ANGLO MEDICAL SCHEME

ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED

31 DECEMBER 2015

ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2015

ANGLO MEDICAL SCHEME
(Registration no. 1012)

The reports and statements set out below comprise the annual financial statements:

BOARD OF TRUSTEES	Mrs CC Elliott Mr MA du Bois Mr DD Barber Mr D Ghavalas Dr FH Fox Mr GAE Howell Mrs MD Graham Mr PA Laubscher Mr CC Mckie Thomson Mrs MR Farrell (served until 20/05/2015) Ms S Hosking (elected 20/05/2015) Mr MF Welz (appointed 20/05/2015) Mr DR McCallum (appointed 20/05/2015) Mr GJ Preston (served until 20/05/2015) Mr S Mayet (resigned 03/02/2015)
PRINCIPAL OFFICER	Mrs FK Robertson
REGISTERED OFFICE	45 Main Street Johannesburg 2001
POSTAL ADDRESS	PO Box 62524 Marshalltown 2107
AUDITOR Registered address of auditor	KPMG Inc 85 Empire Road Parktown Johannesburg 2193
ADMINISTRATOR Registered address of administrator	Discovery Health (Pty) Ltd 16 Fredman Drive Sandton 2146

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

The Trustees are responsible for the preparation and fair presentation of the annual financial statements of Anglo Medical Scheme (the Scheme), comprising the statement of financial position at 31 December 2015, and the statements of comprehensive income, changes in funds and reserves and cash flows for the year then ended, and the notes to the financial statements, which include a summary of significant accounting policies and other explanatory notes, in accordance with International Financial Reporting Standards (IFRS) and the requirements of the Medical Schemes Act of South Africa. In addition, the Trustees are responsible for preparing the report of the Board of Trustees.

The Trustees are also responsible for such internal control as the Trustees determine is necessary to enable the preparation of annual financial statements that are free from material misstatement, whether due to fraud or error, and for maintaining adequate accounting records and an effective system of risk management.

The Trustees have made an assessment of the Scheme's ability to continue as a going concern and have no reason to believe the business will not be a going concern in the year ahead.

The auditor is responsible for reporting on whether the financial statements are fairly presented in accordance with the applicable financial reporting framework.

Approval of the annual financial statements

The annual financial statements of Anglo Medical Scheme, as identified in the first paragraph, were approved by the Trustees on 30 March 2016 and are signed on their behalf by:

Ms CC Elliott
Chairman

Mr D Ghavalas
Vice-Chairman

Ms FK Robertson
Principal Officer

STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES

Anglo Medical Scheme (the Scheme) is committed to the principles and practice of responsibility, accountability, fairness and transparency in its dealings with all stakeholders and applies good governance principles.

The Scheme is committed to ensuring compliance within recognised frameworks and conducting its affairs based on ethical values, by the adoption of risk assessment, evaluation and management processes, regular monitoring of third party administrators and providers in accordance with contractual service level agreements. This includes evaluating the performance of the Board and the Board sub-committees against agreed terms of reference and performance targets, the establishment and management of internal controls by assessing the adequacy and effectiveness through the reports of the internal auditor and calling on expert and professional advice when required.

BOARD OF TRUSTEES

The Board of Trustees and its committees meet regularly and monitor the performance of the Administrator and other service providers. They address a range of key issues and ensure discussion on items of policy, strategy and performance are informed and constructive.

All Trustees have access to the advice and services of the Principal Officer and, where appropriate, the Board may seek independent professional advice at the cost of the Scheme.

INTERNAL CONTROL

The Administrators of the Scheme maintain internal controls and systems designed to provide reasonable assurance of the integrity and reliability of the financial statements and to safeguard, verify and maintain accountability of its assets. Such controls are based on established policies and procedures and are implemented by trained personnel with the appropriate segregation of duties.

No event or item has come to the attention of the Board of Trustees that indicates any material breakdown in the functioning of the key internal controls and systems during the year under review.

Ms CC Elliott
Chairman

Mr D Ghavalas
Vice-Chairman

Ms FK Robertson
Principal Officer

30 March 2016

KPMG Inc
KPMG Crescent
85 Empire Road, Parktown, 2193
Private Bag 9, Parkview, 2122, South Africa

Telephone +27 (0)11 647 7111
Fax +27 (0)11 647 8000
Docex 472 Johannesburg

Independent Auditor's Report

To the Members of Anglo Medical Scheme

Report on the Financial Statements

We have audited the financial statements of Anglo Medical Scheme (the scheme), as set out on pages 4 to 54 which comprise the statement of financial position as at 31 December 2015, and the statements of comprehensive income, changes in funds and reserves and cash flows for the year then ended, and the notes to the financial statements, comprising a summary of significant accounting policies and other explanatory information.

Trustees' Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, these financial statements present fairly, in all material respects, the financial position of Anglo Medical Scheme as at 31 December 2015, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

Other Matter

The financial statements for the year ended 31 December 2014 were audited by another auditor who expressed an unmodified opinion on those financial statements on 25 March 2015.

Report on Other Legal and Regulatory Requirements

Non-compliance with the Medical Schemes Act of South Africa

As required by the Council for Medical Schemes, we report that there are no material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa, that have come to our attention during the course of our audit.

KPMG Inc

Per M Fouché
Chartered Accountant (SA)
Registered Auditor
Director
22 April 2016

STATEMENT OF FINANCIAL POSITION
as at 31 December 2015

ANGLO MEDICAL SCHEME
(Registration no. 1012)

	Notes	2015 R'000	31 December 2014 R'000 Restated	1 January 2014 R'000 Restated
ASSETS				
Assets		2 943 207	2 942 759	2 754 371
Investments held at fair value through surplus or deficit	3	2 044 164	2 069 379	2 033 009
Trade and other receivables	4	8 929	4 272	6 761
Cash and cash equivalents		890 114	869 108	714 601
Medical Scheme funds	5.1	756 447	754 108	613 746
Medical Savings Account 'trust' funds	5.2	133 667	115 000	100 855
Total assets		**2 943 207**	**2 942 759**	**2 754 371**
FUNDS AND LIABILITIES				
Members' funds		2 781 628	2 805 922	2 625 288
Accumulated funds		2 781 628	2 805 922	2 625 288
Liabilities		161 579	136 837	129 083
Outstanding risk claims provision	6	16 982	14 211	100 313
Medical Savings Account 'trust' liability	7	135 816	113 947	4 631
Trade and other payables	8	8 781	8 679	24 139
Total funds and liabilities		**2 943 207**	**2 942 759**	**2 754 371**

* - Refer to note 2 for details on the restated amounts

KPMG INC

STATEMENT OF COMPREHENSIVE INCOME
for the year ended 31 December 2015

ANGLO MEDICAL SCHEME
(Registration no. 1012)

	Notes	2015 R'000	2014 R'000 Restated *
Risk contribution income	9	**369 033**	**369 855**
Relevant healthcare expenditure		**(460 000)**	**(420 993)**
Net claims incurred		(452 925)	(410 555)
Risk claims incurred	10	(454 468)	(410 868)
Third party claims recoveries		1 543	313
Net income/(expense) on risk transfer arrangements	11	2 892	(1 029)
Risk transfer arrangement fees/premiums paid		(26 377)	(25 761)
Recoveries from risk transfer arrangements		29 269	24 732
Managed care: management services	12	(9 967)	(9 409)
Gross healthcare result		**(90 967)**	**(51 138)**
Administration expenses	13	(28 473)	(31 251)
Net impairment gains/(losses)	14	32	(748)
Net healthcare results		**(119 408)**	**(83 137)**
Other income		119 133	285 834
Investment income	15	118 273	285 111
Medical Scheme assets		110 252	278 650
Medical Savings Account 'trust' funds		8 021	6 461
Sundry income	16	860	723
Other expenditure		(24 019)	(22 063)
Expenses for asset management services rendered		(15 998)	(15 602)
Interest paid on Medical Savings Accounts		(8 021)	(6 461)
Net (deficit)/surplus for the year		**(24 294)**	**180 634**
Other comprehensive income		-	-
Total comprehensive (deficit)/income for the year		**(24 294)**	**180 634**

* - Refer to note 2 for details on the restated amounts

KPMG INC

STATEMENT OF CHANGES IN FUNDS AND RESERVES
for the year ended 31 December 2015

ANGLO MEDICAL SCHEME
(Registration no. 1012)

	Accumulated funds R'000
Balance as at 1 January 2014 - as previously reported	**2 511 157**
Effect of restatement *	114 131
Balance as at 1 January 2014 - restated	**2 625 288**
Total comprehensive income for the year	180 634
Balance as at 31 December 2014 - restated	**2 805 922**
Total comprehensive deficit for the year	(24 294)
Balance as at 31 December 2015	**2 781 628**

* - Refer to note 2 for details on the restated amounts

KPMG INC.

STATEMENT OF CASH FLOWS
for the year ended 31 December 2015

ANGLO MEDICAL SCHEME
(Registration no. 1012)

	Notes	2015 R'000	2014 R'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash flows from operations before working capital changes	17	(119 408)	(83 137)
Working capital changes			
• (Increase)/decrease in trade and other receivables		(3 879)	2 489
• Increase in Medical Savings Account 'trust' liability		21 869	13 634
• Increase/(decrease) in outstanding claims provision		2 771	(9 928)
• Increase in trade and other payables		102	4 048
Interest paid		(8 021)	(6 461)
Net cash flows from operating activities		**(106 566)**	**(79 355)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of investments		(600 802)	(372 509)
Proceeds on sale of investments		613 777	504 643
Interest income		85 021	72 883
Dividend income		44 714	43 724
Long-term funding		860	723
Expenses for asset management services rendered		(15 998)	(15 602)
Net cash flows from investing activities		**127 572**	**233 862**
NET INCREASE IN CASH AND CASH EQUIVALENTS		**21 006**	**154 507**
Cash and cash equivalents at the beginning of the year		869 108	714 601
CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		**890 114**	**869 108**
Cash and cash equivalents comprise:		**890 114**	**869 108**
Medical Scheme funds		756 447	754 108
Medical Savings Account 'trust' funds		133 667	115 000

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GENERAL INFORMATION

The Anglo 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 on the JSE Limited.

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

1. PRINCIPAL ACCOUNTING POLICIES

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

1.1 BASIS OF PREPARATION

The financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and the Act, which requires additional disclosures for registered medical schemes. The financial statements are prepared in accordance with the going concern principle using the historical cost basis except for investments carried at fair value through surplus or deficit.

The preparation of financial statements in accordance with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise judgement in the process of applying the accounting policies. The notes to the financial statements set out those areas involving a high degree of judgement or complexity, or areas where assumptions and estimates are significant to the Scheme's financial statements (Note 27).

All monetary information and figures presented in the financial statements are in Rands, which is the Scheme's functional currency, rounded to the nearest thousand, unless otherwise indicated.

New standards, amendments and interpretations effective in 2015 relevant to the Scheme:

Title	Effective date - financial year commencing on or after
IAS 19 - Employee benefits - This amendment applies to contributions from employees or third parties to defined benefit plans. Its objective is to simplify the accounting for contributions that are independent of the number of years of employee service.	1 Jul 2014
IAS 24 - Related party disclosure - The standard is amended to include, as a related party, an entity that provides key management personnel services to the reporting entity or to the parent of the reporting entity ("the management entity").	1 Jul 2014
IFRS 13 - Fair value measurement - The IASB has amended the basis for conclusions of IFRS 13 to clarify that it did not intend to remove the ability to measure short-term receivables and payables at invoiced amounts in such cases.	1 Jul 2014

1.1 BASIS OF PREPARATION (continued)

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

Title	Effective date - financial year commencing on or after
IAS 1 - Presentation of Financial Statements - There is an emphasis on materiality. Specific single disclosures that are not material do not have to be presented – even if they are a minimum requirement of a standard.	1 Jan 2016
IFRS 9 - Financial Instruments - IFRS 9 (2009) retains but simplifies the mixed measurement model for financial assets and establishes two primary measurement categories: amortised cost and fair value. The basis of classification depends on the entity's business model and the contractual cash flow characteristics of the financial asset. IFRS 9 (2010) adds the requirements related to the classification and measurement of financial liabilities, derecognition of financial assets and liabilities. It also includes those paragraphs of IAS 39 that deal with how to measure fair value and accounting for derivatives embedded in a contract that contains a host that is not a financial asset. The new standard is applied prospectively.	1 Jan 2018

The Scheme has not yet assessed the impact of these new standards and amendments.

1.2 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 at fair value through surplus or deficit, loans and receivables and financial liabilities. The Scheme has grouped its financial instruments into the following classes:

- Investments held at fair value through surplus or deficit
- Trade and other receivables;
- Cash and cash equivalents;
- Trade and other payables; and
- Medical Savings Account 'trust' liability.

