2 million and a decrease of 15% would result in a gain of R4 million. This impact would be recognised in the Net Surplus. The sensitivity is based on the assumption that foreign interest rates had increased or decreased by 5% or 15% with all other variables held constant.

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 2013 the Scheme did not consider there to be any significant concentration of legal risk that had not been provided for.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Fair value estimation

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

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

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

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

Capital management

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

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

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

R'000	2013	2012
Total members' funds per Statement of Financial Position	**9 970 118**	8 240 820
Less: cumulative unrealised net gain on remeasurement of investments to fair value	**(136 666)**	–
Accumulated funds per Regulation 29	**9 833 452**	8 240 820
Gross contribution income	**40 463 701**	35 195 627
Solvency margin		
= Accumulated funds/gross contribution income x 100	**24.30%**	23.41%

The Scheme has submitted a business plan to the Council for Medical Schemes in terms of Regulation 29(4) of the Act. The business plan provides that the Scheme will increase the statutory reserves to the required level of 25% by 31 December 2015. The business plan takes into account several assumptions such as membership growth, investment returns and medical inflation. The Council for Medical Schemes has approved the business plan.

At 31 December 2013, the Scheme's regulatory capital level of 24.30% was R282 million less than the statutory capital requirement of 25% but R527 million higher than the solvency phase-in level approved by the Council for Medical Schemes in terms of the business plan.

31 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 invests excess funds in line with the Act.

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

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

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

Breakdown of investments

The investments managed by the Investment Committee are split between the following in the Annual Financial Statements:
– Investments carried at fair value through profit and loss; and
– Cash and cash equivalents.

R'000	Segregated Funds	Collective Investment Schemes	Policy of Insurance	Total
For the year ended 31 December 2013				
Investments:	6 639 514	501 271	466 300	**7 607 085**
Offshore bonds	–	501 271	466 300	**967 571**
Listed equities	706 870	–	–	**706 870**
Yield enhanced bonds	879 120	–	–	**879 120**
Money market instruments	5 053 524	–	–	**5 053 524**
Cash and cash equivalents:	133 872	1 829 196	–	**1 963 068**
Money market instruments	133 872	1 829 196	–	**1 963 068**
	6 773 386	2 330 467	466 300	**9 570 153**

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 out performance of the targeted return.

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

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 2 years. The term of each individual instrument is also limited.

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

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

The local money market portfolios comprise approximately 66% of the Scheme's Financial assets at fair value through profit or loss.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Investment risk (continued)

Breakdown of investments (continued)

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 the BEASSA All Bond Index (ALBI).

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 12% of the Scheme's Financial assets at fair value through profit or loss.

Offshore portfolio:

The Scheme has two offshore portfolios managed by an independent asset manager. 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 13% of the Scheme's Financial assets at fair value through profit or loss.

Equity portfolios:

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

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

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

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

These portfolios comprise approximately 9% of the Scheme's Financial assets at fair value through profit or loss.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Investment risk (continued)

Breakdown of investments (continued)

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

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

For the year ended 31 December 2012	Financial assets and liabilities at fair value through profit and loss		Loans and receivables R'000	Insurance receivables and (payables) R'000	Financial liabilities at an amortised cost R'000	Total carrying amount R'000	Fair value amount R'000
	Designated upon initial recognition R'000	Classified as held for trading R'000					
Investments							
– Offshore bonds	422 942		–	–	–	422 942	422 942
– Listed equities	472 567		–	–	–	472 567	472 567
– Yield enhanced bonds	850 412		–	–	–	850 412	850 412
– Money market instruments	5 222 869		–	–	–	5 222 869	5 222 869
Cash and cash equivalents:							
Medical Scheme assets	–	–	1 419 948			1 419 948	1 419 948
Personal Medical Savings Account trust assets			2 260 141			2 260 141	2 260 141
Trade and other receivables	–	–	163 765	1 295 836	–	1 459 601	1 459 601
Personal Medical Savings Accounts	–	–	–	(2 291 580)	–	(2 291 580)	(2 291 580)
Trade and other payables	–	–	–	(471 900)	(302 832)	(774 732)	(774 732)
Derivatives held for trading							
– Collars	–	(30 814)	–	–	–	(30 814)	(30 814)
– Other	–	(1 859)	–	–	–	(1 859)	(1 859)
	6 968 790	**(32 673)**	**3 843 854**	**(1 467 644)**	**(302 832)**	**9 009 495**	**9 009 495**

