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*medical
aid
society*
there when you need us.



NOTICE IS HEREBY GIVEN THAT THE EIGHTY-FIRST ANNUAL GENERAL MEETING OF BP MEDICAL AID SOCIETY WILL BE HELD ON MONDAY, 25 JUNE 2018, AT 10:00 IN THE KILIMANJARO 8 AND 9 MEETING ROOMS, BP WATERFRONT, PORTSWOOD RIDGE, DOCK ROAD, V&A WATERFRONT, CAPE TOWN.

AGENDA

1. Opening and welcome
2. Apologies
3. To adopt the Minutes of the Annual General Meeting held on Thursday, 22 June 2017
4. To adopt the Annual Report of the Chairperson of the Board for the year ended 31 December 2017
5. To adopt the Annual Financial Statements for the year ended 31 December 2017
6. To note the member-elected and employer-appointed Trustees for the ensuing year
7. To note the composition of the Disputes Committee for the ensuing year
8. To approve the appointment of the Auditors for the ensuing year
9. To report back on matters raised by members at the 2017 Annual General Meeting
10. To transact any other business of which notice was given to the Principal Officer by 18 June 2018

By order of the Board

THABISIWE MLOTSHWA
PRINCIPAL OFFICER

BP MEDICAL AID SOCIETY CHAIRPERSON'S REPORT FOR THE YEAR 2017

2017 results

Once again I am pleased to report on a year in which claims were below what was expected for the age and disease burden profile of the Society. I commend you for looking after your health!

Looking back, 2016 remains an exceptionally good year in that claims (R104.3m) were lower than what was reported in 2015. So, although claims increased in 2017 to R111.4m, it was still below the R113.4m that was budgeted for.

Your Trustees continue to believe that your commitment to looking after your health, coupled with making use of the Society's managed healthcare programmes and comprehensive range of screening and early detection benefits are playing a role in this good claims outcome. We trust that the favourable trend of recent years will continue into the foreseeable future.

The low level of claiming is of the utmost importance in the continued sustainability of the Society. When the monthly management accounts arrive in my inbox, the first figure I look at is the amount of claims for the month. The level of claims in any year is a primary determinant of the level of contributions for the following year.

By the time you read this report, you will be aware that aggregate contributions for 2018 have decreased by 1.8% as a result of the Society's good claims experience and favourable investment returns in 2017. This is an outstanding outcome for any medical aid scheme.

The Society continues to maintain a high level of reserves, which both underwrites the medium-term sustainability of the Society and could also be applied to provide a buffer in the event of a year in which claims experience is significantly worse than the expected level. As we are a Society that covers only 3 759 lives, we can expect significant variations in claims from year to year. We have already experienced such variation in the past five years, but the impact has fortunately been positive.

The impact of the reduction in contributions on various groups of members is, however, different. Some enjoy larger decreases and some face increases. I will expand on the reasons for the changes that have been made in income bands and the contribution rates per band in the section on income bands below.

Income bands

Last year I wrote as follows:

'The Society has 15 income bands for the setting of contributions. In 2016, for a principal member with an adult and a child dependant, the monthly contributions ranged from R717 for the lowest band to R6 836 for the highest band. Certain members' contributions are also, in terms of their contracts of employment, subsidised by the Company.

Your Trustees are very much aware that the contributions for those in the higher bands have to offer value for money when compared to open scheme offerings with similar benefits – especially as many of these members are on total cost to employer packages and therefore do not enjoy a direct subsidy of their contributions.'

The need to accommodate the concerns of the members in the higher bands, who could purchase medical cover more suited to their needs in the open market for less than their Society contribution, became pressing during 2017, as these members, who cross subsidise the low-income members, were increasingly finding ways of not joining the Society. The Society was made to understand that this was to the extent of not joining or of leaving the service of BP.

Therefore, after applying our minds to the matter, your Trustees – who are required to act in the interests of all members – have embarked on a plan to progressively reduce the number of income bands and thereby reducing the extent of income cross subsidisation.

The outcome for 2018 has been a reduction of between 2% and 10% for the higher bands and an increase of 10% for the lowest bands. This 10% increase compares well with the increases of approximately 9% implemented in 2018 by open schemes.

The Trustees also did not increase the monetary values of the band limits. This has, however, had an impact on some members in 2017. As a result of increases in their income, they moved into a higher band, resulting in an increase in contributions. Over time, if the band limits are not increased, more members will move up a band. Of course, those who moved this year will not move again for some time.

**BP MEDICAL AID SOCIETY
CHAIRPERSON'S REPORT FOR THE YEAR 2017 (CONTINUED)**

Income bands (continued)

The Trustees have also, as you may be aware, embarked on a review of incomes and the income bands that members are in. You will in due course be informed of the outcome of this review.

Administrative problems

Unfortunately I need to refer to the severe administrative problems that struck the Society at the end of 2016 and which persisted throughout 2017. This was largely as a result of inadequate planning by our Administrator when they changed their computer systems.

Your Trustees apologise to you for the difficulties and inconvenience that you may have suffered as a result.

Specialist network

With effect from 1 January 2016 a specialist network was set up as a preferred service provider, thereby eliminating member co-payments when they visit a network specialist.

It is the intention of the Trustees that the next step in making the network a designated service provider would be to make it compulsory for members who use a non-network specialist to make a co-payment, as well as a possible out-of-pocket payment if the specialist charges more than the Society benefit.

However, this step has been deferred, as there have been some challenges in making this network as effective as the Trustees would like it to be.

Company support

We all owe a debt of gratitude to the Company for its continued financial support of the Society. In essence, this support is set at the rate of 50% of the contributions of continuation members and in 2017 it amounted to R24.7m. It offsets the cost of the added disease burden that results from our membership profile, where the average age is higher than for almost all other schemes in South Africa. It should be noted that medical expenses typically rise with age.

It is this special support that makes membership of the BP Medical Aid Society something to be valued.

In addition to the continued financial support, the Company also supports the Society on the cost of treatment for HIV/AIDS and covers certain operating costs.

The road ahead for benefit design

Your Society is committed to providing appropriate access to healthcare benefits and efficient administration, thereby ensuring that you will have financial peace of mind during those times when you and those close to you are beset by health issues.

Achieving this means that your Trustees and their advisers need to ensure the well-being of the Society itself.

This, at its most basic, means ensuring good governance and balancing the costs of the benefits that we offer against the size of the contributions needed to fund the resulting claims. Your Trustees are only too well aware that, as the cost of healthcare has been consistently rising faster than the consumer price index (CPI), your contributions are absorbing an increasing part of many of your budgets. That is why the average decrease in contributions that the Society was able to implement in 2017 is so pleasing to the Trustees.

One of the main things occupying the minds of your Trustees, as we move forward, is how to design the benefit package in such a way that it offers both the peace of mind that I referred to and at the same time that it does not result in unaffordable contribution levels.

We will be considering the results of the surveys that you participated in when we design the 2019 benefits.

The road ahead for benefit design (continued)

There are three main levers to keeping claims costs (and therefore contributions) down, namely:

- the use of designated service providers and networks;
- managing health on a preventative care basis; and
- seeking ways to restructure the benefit package so that good cover can be provided in more cost-effective ways.

Your Trustees will continue to look at all of these levers as they seek to further contain contribution increases while still offering good cover.

You also play an important role by living a healthy lifestyle and taking advantage of the preventative tests that are available through our benefits. I encourage you to continue doing so.

In the process of mapping out the way ahead, the Trustees will continue to engage with the Company on any issues that require engagement.

Broader issues

The Trustees, through the Audit and Risk Sub-Committee and its advisers, maintain a watching brief on wider issues affecting the healthcare industry. It should be noted that a decision was made in 2016 to combine the Risk and Audit Committees.

These include the ultimate introduction of a national health insurance scheme, which is still some way off, the Competition Commission's market inquiry into private healthcare, where we provided extensive data to the Commission, and proposals for the introduction of a low-cost private healthcare funding plan, which have been withdrawn for the time being.

The Society remains a member of the Board of Healthcare Funders.

Council for Medical Schemes (CMS)

As you might be aware, the CMS has made it known that as part of the preparations for the introduction of the national health insurance scheme, it has been mandated by government to look at both a reduction in the number of options offered by schemes (which does not affect the Society, as it only has one option) and the amalgamation of smaller schemes with larger ones. This potentially affects the Society as it is, in terms of the number of members, one of the smaller schemes.