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 the financial liability.

Offsetting financial instruments

Where a current legally enforceable right of offset exists for recognised financial assets and financial liabilities, and there is an intention to settle the liability and realise the asset simultaneously or to settle on a net basis, all related financial effects are offset.

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1.2 CLASSIFICATION, RECOGNITION, PRESENTATION AND DERECOGNITION OF FINANCIAL INSTRUMENTS (continued)

Derecognition of financial assets and liabilities

The Scheme derecognises a financial asset when the contractual rights to the asset expire, where there is a transfer of the contractual rights that comprise the asset, or the Scheme retains the contractual rights of the asset but assumes a corresponding liability to transfer these contractual rights to another party and consequently transfers substantially all the risks and benefits associated with the asset.

If a transfer does not result in derecognition because the Scheme has retained substantially all the risks and rewards of ownership of the transferred asset, the Scheme continues to recognise the transferred asset in its entirety and recognises a financial liability for the consideration received. In subsequent periods, the Scheme recognises any income on the transferred asset and any expense incurred on the financial liability.

Where the Scheme neither transfers nor retains substantially all the risks and rewards of ownership of the financial asset, the Scheme determines whether it has retained control of the financial asset. In this case:

(i) If the Scheme has not retained control, it derecognises the financial asset and recognises separately as assets or liabilities any rights and obligations created or retained in the transfer; and

(ii) If the Scheme has retained control, it continues to recognise the financial asset to the extent of its continuing involvement in the financial asset.

The Scheme derecognises a financial liability when the contractual obligations are discharged or expire.

1.3 FINANCIAL ASSETS

Initial and subsequent measurement

Financial instruments are recognised initially at fair value plus any directly attributable transaction costs. Transaction costs for financial assets at fair value through surplus or deficit are expensed as incurred.

Investments

All purchases and sales of investments are recognised on the trade date that the Scheme commits to purchase or sell the asset. Cost of purchases includes transaction costs.

Investments held at fair value through surplus or deficit are subsequently measured at fair value. Realised and unrealised gains and losses arising from a change in the fair value are recognised in surplus or deficit in the period in which they arise.

The fair value of the financial instruments traded in an active market is determined by reference to published indices on the JSE Limited.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after the reporting date. These are classified as non-current assets. The Scheme's loans and receivables comprise trade and other receivables and cash and cash equivalents.

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

1.3 FINANCIAL ASSETS (continued)

Insurance receivables

Insurance receivables comprise contributions outstanding and recoveries from members and suppliers. Insurance receivables are recognised at cost less impairment losses. Impairment losses on insurance receivables are recognised and determined in a similar manner to impairment losses on financial assets carried at amortised cost.

1.4 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:

- Money market instruments;
- Call accounts; and
- Current accounts

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

1.5 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;
- The disappearance of an active market for that financial asset due to financial difficulties;
- Observable data indicating that there is a measurable decrease in the estimated future cash flows from other groups of 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; or
- 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 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 surplus or deficit.

1.5 IMPAIRMENT OF FINANCIAL ASSETS (continued)

An allowance account is used when the carrying amount of impaired assets is not reduced directly. Such impairment losses are recognised in surplus or deficit. In other instances, the carrying value of the asset is reduced where the amounts are proved to be irrecoverable.

When a receivable is irrecoverable, it is written off against the related impairment in the allowance account. 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 surplus or deficit.

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 surplus or deficit.

1.6 FINANCIAL LIABILITIES

Financial liabilities are initially recognised at fair value net of transaction costs incurred. After initial recognition, the financial liabilities are measured at amortised cost, using the effective interest 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.

Trade and other payables

Trade and other 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.

Insurance payables

Insurance payables are measured initially at fair value (which approximates cost) and subsequently measured at amortised cost using the effective interest method.

Medical Savings Account 'trust' liabilities

Members' 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 contract), and accrued interest thereon, net of any savings claims paid on behalf of members in terms of the Scheme's registered rules.

The deposit component of the insurance contracts has been separately presented, since the Scheme can measure the deposit component separately. The deposit component is recognised in accordance with IAS 39 and is initially measured at fair value and subsequently at amortised cost using the effective interest method. The insurance component is recognised as an insurance liability.

Unspent savings at year-end are carried forward to meet future expenses for which the members are responsible. In terms of the Act balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

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

The members medical savings accounts are invested on behalf of members in money market instruments. These monies are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method.

1.7 PROVISIONS

The Scheme recognises provisions 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; and
- A reliable estimate of the amount of the obligation can be made.

Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money. The expected future cash flows are discounted at a pre-tax rate that reflects the current market assessments of the time value of money and the risks specific to the liability. The unwinding of discount is recognised as a finance cost.

Outstanding risk claims provision

Risk claims outstanding comprise provisions for the Scheme's estimate of the ultimate cost of settling all risk claims incurred but not yet reported (IBNR) at the reporting date. Risk claims outstanding are determined as accurately as possible based on a number of factors, which include previous experience in claims patterns, claims settlement patterns, changes in the nature and number of members according to gender and age, 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 from medical savings accounts (MSA) are deducted in calculating the outstanding risk 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.

1.8 UNALLOCATED FUNDS

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

Unallocated funds that have legally prescribed, that is funds older than 3 years, are written back and are included under sundry income in surplus or deficit.

1.9 MEMBER INSURANCE CONTRACTS

Contracts under which the Scheme accepts significant insurance risk from another party (the member and respective registered dependents) by agreeing to compensate the member or another 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 25.

1.10 LIABILITY ADEQUACY TEST

At reporting date, liability adequacy tests are performed to ensure the adequacy of the member insurance contract liability.

Liabilities for insurance contracts are tested for adequacy by discounting current estimates of all future cash flows and comparing this amount to the carrying amount of the liabilities net of any related assets. Where a shortfall is identified, an additional provision is made and charged to surplus or deficit.

1.11 RISK CONTRIBUTION INCOME

Gross contributions comprise risk contributions and MSA contributions.

Risk 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 MSA contributions. Risk contributions are earned from the date of attachment of insurance risk, over the indemnity period on a straight-line basis and are recognised as revenue.

1.12 RELEVANT HEALTHCARE EXPENDITURE

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

Claims incurred

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

Risk claims incurred (net of claims from members' savings accounts; recoveries from members for co-payments, recoveries from third parties (such as motor vehicle accident and forensic recoveries and discounts received from service providers) comprise:

- Risk claims submitted and accrued for services rendered during the year;
- Payments under provider contracts (managed care) for services rendered to members;
- Over or under provision relating to prior year risk claims estimates;
- Risk claims incurred but not yet reported; and
- Risk claims settled in terms of risk transfer arrangements.

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

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1.12 RELEVANT HEALTHCARE EXPENDITURE (continued)

Risk transfer arrangements

Risk transfer arrangements are contractual arrangements whereby a third party 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 decrease the loss the Scheme may incur as a result of carrying on the business of a medical scheme.

Risk transfer arrangement fees are recognised as an expense over the indemnity period on a straight-line basis.

Risk transfer claims and benefits reimbursed are presented in surplus or deficit and in the Statement of Financial Position on a gross basis. Only contracts that give rise to a significant transfer of insurance risk are accounted for as a risk transfer arrangement. Amounts recoverable under such contracts are recognised in the same year as the related claim.

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 provisions, claims reported not yet paid, and settled claims associated with the risk transfer arrangement.

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 health care services to the members of the Scheme. Managed care: management services fees are expensed as incurred.

1.13 INVESTMENT INCOME

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

Interest income is recognised on the effective interest method, taking account of the principal amount 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.

1.14 INTEREST PAID ON MEDICAL SAVINGS ACCOUNTS

The interest paid on Medical Savings Accounts is recognised in surplus or deficit using the effective interest method.

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1.15 LONG-TERM FUNDING

Additional contributions received from participating employers are intended to compensate for the above average cross-subsidisation of pensioners by active members. Amounts received from participating employers are recognised as other income on a cash receipts basis as there is no legal obligation to refund the amounts to the employer. Long-term funding is recognised in sundry income in surplus or deficit.

1.16 INCOME TAX

In terms of Section 10(1)(d) of the Income Tax Act, No 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from income tax. A medical scheme is included in the definition of a benefit fund and consequently the Scheme is exempt from income tax.

1.17 ALLOCATION OF INCOME AND EXPENDITURE TO BENEFIT OPTIONS

The following items are directly allocated to benefit options:

- Risk contribution income;
- Risk claims incurred;
- Risk transfer arrangement fees;
- Administration fees; and
- Managed care: management services

For disclosure purposes, the remaining items are apportioned based on the number of members on each option, except for Value Care Option which is allocated on an average of its proportion of contribution income and membership.

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2. RESTATEMENT OF COMPARATIVE FIGURES

The Scheme's investment portfolio is held and managed as a single portfolio, targeting long-term investment returns required to meet the long-term funding objectives of the Scheme. As such, the entire portfolio should be classified as held at fair value through surplus or deficit. The Board of Trustees have restated comparative information in order to consistently classify all assets in the portfolio, with the result that assets previously reflected as held-to-maturity (non-current) are now recorded at fair value through surplus or deficit. The effect of the restatement is set out below:

Statement of comprehensive income R'000	**Year ended 31 December 2014**		
	As previously reported	**Effect of restatement**	**As restated**
Net healthcare result	(83 137)	-	(83 137)
Other income	277 077	8 757	285 834
Investment income	276 354	8 757	285 111
Medical Scheme assets	269 893	8 757	278 650
Medical Savings Account 'trust' funds	6 461	-	6 461
Sundry income	723	-	723
Other expenditure	(22 063)	-	(22 063)
Net surplus for the year	**171 877**	**8 757**	**180 634**

Statement of financial position R'000	**As at 1 January 2014**		
	As previously reported	**Effect of restatement**	**As restated**
Total assets	2 640 240	114 131	2 754 371
Members' funds	2 511 157	114 131	2 625 288

	As at 31 December 2014		
	As previously reported	**Effect of restatement**	**As restated**
Total assets	2 819 871	122 888	2 942 759
Members' funds	2 683 034	122 888	2 805 922

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	2015 R'000	2014 R'000 Restated *
3. INVESTMENTS HELD AT FAIR VALUE THROUGH SURPLUS OR DEFICIT		
Fair value at the beginning of the year	2 069 379	2 033 009
Additions	600 802	372 509
Disposals	(546 238)	(400 483)
Movement on revaluation to market value	(79 779)	64 344
Fair value at the end of the year	**2 044 164**	**2 069 379**
The investments included above represent investments in:		
Bonds	617 397	574 648
Commodities	84 286	80 455
Listed equities	1 329 263	1 396 155
Derivatives	13 218	18 121
Fair value at the end of the year	**2 044 164**	**2 069 379**
The investments were managed by the following asset managers at year-end:		
Coronation Assets Management (Pty) Ltd	691 338	590 352
Allan Gray South Africa (Pty) Ltd	613 947	535 241
Investec Asset Management (Pty) Ltd	738 879	943 786
	2 044 164	**2 069 379**
Fair value at the end of the year includes cumulative unrealised gains	409 951	463 393

* - Refer to note 2 for details on the restated amounts

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	2015 R'000	2014 R'000
4. TRADE AND OTHER RECEIVABLES		
Insurance receivables		
Contribution receivables	5 928	2 665
Member and service provider claims receivable	583	81
Amount due	886	622
Less: Allowance for impairment	(303)	(541)
Receivables arising from insurance contracts	6 511	2 746
Loans and receivables		
Interest receivable	778	786
Sundry accounts receivable	1 640	740
Receivables arising from loans and receivables	2 418	1 526
Total trade and other receivables	**8 929**	**4 272**

At 31 December 2015 the carrying amounts of loans and 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.

5. CASH AND CASH EQUIVALENTS		
5.1 CASH AND CASH EQUIVALENTS - MEDICAL SCHEME ASSETS		
Call accounts	19 095	22 316
Current accounts	221 991	229 059
Money market accounts	515 361	502 733
	756 447	**754 108**

The weighted average effective interest rate on cash and cash equivalents was 5.86% (2014 - 5.90%). The call accounts have an average maturity of 1 day (2014 - 1 day) as these are used as a clearing facility.

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	2015 R'000	2014 R'000
5. CASH AND CASH EQUIVALENTS (continued)		
5.2 CASH AND CASH EQUIVALENTS - MEDICAL SAVINGS ACCOUNT 'TRUST' FUNDS		
Current accounts	13 071	2 336
Money market accounts	120 596	112 664
	133 667	**115 000**

The weighted average effective interest rate on cash and cash equivalents was 6.35% (2014 - 5.90%).