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Fair value hierarchy for financial assets measured at fair value

Assets measured at fair value

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

2012	Fair value measurement at end of the year using: R'000	Level 1 R'000	Level 2 R'000
Financial assets at fair value through profit or loss:			
Listed equities	**472 567**	472 567	**–**
Government bonds	**271 249**	271 249	**–**
Corporate bonds	**2 057 294**	**–**	2 057 294
Other investments	**4 135 007**	**–**	4 135 007
	6 936 117	**743 816**	**6 192 301**

The fair value assets are classified using a fair value hierarchy that reflects the significance of the inputs used in determining the measurements.
The fair value hierarchy has the following levels:
Level 1 – These are assets measured using quoted prices in an active market.
Level 2 – These are assets measured using inputs other than quoted prices included within Level 1, that are either directly or indirectly observable.
Level 3 – These are assets measured using inputs that are not based on observable market data.

The Scheme does not have any assets falling under Level 3.

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

Description	Fair value as at 31 December 2013	Valuation techniques	Observable input
Financial assets at fair value through profit or loss:			
Unlisted:			
Debt securities	474 763	Reference to listed benchmarks	Risk free yield to maturity curve, risk free zero curve
Equity linked securities	49 309	Discounted cash flow valuation, net asset value	Published interest rate curve, published credit spread curve/implied credit spread curve
Money market securities	5 806 235	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
	6 330 307		

31 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:

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

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

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

Trade and other receivables

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

R'000	Note	2013	2012
Insurance receivables	3	**1 397 714**	1 295 836
Contribution receivables[1]		**1 322 098**	1 193 672
Less provision for impairment		**(5 734)**	(3 878)
Member and service provider claims receivables[2]		**224 878**	205 303
Less provision for impairment		**(171 956)**	(151 508)
Recoveries due from other risk transfer arrangements		**111**	81
Less provision for impairment		**–**	–
Share of outstanding claims provision (Note 6)		**2 490**	3 127
Broker fee receivables		**570**	532
Less provision for impairment		**(426)**	(342)
Other insurance receivables		**25 683**	48 849
Loans and receivables	3	**100 207**	163 765
Balance due by related parties		**13 191**	19 800
Sundry accounts receivables		**85 661**	142 491
Interest receivable		**1 355**	1 474
Total		**1 497 921**	**1 459 601**

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

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

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk

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

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

Contribution debtors	Gross 2013 R'000	Impairment 2013 R'000	Gross 2012 R'000	Impairment 2012 R'000
Not past due	**1 311 926**		1 187 686	
Past due 4 – 30 days not impaired	**6 111**		6 020	
Past due 31 – 60 days not impaired	**17 169**		4 850	
Past due 61 – 90 days not impaired	**(13 265)**		(1 357)	
91 days to more than one year	**157**		(3 527)	
Total	**1 322 098**	**(5 734)**	**1 193 672**	**(3 878)**

Total Member and service provider claims debtors	Gross 2013 R'000	Impairment 2013 R'000	Gross 2012 R'000	Impairment 2012 R'000
Not past due	**–**		–	
Past due 0 – 30 days not impaired	**18 339**		12 952	
Past due 31 – 60 days not impaired	**9 987**		8 094	
Past due 61 – 90 days not impaired	**11 399**		4 546	
Past due 91 – 120 days not impaired	**3 514**		5 769	
Past due 121 – 150 days not impaired	**12 840**		11 852	
151 days to more than one year	**168 800**		162 100	
Total	**224 878**	**(171 956)**	**205 313**	**(151 508)**

Active member claims debtors	Gross 2013 R'000	Impairment 2013 R'000	Gross 2012 R'000	Impairment 2012 R'000
Not past due	**–**		–	
Past due 0 – 30 days not impaired	**3 346**		2 605	
Past due 31 – 60 days not impaired	**1 847**		1 023	
Past due 61 – 90 days not impaired	**1 769**		1 013	
Past due 91 – 120 days not impaired	**1 811**		1 337	
Past due 121 – 150 days not impaired	**1 450**		1 823	
151 days to more than one year	**27 787**		27 948	
Total	**38 011**	**(17 005)**	**35 749**	**(17 394)**