You will be kept informed of any developments in this matter.

Principal Officer and Board membership

In November 2015 we welcomed Ms Thabisiwe (Thabi) Mlotshwa as our Principal Officer. Thabi is continuing to play her role with great success. I am indebted to her for all she does.

2016 was an election year, which saw Mr John Bush, a stalwart of many a year in service of the Society, including long terms as Chairperson, deciding not to seek re-election. We have to adapt to guiding the Society without his wealth of knowledge of both the industry and the Society at our disposal.

Thanks to John for agreeing to continue as member of the Clinical Sub-Committee in 2018.

Mr André Stapelberg was the successful candidate in the 2017 election. We welcome André to the Board. He is making quiet, but firm, contributions to the work of the Board of Trustees.

The Company also made some changes in its appointments to the Board. Ms Bahijah Hashim stood down (though she continues to serve the Society as the Chairperson of the Audit Committee), as did Ms Dawn Fortune.

Ms Welmie Schoeman and Ms Prinisha Khoosal joined the Board and are making valuable contributions to our deliberations.

**BP MEDICAL AID SOCIETY
CHAIRPERSON'S REPORT FOR THE YEAR 2017 (CONTINUED)**

Thanks

On behalf of all of our members I would like to express thanks to many people and entities associated with the Society:

- Our Principal Officer –Thabi Mlotshwa
- The Trustees who served in 2017 – Solly Molekwa, John Bush, Guy McGregor, Bahijah Hashim, Michael Petersen, Dawn Fortune, Andre Stapelberg, Welmie Schoeman and Prinisha Khoosal; a special thank you to the Trustees who have left the Board
- Our Medical Adviser and Chairperson of the Clinical Sub-Committee – Dr Shuaib Manjra
- The Chairperson of our Audit and Risk Committee – Ms Bahijah Hashim; our special thanks to Adv David Mitchell, who stood down by rotation after a term of some seven years as Chairperson and who has agreed to continue to serve as a member of the Committee
- The members of our Committees and Sub-Committees – Audit, Clinical, Legal, Compliance and Contractual, Investment, Operations, Communications and Disputes; special thanks to Danel Stoffberg, who accepted the challenge of becoming the Chairperson of the Legal, Compliance and Contractual Sub-Committee
- Our service providers:
 - Our Administrator – MMI Health, led by Ms Abeeda English, who is ably assisted on financial aspects by Mr Victor Saku and on secretarial matters by Mr Deon Skade and Ms Noxolo Macwili
 - Alexander Forbes, our healthcare actuarial consultants, led by Mr Casper de Vries
 - MMI Health – our managed healthcare provider
 - Our designated and preferred service providers – Mediclinic hospital group, Life Healthcare hospital group, Dis-Chem, Clicks Retail, Clicks Direct Medicines, Independent Clinical Oncology Network, Iso Leso, Netcare 911 and the specialist network
 - Our investment managers – Alexander Forbes Investment and Acsis Limited
 - Our external Auditors, Ernst and Young Inc, led by Cindy Cronning and Jacques Vermeulen

I have earlier expressed our thanks to the Company for their vital support.

Closure

As I did last year, I ask that you take some time to read the Report of the Board of Trustees on page 11. This report gives a lot more information on the affairs of the Society, such as the work of the sub-committees, key statistical data and the investment strategy. And, of course, take the time to review just two pages of the Annual Financial Statements: the Statement of Financial Position on page 23 and the Statement of Comprehensive Income on page 24, which are both quite easy to follow.

I hope that all members enjoy the best of health in 2018, but that should illnesses strike, the Society will be there to hold your hand and give you peace of mind that the financial burden will be taken care of.



C McClelland
CHAIRPERSON

May 2018

**BP MEDICAL AID SOCIETY
STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES
for the year ended 31 December 2017**

The Trustees are responsible for the preparation, integrity and fair presentation of the Annual Financial Statements of the BP Medical Aid Society (the Society). The Annual Financial Statements presented on pages 23 to 56 have been prepared in accordance with International Financial Reporting Standards (IFRS) and the Medical Scheme's Act of South Africa and include amounts based on judgements and estimates made by management under the guidance and oversight of the Trustees.

The Trustees consider that in preparing the Annual Financial Statements, they have used the most appropriate accounting policies, consistently applied and supported by reasonable and prudent judgements and estimates.

The Trustees are satisfied that the information contained in the Annual Financial Statements fairly presents the results of operations for the year, the cash flow and the financial position of the Society at year-end. The Trustees are also responsible for the preparation of the other information included in the Annual Report and are responsible for both its accuracy and its consistency with the financial statements.

The Trustees have responsibility for ensuring that accounting records are kept. The accounting records should disclose with reasonable accuracy the financial position of the Society, which enables the Trustees to ensure that the Annual Financial Statements comply with the relevant legislation.

The going-concern basis has been adopted in preparing the Annual Financial Statements. The Trustees have no reason to believe that the Society will not be a going concern in the foreseeable future, based on forecasts and available cash resources. These Annual Financial Statements support the viability of the Society.

The Society's external Auditors, Ernst & Young Inc, audited the financial statements in terms of International Standards on Auditing, and their report is presented on pages 8 to 10.

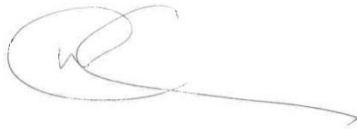
The financial statements were approved by the Board of Trustees on 17 April 2018 and are signed on its behalf by:



C McClelland
CHAIRPERSON



G McGregor
TRUSTEE



T Mlotshwa
PRINCIPAL OFFICER

18 April 2018

**BP MEDICAL AID SOCIETY
STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES
for the year ended 31 December 2017**

The BP Medical Aid Society is committed to the principles and practice of fairness, openness, integrity and accountability in all dealings with its stakeholders. The Society conducts its affairs according to ethical values. The Trustees of the Society are appointed or elected by the participating employers or the members of the Society respectively. The Trustees recognise the need to conduct the business of the Society in accordance with the principles of the King Code of Corporate Practices and Conduct ('King code'), as applicable.

BOARD OF TRUSTEES

The Trustees monitor the performance of the Administrator. They address a range of key issues and ensure that discussion of items of policy, strategy and performance is critical, 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 expense of the Society.

INTERNAL CONTROLS

The Administrator of the Society maintains internal controls and systems designed to provide reasonable assurance as to the integrity, adequacy and reliability of the financial statements and to safeguard, verify and maintain accountability for the Society's assets. Such controls are based on established policies and procedures and are implemented by trained personnel with the appropriate segregation of duties.

With effect from 15 December 2016, the Administrator migrated from the Reflections to iSquare administration platform. The Society experienced various issues in relation to its business processes, control activities and internal control systems during the months following the migration. The Society's external auditors were requested to perform additional work in order to provide the Audit Committee and the Board of Trustees with the necessary level of comfort.

The Society now operates in a well-established control environment, which is well documented and reviewed. This incorporates risk management and internal control procedures, which are designed to provide reasonable, but not absolute, assurance that assets are safeguarded and the risks facing the Society are being controlled.



C McClelland
CHAIRPERSON



G McGregor
TRUSTEE



T Mlotshwa
PRINCIPAL OFFICER

18 April 2018

REPORT OF THE INDEPENDENT AUDITOR TO THE TRUSTEES OF BP MEDICAL AID SOCIETY
Independent Auditor's report
to the Members of the BP Medical Aid Society

Report on the audit of the financial statements

Opinion

We have audited the financial statements of BP Medical Aid Society, which comprise the statement of financial position as at 31 December 2017, the statement of comprehensive income, the statement of changes in equity and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of BP Medical Aid Society as at 31 December 2017, its financial performance and its cash flows for the year then ended in accordance with International Financial Reporting Standards (IFRSs) and the requirements of the Medical Schemes Act of South Africa.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of BP Medical Aid Society within the meaning of the Codes of Professional Conduct issued by the Independent Regulatory Board for Auditors (IRBA) and the International Federation of Accountants (IFAC) and have fulfilled our other responsibilities under those ethical requirements.