6. OUTSTANDING RISK CLAIMS PROVISION		
Outstanding risk claims provision - not covered by risk transfer arrangements	**16 982**	**14 211**
Analysis of movement in outstanding risk claims provision		
Balance at beginning of year	14 211	24 139
Payments in respect of prior year	(14 154)	(23 723)
Over provision in respect of prior year	57	416
Movement for the current year	16 925	13 795
Outstanding risk claims provision	**16 982**	**14 211**
Analysis of outstanding risk claims provision		
Estimated gross claims	18 649	15 515
Less: Estimated recoveries from members' savings accounts (Note 7)	(1 667)	(1 304)
Total outstanding risk claims provision at year end	**16 982**	**14 211**

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6. OUTSTANDING RISK CLAIMS PROVISION (continued)

Basis for determining the outstanding risk claims provision

The outstanding risk claims provision is a provision for the estimated cost of healthcare benefits that have occurred before the reporting date but have not been reported to the Scheme by that date. The provision is determined as accurately as possible based on a number of assumptions which are outlined below.

Process used to determine the assumptions

The process used to determine the assumptions is intended to result in a realistic estimate of the most likely or expected outcome. The sources of data used as inputs for the assumptions are internal, using detailed studies of historical claiming patterns to establish a "claims run-off" period per discipline. More emphasis is placed on recent information, particularly where current claims do not appear to follow prior year trends. Where, in prior years, there is insufficient information to make a reliable best estimate of claims development, prudent assumptions are used.

To the extent that historical claims development is used to determine the claims "run-off period", it is assumed that this pattern will occur again in future. There are reasons why this may not be the case, which, insofar as they can be identified, have been allowed for by modifying the methods. Such reasons, inter alia, include:

- Changes in processes that affect the development or recording of claims paid and incurred (such as changes in claims submission mechanisms);
- Changes in membership profile of the Scheme;
- Random fluctuations; and
- Legislative changes (e.g. expansion of the definition of a Prescribed Minimum Benefit ("PMB")/Chronic Disease Listing ("CDL") condition).

Notified claims are assessed with due regard to the claim circumstances, medical discipline, anticipated development, expected seasonal fluctuations, and information available from managed care: management services (specifically hospital pre-authorisation). The provision is a best estimate based on the most recent information available and may be affected by the differing claims run-off periods between the various medical disciplines. Estimates calculated on the "run-off" period of disciplines with lower utilisations may be subject to a higher degree of volatility due to the relatively small claims history. This is largely negated by the medical disciplines where the majority of the risk claims are incurred and which therefore constitute the bulk of the provision.

Assumptions

The assumptions that have the greatest effect on the measurement of the outstanding risk claims provision are the claims "run-off periods" for the most recent benefit years (split by discipline), in particular the in-hospital category. The run-off factor relates to the emergence and settlement patterns of risk claims and is expressed as the percentage of risk claims settled in respect of total claims expected to emerge in a specific service month. This factor is then used to project the remainder of the outstanding risk claims relating to the specified service month. A "seasonality factor" is further incorporated into the calculation, also based on past claims experience. Consistent assumptions have been used for assessing the outstanding risk claims provisions for the 2014 and 2015 benefit years.

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6. OUTSTANDING RISK CLAIMS PROVISION (continued)

Changes in assumptions

The table below outlines the sensitivity of insured liability estimates to particular movements in assumptions used in the estimation process. It should be noted that this is a deterministic approach with no correlations between the key variables. 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 sensitivity around various scenarios for the general medical insurance business provides an indication of the adequacy of the estimation process. The Trustees believe that the liability for risk claims reported in the statement of financial position is adequate. However, they recognise that the process of estimation is based upon certain variables and assumptions which could differ when claims arise. Consequently, if for example the estimates of the unreceived portion of risk claims costs for the year was 5% inaccurate, the impact on the net surplus of the Scheme would be as follows:

Impact on reported profits due to changes in key variables:

	Change in variables	Change in claims cost 2015 R'000	Change in claims cost 2014 R'000
Hospitalisation	5%	84	80
Chronic medication	5%	30	28
Day-to-day benefits	5%	11	12

This analysis has been prepared for a change in run-off factors with other assumptions remaining constant. The change in liability also represents the absolute change in net surplus for the period. It should be noted that an increase in liabilities will result in a decrease in the surplus and vice versa.

Day-to-day claims have been calculated for the Standard Care Plan and the Managed Care Plan's portion that relates to prescribed minimum benefits (PMB's). Managed Care Plan claims paid from savings are not included. Inflation is not a factor as retrospective inflation is known.

The sensitivity of the estimation process is reduced by the value of the risk claims paid subsequent to the year end related to the period ended 31 December 2015, as detailed in the table below:

	2015 R'000	2014 R'000
Outstanding risk claims provision	16 982	14 211
Portion of outstanding risk claims provision paid to 29 February 2016 (2014: 28 February 2015)	(14 473)	(11 827)
Residual estimate of risk claims incurred but not paid	2 509	2 384

	2015 R'000	2014 R'000
7. MEDICAL SAVINGS ACCOUNT (MSA) 'TRUST' LIABILITY		
Balance on MSA liability at the beginning of the year	113 947	98 445
Add:		
MSA contributions received for the current year (Note 9)	77 822	71 347
Transfers received from other medical schemes	51	297
Interest earned on MSA 'trust' funds	8 021	6 461
Less:		
Claims paid to or on behalf of members (Note 10)	(59 066)	(55 477)
Refunds on death or resignation	(4 959)	(7 126)
Balance on MSA liability at the end of the year	**135 816**	**113 947**

In accordance with the rules of the Scheme, the MSA is underwritten by the Scheme.

In line with the requirements of Circular 38 of 2011 issued by the Council for Medical Schemes, the Scheme placed all Medical Savings Account funds in a separate bank account and invested the funds in a money market account which are being referred to as *'trust'* accounts as directed.

MSAs contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's MSA must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option, and enrols in another benefit option or medical scheme without a MSA, or does not enrol in another medical scheme.

Estimated claims to be paid out of members' MSA in respect of claims incurred in prior year but not yet reported: (Note 6)	1 667	1 304

Actual interest earned, net of related expenses, is paid on MSA. Investment of MSA 'trust' monies managed by the Scheme on behalf of its members, has been separately disclosed under note 15.

The mismatch between the MSA 'trust' liability and the MSA 'trust' funds relate to timing differences. These differences are cleared after year-end.

At 31 December 2015 the carrying amount of the MSA 'trust' liability approximates its fair value, since it is payable on demand. These amounts were not discounted to present values due to their demand feature.

	2015 R'000	2014 R'000
8. TRADE AND OTHER PAYABLES		
Insurance liabilities		
Credit balances on contributions receivable	-	169
Reported claims not yet paid	1 476	1 346
Stale cheques	747	525
Unpresented cheques	2 616	1 826
Total liabilities arising from insurance contracts	4 839	3 866
Financial liabilities		
Balances due to related party - Discovery Health (Pty) Ltd	2 889	3 158
Accruals	601	1 155
Unallocated funds	452	500
Total arising from financial liabilities	3 942	4 813
Total trade and other payables	**8 781**	**8 679**

At 31 December 2015 the carrying amounts of other liabilities approximate their fair values due to the short-term maturities of these liabilities.

9. RISK CONTRIBUTION INCOME		
Gross contributions per registered rules	446 855	441 202
Less: savings contributions received*	(77 822)	(71 347)
Risk contribution income per statement of comprehensive income	**369 033**	**369 855**

* The savings contributions are received by the Scheme in terms of Regulation 10(1) and the Scheme's registered rules and held in 'trust' on behalf of its members. Refer to note 7 for more detail on how these monies were utilised.

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10. RISK CLAIMS INCURRED

	2015 R'000	2014 R'000
Claims incurred excluding claims in respect of related risk transfer arrangements		
Current year claims per registered rules	467 340	427 819
Movement in outstanding risk claims provision	16 925	13 794
Over provision in respect of prior year (Note 6)	(57)	(416)
Adjustment for current year (Note 6)	16 982	14 210
Claims paid from medical savings accounts	(59 066)	(55 477)
	425 199	386 136
Claims incurred in respect of risk transfer arrangements		
Netcare 911		
Current year claims	2 007	1 974
Prime Cure		
Current year claims	6 287	4 706
Centre for Diabetes and Endocrinology		
Current year claims	20 975	18 052
	29 269	24 732
Risk claims per statement of comprehensive income	**454 468**	**410 868**

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11. NET INCOME/(EXPENSE) ON RISK TRANSFER ARRANGEMENTS

	2015 R'000	2014 R'000
Capitation fees paid to third party providers	(26 377)	(25 761)
Recoveries under risk transfer arrangements	29 269	24 732
	2 892	**(1 029)**

Made up as follows:

Netcare 911	146	204
Capitation fees paid	(1 861)	(1 770)
Recovery from service provider	2 007	1 974

Risk transfer arrangement providing ambulance services (air and land) for members on the Scheme.

Prime Cure	2 405	1 399
Capitation fees paid	(3 882)	(3 307)
Recovery from service provider	6 287	4 706

Risk transfer arrangement providing an agreed structure of day-to-day benefits, including treatment of chronic conditions, for members registered on the Value Care Plan. The contract excludes the provision of treatment for hospital admissions above R150,000.

Centre for Diabetes and Endocrinology	341	(2 632)
Capitation fees paid	(20 634)	(20 684)
Recovery from service provider	20 975	18 052

Risk transfer arrangement covering treatment for members diagnosed with diabetes.

	2 892	**(1 029)**

The Scheme has entered into selective risk transfer arrangements with these third party providers in order to reduce their exposure to claims risk and receive specialist case management. These arrangements form a relatively small component of the total claims cost of the Scheme.

Recoveries from service providers are calculated based on the services provided to members, multiplied by the Scheme's re-imbursement rate.

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12. MANAGED CARE: MANAGEMENT SERVICES

	2015 R'000	2014 R'000
Chronic medicine management services	1 046	998
Disease management services	1 885	1 745
Hospital management services	4 427	4 195
Pharmaceutical benefit management services	1 281	1 213
Provider network management services	1 328	1 258
	9 967	**9 409**

Circular 56 of 2015 issued by the Council for Medical Schemes on 9 September 2015 concluded that all accredited managed care services should be included as part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of medical schemes. The managed care fee has therefore been reallocated to 'Relevant healthcare expenditure' in the Statement of Comprehensive Income for 2014 and 2015. The reallocation has not affected or altered the 'Net healthcare result' or net position of the Scheme.

13. ADMINISTRATION EXPENSES

Administration fees	17 265	20 764
Staff costs	2 703	2 640
Principal Officer remuneration and related expenses	1 985	1 938
Consulting fees	1 693	1 806
Electronic checking fees	1 056	828
Trustee remuneration and considerations	1 120	972
Strategic actuarial project costs	764	-
Publications	532	520
Travel and entertainment	365	148
Audit fees	290	536
Audit services	290	477
Non-audit services	-	59
Council for Medical Schemes expenses	285	265
General expenses	242	451
Head office rental and management fees	173	179
Administrator tender process	-	204
	28 473	**31 251**

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	2015 R'000	2014 R'000
14. NET IMPAIRMENT GAINS/(LOSSES)		
Insurance receivables		
Outstanding contributions	-	(196)
Movement in allowance account	206	(196)
Written off	(206)	-
Members claims debt	(313)	(76)
Movement in allowance account	(313)	(52)
Written off	-	(24)
Suppliers claims debt	345	(259)
Movement in allowance account	345	(93)
Written off	-	(166)
Advances on savings plan accounts	-	(217)
Movement in allowance account	-	102
Written off	-	(319)
	32	**(748)**
15. INVESTMENT INCOME		**Restated**
Medical Scheme funds		
Interest income on cash and cash equivalents	1 797	1 833
Income from investments	161 897	208 895
Interest income	75 981	64 589
Dividend income	44 714	43 724
Net gains on fair value adjustments	41 202	100 582
Unrealised (losses)/gains on investments	(53 442)	67 922
	110 252	278 650
Medical Savings Account 'trust' funds		
Interest income on cash and cash equivalents	8 021	6 461
	118 273	**285 111**

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	2015 R'000	2014 R'000
16. SUNDRY INCOME		
Long-term funding	759	723
Prescribed income	101	-
	860	**723**

		Restated
17. CASH FLOWS FROM OPERATING ACTIVITIES BEFORE WORKING CAPITAL CHANGES		
Net (deficit)/surplus for the year	(24 294)	180 634
Adjustments for:		
Investment income excluding fair value gains/(losses) (Note 15)	(171 715)	(217 189)
Interest paid on Medical Savings Account 'trust' funds	8 021	6 461
Unrealised losses/(gains) on investments (Note 15)	53 442	(67 922)
Sundry income (Note 16)	(860)	(723)
Expenses for asset management services rendered	15 998	15 602
Cash flows from operations before working capital changes	**(119 408)**	**(83 137)**

18. FIDELITY COVER

The Scheme participates in fidelity guarantee and Trustees professional indemnity insurance arranged by Anglo American South Africa Ltd amounting to USD 35 million.