Withdrawn member claims debtors	Gross 2013 R'000	Impairment 2013 R'000	Gross 2012 R'000	Impairment 2012 R'000
Not past due	**–**		–	
Past due 0 – 30 days not impaired	**7 715**		6 354	
Past due 31 – 60 days not impaired	**4 973**		3 964	
Past due 61 – 90 days not impaired	**6 307**		4 793	
Past due 91 – 120 days not impaired	**7 211**		5 974	
Past due 121 – 150 days not impaired	**6 934**		6 906	
151 days to more than one year	**136 216**		129 282	
Total	**169 355**	**(142 327)**	**157 273**	**(124 518)**

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk (continued)

Service provider claims debtors	Gross 2013 R'000	Impairment 2013 R'000	Gross 2012 R'000	Impairment 2012 R'000
Not past due	–		–	
Past due 0 – 30 days not impaired	**7 277**		3 983	
Past due 31 – 60 days not impaired	**3 168**		3 107	
Past due 61 – 90 days not impaired	**3 323**		(1 260)	
Past due 91 – 120 days not impaired	**(5 509)**		(1 542)	
Past due 121 – 150 days not impaired	**4 456**		3 123	
151 days to more than one year	**4 797**		4 870	
Total	**17 512**	**(12 623)**	**12 281**	**(9 596)**

Other risk transfer arrangements	Gross 2013 R'000	Impairment 2013 R'000	Gross 2012 R'000	Impairment 2012 R'000
Not past due	**2 601**		3 208	
Past due 0 – 30 days not impaired	–		–	
Past due 31 – 60 days not impaired	–		–	
Past due 61 – 90 days not impaired	–		–	
Past due 91 – 120 days not impaired	–		–	
Past due 121 – 150 days not impaired	–		–	
151 days to more than one year	–		–	
Total	**2 601**	**–**	**3 208**	**–**

Broker fee debtors	Gross 2013 R'000	Impairment 2013 R'000	Gross 2012 R'000	Impairment 2012 R'000
Not past due	–		–	
Past due 0 – 30 days not impaired	**219**		247	
Past due 31 – 60 days not impaired	**–**		107	
Past due 61 – 90 days not impaired	**(23)**		123	
Past due 91 – 120 days not impaired	**81**		(100)	
Past due 121 – 150 days not impaired	**351**		60	
151 days to more than one year	**(57)**		94	
Total	**570**	**(426)**	**531**	**(342)**

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.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Trade and other receivables (continued)

Exposure to credit risk (continued)

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

	Trade and other receivables				
	Insurance receivables				
R'000	Contribution debtors	Member and service provider claims debtors	Other risk transfer arrangements	Broker fee debtors	Total
Balance as at 1 January 2012	**6 122**	**140 309**	**–**	**293**	**146 724**
Increase in provision for impairment	(2 244)	47 763	–	48	45 567
Amounts utilised during the year	–	(36 564)	–	–	(36 564)
Balance as at 31 December 2012	**3 878**	**151 508**	**–**	**341**	**155 727**
Balance as at 1 January 2013	3 878	151 508	–	341	155 727
Increase in provision for impairment	1 856	48 711	–	84	50 651
Amounts utilised during the year	–	(28 263)	–	–	(28 263)
Balance as at 31 December 2013	**5 734**	**171 956**	**–**	**425**	**178 115**

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

Credit quality

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

	2013 R'000	2012 R'000
Insurance receivables		
Counterparties without external credit rating net of provision for impairment:		
Contribution debtors	**1 316 364**	1 189 794
Member and service provider claims debtors	**52 922**	53 795
Active member claims debtors	**21 006**	18 355
Withdrawn member claims debtors	**27 028**	32 755
Service provider claims debtors	**4 889**	2 685
Broker fee debtors	**144**	190
Other insurance receivables	**25 683**	48 849
	1 395 113	**1 292 628**

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Contribution debtors

The Scheme collected over 97% (2012: 98%) of outstanding debt in January 2014. Therefore we can reasonably establish that the credit quality of contribution debtors is high. Consequently no additional disclosure of the credit quality is provided.

Active member claims debtors

These debtors are current members of the Scheme and are expected to have similar credit quality to the Contribution debtors. A provision for impairment covering 45% (2012: 49%) of the debtors has been raised.