We conducted our audit in accordance with International Standards on Auditing (ISA). Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Society in accordance with the Independent Regulatory Board for Auditors Code of Professional Conduct for Registered Auditors (IRBA code), the International Ethics Standards Board for Accountants Code of Ethics for Professional Accountants (IESBA code) and other independence requirements applicable to performing audits of BP Medical Aid Society. We have fulfilled our other ethical responsibilities in accordance with the IRBA and IESBA codes and in accordance with other ethical requirements applicable to performing the audits of BP Medical Aid Society.

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

Key audit matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current period. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. For the matter below, our description of how our audit addressed the matter is provided in that context.

We have fulfilled the responsibilities described in the Auditor's responsibilities for the audit of the financial statements section of our report, including in relation to this matter. Accordingly, our audit included the performance of procedures designed to respond to our assessment of the risks of material misstatement of the financial statements. The results of our audit procedures, including the procedures performed to address the matters below, provide the basis for our audit opinion on the accompanying financial statements.

With effect from 15 December 2016 the Society's Administrator transitioned the administrative and operational system from Reflections to the iSquare platform. This transition had an impact on the Society's business processes, control activities and internal control systems. We focused on this matter as part of our audit because this was a significant accounting and auditing matter that could have resulted in material misstatement should the system implementation not have occurred with proper oversight and a focus on maintaining effective internal controls throughout the process.

Independent Auditor's report to the Members of the BP Medical Aid Society (continued)

How the key audit matter was addressed in the audit

Our procedures included, amongst others, the following:

- We performed procedures to obtain an understanding of the iSquare system.
- We analysed and reviewed the reports and working papers prepared by the internal audit function of the Administrator in relation to the work performed on the data migration, benefit rollover and claims testing. This included computer-assisted audit techniques (CAATs), which were performed over the claims, membership and premiums data to identify anomalies and inconsistencies. Direct testing was performed on exceptions identified by the Administrator's internal audit function.
- In addition, a sample of the work performed by the Administrator's internal audit function was re-tested.
- Making use of data analytics, we performed analytical review procedures to analyse the claims profile for the financial year.
- For a sample of claims, we tested the accuracy of the processing by the Administrator.
- We reviewed the report on IT general controls performed by internal audit and assessed the design, implementation and operating effectiveness of management's general IT controls.

Other reports required by the Medical Schemes Act

The Trustees are responsible for the other information. The other information comprises the Board of Trustees' Report. The other information does not include the financial statements and our auditors' report thereon.

Our opinion on the Financial Statements does not cover the other information and we do not express an audit opinion or any form of assurance conclusion thereon.

In connection with our audit of the Financial Statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the Trustees and those charged with governance or other appropriate terms for the financial statements

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

In preparing the financial statements, the Trustees are responsible for assessing the Society's ability to continue as a going concern, disclosing, as applicable matters related to going concern and using the going-concern basis of accounting unless they either intend to liquidate the Society or to cease operations or has no realistic alternative but to do so. Those charged with governance are responsible for overseeing the Society's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

The objectives of our audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

**Independent Auditor's report
to the Members of the BP Medical Aid Society (continued)**

Auditor's responsibilities for the audit of the financial statements (continued)

As part of an audit in accordance with ISAs, we exercise professional judgment and maintain professional scepticism throughout the planning and performance of the audit. We also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion; the risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control
- obtain an understanding of internal control relevant to the audit 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 Society's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Trustees
- come to a conclusion on the appropriateness of the Trustees' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Society's ability to continue as a going concern; if we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion; our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Society to cease to continue as a going concern
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation
- obtain sufficient, appropriate audit evidence regarding the financial information of the Society to express an opinion on the financial statements; we are responsible for the direction, supervision and performance of the audit; we remain solely responsible for our audit opinion.

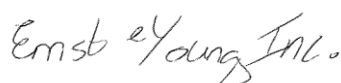
We communicate with the Trustees regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

We also provide the Trustees with a statement that we have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on our independence and, where applicable, related safeguards.

From the matters communicated with the Trustees, we determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters. We describe these matters in our Auditor's Report unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, we determine that a matter should not be communicated in our report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Report on other legal and regulatory requirements

As required by the Council for Medical Schemes, we draw your attention to note 23 – instances of non-compliance with the Medical Schemes Act of South Africa.



Ernst & Young Inc
Executive Director: Cindy Cronning
Registered Auditor
Chartered Accountant (SA)

Date: 18 April 2018

Cape Town

**BP MEDICAL AID SOCIETY
REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2017**

The Board of Trustees hereby presents its report for the year ended 31 December 2017.

Registration number: 1237

1. MANAGEMENT

1.1 BOARD OF TRUSTEES

The following persons served on the Board of Trustees during the year under review:

Employer appointed

P Khoosal	Appointed: 22 June 2017
S Molekwa	
L Phillip	Appointed: 22 June 2017 (Resigned July 2017)
W Schoeman	Appointed: August 2017
D Fortune	Resigned: 22 June 2017
B Hashim	Resigned: 22 June 2017

Member elected

C McClelland	Chairperson
J Bush	Resigned: 22 June 2017
G McGregor	
A Stapelberg	Appointed: 22 June 2017

Trade union representative

M Petersen

1.2 PRINCIPAL OFFICER

T Mlotshwa

BP Waterfront	PO Box 6006
Dock Road	Roggebaai
Portwood Ridge	8012
V&A Waterfront	
8002	

1.3 REGISTERED OFFICE ADDRESS AND POSTAL ADDRESS

BP Waterfront	PO Box 6006
Dock Road	Roggebaai
Portwood Ridge	8012
V&A Waterfront	
8002	

Country of registration and domicile: South Africa

1.4 MEDICAL SCHEME ADMINISTRATOR AND MINUTE TAKING

MMI Health (Pty) Ltd

268 West Avenue	PO Box 7400
Centurion	Centurion
0157	0046

Accreditation number: 13

**BP MEDICAL AID SOCIETY
REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2017 (continued)**

1. MANAGEMENT (CONTINUED)

1.5 MANAGED CARE

MMI Health (Pty) Ltd

268 West Avenue
Centurion
0157

PO Box 7400
Centurion
0046

Accreditation number: MCO: 59

1.6 INVESTMENT MANAGERS

1.6.1 Alexander Forbes Investments Ltd

115 West Street
Sandown
2146

PO Box 787240
Sandton
2146

Accreditation number: 711

1.6.2 Acsis Ltd

93 Grayston Drive
Umnotho Building
2nd Floor
Sandton
2196

PO Box 2444
Saxonwold
Johannesburg
2132

Accreditation number: FSB 588

1.7 AUDITOR

Ernst & Young Inc

3rd floor, Waterway House
3 Dock Road
V&A Waterfront
8001

PO Box 656
Cape Town
8000

1.8 ACTUARIAL CONSULTANTS

Alexander Forbes Health (Pty) Ltd

40 Dorp Street
Stellenbosch
7600

PO Box 700
Stellenbosch
7599

2. DESCRIPTION OF THE MEDICAL SCHEME

The BP Medical Aid Society (the Society) is a not-for-profit, restricted membership scheme registered in terms of the Medical Schemes Act. Membership of the Society is open to all employees of BP Southern Africa (Pty) Ltd, former employees (subject to qualifying conditions) and employees of any other associated employer to whom membership has been extended and to the dependants of such employees.

2.1 BENEFIT OPTIONS WITHIN THE SOCIETY

The Society offers a single, comprehensive benefit plan.

**BP MEDICAL AID SOCIETY
REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2017 (continued)**

2. DESCRIPTION OF THE MEDICAL SCHEME (CONTINUED)

2.2 SAVINGS PLAN

There is no savings plan.

2.3 RISK TRANSFER ARRANGEMENTS

The Society entered into an agreement with Iso Leso Optics Ltd, whereby Iso Leso facilitates optometric services through a network of contracted providers to the beneficiaries on behalf of the Society.

The Society entered into an agreement with Netcare 911, whereby Netcare 911 facilitates emergency transport to beneficiaries on behalf of the Society.

2.4 OPERATING ENVIRONMENT

There have been no significant changes in the Society's operating environment.

3. INVESTMENT STRATEGY

The Board of Trustees has a statutory and fiduciary duty to invest the Society's assets in line with the requirements of the Medical Schemes Act, 131 of 1998 (as amended) and in a responsible manner in order to protect the Society's accumulated funds and reserves.