19. COMMITMENTS AND CONTINGENT LIABILITIES

The Scheme does not have any commitments or contingent liabilities outstanding at 31 December 2015 (2014: Nil).

20. CONTINGENT ASSET

As at 31 December 2015 the Scheme had pending motor vehicle accident medical claims submitted to the Road Accident Fund (RAF) for assessment. This will only be accounted for when an amount is certain to be received from the RAF.

21. EVENTS AFTER THE REPORTING DATE

There have been no facts or circumstances of a material nature that have occurred between the accounting date and the date of this report.

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22. RELATED PARTY TRANSACTIONS

The Scheme is controlled by the Board of Trustees who are appointed by the participating employers or elected by the members of the Scheme.

Key management personnel

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 Principal Officer.

Close family members include close family members of the Board of Trustees and Principal Officer, and are also related parties.

Parties with significant influence over the Scheme

Administrator and managed care organisation
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 and managed care services. These transactions are conducted on an arm's length basis.

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22. 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 year.

	2015 R'000	2014 R'000
Transactions with key management personnel		
Statement of Comprehensive Income transactions		
Gross contributions received	1 358	1 475
Gross claims paid	1 196	813
Interest on MSA balances	19	12
Key management personnel remuneration	4 688	4 578
Trustee remuneration and considerations	1 120	972
Statement of Financial Position transactions		
Medical Savings account balances	290	261

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

Transactions	*Nature of transactions and their terms and conditions*
Gross 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 all members.
Gross claims paid	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 all members.
Interest on MSA balances	Interest is earned on positive MSA balances at an average effective interest rate of 6,35% (2014: 5,9%) per annum.
Medical Savings Account balances	The amounts owing to the related parties relate to Medical Savings Account balances to which the parties have a right. In line with the terms applied to all members, the balances earn interest monthly at predetermined interest rates, on an accrual basis. The amounts are all current and are payable on demand if an appropriate claim is issued, or if the member resigns from the Scheme, as applicable to all members.

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22. RELATED PARTY TRANSACTIONS (continued)

Transactions with related parties (continued)

	2015 R'000	2014 R'000
Discovery Health (Pty) Ltd - Administrator		
Statement of Comprehensive Income transactions		
Administration fees	17 265	16 321
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd	2 188	2 496
Discovery Health (Pty) Ltd - Managed care organisation		
Statement of Comprehensive Income transactions		
Managed care: management services	8 538	8 089
Statement of Financial Position transactions		
Balance due to Discovery Health (Pty) Ltd	701	662
Momentum Medical Scheme Administrators (Pty) Ltd		
- Administrator (2013 administration runoff in 2014)		
Statement of Comprehensive Income transactions		
Administration fees	-	4 443

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

Administration and managed care agreements

The administration and managed care management service agreements are in terms of the rules of the Scheme and in accordance with instructions given by the Board of Trustees. The agreements are 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/Managed Healthcare Organisation 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 no interest and is due within 7 days.

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23. TRUSTEE REMUNERATION AND CONSIDERATIONS

Trustees	Fees for meeting attendance		Disbursements		Accommodation, travelling and meals		Conference fees		Total	
	2015 R'000	2014 R'000	2015 R'000	2014 R'000	2015 R'000	2014 R'000	2015 R'000	2014 R'000	2015 R'000	2014 R'000
Barber DD	73	71	12	9	-	-	-	-	85	80
du Bois MA*	142	151	-	-	37	18	8	-	187	169
Elliot CC*	36	32	-	-	-	-	-	-	36	32
Farrell MR*	68	93	-	-	-	-	-	-	68	93
Fox FH*	104	94	-	-	12	-	8	-	124	94
Ghavalas D*	87	104	-	-	3	7	-	8	90	119
Graham MD	70	93	12	9	-	-	-	-	82	102
Hosking S*	28	-	-	-	17	-	-	-	45	-
Howell GA*	64	43	-	-	-	-	-	-	64	43
Laubscher PA*	48	45	-	-	-	-	-	-	48	45
Liston J*	52	49	-	-	3	-	-	-	55	49
Mason-Gordon N*	32	-	-	-	-	-	-	-	32	-
Mayet S*	-	4	-	-	-	-	-	-	-	4
McCallum DR*	61	24	-	-	12	-	8	-	81	24
Mckie Thomson CC	53	36	6	6	3	-	-	-	62	42
Preston GJ	19	36	5	9	7	17	-	-	31	62
Troskie J*	-	14	-	-	-	-	-	-	-	14
Welz M*	30	-	-	-	-	-	-	-	30	-
TOTAL	**967**	**889**	**35**	**33**	**94**	**42**	**24**	**8**	**1 120**	**972**

* Trustees fees ceded to employers

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24. (DEFICIT)/SURPLUS PER BENEFIT OPTION

2015	MANAGED CARE PLAN R'000	STANDARD CARE PLAN R'000	VALUE CARE PLAN R'000	TOTAL R'000
Risk contribution income	234 643	129 638	4 752	369 033
Relevant healthcare expenditure	(315 991)	(139 890)	(4 119)	(460 000)
Net claims incurred	(310 509)	(135 892)	(6 524)	(452 925)
Risk claims incurred	(311 585)	(136 358)	(6 525)	(454 468)
Third party claims recoveries	1 076	466	1	1 543
Net expense on risk transfer arrangements	320	167	2 405	2 892
Risk transfer arrangement fees/premiums paid	(14 777)	(7 718)	(3 882)	(26 377)
Recoveries from risk transfer arrangements	15 097	7 885	6 287	29 269
Managed care: management services	(5 802)	(4 165)	-	(9 967)
Gross healthcare result	(81 348)	(10 252)	633	(90 967)
Administration expenses	(16 275)	(11 705)	(493)	(28 473)
Net impairment losses	18	13	1	32
Net healthcare results	(97 605)	(21 944)	141	(119 408)
Other income	68 161	46 474	4 498	119 133
Other expenditure	(13 742)	(9 370)	(907)	(24 019)
Net (deficit)/surplus for the year	(43 186)	15 160	3 732	(24 294)
Number of members at year-end	5 033	3 678	437	9 148

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24. SURPLUS/(DEFICIT) PER BENEFIT OPTION (continued)

2014	MANAGED CARE PLAN R'000 Restated	STANDARD CARE PLAN R'000 Restated	VALUE CARE PLAN R'000 Restated	TOTAL R'000 Restated
Risk contribution income	246 772	119 409	3 674	369 855
Relevant healthcare expenditure	(289 787)	(127 746)	(3 460)	(420 993)
Net claims incurred	(282 541)	(123 155)	(4 859)	(410 555)
Net expense on risk transfer arrangements	(1 636)	(792)	1 399	(1 029)
Risk transfer arrangement fees/premiums paid	(14 881)	(7 573)	(3 307)	(25 761)
Recoveries from risk transfer arrangements	13 245	6 781	4 706	24 732
Managed care: management services*	(5 610)	(3 799)	-	(9 409)
Gross healthcare result	(43 015)	(8 337)	214	(51 138)
Administration expenses	(18 987)	(11 840)	(424)	(31 251)
Net impairment losses	(438)	(294)	(16)	(748)
Net healthcare results	(62 440)	(20 471)	(226)	(83 137)
Other income #	163 538	111 503	10 793	285 834
Other expenditure	(12 623)	(8 607)	(833)	(22 063)
Net surplus for the year	88 475	82 425	9 734	180 634
Number of members at year-end	5 258	3 585	347	9 190

* Refer to note 12 regarding reclassification

Refer to note 2 for details on the restated amounts

KPMG INC

25. INSURANCE RISK MANAGEMENT REPORT

Nature and extent of risks arising from insurance contracts

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

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

Insurance risk

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

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

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

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

Hospital benefits
In-hospital benefits cover all costs incurred by members, while they are in hospital to receive authorised treatment for certain medical conditions. This includes accommodation, theatre, professional, medication, equipment and consumables.

Chronic benefits
Chronic benefits cover the cost of certain prescribed medicines consumed by members and consultations including defined procedures for chronic conditions/diseases, such as high blood pressure, cholesterol and asthma.

Day-to-day benefits
Day-to-day benefits cover the cost of out of hospital medical attention, such as visits to general practitioners, dentists and specialists as well as prescribed non-chronic medicines other than those funded from members' savings accounts.

25. INSURANCE RISK MANAGEMENT REPORT (continued)

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

Hospital benefit risk

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

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

The following table shows various factors that impact hospital claims:

Key indicators	2015	2014	% Increase/ (decrease)
Length of stay (days)	3.88	4.00	(3.0%)
Average hospital cost per admission (R)	27 970	25 698	8.8%
Total cost per life per month (R)	41 280	38 218	8.0%
Admissions per 1 000 lives	340	330	3.0%

Chronic benefit risk

The main factors impacting the frequency and severity of chronic claims are the number of claimants and the cost per claimant. An increase/decrease in the number of claimants results in an increase/decrease in the frequency of claims. Higher increases in claimants and severity of claims may be attributed to increases in the number of claimants at older ages or beneficiaries who are more sickly. Conversely, lower prevalence rates may be indicative of a healthier membership.

The mix between the various chronic conditions impacts the frequency and severity of claims. Certain factors that impact chronic cost are shown below:

Key indicators	2015	2014	% Increase/ (decrease)
Claimants per 1 000 lives	78.65	78.93	(0.4%)
Amount paid per life per month	2 050	1 837	11.6%

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25. INSURANCE RISK MANAGEMENT REPORT (continued)

Day-to-day benefit risk

The main factors impacting the frequency and severity of day-to-day 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. The mix of members between the different benefit options will also have an impact on the claims.

Risk management

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

- Members have to be referred by a doctor prior to an elective admission;
- All hospital admissions have to be authorised. There have also been amendments to the pre-authorisation length of stay benchmarks;
- Case managers monitor members with hospital stays that are longer than expected to ensure that members are discharged at appropriate times; and
- Out-of-hospital programs addressing risk and preventing re-admissions.

Concentration of insurance risk

The following table summarises the concentration of insurance risk per beneficiary, with reference to the carrying amount, net of adjustments, of the insurance claims incurred by age group and in relation to the type of risk covered/benefits provided.

2015 Age grouping (in years)	Hospital R	Chronic R	Day-to-day R	Total R
< 26	4 083	279	1 813	6 175
26 - 35	5 846	537	3 943	10 326
36 - 50	8 058	1 397	4 848	14 303
51 - 65	18 059	3 087	7 372	28 518
> 65	33 308	4 198	8 848	46 354

2014 Age grouping (in years)	Hospital R	Chronic R	Day-to-day R	Total R
< 26	3 137	242	2 623	6 002
26 - 35	5 204	545	4 354	10 103
36 - 50	7 266	1 381	6 434	15 081
51 - 65	17 318	3 103	9 758	30 179
> 65	28 460	3 899	12 794	45 153

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25. INSURANCE RISK MANAGEMENT REPORT (continued)

Risk transfer arrangements

The Scheme has three risk transfer agreements in which suppliers are paid to provide certain minimum benefits to Scheme members. These arrangements fix the cost to the Scheme of providing these benefits.

The first risk transfer arrangement covers day to day expenditure, including treatment of chronic conditions, and hospital admissions under R150,000 for members on the Value Care Plan. The second arrangement provides emergency transport to all members and the third arrangement with CDE covers the treatment for members diagnosed with diabetes (type I and II).

Risk in terms of risk transfer arrangements

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

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

Claims development

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

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

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

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

	Change in variable	2015 R'000	2014 R'000
In-hospital claims incurred	5% increase in claims cost	84	80
Out-of-hospital claims incurred		30	28
Chronic claims incurred		11	12

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26. 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 potentially adverse effects on the financial performance of the investments that the Scheme holds to meet its obligations to its members.

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 sub-committee (the Committee) of the Board of Trustees, determines, recommends, implements and maintains investment policies and procedures. The Committee advises the Board of Trustees on the strategic and operating matters in respect of the investment of Scheme funds and meets at least quarterly;
- The Scheme has appointed reputable external asset managers to manage its investments and their performance is monitored regularly; and
- 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.

Medical Savings Account 'trust' funds

The Scheme appointed an asset manager, Investec Asset Management, to manage the assets underlying the members' Medical Savings Account balances. The portfolio is managed in accordance with Circular 38 of 2011 and Circular 5 of 2012 issued by the Council for Medical Schemes.