Withdrawn member claims debtors

These amounts are due from members that have withdrawn from the Scheme. A provision for impairment covering 84% (2012: 79%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Other insurance receivables

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

Financial assets held at fair value through profit or loss

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

R'000	2013	2012
Financial assets held at fair value through profit or loss		
Current assets		
– Offshore bonds	**967 571**	422 942
– Listed equities	**706 870**	472 567
– Yield enhanced bonds	**879 120**	850 412
– Money market instruments	**5 053 524**	5 222 869
	7 607 085	**6 968 790**

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

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

Exposure to credit risk

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

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

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

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Financial assets held at fair value through profit or loss (continued)

Credit quality

R'000	Total	Govt	F1+	F1	AAA	AA+ to AA-	A+ to A-	B to BBB	CCC+ to CCC-	Not rated
2013										
At fair value through profit or loss:	**6 900 215**	**569 908**	**70 839**	**13 837**	**697 569**	**3 937 694**	**1 304 707**	**144 971**	**1 995**	**158 695**
– Offshore bonds	**967 571**	**287 350**	**–**	**–**	**1 951**	**471 671**	**26 591**	**111 094**	**1 995**	**66 919**
– Yield enhanced bonds	**879 120**	**130 550**	**–**	**–**	**139 970**	**243 991**	**238 956**	**33 877**	**–**	**91 776**
– Money market instruments	**5 053 524**	**152 008**	**70 839**	**13 837**	**555 648**	**3 222 032**	**1 039 160**	**–**	**–**	**–**
Cash and cash equivalents	**5 449 279**	**–**	**760 690**	**137 000**	**30 978**	**4 343 796**	**152 821**	**56**	**–**	**23 938**
Total	**12 349 494**	**569 908**	**831 529**	**150 837**	**728 547**	**8 281 490**	**1 457 528**	**145 027**	**1 995**	**182 633**
2012										
At fair value through profit or loss:	6 496 223	271 249	–	–	750 364	3 692 272	1 508 721	188 281	4 963	80 373
– Offshore bonds	422 942	205 215	–	–	1 014	5 304	21 280	105 715	4 963	79 451
– Yield enhanced bonds	850 412	66 034	–	–	114 961	252 866	333 984	82 566	–	–
– Money market instruments	5 222 869	–	–	–	634 388	3 434 102	1 153 456	–	–	922
Cash and cash equivalents	3 680 089	–	516 268	300 861	5 749	2 614 086	–	–	–	243 125
Total	**10 176 313**	**271 249**	**516 268**	**300 861**	**756 113**	**6 306 358**	**1 508 721**	**188 281**	**4 963**	**323 498**

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.

The Scheme has appointed reputable external asset managers to manage its investments and their performance is regularly monitored.

An external asset consulting company has been appointed to assist in formulating fund strategy and to provide ongoing reporting and monitoring of the asset managers.

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

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Liquidity risk (continued)

Credit rating scales

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

Definitions of the symbols are presented below.

Short term rating scales

F1: Highest short-term credit quality

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

Long term rating scales

AAA: Highest credit quality

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

AA: Very high credit quality

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

A: High credit quality

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

B to B1 comprise BBB, BB and B symbols and these are defined below.

BBB: Good credit quality

BBB ratings indicate that expectations of default risk are currently low. The capacity for payment of financial commitments is considered adequate but adverse business or economic conditions are more likely to impair this capacity. In 2013 1.1% (2012: 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. In 2013 0.3% (2012: 0.4%) of the Scheme's Financial assets at fair value through profit or loss invested in instruments with this credit rating.

B: Highly speculative

B ratings indicate that material default risk is present, but a limited margin of safety remains. Financial commitments are currently being met; however, capacity for continued payment is vulnerable to deterioration in the business and economic environment. In 2013 0.2% (2012: 0.4%) 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.

31 FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Financial assets held at fair value through profit or loss (continued)

Credit quality (continued)

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

Name and Description	2013 R'000	Authorised programme size	% of Authorised programme size	Underlying assets
Asset backed commercial paper	R28 million	R111 billion	0.03	Public Debt Obligations Corporate Loans Equipment Leases
Residential mortgage-backed securitisations	R431 million	R71.23 billion	0.61	Eskom Employee Residential Mortgages Prime Home Loans
Asset backed securitisations	R151 million	R13.73 billion	1.10	SASFIN Operating Equipment Leases Unsecured Loans Auto Loans Food Producers
Commercial mortgage-backed securitisations	R73 million	R1.35 billion	5.37	Commercial Property
Collective investment schemes	R36 million R501 million R2 billion			Futuregrowth Power Fund Investec Global Strategic Income Fund Nedgroup Money Market