For the purposes of the Society's investment strategy, the Board of Trustees has categorised the Society's assets as follows:

Acsis Ltd was appointed as Cash Manager.

Type of asset	Purpose	Allocation	Target return/objectives
Cash: Current accounts, call accounts and fixed deposits	Ensure sufficient cash is available to pay claims and other operational expenses. These cash assets are managed by both MMI Health (Pty) Ltd and by Acsis Ltd. Acsis Ltd has a mandate to maximise cash returns by investing in call and fixed deposits for durations not exceeding twelve months.	Greater of 20% of assets less accounts receivable or 20% of annual contributions less the continuing financial commitment (CFC).	Consumer price index (CPI) in respect of the current account and STefl Call (i.e. short-term fixed interest call index) in respect of call and fixed deposits.
Solvency reserve: Medical Scheme's Real Return Focus Portfolio	These assets are required to ensure that the Society's solvency ratio meets the Board of Trustees' minimum solvency threshold target of 70%.	70% of annual contributions less the cash allocation.	CPI + 4% per annum during any rolling three-year period. Minimise the risk of capital loss during any rolling 12-month period.
Assets in excess of the Board of Trustees' solvency ratio target: Alexander Forbes Performer Local and Pure Equity Portfolio	Enhances the return on the Society's investments. This portfolio is a fully discretionary, balanced portfolio with a moderate to aggressive risk profile.	Assets in excess of 70% of annual contributions. The strategy is being progressively implemented by the regular transfer of funds from the AFI Medical Scheme Return Focus Portfolio to the AFI Performer Local and AFI Pure Equity Portfolio.	This portfolio aims to achieve capital growth through investment in the South African equity market. It aims to outperform the median manager on the Alexander Forbes Investment SA Large Manager Watch.

**BP MEDICAL AID SOCIETY
REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2017 (continued)**

4. MANAGEMENT OF INSURANCE RISK

The primary insurance activity carried out by the Society assumes the risk of loss from members and their dependants who are directly subject to the risk. This risk relates to the health of the Society's members. As such the Society is exposed to the uncertainty surrounding the timing and severity of claims under the contract between the Society and its members. The Society also has exposure to market risk through its insurance and investment activities.

The Society manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, as well as the monitoring of emerging issues, and network arrangements through the appointment of designated and preferred service providers.

The Society uses several methods to assess and monitor insurance risk exposures, both for individual types of risks insured and overall risks. The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and severity of claims is greater than expected.

Insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated using established statistical techniques.

5. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

5.1 OPERATIONAL STATISTICS

	2017	2016
Number of members at year-end	1 845	1 871
Average number of principal members for the year	1 867	1 897
Average number of beneficiaries for the year	3 819	3 923
Number of beneficiaries at year-end	3 759	3 847
Average dependants per principal member	1.05	1.07
Average age of beneficiaries	45.69	44.78
Pensioner ratio (i.e. the proportion of beneficiaries who are 65 years of age and older)	29.0%	27.9%
Continuation member ratio (i.e. all principal members not actively employed by the employer)	56.6%	57.5%
Average Continuing Financial Commitment per member (R)	1 192	1 119
Average Continuing Financial Commitment per beneficiary (R)	583	541
Average contribution per member per month (R)	4 370	4 154
Average contribution per beneficiary per month (R)	2 137	2 009
Average relevant healthcare expenditure per member per month (R)	5 055	4 666
Average relevant healthcare expenditure per beneficiary per month (R)	2 471	2 256
Average administration costs per member per month (R)	261	234
Average managed care: Management services per member per month (R)	100	90
Average accumulated funds per member at 31 December (R)	69 578	61 943
Relevant healthcare expenditure as a percentage of contributions	115.7%	112.3%
Managed care: Management services as a percentage of contributions	2.4%	2.4%
Administration expenses as a percentage of contributions	6.0%	5.6%
Amounts paid to administrator (R)	5 518 064	5 317 544
- Administration fees (refer note 11) (R)	3 223 254	3 101 917
- Managed care fees (refer note 10) (R)	2 294 810	2 215 627
Non-healthcare expenditure per beneficiary per month (R)	130	116
Return on investments as a percentage of investments	5.2%	6.3%

**BP MEDICAL AID SOCIETY
REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2017 (continued)**

5. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES (CONTINUED)

5.2 RESULTS OF OPERATIONS

The results of the Society's operations for the year under review and financial position at 31 December 2017 are set out in the Annual Financial Statements. The Trustees believe that no further clarification is required.

5.3 ACCUMULATED FUNDS RATION

	2017	2016
	R	R
The accumulated funds ratio is calculated on the following basis:		
Total accumulated funds per the Statement of Financial Position	<u>129 901 812</u>	<u>117 506 262</u>
Annual contributions	<u>97 912 342</u>	<u>94 560 685</u>
Accumulated funds ratios:		
Accumulated funds/annual contributions X 100 %	<u>132.67%</u>	<u>124.27%</u>

5.4 LIABILITY ADEQUACY TEST

Liability adequacy tests are performed to ensure the adequacy of insurance payables as at the reporting date. In performing these tests, current estimates of future cash flows under the Society's insurance payables are used and any deficiency is recognised in the surplus or deficit.

5.5 REVALUATION RESERVE

The revaluation reserve in the Statement of Financial Position reflects the unrealised gains/losses on the Society's investment portfolio in the Investment Solutions portfolio.

5.6 OUTSTANDING CLAIMS

Movements on the outstanding claims provision are set out in note 7 to the Annual Financial Statements. There have been no unusual movements that the Trustees believe should be brought to the attention of the members of the Society.

6. EVENTS POST THE REPORTING DATE

There have been no events that have occurred subsequent to the end of the accounting period that affect the Annual Financial Statements, which the Trustees consider should be brought to the attention of members.

7. CONTINUING FINANCIAL COMMITMENT FROM EMPLOYER

BP Southern Africa (Pty) Ltd (BPSA) agreed to pay additional amounts to assist in funding the shortfall arising from the ageing membership. These additional amounts are reflected as a continuing financial commitment, as provided for in the agreement between the Society and BPSA dated 22 October 2002. The continued sustainability of the Society is clearly dependent on the continuing financial commitment.

8. FIDELITY COVER

The Society's Trustees are covered under a Marsh (Pty) Ltd policy underwritten by Camargue Underwriting Managers. The level of cover was reviewed and on 31 December 2017 the value of the fidelity cover was R15 000 000 (2016: R 15 000 000).

**BP MEDICAL AID SOCIETY
REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2017 (continued)**

9. ACTUARIAL SERVICES

The Society's actuaries, Alexander Forbes Health (Pty) Ltd, have been consulted in the determination of the contribution and benefit levels.

10. INVESTMENTS IN AND LOANS TO EMPLOYERS OF MEMBERS OF THE SOCIETY AND OTHER RELATED PARTIES

The Society holds no investments in and has made no loans to any participating employers of the Society's members. Refer to note 16 of the Annual Financial Statements for other related-party transactions.

11. AUDIT COMMITTEE

A representative Audit Committee was appointed and has six members of whom two are members of the Board of Trustees.

During the year the Audit Committee comprised: Adv D Mitchell (independent Chairperson – he resigned as Chairperson as per the Society's rotation strategy on 27 June 2017, but continued as an independent member), Mr N Harris (independent member), Mr A Rumble (independent member), Ms B Hashim (Trustee until appointed as independent Chairperson on 27 June 2017), Ms D Fortune (Trustee – resigned 22 June 2017), Mr A Stapelberg (appointed trustee from 27 June 2017), and Ms P Khoosal (Trustee from 27 June 2017). The Principal Officer attended the meetings as is required of the office-bearer.

The Committee met on three occasions during the course of the year, as follows:

- 3 April 2017;
- 14 August 2017; and
- 17 October 2017.

The Administrator and the external Auditors attend all Committee meetings and have unrestricted access to the Chairperson of the Committee.

In accordance with the provisions of the Medical Schemes Act, the primary responsibility of the Committee is to assist the Board of Trustees in carrying out its duties relating to the Society's accounting policies, internal control systems and financial reporting practices. The external Auditors formally report to the Committee on critical findings arising from audit activities.

12. INVESTMENT SUB-COMMITTEE

An Investment Sub-Committee was established and is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. This Sub-Committee has four members.