Changes in 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' Medical Savings Account balance. Consequently, no further analysis is presented.

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26. FINANCIAL RISK MANAGEMENT REPORT (continued)

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

Currency risk is the risk that the value of a financial instrument will fluctuate due to changes in foreign exchange rates. The Scheme operates in South Africa and therefore its cash flows are denominated in South African Rand (ZAR). In terms of the diversified investment strategy operated by the investment committee and the restrictions imposed by the Medical Schemes Act, the Scheme has a relatively small number of investments off-shore. The Scheme is exposed to foreign exchange risk arising from currency exposures, primarily with respect to the US Dollar (USD). 3,6% (2014: 2,7%) of total investments were invested in foreign investments.

The following table illustrates the concentration of direct currency risk to which the Scheme is currently exposed.

As at 31 December 2015	ZAR R'000	USD R'000	TOTAL R'000
Investments held at fair value through surplus or deficit	1 942 049	102 115	2 044 164
Cash and cash equivalents	890 114	-	890 114
	2 832 163	102 115	2 934 278

As at 31 December 2014	ZAR R'000 Restated *	USD R'000	TOTAL R'000 Restated *
Investments held at fair value through surplus or deficit	1 993 024	76 355	2 069 379
Cash and cash equivalents	869 108	-	869 108
	2 862 132	76 355	2 938 487

There has been significant movement in the ZAR against major currencies during the year. Holding all other variables constant, and adjusting currencies with 10% for the year, the net result of the Scheme would be negatively impacted as follows:

	% ZAR weakening	2015 R'000	2014 R'000
USD	10%	10 212	7 636

* - Refer to note 2 for details on the restated amounts

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26. FINANCIAL RISK MANAGEMENT REPORT (continued)

Equity risk

Equity risk is the risk that the value of a financial instrument will fluctuate as a result of changes in the market place.

Equities are reflected at market values, which are susceptible to fluctuations. The Scheme manages its equity risk by employing the following procedure:

- Mandating a specialist fund manager to invest in equities, where there is an active market and where access is gained to a broad spectrum of financial information relating to the companies invested in;
- Diversifying across many securities to reduce risk. Diversification is guided by the Medical Schemes Act; and
- Considering the risk-reward profile of holding equities and bearing the risk in order to obtain higher expected returns on assets.

If the South African equities market were to move by 10%, assuming all other variables remain constant, and the recent past is predictive of the future, the below table illustrates the impact to the value of investments of the Scheme:

	% SA market movement	2015 R'000	2014 R'000 Restated *
Investments held at fair value through surplus or deficit: Equities	10%	103 324	106 047

* - Refer to note 2 for details on the restated amounts

KPMG INC

26. FINANCIAL RISK MANAGEMENT REPORT (continued)

Interest rate risk

Interest rate risk is the exposure that the Scheme has to changes in interest rates. As the Scheme holds no debt with the exception of the members' saving liability on which interest is paid, the main exposure to the Scheme would be a reduction in interest income on investments if interest rates were to decrease. In order to reduce the impact of any potential interest rate changes, the Scheme holds a diversified portfolio of both long and short term 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 2015	0 - 3 months R'000	3 - 12 months R'000	> 12 months R'000	Total R'000
Cash and cash equivalents	848 243	16 987	24 884	890 114
Investments held at fair value through surplus or deficit	1 534 192	5 975	503 997	2 044 164

As at 31 December 2014	0 - 3 months R'000	3 - 12 months R'000	> 12 months R'000 Restated *	Total R'000 Restated *
Cash and cash equivalents	769 185	90	99 833	869 108
Investments held at fair value through surplus or deficit	1 607 006	17 543	444 830	2 069 379

* - Refer to note 2 for details on the restated amounts

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

	2015 %	2014 %
Cash and cash equivalents	5.86%	5.90%

A change of 100 basis points in interest rates at the reporting date would have an effect on surplus or deficit by the amounts shown below. This analysis assumes that all other variables remain constant. The analysis is performed on the same basis for 2014.

	% change in interest rates	2015 R'000	2014 R'000
Cash and cash equivalents	1%	14 641	12 437

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26. FINANCIAL RISK MANAGEMENT REPORT (continued)

Fair value estimation

The fair value of publicly traded financial instruments held as investments at fair value through surplus or deficit, is based on quoted market prices at the statement of financial position date. As such, all financial assets are considered level 1 assets.

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' Medical Savings Accounts contain a demand feature. In terms of Regulation 10 of the Act, any credit balance on a member's 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' 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.

	2015 R'000	2014 R'000
Total Members' Funds per the Statement of Financial Position	2 781 628	2 805 922
Less: cumulative unrealised net gain on measurement of investments to fair value	(409 951)	(463 393)
Accumulated funds per Regulation 29	2 371 677	2 342 529
Gross contribution income (R'000)	446 855	441 202
Solvency margin		
= Accumulated funds/gross contribution income x 100	530.75%	530.94%

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26. 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 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.

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.

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26. FINANCIAL RISK MANAGEMENT REPORT (continued)

Breakdown of investments

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

As at 31 December 2015	Financial assets and liabilities at fair value through profit and loss R'000	Loans and receivables R'000	Insurance receivables and (payables) R'000	Financial assets/ liabilities at amortised cost R'000	Total carrying amount R'000	Fair value amount R'000
Investments						
Hold-for-trading investments	2 044 164	-	-	-	2 044 164	2 044 164
Cash and cash equivalents						
Medical Scheme assets	-	756 447	-	-	756 447	756 447
Medical Savings Account 'trust' assets	-	133 667	-	-	133 667	133 667
Trade and other receivables	-	2 418	6 511	-	8 929	8 929
Medical Savings Account 'trust' liability	-	-	(135 816)	-	(135 816)	(135 816)
Trade and other payables	-	-	(4 839)	(3 942)	(8 781)	(8 781)
	2 044 164	892 532	(134 144)	(3 942)	2 798 610	2 798 610

As at 31 December 2014	R'000 Restated *	R'000	R'000	R'000	R'000 Restated *	R'000 Restated *
Investments						
Hold-for-trading investments	2 069 379	-	-	-	2 069 379	2 069 379
Cash and cash equivalents						
Medical Scheme assets	-	754 108	-	-	754 108	754 108
Medical Savings Account 'trust' assets	-	115 000	-	-	115 000	115 000
Trade and other receivables	-	1 526	2 746	-	4 272	4 272
Medical Savings Account 'trust' liability	-	-	(113 947)	-	(113 947)	(113 947)
Trade and other payables	-	-	(3 866)	(4 813)	(8 679)	(8 679)
	2 069 379	870 634	(115 067)	(4 813)	2 820 133	2 820 133

* - Refer to note 2 for details on the restated amounts

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26. FINANCIAL RISK MANAGEMENT REPORT (continued)

Assets measured at fair value

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

- Level 1: Quoted market price (unadjusted in an active market for an identical instrument);
- Level 2: Valuation techniques based on observable inputs, either directly (i.e. as prices) or indirectly (i.e. derived from prices). This category includes instruments valued using: quoted market prices in active markets for similar instruments; quoted prices for identical or similar instruments in markets that are considered less than active; or other valuation techniques where all significant inputs are directly or indirectly observable from market data; and
- Level 3: Valuation techniques using significant unobservable inputs. This category includes all instruments where the valuation technique includes inputs not based on observable data and the unobservable inputs have a significant effect on the instrument's valuation. This category includes instruments that are valued based on quoted prices for similar instruments where significant unobservable adjustments or assumptions are required to reflect differences between the instruments.

The Scheme's financial instruments, measured at fair value at the end of the reporting period, are all categorised as Level 1 investments.

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 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 bond instruments, commodities and equities. 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.
- 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 50.

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26. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

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

	2015 R'000	2014 R'000
Insurance receivables	6 511	2 746
Contribution receivables (a)	5 928	2 665
Member and service provider claims receivables (b)	886	622
Less: Allowance for Impairment losses	(303)	(541)
Loans and receivables	2 418	1 526
Interest receivable	778	786
Sundry accounts receivable	1 640	740

a. Contributions receivable are not credit rated by the Scheme as exposure to any single member is insignificant. Contributions receivable 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.

b. Member and service provider claims receivable 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.

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.

Insurance receivables	Gross 2015 R'000	Impairment 2015 R'000	Gross 2014 R'000	Impairment 2014 R'000
Not past due	6 076	-	2 726	-
Past due 0 - 30 days	194	-	100	80
Past due 31 - 60 days	34	-	149	149
Past due 61 - 150 days	145	144	155	155
151 days to more than 1 year	365	159	157	157
	6 814	303	3 287	541

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26. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Impairment losses

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 counterparties.

Below is the movement in the impairment for each component of Trade and other receivables during the year ended 31 December:

	Insurance receivables		Loans and receivables	Total
	Contribution debtors R'000	Member and service provider claims debtors R'000	R'000	R'000
Balance as at 1 January 2014	10	189	102	301
Movement in impairment allowance	196	337	217	750
Amounts utilised during the year	-	(191)	(319)	(510)
Balance as at 31 December 2014	**206**	**335**	**-**	**541**
Balance as at 1 January 2015	206	335	-	541
Movement in impairment allowance	-	(32)	-	(32)
Amounts utilised during the year	(206)	-	-	(206)
Balance as at 31 December 2015	**-**	**303**	**-**	**303**

Based on past experience, the Scheme believes that no provision for impairment is required in respect of Contribution debtors. For member and service provider claims debtors that are past due and outstanding for less than 90 days, past experience has indicated that no provision is required.

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26. FINANCIAL RISK MANAGEMENT REPORT (continued)

Credit risk (continued)

Credit quality

The credit quality of financial assets that are neither past due nor impaired can be assessed by historical information about counterparty default rates:

Insurance receivables	2015 R'000	2014 R'000
Contributions receivable	5 927	2 459
Member and service provider claims receivable		
Active member claims receivable	40	123
Withdrawn member claims receivable	23	50
Service provider claims receivable	314	114
	6 304	2 746

Contribution receivables
The Scheme collected over 99% (2014: 97%) of outstanding debt in January 2016. 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 claim receivables
These debtors are current members of the Scheme. An impairment allowance covering 46% (2014: 45%) of the debtors has been raised.

Withdrawn member claim receivables
These amounts are due from members that have withdrawn from the Scheme. An impairment allowance covering 67% (2014: 84%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Service provider claim receivables
These debtors are the healthcare providers of the Scheme. The amounts due to the Scheme are offset against future payments to be made to these providers. An impairment allowance covering 23% (2014: 84%) of the total amount due has been raised and the Trustees are satisfied that this is adequate.

Cash and cash equivalents	2015	2014
Invested with counterparties with high quality credit ratings	890 114	869 108

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26. FINANCIAL RISK MANAGEMENT REPORT (continued)

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 objectives 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.

An expected maturity analysis for financial liabilities, including insurance liabilities is provided below:

As at 31 December 2015	Less than 1 month R'000	Between 2 and 4 months R'000	More than 4 months R'000	Total R'000
Medical Savings Account 'trust' liability	839	1 176	133 801	135 816
Trade and other payables	8 781	-	-	8 781
Outstanding risk claims provision	12 052	4 885	45	16 982

As at 31 December 2014				
Medical Savings Account 'trust' liability	647	395	112 905	113 947
Trade and other payables	8 679	-	-	8 679
Outstanding risk claims provision	9 797	4 052	362	14 211

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27. CRITICAL ACCOUNTING ESTIMATES AND JUDGEMENTS

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 6.

Other risk transfer arrangements

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

28. COMPLIANCE WITH THE MEDICAL SCHEMES ACT

The Trustees are of the opinion that there are no material deviations from the Medical Schemes Act (the Act) as a result of the Scheme having obtained the necessary exemptions from the Council for Medical Schemes to achieve compliance.

28.1 Outstanding contributions

Nature and impact

In terms of Section 26(7) of the Act, contributions should be received in accordance with the rules of the Scheme. Per the Scheme rules, contributions are required to be received at least three days after their due date. Instances were noted where contributions were received late.

Causes for failure

Balances after three days are due to reconciling discrepancies between the participating employers and the Scheme. The risk of default on payments due to the Scheme is small because of the restricted nature of the Scheme and employer base. The trustees consider this to be immaterial.

Corrective action

Suspension policies are in place and applied where contributions are outstanding for individual paying members outside the participating employers' obligation.

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28. COMPLIANCE WITH THE MEDICAL SCHEMES ACT (continued)

28.2 Investment in participating employer

Nature and impact

Section 35(8)(a) of the Act states that a medical scheme shall not invest any of its assets in a participating employer. During the year the Scheme had exposure to investments in participating employer groups.

Causes for failure

The Scheme invests in pooled investment vehicles which allow investment managers discretion to invest in a combination of shares and bonds that will best achieve their stipulated benchmark. Given this approach, the Scheme was exposed to participating employer shares.