Liquidity risk

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

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

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

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

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

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

As at 31 December 2012	Less than 1 year R'000	Between 1 and 2 years R'000	Between 2 and 5 years R'000
Personal Medical Savings Accounts	2 291 580	–	–
Insurance and other payables (Note 9)	302 832	–	–

32 CRITICAL ACCOUNTING ESTIMATES AND JUDGEMENTS

Critical accounting estimates and assumptions

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

Outstanding claims provision

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

Other risk transfer arrangements

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

Impairment of assets

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

33 MATERIAL NON-COMPLIANCE MATTERS

Statutory Scheme Solvency

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

The Scheme has submitted a business plan to the Council for Medical Schemes in terms of Regulation 29(4) to the Act. The business plan provides that the Scheme will increase the statutory reserves to the required level of 25% by 31 December 2015. The business plan takes into account several assumptions such as membership growth, investment returns and medical inflation. The Council for Medical Schemes has approved the business plan.

At 31 December 2013, the Scheme's accumulated funds expressed as a percentage of gross annual contributions was 24.30% (2012: 23.41%) which is less than the statutory requirement of 25% but exceeded the business level of 23% by R527 million.

Sustainability of benefit plans

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

At 31 December 2013 the following plans did not comply with Section 33(2):

Plan	Net underwriting deficit R'000	Net (deficit)/surplus R'000
Executive	**(257 289)**	**(248 234)**
Classic Comprehensive	**(521 739)**	**(384 241)**
Classic Comprehensive Zero MSA	**(1 809)**	**(1 537)**
Coastal Saver	**(62 750)**	**60 216**
KeyCare Plus	**(210 918)**	**(89 838)**

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

INFORMATION TOOLKIT //
who to contact and when

When you:

want to submit a claim	Email **claims@discovery.co.za** *Remember to put your membership number in the subject line of the email*
have a query about how a claim was paid	**https://www.discovery.co.za/portal/individual/claims-search** *Register as a website user so you are able to find the information you need*
want to find information about how we cover certain procedures	**https://www.discovery.co.za** *Log in, then go to* **Health – Benefits and cover – Do we cover**
want to find a doctor where you won't have to pay a co-payment	**https://www.discovery.co.za** *Log in, then go to* **Health – Health Tools – Find a provider using MaPs**
need a document, e.g. tax certificate or membership certificate	**https://www.discovery.co.za** *Log in, then go to* **Health – I need a document**
want to submit a complaint or compliment	Email **healthinfo@discovery.co.za** *Remember to include your Discovery Health Medical Scheme membership number*
want to escalate a complaint to which you haven't received a satisfactory answer	Submit your query via our website **https://www.discovery.co.za** *Then go to* **Contact us**. *Specify in your email that you would like a Client Relationship Manager to contact you.*
want to submit a written complaint about a query that has not been resolved or want to submit a written compliment about excellent service want to report fraud	Complete our online complaints form available at **https://www.discovery.co.za** *Then go to* **Contact us**.
want to report fraud	Email **forensicinvestigationsunit@discovery.co.za**

for any queries about your health plan call **0860 99 88 77**

When you want to lodge a formal dispute

email **mydispute@discovery.co.za** or call **+27 11 529 2888**

Ask for the convener of the Disputes Committee in the DiscoveryCare team

When you want to submit a complaint to the Council for Medical Schemes

email **complaints@medicalschemes.com** or call **+27 12 431 0500**

You will need to have exhausted all avenues of trying to resolve the matter with the Scheme. You will be asked to complete a form detailing your complaint

Principal Officer contact details

email **principalofficer@discovery.co.za** or call **+27 11 529 2522**

REGISTERED ADDRESS AND THIRD PARTY SERVICE PROVIDER DETAILS //

Principal Officer

Milton Streak
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Sandton
2146

Registered office address and postal address

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Sandton

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Sandton
2146

Administrator and Managed Care Provider of the Scheme

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Sandton
2146

PO Box 786722
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2146

Auditors

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2157

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Principal bankers

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2000

Investment Managers

Momentum Asset Management

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2196

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Sandton
2146

Investec Asset Management (Pty) Ltd

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8000

Taquanta Asset Managers (Pty) Ltd

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7735

Electus Equity Specialists

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7405

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8000

Futuregrowth Asset Management (Pty) Ltd

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Notes