During the year the Sub-Committee comprised: Mr G McGregor (Chairperson), Mr C McClelland, Dr S Molekwa (Employee-elected Trustee), Mr Q Fourie (independent member) and Mr A Stapelberg (member-elected Trustee – appointed 27 June 2017). The Principal Officer attended the meetings as is required of the office-bearer.

The Sub-Committee met on three occasions during the course of the year, as follows:

- 8 February 2017;
- 5 May 2017; and
- 3 August 2017.

The primary responsibility of the Sub-Committee is to assist the Board of Trustees in carrying out its duties relating to the investment strategy of the Society.

**BP MEDICAL AID SOCIETY
REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2017 (continued)**

13. LEGAL, COMPLIANCE AND CONTRACTUAL SUB-COMMITTEE

A Legal, Compliance and Contractual Sub-Committee was established and is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. This Sub-Committee has four members.

During the year the Sub-Committee comprised: Ms D Stoffberg (independent Chairperson from 27 June 2017), Mr J Bush (Chairperson – resigned 22 June 2017), Mr G McGregor, Mr C McClelland and Mr A Stapelberg (member-elected Trustee – appointed 27 June 2017). The Principal Officer attended the meetings as is required of the office-bearer.

The Sub-Committee met on four occasions during the course of the year, as follows:

- 1 March 2017;
- 31 May 2017;
- 17 August 2017; and
- 16 Nov 2017.

The primary responsibility of the Sub-Committee is to assist the Board of Trustees in carrying out its duties relating to legal, compliance and contractual matters of the Society.

14. COMMUNICATIONS SUB-COMMITTEE

A Communications Sub-Committee was established and is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. This Sub-Committee has four members.

During the year the Sub-Committee comprised Dr S Molekwa (Chairperson), Mr C McClelland, Mr G McGregor and Mr M Petersen (trade union representative – appointed 27 June 2017). The Principal Officer attended the meetings as is required of the office-bearer.

The Sub-Committee met on two occasions during the course of the year, as follows:

- 7 February 2017; and
- 1 November 2017.

The primary responsibility of the Sub-Committee is to assist the Board of Trustees in carrying out its duties relating to communication to members of the Society.

15. CLINICAL SUB-COMMITTEE

A Clinical Sub-Committee was established and is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. This Sub-Committee has four members.

During the year the Sub-Committee comprised Dr S Manjra (Chairperson and Medical Advisor), Mr J Bush, Dr S Molekwa and Mr C McClelland. The Principal Officer attended the meetings as is required of the office-bearer.

The Sub-Committee met on four occasions during the course of the year, as follows:

- 6 February 2017;
- 9 May 2017;
- 1 August 2017; and
- 31 October 2017.

The primary responsibility of the Sub-Committee is to assist the Board of Trustees in carrying out its duties relating to clinical matters.

**BP MEDICAL AID SOCIETY
REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2017 (continued)**

16. OPERATIONS SUB-COMMITTEE

An Operations Sub-Committee was established and is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. This Sub-Committee comprises one Trustee, as well as the Principal Officer and operational staff from the Employer (BPSA) and the Administrator (MMI Health).

During the year the Sub-Committee comprised the following Trustees: Mr J Bush (resigned 22 June 2017), Mr M Petersen (appointed 27 June 2017) and Ms B Hashim (resigned 27 June 2017). The Principal Officer chairs the meetings.

The Sub-Committee met on four occasions during the course of the year, as follows:

- 7 February 2017;
- 10 May 2017;
- 2 August 2017; and
- 1 November 2017.

The primary responsibility of the Sub-Committee is to assist the Board of Trustees in carrying out its duties relating to operational matters of the Society.

17. DISPUTES SUB-COMMITTEE

A Disputes Sub-Committee was established and is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. This Committee has three members.

During the year the Sub-Committee comprised: Mr T Matlhare (Chairperson), Mr C Germeshuys and Ms I Juhnke.

The primary responsibility of the Sub-Committee is to assist the Board of Trustees in carrying out its duties in respect of disputes.

No matters were referred to the Committee and therefore the Committee was not required to meet during the course of the year.

**BP MEDICAL AID SOCIETY
REPORT OF THE BOARD OF TRUSTEES
for the year ended 31 December 2017 (continued)**

18. TRUSTEE MEETING ATTENDANCE

The following schedule sets out attendance at Board of Trustee meetings and other committee meetings by members of the Board and independent members.

Trustee/Sub-Committee member	Board meetings		Audit Committee		Investment Sub-Committee		Legal, Compliance and Contractual Sub-Committee		Communications Sub-Committee		Operations Sub-Committee		Clinical Sub-Committee	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B
J Bush	3	1					2	2			2	2	3	3
D Fortune	3	3	1	0										
Q Fourie*					3	3								
N Harris*			1	0										
B Hashim	3	3	3	3							2	2		
S Manjra (Medical Advisor)	8	8											4	4
C McClelland (Chairperson)	8	8			3	3	4	4	2	2			4	4
G McGregor	8	7			3	3	4	3	2	2				
D Mitchell*	1	1	3	3										
T Mlotshwa	8	8	3	3	3	3	4	4	2	2	4	4	4	4
S Molekwa	8	7							2	2			4	4
M Petersen	8	8							2	0	2	2		
P Khoosal	5	1	2	1										
A Rumble*			3	2										
W Schoeman	3	2												
A Stapelberg	5	5	2	2	1	0	2	2						
P Lenon	1	0												
D Stoffberg*							4	4						

A – total possible number of meetings could have attended

B – actual number of meetings attended

* – independent members

18. TRUSTEE MEETING ATTENDANCE (CONTINUED)

IMPORTANT:

Four of the eight Board meetings were normal, quarterly meetings and the other four were, as follows:

- February – approval of contributions;
- April – approval of the Annual Financial Statements for 2016;
- August – approval of the benefits for 2018; and
- December – a special meeting on the tender process for administration and managed care services.

19. NON-COMPLIANCE MATTERS

19.1 CONTRAVENTION OF SECTION 35(8)(C) OF THE MEDICAL SCHEMES ACT

Nature and impact

The Society holds shares in MMI Holdings Ltd, Sanlam Ltd and Discovery Group Ltd. This is in contravention of Section 35(8) of the Act, as the Society is not allowed to hold shares in the holding company of any administrator.

Causes for the failure

The Society invests in a pooled portfolio and does not have control over the underlying assets.

Corrective action

The Society received an open-ended exemption in October 2012 from the Council for Medical Schemes from complying with Section 35(8)(c), insofar as it relates to investments placed with asset managers who invest on behalf of the Society and where such investment choices are not influenced by the Society.

19.2 CONTRAVENTION OF SECTION 26(7) OF THE MEDICAL SCHEMES ACT

Nature and impact

In terms of Section 26(7) of the Act, contributions should be received in accordance with the rules of the Society. The rules indicate that contributions should be received by no later than three days after they become due. As at 31 December 2017, there were contribution debtors outstanding for more than 30 days to the value of R574 598 (2016: R204 744). This amount represents 0.58% of the total contributions received during the year, but the delay in receipt is in contravention of Section 26(7) of the Act.

Causes for the failure

Delays were experienced in respect of payment from some employer groups.

Corrective action

This non-compliance is a result of the following:

Section 26(7) does not adequately provide for circumstances where member contributions are remitted from other countries of residence and the Society has pensioner members who reside outside South Africa.

Retirees of the BPSA Provident Fund pay their contributions via monthly debit order. Timely receipt of these contributions is dependent upon factors beyond the control of the Society. Established processes of pursuing responsible parties are followed when member contributions are not received.

19. NON-COMPLIANCE MATTERS (CONTINUED)

19.3 CONTRAVENTION OF REGULATIONS TO THE MEDICAL SCHEMES ACT, 131 OF 1998, CHAPTER 2, SECTION 3(1)(B)

Nature and impact

In terms of the rules of the Society, all registered members must have valid South African identity numbers. There are currently 12 members and 44 dependants of the Society who do not have valid identity numbers. This constitutes non-compliance with the rules of the Society.

Causes for the failure

Historically identity numbers were not a requirement to register on the Society. This is a legacy problem as it relates to beneficiaries who joined before 2015.

Corrective action

Management will on a continual basis review the data integrity of membership details and endeavour to comply with requisite legislation.