Corrective action

The Scheme has applied to the Council for Medical Schemes and received an exemption from this section of the Act.

28.3 Investment in administrator

Nature and impact

Section 35(8)(c) of the Act states that a medical scheme shall not invest any of its assets in any administrator. During the year the Scheme had exposure to such investments.

Causes for failure

The Scheme invests in pooled investment vehicles which allow investment managers discretion to invest in a combination of shares and bonds that will best achieve their stipulated benchmark.

Corrective action

The Scheme has applied to the Council for Medical Schemes and received an exemption from this section of the Act.

KPMG INC

28. COMPLIANCE WITH THE MEDICAL SCHEMES ACT (continued)

28.4 Investment limitations

Nature and impact

Regulation 30(3) states that a medical scheme shall not invest more than 40% of its assets in local equities. The Scheme exceeded this limit throughout the year.

Causes for failure

The Act makes provision for medical schemes to exceed the limit of 40% on local equities under certain circumstances. The Board of Trustees decided to exceed the limit after complying with all the required circumstances. The purpose is to maximise investment income on a long-term basis.

Corrective action

The Scheme submitted a certified statement prepared by its consultants to the Council for Medical Schemes to state that an alternative percentage of 75% should apply to the excess assets as permitted in Regulation 30(3).

28.5 Sustainability of benefit options

Nature and impact

In terms of section 33(2) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance. At 31 December 2015 two of the three benefit options incurred deficits before investment income as set out in note 24 to the annual financial statements.

Causes for failure

The Board of Trustees annually maintain market related benefit offerings and competitive contribution increases. Due to the Scheme demographics, this gives rise to the non-compliance.

Corrective action

Anglo American South Africa sold numerous subsidiaries over a period of time resulting in the loss of active employees and retention of pensioners. To compensate the Scheme for the resultant high pensioner ratio and expected deterioration of the claiming profile, the Participating Employers pre-funded the additional liability to the extent that the Scheme could maintain market related benefits and contribution increases into the future. The Scheme meets its responsibility to the members by subsidising the expected claims excess over contributions from the reserves. The Trustees believe that the current and expected future investment returns are sufficient to meet the shortfall.

The Council for Medical Schemes is aware of the Scheme's strategy and approves the benefits and contributions annually without any requirement to take further corrective action.

REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2015

The Board of Trustees hereby presents its report for the year ended 31 December 2015.

1. DESCRIPTION OF THE MEDICAL SCHEME

1.1. Terms of registration

The Anglo Medical Scheme (the Scheme) is a not for profit restricted medical scheme registered in terms of the Medical Schemes Act 131 of 1998 (the Act), Registration number 1012. The Scheme was established by Anglo American South Africa and its purpose is to provide medical cover to the employees, retirees and continuation members of the participating employer groups and their affiliated companies. The principal participating employer groups are Anglo Operations (Pty) Ltd, Mondi Limited, Mpact Limited, and E Oppenheimer and Son (Pty) Ltd.

At 31 December 2015 the Scheme provided benefits to 9 148 members and 10 067 dependants. 51.13% of the members and dependants are female. Members are located primarily in Gauteng (40%), KwaZulu-Natal (37%) and the Western Cape (10%). The balance of membership is spread across South Africa.

1.2. Benefit options with Anglo Medical Scheme

Anglo Medical Scheme provides its members with a choice of three Plans; at 31 December 2015, Managed Care Plan serving 9 569 beneficiaries, average age 52.5 years, Standard Care Plan, 8 692 beneficiaries, average age 32.7 years and Value Care Plan 954 beneficiaries, average age 24.4 years old.

- **The Managed Care Plan (MCP)**

  This plan offers unlimited cover for hospitalisation and most non-discretionary healthcare services. Out-of-hospital and discretionary benefits are provided through a medical savings account. An additional GAP benefit is available to MCP members which pays up to 200% of the Scheme rate for specialist services rendered in hospital with the exception of Radiology and Pathology.

- **The Standard Care Plan (SCP)**

  This is a traditional plan with defined benefits and annual limits. Hospital benefits are unlimited. Out-of-hospital benefits are limited, with consultations and medicines including auxiliary services being limited under a single benefit. The Scheme provides stand alone benefits for Radiology and Pathology. Benefits are reimbursed at 100% of the Scheme Reimbursement Rate.

- **The Value Care Plan (VCP)**

  This a primary health care plan providing services through a capitated arrangement with Prime Cure. Members may only obtain services from Prime Cure facilities or network providers. Management is achieved through the Prime Cure protocols.

1.3. Registered office

45 Main Street	PO Box 62524
Johannesburg	Marshalltown
2001	2107

1. DESCRIPTION OF THE MEDICAL SCHEME (continued)

1.4. Scheme administrator in office during the year under review

Discovery Health (Pty) Ltd
16 Fredman Drive
Sandton
2146

1.5. Investment managers and custodian bank in office during the year under review

Allan Gray South Africa (Pty) Ltd
1 Silo Square, V&A Waterfront
Cape Town
8001

Coronation Asset Management (Pty) Ltd
Mont Clare Place, 7th Floor, Cnr Campground and Main Roads
Claremont
7700

Investec Asset Management (Pty) Ltd
36 Hans Strydom Avenue, Foreshore
Cape Town
8001

Standard Bank of South Africa Limited
Investor Services, 2nd Floor, 25 Sauer Street
Johannesburg
2001

1.6. Investment advisor in office during the year under review

Towers Watson
1st Floor, 44 Melrose Boulevard
Melrose Arch
2076

1.7. Actuarial advisor in office during the year under review

NMG Consultants and Actuaries (Pty) Ltd
NMG House, 411 Main Avenue
Randburg
2125

1. DESCRIPTION OF THE MEDICAL SCHEME (continued)

1.8. External auditor for the year under review, as approved by the Annual General Meeting

KPMG Inc.
KPMG Crescent
85 Empire Road
Parktown
2193

2. SCOPE OF THE REPORT

2.1. Guidelines

The Anglo Medical Scheme adheres to the governance framework set out in the King Report on Governance for South Africa and the King Code of Governance Principles (King III).

The Scheme's financial policies and Annual Financial Statements comply with the International Financial Reporting Standards (IFRS) as informed by the Medical Schemes Accounting Guide issued by the South African Institute of Chartered Accountants (SAICA) and the regulatory requirements as set out in the Act and its supporting Regulations.

2.2. Assurance

The Scheme's Actuaries comply with the best practice guideline issued in the Professional Guidance Note published by the Actuarial Society of South Africa.

The External Auditor expresses an audit opinion on whether the financial statements are prepared in all material respects with IFRS and the requirements of the Medical Schemes Act of South Africa. The External Auditor complies with International Standards on Auditing (ISA) in conducting the audit.

2.3. Independence

The External Auditor has adopted independence standards in compliance with the requirement of the International Federation of Accountants, Code of Ethics (IFAC).

3. CORPORATE RESPONSIBILITY AND SUSTAINABILITY

Anglo Medical Scheme offers comprehensive healthcare benefits and services to its members which are high-quality, market competitive, cost-effective and consumer focused. These are supported by sound financial and risk management, administrative efficiency and the active participation of the members and employers. This ensures the Scheme's active compliance with the spirit of the law, ethical standards and international norms.

The affairs of the Scheme are managed by the Board of Trustees in compliance with the Scheme Rules in a manner that is fair, transparent, non-discriminatory and upholds the rights, values and dignity of members and other stakeholders. The Board performs its duties in accordance with the Board Charter and the Code of Conduct against which the Trustees annually evaluate their performance and the performance of the Board as a whole. The Board shall at all times avoid conflicts of interests and Trustees are required to declare any interest they may have in any particular matter serving before the Board.

The Board cedes some of its responsibilities to the duly appointed and constituted sub-committees (the Committees). It determines the Terms of Reference of the Committees, approves all policies proposed by the Committees and receives quarterly reports from the Committees. The Committees do not relieve the Trustees of any of their responsibilities, but assists them to fulfil those responsibilities.

The Audit Committee meets independently with the Internal and External Auditors annually. Based on the review of the internal controls and risk management, the assurance and results of the audit and the recommendation of the Audit Committee, the Board of Trustees is of the opinion that accounting policies, the internal control systems and the financial reporting practices have been found to be adequate and effective and that the basis for the preparation of the financial statements is sound.

The Scheme has supported aspects of the participating employers' social responsibility initiatives by adopting a progressive stand in the fight against HIV/Aids and diseases such as diabetes and cancer. The Scheme regularly communicates with the membership on health and benefit matters in the recognition that a healthy, educated workforce becomes a sustainable asset to a participating employer.

The commitment to the long-term sustainability of the Scheme for the benefit of its members remains the guiding principle of the Scheme. This has been strongly supported by the employers participating in the Scheme. To this end provision has been made to prefund the liability of the ageing population of the Scheme to ensure premiums and benefits remain market-related and competitive.

4. SCHEME STRATEGY AND OBJECTIVES

4.1. Long term funding

The Scheme's significantly higher beneficiary pensioner ratio than the industry average (25.4% compared to 7.3% - CMS report September 2015) increases the expected overall cost of providing adequate healthcare benefits at market related rates to our members. The Council for Medical Schemes definition of a pensioner is a beneficiary over the age of 65.

The Scheme entered into arrangements with the participating employer groups for grants to be made from time to time, at the employer's discretion, to meet the ongoing and the future cost of providing benefits for the large number of pensioner members. Annual actuarial valuations are performed in order to calculate the funding needed to continue to provide cost effective benefits to all members.

In performing the actuarial valuation, the actuary makes long-term assumptions which may differ from those used during the Scheme's annual short-term budget process, as disclosed elsewhere in the notes to these annual financial statements.

The value of the Scheme's total long-term assets as at 31 December 2015 was R2.763 billion. This compares against the gross long-term liability calculated by the Scheme's consultants and actuaries of R2.751 billion. The assets required by the Scheme to carry the liability for the next 25 years are calculated as R2.194 billion.

4.2. Rate of contribution increase strategy

Due to the average age of the Scheme membership being significantly higher than the average age of the industry, healthcare costs are also significantly higher. Likewise, contributions and annual increases would need to be higher than the industry average to fund the payment of claims. To prevent the member carrying the burden of these increased costs, an amount is budgeted annually to provide for the shortfall between the budgeted risk contribution income and claims incurred.

4. SCHEME STRATEGY AND OBJECTIVES (continued)

4.3. Investment strategy

The Scheme's investment strategy has been, and remains, aimed at maximising the annual return at an acceptable level of risk within the constraints of the Medical Schemes Act. The Scheme believes that risk should be managed, in part, by holding a conservative, yet diversified portfolio with a significant proportion of the assets providing returns that offer protection against inflation over the longer term.

The investment objective is to earn a gross return which exceeds the Consumer Price Index by at least 3.5% p.a. over a rolling five year period.

Period	Portfolio Performance (before management fees)	Consumer Price Index	CPI plus 3,5% p.a.
1 January - 31 December 2015 (p.a.)	3.9%	5.2%	8.7%
5 Years (p.a.)	7.6%	5.5%	9.0%
Since inception (180 months) (p.a.)	13.0%	5.7%	9.2%

The average increase in contributions over the five year period has been 7.6% p.a. The average estimated increase in contributions, had there not been additional funding provided from the Scheme's reserves, would have been 12.5% p.a.

Based on the above, the Trustees are confident that the overall long-term strategy will provide for the healthcare needs of the Scheme members into the foreseeable future.

5. KEY PERFORMANCE MEASURES

The performance of the Scheme is measured by the contribution increase that is effected annually coupled with benefit changes. Contributions have increased at a rate between 1.9% - 2.1% above CPI which is closely aligned to the medical inflation rate and below the industry average. Benefits have been improved over the period.

Year	2016	2015	2014	2013	2012
Average annual contribution increase per member	8.5%	6.5%	7.3%	7.5%	7.9%
CPI		4.6%	5.3%	5.4%	5.8%
*Industry gross average increase per beneficiary **		*9.9%*	*9.4%*	*9.7%*	*6.9%*

* *The industry figure quoted serves as a guide only. It reflects the industry average percentage increase in the gross contribution income per beneficiary as reported by the Council for Medical Schemes.*

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

6.1. Operational results

The Scheme sets targets each year for expected healthcare results taking the expected draw down from reserves into consideration. Any net surplus is reinvested to meet expected future contribution shortfalls.