19.4 CONTRAVENTION OF SECTION 59(2) OF THE MEDICAL SCHEMES ACT

Nature and impact

A number of claims were settled outside the statutory 30-day timeframe. These claims were not erroneous or unacceptable for payment.

Causes for the failure

A change in the operating system used by the Administrator in December 2016 resulted in claims being settled outside the 30-day timeframe.

Corrective action

The settlement of claims that might fall outside the statutory timeframe was prioritised to ensure future claims that are received are paid within the 30-day timeframe.

19.5 NON-COMPLIANCE WITH REGULATION 30 – EQUITY

Nature and impact

In terms of Regulation 30 of the Act, a Scheme is prohibited from investing more than 40% of its investments in equity instruments.

Causes for the failure

The Society has equities invested in managed portfolios above the limit of 40% specified in category 4(a) of Annexure B to the Medical Scheme Regulations.

Corrective action

A motivation was sent to the Council for Medical Schemes in December 2015 to hold equities above the specified limit of 40% in category 4(a) of Annexure B to the Medical Scheme Regulations.

19.6 CONTRAVENTION OF REGULATION 8(1) OF THE MEDICAL SCHEMES ACT, NO 101 OF 1998

Nature and impact

Regulation 8(1) of the Medical Schemes Act, no 131 of 1998, states that any benefit option that is offered by the Society, must pay in full and without imposing co-payments for prescribed minimum benefits (PMBs). PMBs were not paid for in full as per the Medical Schemes Act and the Society's rules.

19. NON-COMPLIANCE MATTERS (CONTINUED)

**19.6 CONTRAVENTION OF REGULATION 8(1) OF THE MEDICAL SCHEMES ACT, NO 101 OF 1998
(CONTINUED)**

Causes for the failure

An assessor error resulted in claims not being reprocessed correctly.

Corrective action

Management continues to monitor abuse relating to PMBs in order to intervene and reduce the Society's financial exposure. Management ensures compliance with the Society's rules and legislation. These claims were reworked and paid as per the PMB mandate.

**BP MEDICAL AID SOCIETY
STATEMENT OF FINANCIAL POSITION
as at 31 December 2017**

ASSETS	Notes	2017 R	2016 R
Non-current assets			
Available-for-sale investments	3	91 391 343	73 058 028
Current assets			
Trade and other receivables	4	4 044 436	3 776 527
Available-for-sale investments	3	21 244 367	18 455 050
Cash and cash equivalents	5	35 079 813	37 662 442
Total assets		151 759 959	132 952 047
FUNDS AND LIABILITIES			
Members' funds			
Accumulated funds		129 901 812	117 506 262
Revaluation reserve: Available-for-sale investments		14 758 804	8 684 611
Current liabilities			
Trade and other payables	6	3 697 557	1 220 878
Outstanding claims provision	7	3 401 786	5 540 296
Total funds and liabilities		151 759 959	132 952 047

BP MEDICAL AID SOCIETY
STATEMENT OF COMPREHENSIVE INCOME
for the year ended 31 December 2017

	Notes	2017 R	2016 R
Contribution income	8	97 912 342	94 560 685
Relevant healthcare expenditure		(113 245 619)	(106 226 988)
Net claims incurred		(113 676 520)	(106 293 238)
Claims incurred	9	(111 367 412)	(104 265 329)
Managed care: Management services	10	(2 309 108)	(2 229 904)
Third-party claims recoveries		-	201 995
Net income on risk transfer arrangements	9	430 901	66 250
Risk transfer arrangement fees/premiums paid		(1 871 660)	(2 048 288)
Recoveries from risk transfer arrangements		2 302 561	2 114 538
Gross healthcare result		(15 333 277)	(11 666 303)
Administration expenses	11	(5 849 707)	(5 335 292)
Net impairment loss	12	(403 577)	(41 561)
Net healthcare result		(21 586 561)	(17 043 156)
Other income		34 462 107	32 322 309
Investment income	13	7 734 090	6 845 247
Continuing financial commitment from Employer	14	26 704 231	25 467 665
Stale cheques written back	14	23 786	9 397
Other expenditure			
Asset management fees	3	(479 996)	(404 244)
Net surplus for the year		12 395 550	14 874 909
Other comprehensive loss/income			
Items that will be reclassified to surplus or deficit			
Fair value adjustment on available-for-sale investments	3	6 074 193	1 745 337
Total comprehensive income for the year		18 469 743	16 620 246

**BP MEDICAL AID SOCIETY
STATEMENT OF CHANGES IN FUNDS AND RESERVES
for the year ended 31 December 2017**

	2017	2016
	R	R
Accumulated funds		
Balance at beginning of year	117 506 262	102 631 353
Total comprehensive income for the year	12 395 550	14 874 909
Balance at the end of the year	<u>129 901 812</u>	<u>117 506 262</u>
Revaluation reserve: Available-for-sale investments		
Balance at beginning of year	8 684 611	6 939 274
Other comprehensive income for the year	6 074 193	1 745 337
Balance at end of the year	<u>14 758 804</u>	<u>8 684 611</u>
Members' funds	<u>144 660 616</u>	<u>126 190 873</u>

**BP MEDICAL AID SOCIETY
STATEMENT OF CASH FLOWS
for the year ended 31 December 2017**

CASH FLOWS FROM OPERATING ACTIVITIES	Notes	2017 R	2016 R
Surplus for the year		12 395 550	14 874 909
Investment income - interest	13	(5 850 926)	(5 386 113)
- dividends	13	(1 883 164)	(1 459 134)
Asset management fees	3	479 996	404 244
Cash flows from operations before working capital changes		5 141 456	8 433 906
Working capital changes			
- Increase in trade and other receivables		(267 909)	(3 078 613)
- (Decrease)/Increase in outstanding claims provision		(2 138 510)	942 898
- Increase in trade and other payables		2 476 679	502 897
Net cash inflows from operating activities		5 211 716	6 801 088
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of available-for-sale investments	3	(10 000 000)	-
Interest received on cash and cash equivalents	13	2 205 655	2 109 039
Net cash flows from investing activities		(7 794 345)	2 109 039
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS		(2 582 629)	8 910 127
Cash and cash equivalents at beginning of the year	5	37 662 442	28 752 315
CASH AND CASH EQUIVALENTS AT END OF THE YEAR	5	35 079 813	37 662 442

BP MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017

1. PRINCIPAL ACCOUNTING POLICIES

The principal accounting policies applied in the preparation of the BP Medical Aid Society (the Society) Annual Financial Statements, as set out below, are in accordance with International Financial Reporting Standards (IFRS) and interpretations issued by the International Financial Reporting Interpretations Committee (IFRIC) and in the manner required by the Medical Schemes Act.

The accounting policies adopted are consistent with those of the previous financial year, except as otherwise stated.

Refer to note 2 for amendments to standards in issue but not yet effective.

1.1 BASIS OF PREPARATION

The Annual Financial Statements have been prepared in accordance with International Financial Reporting Standard (IFRS), as issued by the International Accounting Standards Board (IASB) and the requirements of the Medical Schemes Act, 131 of 1998. They have been prepared on the historical cost basis, except for available-for-sale investments that are recorded at fair value. The presentation currency is the rand, rounded to the nearest rand.

Amendments to standards adopted in the current year

New standards, amendments and interpretations that became effective for the current year did not have an impact on the Society.

1.2 FINANCIAL INSTRUMENTS

Financial assets and liabilities are recognised on the Society's Statement of Financial Position when it becomes a party to the contractual provisions of the instrument.

Initial measurement

Financial assets are recognised initially at fair value, plus transaction costs.

Available-for-sale investments

Investments intended to be held for an indefinite period of time, which may be sold in response to needs in liquidity or changes in market conditions, are classified as available for sale; these are included in non-current assets unless management has the express intention of holding the investment for less than 12 months from the reporting date or unless they will need to be sold to raise operating capital, in which case they are included in current assets.

All purchases and sales of investments are recognised on the trade date, which is the date that the Society commits to purchase or sell the asset. The cost of purchases includes transaction costs. Available-for-sale investments are subsequently carried at fair value. Unrealised gains and losses arising from changes in the fair value of the available-for-sale investments are included in the revaluation reserve and are reflected as other comprehensive income in the Statement of Comprehensive Income. Once the available-for-sale investment is sold, the realised fair value gain or loss on the changes in the fair value of the available-for-sale investment is included in surplus or deficit.

The fair value of investments that are actively traded in organised financial markets is determined by reference to quoted market prices at the reporting date.

Trade and other receivables

Trade and other receivables are measured on initial recognition at fair value, plus directly attributable transaction costs and are subsequently measured at amortised cost, using the effective interest rate method, less impairment. An appropriate allowance for estimated irrecoverable amounts is recognised in surplus or deficit when there is objective evidence that the asset is impaired. Objective evidence would include the probability of insolvency or significant financial difficulties of the debtor.

1. PRINCIPAL ACCOUNTING POLICIES (CONTINUED)

1.2 FINANCIAL INSTRUMENTS (CONTINUED)

Trade and other receivables (continued)

This allowance is measured as the difference between the asset's carrying amount and the present value of the estimated future cash flow, as discounted at the effective interest rate compounded at initial recognition. The carrying amount of the asset is reduced by use of an allowance account. Permanent impairments are written off to surplus or deficit when identified.

Short duration receivables with no stated interest rate are measured at original invoice amount unless the effect of imputing interest would be significant.

Trade and other receivables are classified in the loans and receivables category of the Society's financial instruments.

Cash and cash equivalents

Cash and cash equivalents comprise cash on hand, deposits held on call with banks and other short-term, liquid investments that are readily convertible within three months to a known amount of cash and are subject to an insignificant risk of change in value. Cash and cash equivalents are subsequently measured at amortised cost.

Cash and cash equivalents are classified in the loans and receivables category of the Society's financial instruments.

Financial liabilities

Financial liabilities are initially measured at fair value plus, in the case of loans and borrowings, directly attributable transaction costs and are subsequently measured at amortised cost using the effective interest rate method.

The only financial liabilities held by the Society are loans and borrowings comprising trade and other payables.

Offsetting of 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 it on a net basis, all related financial effects are offset.

1.3 DE-RECOGNITION OF FINANCIAL ASSETS AND LIABILITIES

Financial assets

A financial asset is derecognised when:

- the rights to receive cash flows from the asset have expired;
- the Society retains the rights to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a pass-through arrangement; or
- the Society has transferred its rights to receive cash flows from the asset and either (a) has transferred substantially all risks and rewards of the asset, or (b) has neither transferred nor retained substantially all the risks and rewards of the asset, but transferred control of the asset.

Financial liabilities

A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

1. PRINCIPAL ACCOUNTING POLICIES (CONTINUED)

1.4 IMPAIRMENT LOSSES

The carrying amounts of the Society's assets are reviewed at each reporting date to determine whether there is any indication of impairment. Objective evidence which would indicate an impairment would include significant or prolonged decline in the fair value of the investment below its cost. If any such indication exists, the asset's recoverable amount is estimated.

'Significant' is evaluated against the original cost of the investment and 'prolonged' against the period in which the fair value has been below its original cost. When there is evidence of impairment, the cumulative loss – measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that investment previously recognised in surplus or deficit – is removed from other comprehensive income and recognised in surplus or deficit. Impairment losses on equity investments are not reversed through surplus or deficit; increases in their fair value after impairment are recognised directly in other comprehensive income.

An impairment loss is recognised whenever the carrying amount of an asset exceeds its recoverable amount. Impairment losses are recognised in surplus or deficit.

Calculation of recoverable amount

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in other comprehensive income and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in other comprehensive income is removed from other comprehensive income and recognised in surplus or deficit even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in surplus or deficit is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in surplus or deficit.

The recoverable amount of the Society's receivables, carried at amortised cost, is calculated as the present value of estimated future cash flows, discounted at the original, effective interest rate (i.e. the effective interest rate computed at initial recognition of these financial assets). Receivables with a short duration are not discounted.

Reversals of impairment

An impairment loss in respect of a receivable carried at amortised cost is reversed if the subsequent increase in recoverable amount can be related objectively to an event occurring after the impairment loss was recognised.

An impairment loss recognised as a loss with regards to an investment in an equity instrument classified as available-for-sale is not reversed through surplus or deficit. If, in a subsequent period, the fair value of a debt instrument classified as available-for-sale increases and the increase can be objectively related to an event occurring after the impairment loss was recognised in surplus or deficit, the impairment loss shall be reversed, with the amount of the reversal recognised in surplus or deficit.

Impairment losses are recognised directly against available-for-sale investments and not through an allowance account.

1.5 PROVISIONS

Provisions are recognised when the Society has a present legal or constructive obligation as a result of past events, for which it is probable that an outflow of economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. Where the effect of discounting to present value is material, provisions are adjusted to reflect the time value of money.

Outstanding claims

Claims outstanding comprise provisions for the Society's estimate of the ultimate cost of settling all claims incurred, but not yet reported at the reporting date and related internal and external claims handling expenses.

1. PRINCIPAL ACCOUNTING POLICIES (CONTINUED)

1.5 PROVISIONS (CONTINUED)

Outstanding claims (continued)

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.

The Society does not discount its provision for outstanding claims on the basis that claims must be submitted within four months of the medical event.

1.6 INSURANCE CONTRACTS

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

The contracts issued compensate the Society's members for healthcare expenses incurred.

1.7 CONTRIBUTIONS

Contributions are received monthly and are brought into account on an accrual basis when their collection in terms of the insurance contract is reasonably certain. The earned portion of contributions received is recognised as revenue. Contributions are earned from the date of attachment risk, over the indemnity period on a straight-line basis.

1.8 RELEVANT HEALTHCARE EXPENDITURE

Relevant healthcare expenditure consists of net claims incurred, managed care services 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 Society is responsible, whether or not reported by the end of the year.

Net claims incurred comprise:

- claims submitted and accrued for services rendered during the year;
- claims for services rendered during the previous year not included in the outstanding claims provisions for that year;
- claims settled in terms of risk transfer arrangements; and
- movement in the outstanding claims provision.

Claims incurred relating to risk transfer arrangements are calculated by applying an inflation-adjusted Society rate to the different categories of services provided by the capitation provider.

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

1.9 LIABILITIES AND RELATED ASSETS UNDER LIABILITY ADEQUACY TEST

The liability for insurance contracts is tested for adequacy by discounting current estimates of all future contractual cash flows and comparing this amount to the carrying value of the liability net of any related assets. Where a shortfall is identified, an additional provision is made and the Society recognises the deficiency in surplus or deficit for the year.

1. PRINCIPAL ACCOUNTING POLICIES (CONTINUED)

1.10 RISK TRANSFER ARRANGEMENTS

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

Risk transfer premiums and benefits reimbursed are presented in surplus or deficit and 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 insurance. 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.

Amounts recoverable under risk transfer arrangements are assessed for impairment at the reporting date. Such assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the Society may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Society will receive under the risk transfer arrangement.

1.11 MANAGED CARE: MANAGEMENT SERVICES EXPENSES

These expenses represent internal expenditure and the amounts paid or payable to the third-party administrator, related parties and other third parties for managing the utilisation, costs and quality of healthcare services provided to the members of the Society.

1.12 REIMBURSEMENTS FROM THE ROAD ACCIDENT FUND (RAF)

The Society grants assistance to its members in defraying expenditure incurred in connection with the rendering of any relevant health service in the case of a road accident. Such expenditure may be in connection with a claim that is also made to the RAF, administered in terms of the Road Accident Fund Act, no 56 of 1996. If the member is reimbursed by the RAF, he/she is obliged contractually to refund that payment to the Society to the extent that he or she has already been compensated.

A reimbursement from the RAF is a possible asset that arises from claims submitted to the RAF. Its existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Society. The contingent assets are assessed continually to ensure that developments are appropriately reflected in the financial statements. If it has become virtually certain that an inflow of economic benefits will arise, the asset and the related income are recognised in the financial statements of the period in which the change occurs. If an inflow of economic benefits has become probable, the Society discloses the contingent asset. Amounts received in respect of reimbursements from the RAF are recognised as part of net claims incurred in the surplus or deficit.

1.13 INVESTMENT INCOME

Interest is recognised on a yield-to-maturity basis, taking account of the principal outstanding and the effective rate over the period to maturity, when it is determined that such income will accrue to the Society. Dividend income is recognised when the right to receive payments is established.

1.14 FUNCTIONAL AND PRESENTATION CURRENCY

Items included in the financial statements are measured using the currency that best reflects the economic substance of the underlying events and circumstances relevant to the entity ('the functional currency'). The financial statements are presented in South African rand ('the presentation currency'), which is the functional currency of the Society.