	2015 R'000	2014 R'000
Net healthcare result	(119 408)	(83 137)
Managed Care Plan	(97 605)	(62 440)
Standard Care Plan	(21 944)	(20 471)
Value Care Plan	141	(226)
Add: Net investment and other income	95 114	263 771
Net (deficit)/surplus for the year	(24 294)	180 634

The adult and child contributions are rebalanced annually by Plan, adjusting for changes in family size and ageing trends. Cognisance is taken of the employee salary increases and the claims experience of each Plan when determining contribution increases to ensure affordability. For the period under review the increases and contributions were as follows:

	2015		2014	
Average contribution increase 6.5%	Adult	Child	Adult	Child
Managed Care Plan	3 169	727	2 975	683
Standard Care Plan	1 700	508	1 596	477
Value Care Plan	649	148	609	139

6.2. Outstanding risk claims

Movements in the outstanding risk claims provision are set out in Note 6 to the financial statements. The basis of calculation is consistent with the prior year.

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES (continued)

6.3. Accumulated funds

Movements in the accumulated funds are set out in the Statement of Changes in Accumulated Funds as reflected on page 6 in the financial statements.

	2015 R'000	2014 R'000
Total members' funds per Statement of Financial Position	2 781 628	2 805 922
Less: cumulative unrealised net gain on measurement of investments to fair value	(409 951)	(463 393)
Accumulated funds per Regulation 29 of the Act	2 371 677	2 342 529
Gross contribution income (Note 9)	446 855	441 202
Accumulated funds ratio per Regulation 29 (including unrealised gains)	622.5%	636.0%
Accumulated funds ratio per Regulation 29 (excluding unrealised gains)	530.7%	530.9%
Minimum ratio required by Regulation 29 of the Act	25.0%	25.0%

Refer to Note 4.1 above for the reasons for this level of funding.

The average accumulated funds per member as at 31 December 2015 was R304 070 (2014: R305 323).

6.4. Medical Savings Account 'trust' liability

Refer to note 1.6 and note 7 of the annual financial statements.

The Medical Schemes Act stipulates that member savings balances do not form part of a scheme's assets and may not be used to pay scheme expenses or risk claims.

The Scheme continues to manage member's savings balances in accordance with Circular 38 of 2011. The members' ring-fenced savings are invested in an Investec Money Market account and a FNB current account which are reflected in the Statement of Financial Position as the Medical Savings Account 'trust' funds in current assets, standing at R133.67 million as compared to R115.00 million at the end of 2014.

The liability to members in respect of the savings accounts is reflected as a current liability in the annual financial statements, repayable in terms of Regulation 10 of the Act.

7. RISK

The Board of Trustees is responsible for the total risk management of the Scheme and has determined the risk strategy and policies based on the Scheme's appetite or tolerance for risk in line with the King Governance Principles set out in King III.

The Scheme has implemented a robust risk management frame work, which ensures an effective ongoing process to identify risk, the measurement of potential impact against a broad set of assumptions and that risk is proactively managed.

One of the primary objectives of the risk assessment process is to identify the key risks so that these can be monitored and managed. The risk assessment process provides a structured methodology to identify the risks within each area of business and assess the controls upon which management relies to mitigate these risks.

The Scheme risk assessment is a forward looking evaluation of both the potential and current risks faced by the Scheme on a long-term and a daily basis. Assessments are completed which enable the Scheme sub-Committees, Head Office and the management of the administrator to proactively identify, assess, monitor and manage the risks to which the Scheme is exposed.

The Board of Trustees identified the primary risks facing the Scheme to be as follows:

7.1. Strategic risk

The potential loss of value to the members and the employer groups due to the Scheme's inability to provide competitive, cost-effective high-quality products and services that are market related.

Factors driving this risk relate to its investments not delivering the required returns and escalation of healthcare costs. Much of this risk management and mitigation is discussed under Strategy, point 4 above and below under Committees of the Board of Trustees, point 10.

Legislative changes might impact the Scheme's ability to provide for the lifelong healthcare needs of the members. For example, the potential changes required to implement the proposed National Health Insurance policy may have a profound impact on the way the Scheme operates.

7.2. Operational risks

The risk of loss arising from failed or inadequate internal processes, people, systems and/or external events. This category includes legal risk, project risk, business continuity risk, data risk, information technology risk, and human capital risk. The day-to-day management of the Scheme in accordance with all legislative requirements and best practice guidelines is monitored and measured on an ongoing basis and is discussed under point 8.

7. RISK (continued)

7.3. Investment risk

The Scheme has identified investment risk as the risk of a decline in the net realisable value of investment assets as a result of adverse movements in market prices or factors specific to an investment itself which may impact on the Scheme's long term objectives. These may arise due to movements in interest rates, property values, exchange rates, or equity and commodity prices and may be a result of macro global trends or internal domestic fluctuations.

7.4. Compliance risk

As defined in the Act, the business of a scheme is to undertake liability in return for a premium or contribution and to grant assistance in defraying expenditure incurred in obtaining any relevant health service. Compliance risk is the risk of statutory or regulatory sanction or material financial losses as a result of a failure to comply with applicable laws, regulations or supervisory requirements.

8. RISK MANAGEMENT AND MITIGATION

Refer to notes 25 and 26 of the annual financial statements.

The Scheme maintains a sound system of risk management and internal control providing reasonable assurance in the achievement of the organisational objectives with respect to:

- effectiveness and efficiency of operations;
- safeguarding of the Scheme's assets (including information);
- compliance with applicable laws, regulations and supervisory requirements;
- supporting business sustainability under normal and adverse operating conditions;
- reliability of reporting; and
- behaving responsibly towards all stakeholders.

The risk assessment process:

- Focuses on the underlying causes of risks and not just the financial impacts;
- Facilitates the assessment of existing controls;
- Identifies priority areas so that effective testing of controls can take place;
- Assists management to determine the actions required to address the key risks identified;
- Assists in forecasting the Scheme's potential risk exposure going forward; and
- Allocates actions to staff that are able to effectively oversee the required activities.

The Board ensures that a systematic, documented assessment of the processes and outcomes surrounding key risks is undertaken annually and at appropriately considered intervals for the purpose of making its public statement on risk management.

Risk management and internal control are practiced throughout the Scheme by all staff, and are embedded in day-to-day activities.

8. RISK MANAGEMENT AND MITIGATION (continued)

Several methods are employed to assess and monitor risk exposure both for individual types of risks insured and overall risks. These methods include the use of internal risk measurement models, sensitivity analyses and scenario analyses all of which are subject to strict audit criteria.

In addition to the Scheme's other compliance and enforcement activities, the Board has implemented a confidential reporting process ("whistleblowing") covering fraud and other risks.

The Board has delegated the risk management process to the Management Committee and the oversight of the risk management to the Audit Committee and Investment Committee. These sub-Committees are answerable to the Board and neither relieves the Trustees of any of their responsibilities, but assists them to fulfil those responsibilities.

8.1. Risk transfer arrangements

Refer to note 11 of the financial statements.

In line with the vision to soundly manage the claims risk, the Scheme has entered into risk-sharing agreements with third party service providers to ensure cost effective services. This provides the Scheme with the ability to mitigate an identified risk by agreement with a third party service provider. The principal is based on the sharing of predefined potential claims loss in return for exclusivity of delivering the service.

The following risk transfer capitation arrangements were in place for the year:

Organisation	Services capitated	Scheme benefit option
Prime Cure (Pty) Ltd	Provides primary healthcare services at Healthcare centres and contracted network service providers, including a limited hospital benefit.	Value Care Plan
Netcare 911 (Pty) Ltd	Provides emergency transport services and other ambulance services.	Managed Care Plan Standard Care Plan
Centre for Diabetes and Endocrinology (CDE)	Provides diabetes related medical services including related hospitalisation expenses.	Managed Care Plan Standard Care Plan

9. GOVERNANCE

The Scheme vision is supported by the Board Charter wherein the Board commits to act in good faith with utmost due care, diligence and skill. Each Trustee is required to aspire to the core ethical principles of fairness, transparency, honesty, non-discrimination, accountability and respect for human dignity and rights.

The Board delegates the duty of delivery and operation of the functions to the duly constituted Committees while remaining fully responsible for the performance of the Scheme and accountable to the membership. The principles of good governance and sound business ethics are firmly adhered to through the adoption of the King III guidelines, a culture of rigorous risk and financial management and a stringent auditing process.

The Scheme complies with International Financial Reporting Standards and all the relevant legislative requirements.

10. MANAGEMENT

10.1. **Board of Trustees** in office during 2015:

Elliott CC (Chairman)	Employer appointed (elected Chairman 20/05/2015)
Ghavalas D (Vice-Chairman)	Employer appointed (elected Vice Chairman 20/05/2015)
du Bois MA	Employer appointed
Howell GAE	Employer appointed
McCallum DR	Employer appointed (appointed 20/05/2015)
Welz MF	Employer appointed (appointed 20/05/2015)
Mayet S	Employer appointed (resigned 03/02/2015)
Fox Dr FH	Employer appointed (served until 20/05/2015)
	Member elected (elected 20/05/2015)
Barber DD	Member elected
Graham MD	Member elected
Laubscher PA	Member elected
Mckie Thomson CC	Member elected
Hosking S	Member elected (elected 20/05/2015)
Preston GJ	Member elected (served until 20/05/2015)
Farrell MR	Member elected (served until 20/05/2015)

10. MANAGEMENT (continues)

10.2. Alternate Trustees in office during 2015:

Chetty P	Member elected (Retired 20/05/2015)
Farrell MR	Member elected (20/05/2015)
Hosking S	Member elected (Served until 20/05/2015)
Liston J	Employer appointed
Masarira A	Employer appointed (Retired 20/05/2015)
Mason-Gordon NJ	Employer appointed
McCallum DR	Employer appointed (Served until 20/05/2015)
Sanford LR	Member elected (Served until 20/05/2015)
Stanley J	Employer appointed (Served until 20/05/2015)
Switala BI	Member elected (Served until 20/05/2015)
Vatsha P	Employer appointed (Served until 20/05/2015)
Abramowitz D	Employer appointed (Appointed 20/05/2015)

10.3. Management Committee in office at 31 December 2015

Ghavalas D (Elected Chairman 20/05/2015); du Bois MA; Fox Dr FH; Graham MD; Liston J; McCallum DR; Welz MF.

10.4. Health Risk Management and Communications sub-committees of the Management Committee: not convened during the year under review.

10.5. Audit Committee in office during the year under review:

Brown M (Chairman, Independent); Barber DD; Howell GAE; Prinsloo J (Independent); Rood EJ (Independent)

10.6. Ex-gratia Committee in office during the year under review:

Fox Dr FH (Chairman); Laubscher PA; Mckie Thomson CC; Hosking S; Farrell MR; Pienaar J (Independent)

10.7. Investment Committee in office during the year under review:

Barber DD (Chairman); Colebank CJ (External consultant- contract ended 31/12/2015); du Bois MA; Elliott CC; Ghavalas D; Mason-Gordon NJ; Liston J; Thompson HM (External consultant); Yates CWP (External consultant - contract ended 31/12/2015)

10. MANAGEMENT (continues)

10.8. Communications Committee in office during the year under review:

It has been agreed that the functions of the Communications Committee will be overseen by the Management Committee. Should a Committee be required, it would be ad-hoc and not formally constituted.

10.9. Disputes Committee in office during the year under review:

Demetriou C (member elected); Dixon C (member elected); Van Staden M (member elected).

10.10. Principal Officer and staff in office during the year under review:

Robertson FK	Principal Officer	Scheme employed
Gröpp-Els E	Scheme and Clinical Manager	Scheme employed
Friese J	Communications Manager	Scheme employed
Landsberg Y	Scheme Secretary	Scheme employed

11. SUB-COMMITTEES OF THE BOARD OF TRUSTEES

11.1. Audit Committee

The Audit Committee (the Committee) is established in accordance with the provisions of the Act and is mandated by the Board of Trustees by written terms of reference as to its membership, authority and duties. The Committee consists of five members, two of whom are members of the Board of Trustees.

The majority of the Committee, including the chairperson, is independent and does not serve on the Board of the Scheme or act on behalf of the administrator.

In accordance with the provisions of the Act, the primary responsibility of the Committee is to assist the Board of Trustees in carrying out its duties relating to the Scheme's accounting policies, internal control systems and financial reporting practices.

The External Auditor formally reports to the Committee on critical findings arising from the statutory audit. The Internal Auditor attends meetings and reports findings to the Audit Committee.

The Committee met regularly during the year and both the Internal and External Auditor are invited to attend all Committee meetings, who also had unrestricted access to the Chairman of the Committee at all times.

The Committee oversaw the external audit tender in 2015 and recommended KPMG Inc be appointed. This was approved by the members at the AGM held on 20 May 2015 and subsequently by the Council for Medical Schemes.

11. SUB-COMMITTEES OF THE BOARD OF TRUSTEES (continued)

11.1. Audit Committee (continued)

The Audit Committee is pleased to report that:

- It has carried out its duties in terms of the Medical Schemes Act and the Board of Trustees written Audit Committee charter;
- The External Auditor has confirmed their independence;
- The assurances provided by Administrator management, the External Auditor and the Internal Auditor have satisfied the committee that the controls are adequate and effective;
- It has ensured the co-ordination of the approaches of the Internal and External Auditor and has had oversight of the financial reporting process;
- It has evaluated the effectiveness of the risk management and governance;
- It has received the assurance from the External and Internal Auditors that nothing had come to their attention that compromised the effectiveness of the controls as they apply to the annual financial statements; and
- It has reviewed the approach taken to the application of King III and has found no material weakness.

The Audit Committee has reviewed the Scheme's annual financial statements, reviewed the accounting policies, obtained assurances from the External Auditor and recommended the adoption of the annual financial statements by the Board of Trustees for presentation to members.

11.2. Investment Committee

The Investment Committee (the Committee) is a duly constituted sub-committee of the Board of Trustees and has the responsibility to assist the Board of Trustees in carrying out their duties relating to the Scheme's investment policy and strategy. It is mandated by means of written terms of reference as to its membership, authority and duties.

The Investment Committee consists of six members, 50% of whom are Trustees. The Scheme appointed Towers Watson as independent investment consultants to assist the Committee. The current investment managers of the Scheme are Investec Asset Management (Pty) Ltd, Coronation Asset Management (Pty) Ltd and Allan Gray South Africa (Pty) Ltd. The recent review of the investment strategy is discussed in more detail in Section 3 of this report.

The Committee met regularly during the year and the investment consultant attended all Committee meetings with the investment managers attending at least one meeting per annum.

The Committee reviews the strategy regularly in accordance with the mandate set by the Board of Trustees and advises on the structure of the portfolio as well as risk mitigation to ensure sustainability of the Scheme's long-term cross subsidy liability funding requirements.

11. SUB-COMMITTEES OF THE BOARD OF TRUSTEES (continued)

11.3. Management Committee

The Management Committee (the Committee) is mandated by the Board of Trustees to oversee and review the management of the day-to-day administrative and financial risk management (with the exception of investment risk management), and financial functions of the Scheme, by means of written terms of reference as to its membership, authority and duties.

This Committee is chaired by the Vice Chairman of the Scheme and comprises six Trustees and one alternate trustee who meet a minimum of six times a year to review key indicators and make formal proposals and recommendations to the Board of Trustees. The Chairman of the Scheme is invited to attend the meetings ex-officio.

Administrative risk management measures are employed to ensure good governance of the access to benefits; these include, but not limited to pre-authorisation, case management, service provider profiling, billing audits and interventions in respect of fraud.

11.4. Ex Gratia Committee, previously the Appeals Committee

The Ex Gratia Committee (the Committee) is mandated by the Board of Trustees to assist members by awarding ex-gratia payments where services were either denied or rejected due to limited or uncovered benefits as deemed appropriate according to the individual merits of each case. These awards are granted on the basis of the clinical circumstances of the case and/or financial hardship of the individual member.

The Committee is governed by means of written terms of reference as to its membership, authority and duties. This Committee meet bi-monthly and is chaired by a Trustee who is a medical practitioner and assisted by three Trustees.

11. SUB-COMMITTEES OF THE BOARD OF TRUSTEES (continued)

11.5. Communications Committee

The overall objective of the Communications Committee (the Committee) is to advise and educate members and employers on benefits and Scheme matters and also to create an understanding of the complexities of the healthcare industry. The Committee is an ad-hoc Committee and meets as and when required. Communications oversight is a function of the Management Committee.

11.6. Disputes Committee

The Disputes Committee (the Committee) is an independent Committee and comprises three members who are appointed by members at the Annual General Meeting. The appointed members may not be administrators, trustees or officers of the Scheme.

The main function of the Committee is to deal with member disputes where the member is dissatisfied with any decision taken by the Board or a committee or an administrator of the Scheme. No disputes were raised in 2015, therefore no meetings were held during the year.

11.7. Regional Committees

Regions are established based on the number of members represented in a specific region. Business units are defined and designated by participating employers in each region.

There are currently three regions, namely; Central Region (Gauteng, Limpopo and Mpumalanga), Eastern Region (KwaZulu Natal) and the Southern Region (Western Cape, Eastern Cape, Northern Cape).

Each Regional Committee comprises a chairperson, Trustee, employer and member representative and meets biannually. The main function of these Committees is to provide feedback from the Board of Trustees meetings to the participating employers of the Scheme; who in turn provide feedback to all their respective active and retired members.

12. TRUSTEE AND NON-TRUSTEE MEMBERS ATTENDANCE AT COMMITTEE MEETINGS

	Board of Trustees		Audit Committee		Investment Committee		Manage-ment Committee		Ex-gratia Appeals Committee	
Trustees	A	B	A	B	A	B	A	B	A	B
Elliott CC	6	6			1	1	1*	1*		
du Bois MA	6	6			4	4	8	8		
Barber DD	6	6	4	3	4	3				
Ghavalas D	6	6			4	3	8	7		
Fox Dr FH	6	6					8	8	7	7
Howell GAE	6	5	4	4			2*	2*		
Farrell MR	3	3					4	4	7	7
Graham MD	6	4					8	7	4	3
Laubscher PA	6	5					1*	1*	7	4
Mckie Thomson CC	6	6					6	6	4	3
Preston GJ	3	3					1*	1*		
Hosking S	4	3							4	3
McCallum DR	4	4					8	8		
Welz MF	4	3					4	3		
Alternate Trustees and Consultants										
Mason-Gordon NJ	1	1			3	3	1	1		
Liston J					2	2	8	7		
Abramowitz D					1*	1*				
Thompson HM					4	3				
Pienaar J									7	6
Brown M			4	4						
Prinsloo J			4	3						
Rood E			4	4						
Yates C					4	4				
Colebank C					4	3				

A = maximum possible attendance

B = actual attendance

* = voluntary attendance

13. OPERATIONAL STATISTICS

The detailed statistics per plan are reflected in the table below:

	Managed Care Plan			Standard Care Plan			Value Care Plan			Total		
	2015	2014	%	2015	2014	%	2015	2014	%	2015	2014	%
Number of members at end of accounting period	5 033	5 258	-4%	3 678	3 585	3%	437	347	26%	9 148	9 190	0%
Average (avg) number of members for the period	5 116	5 372	-5%	3 673	3 593	2%	396	321	23%	9 184	9 286	-1%
Beneficiaries at end of accounting period	9 569	10 216	-6%	8 692	8 551	2%	954	780	22%	19 215	19 547	-2%
Beneficiaries per member at end of accounting period	1.90	1.94	-2%	2.36	2.39	-1%	2.18	1.95	12%	2.10	2.12	-1%
Average age of beneficiaries	52.5	51.2	3%	32.71	32.46	1%	24.4	24.6	-1%	42.15	41.94	1%
Pensioner ratio (beneficiary > 65 years)	41.37%	38.86%	6%	10.48%	10.34%	1%	1.26%	1.41%	-11%	25.41%	24.89%	2%
Avg gross contribution per member per month	5 090	4 844	5%	2 942	2 769	6%	1 001	954	5%	4 055	3 907	4%
Avg gross contribution per beneficiary per month	2 667	2 547	5%	1 245	1 164	7%	449	452	-1%	1 927	1 866	3%
Avg gross claim per member per month	6 109	5 602	9%	3 174	2 963	7%	867	898	-3%	4 710	4 276	10%
Avg gross claim per beneficiary per month	3 201	2 868	12%	1 343	1 243	8%	389	384	1%	2 239	2 005	12%
Avg administration cost per member per month	265	295	-10%	266	275	-3%	104	110	-6%	258	280	-8%
Avg administration cost per beneficiary per month	139	151	-8%	112	115	-2%	47	47	-1%	123	131	-7%
Risk claims as a % of risk contributions	134.7%	117.4%	15%	107.9%	107.0%	1%	86.7%	94.2%	-8%	124.7%	113.8%	10%
Administration cost as a % of gross contributions	5.2%	5.8%	-11%	9.0%	9.9%	-9%	10.4%	11.5%	-10%	5.5%	7.0%	-22%

14. ACTUARIAL SERVICES

The Scheme's actuaries are contracted to identify and monitor health related risks, establish claiming patterns and determine contribution and benefit levels. They also participate in the monthly and annual calculations of the outstanding claims incurred, but not yet reported and paid by the Scheme (IBNR). The Scheme's long-term funding valuation is calculated and reviewed annually by the actuaries.

15. GUARANTEES RECEIVED BY THE SCHEME FROM A THIRD PARTY

None

16. INVESTMENTS IN AND LOANS TO EMPLOYERS OF MEMBERS OF THE SCHEME AND TO OTHER RELATED PARTIES

Refer to related parties disclosure in Note 22 of the financial statements.

17. RELATED PARTY TRANSACTIONS

Refer to related parties disclosure in Note 22 of the financial statements. Trustee remuneration is disclosed in Note 23 of the annual financial statements.

18. SUBSEQUENT EVENTS

No events have occurred subsequent to the end of the accounting period to the date of this report that affect the annual financial statements that the Trustees consider should be brought to the attention of the members of the Scheme.

19. COMPLIANCE WITH THE MEDICAL SCHEMES ACT

The Trustees are of the opinion that there are no material deviations from the Act.

19.1. Outstanding contributions

Nature and impact

In terms of Section 26(7) of the Act, contributions should be received in accordance with the rules of the Scheme. Per the Scheme rules, contributions are required to be received at least three days after their due date. Instances were noted where contributions were received late.

Causes for failure

Balances after three days are due to reconciling discrepancies between the participating employers and the Scheme. The risk of default on payments due to the Scheme is small because of the restricted nature of the Scheme and employer base. The trustees consider this to be immaterial.

Corrective action

Suspension policies are in place and applied where contributions are outstanding for individual paying members outside the participating employers' obligation.

19.2. Investment in participating employer

Nature and impact

Section 35(8)(a) of the Act states that a medical scheme shall not invest any of its assets in a participating employer. During the year the Scheme had exposure to investments in participating employer groups.

Causes for failure

The Scheme invests in pooled investment vehicles which allow investment managers discretion to invest in a combination of shares and bonds that will best achieve their stipulated benchmark. Given this approach, the Scheme was exposed to participating employer shares.

Corrective action

The Scheme has applied to the Council for Medical Schemes and received an exemption from this section of the Act.

19. COMPLIANCE WITH THE MEDICAL SCHEMES ACT (continued)

19.3. Investment in administrator

Nature and impact

Section 35(8)(c) of the Act states that a medical scheme shall not invest any of its assets in any administrator. During the year the Scheme had exposure to such investments.

Causes for failure

The Scheme invests in pooled investment vehicles which allow investment managers discretion to invest in a combination of shares and bonds that will best achieve their stipulated benchmark.

Corrective action

The Scheme has applied to the Council for Medical Schemes and received an exemption from this section of the Act.

19.4. Investment limitations

Nature and impact

Regulation 30(3) states that a medical scheme shall not invest more than 40% of its assets in local equities. The Scheme exceeded this limit throughout the year.

Causes for failure

The Act makes provision for medical schemes to exceed the limit of 40% on local equities under certain circumstances. The Board of Trustees decided to exceed the limit after complying with all the required circumstances. The purpose is to maximise investment income on a long-term basis.

Corrective action

The Scheme submitted a certified statement prepared by its consultants to the Council for Medical Schemes to state that an alternative percentage of 75% should apply to the excess assets as permitted in Regulation 30(3).

19. COMPLIANCE WITH THE MEDICAL SCHEMES ACT (continued)

19.5. Sustainability of benefit options

Nature and impact

In terms of section 33(2) of the Act, each benefit option shall be self-supporting in terms of membership and financial performance. At 31 December 2015 two of the three benefit options incurred deficits before investment income as set out in note 24 to the annual financial statements.

Causes for failure

The Board of Trustees annually maintain market related benefit offerings and competitive contribution increases. Due to the Scheme demographics, this gives rise to the non-compliance.

Corrective action

Anglo American South Africa sold numerous subsidiaries over a period of time resulting in the loss of active employees and retention of pensioners. To compensate the Scheme for the resultant high pensioner ratio and expected deterioration of the claiming profile, the Participating Employers pre-funded the additional liability to the extent that the Scheme could maintain market related benefits and contribution increases into the future. The Scheme meets its responsibility to the members by subsidising the expected claims excess over contributions from the reserves. The Trustees believe that the current and expected future investment returns are sufficient to meet the shortfall.

The Council for Medical Schemes is aware of the Scheme's strategy and approves the benefits and contributions annually without any requirement to take further corrective action.