1.15 TAXATION

The Society is registered under the Medical Schemes Act. It therefore falls within the definition of a benefit fund as defined in the Income Tax Act. The receipts and accruals of the Society are exempt from taxation under Section 10(1)(d) of the Income Tax Act.

1. PRINCIPAL ACCOUNTING POLICIES (CONTINUED)

1.16 CONTINUING FINANCIAL COMMITMENT

BP Southern Africa (Pty) Ltd (BPSA) agreed to pay additional amounts to assist in funding the shortfall arising from the ageing membership, as well as the costs for the Principal Officer and HIV/AIDS. This amount is disclosed under other income in the Statement of Comprehensive Income.

2. NEW STANDARDS AND AMENDMENTS TO STANDARDS

Accounting standards issued, but not yet effective

Standards issued but not yet effective up to the date of the end of the accounting period are listed below. These listings include standards and interpretations issued, which the Society reasonably expects to be applicable to its activities and operations, at a future date. The Society will adopt these standards when they become effective.

IFRS 9 financial instruments

IFRS 9, published in July 2014, replaces the existing guidance in IAS 39 Financial Instruments Recognition and Measurement. IFRS 9 includes revised guidance on the classification and measurement of financial instruments, a new expected credit loss model for calculating impairment on financial assets, and new general hedge accounting requirements. It also carries forward the guidance on recognition and de-recognition of financial instruments from IAS 39. IFRS 9 is effective for annual reporting periods beginning on or after 1 January 2018, with early adoption permitted.

The Society currently applies IFRS 4 insurance contracts. Amendments were made to IFRS 4 to address concerns arising from implementing IFRS 9, before implementing the new insurance contracts standard, IFRS 17, which replaces IFRS 4. The amendments introduce a potential temporary exemption from applying IFRS 9 to 2021 when IFRS 17 becomes effective. To qualify for the exemption, 90% or more of the Society liabilities would have to have been connected with insurance based on the Society's 2015 financial statements.

The Board of Trustees is considering the effect of the amendment to IFRS 4 and will consider any guidance from the CMS before implementation. The implementation of IFRS 9 will result in certain available-for-sale investments currently measured at fair value through other comprehensive income, to be measured as investments at fair value through profit or loss. In addition, the revaluation reserve will be reclassified to the general reserve. The new expected credit loss model for calculating impairment on financial assets is not expected to have a material impact on the Society.

Effective: 1 January 2018

IFRS 15 revenue from contracts from customers

IFRS 15 revenue from contracts with customers replaces IAS 11 construction contracts, IAS 18 revenue and related interpretations. IFRS 15 specifies the accounting treatment for all revenue arising from contracts with customers. It applies to all entities that enter into contracts to provide goods or services to their customers, unless the contracts are in the scope of other IFRSs, such as IAS 17 leases. The standard also provides a model for the measurement and recognition of gains and losses on the sale of certain non-financial assets, such as property or equipment. Under the new standard extensive disclosures will be required, including disaggregation of total revenue; information about performance obligations; changes in contract asset and liability account balances between periods and key judgements and estimates. The Society applies IFRS 4 in the recognition of contribution revenue. As such, the new standard is not expected to have an impact on the Society.

Effective: 1 January 2018

BP MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)

2. NEW STANDARDS AND AMENDMENTS TO STANDARDS (CONTINUED)

Accounting standards issued, but not yet effective (continued)

IFRS 17

In May 2017, the IASB issued IFRS 17 insurance contracts (IFRS 17), a comprehensive, new accounting standard for insurance contracts covering recognition and measurement, presentation and disclosure. Once effective, IFRS 17 will replace IFRS 4 insurance contracts (IFRS 4) that was issued in 2005. IFRS 17 applies to all types of insurance contracts (i.e., life, non-life, direct insurance and re-insurance), regardless of the type of entities that issue them, as well as to certain guarantees and financial instruments with discretionary participation features. A few scope exceptions will apply. The overall objective of IFRS 17 is to provide an accounting model for insurance contracts that is more useful and consistent for insurers. The impact of this amendment is still being assessed by the scheme.

Effective: 1 January 2021

IFRS 16 leases

The IASB issued a new standard that requires lessees to recognise most leases on their balance sheets. Lessees will have a single accounting model for all leases, with certain exemptions. Lessor accounting is substantially unchanged. The new standard will be effective from 1 January 2019 with limited early application permitted. Given that the Society is not party to any lease agreements this standard is not expected to have an impact on the Society.

Effective: 1 January 2019

3. AVAILABLE-FOR-SALE INVESTMENTS	2017	2016
	R	R
Fair value at the beginning of the year	91 513 078	85 435 777
Capitalised interest and dividends	5 528 435	4 736 208
Asset management fees	(479 996)	(404 244)
Unrealised gain on available-for-sale investments	6 074 193	1 745 337
Additions to investments	10 000 000	-
Fair value at the end of the year	<u>112 635 710</u>	<u>91 513 078</u>
Non-current assets	91 391 343	73 058 028
Current assets	<u>21 244 367</u>	<u>18 455 050</u>
	<u>112 635 710</u>	<u>91 513 078</u>

The investments are unitised and are part of a pooled portfolio through a linked policy of insurance, where the underlying assets are owned by the insurer.

Bonds and debentures	29 129 357	23 571 141
Listed property	6 372 976	5 924 187
Equities with primary listing on the JSE	55 889 010	43 562 700
Local cash	<u>21 244 367</u>	<u>18 455 050</u>
	<u>112 635 710</u>	<u>91 513 078</u>

The investments have no fixed maturity. The fair value of the investments is based on the market value as at 31 December 2017.

A register of investments is available for inspection at the registered office of the Society.

MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)

4. TRADE AND OTHER RECEIVABLES

	2017	2016
	R	R
Insurance receivables	3 879 847	3 181 804
Contributions outstanding	1 096 823	1 308 784
Amounts owing by members and service providers	544 266	45 853
Income receivable – BPSA refunds	2 238 758	1 827 167
Less:		
Provision for impairment losses on insurance receivables	(509 871)	(106 294)
Balance at the beginning of the year	(106 294)	(93 713)
Provision made during the year	(403 577)	(41 560)
Written off during the year	-	29 710
Amounts recovered during the year	-	(731)
Other receivables	627 394	662 460
Interest receivable	627 394	662 460
Risk transfer arrangements	47 066	38 557
Share of outstanding claims provision	47 066	38 557
	<u>4 044 436</u>	<u>3 776 527</u>

Ageing of insurance receivables – 2017

	Current	30 days	60 days	90 days	120 days+	TOTAL
Contribution debt	524 225	146 073	161 641	53 420	211 464	1 096 823
Member and provider debt	193 102	12 822	67 128	14 657	256 557	544 266
Income receivable – BPSA refunds	411 800	40 930	525 817	37 895	1 222 316	2 238 758
	<u>1 129 127</u>	<u>199 825</u>	<u>754 586</u>	<u>105 972</u>	<u>1 690 337</u>	<u>3 879 847</u>

Ageing of insurance receivables – 2016

	Current	30 days	60 days	90 days	120 days+	TOTAL
Contribution debt	1 104 040	72 823	44 017	5 449	82 455	1 308 784
Member and provider debt	23 188	1 884	1 718	28	19 035	45 853
Income receivable – BPSA refunds	287 960	37 896	-	323 522	1 177 789	1 827 167
	<u>1 415 188</u>	<u>112 603</u>	<u>45 735</u>	<u>328 999</u>	<u>1 279 279</u>	<u>3 181 804</u>

	2017	2016
	R	R
Analysis of movements in respect of risk transfer arrangements		
Balance at the beginning of the year	38 557	59 556
Payment in respect of prior year	(38 557)	(59 556)
Over/(under) provision in prior year	-	-
Adjustments for current year	47 066	38 557
Balance at end of year	<u>47 066</u>	<u>38 557</u>

MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)

4. TRADE AND OTHER RECEIVABLES (CONTINUED)

The carrying amounts of trade and other receivables approximate their fair values due to the short-term maturities of these assets.

Contribution debtors as well as member and provider debtors are periodically tested for impairment. Contribution debtors largely relate to the continuation members and are made up of both member debtors and employer debtors and receivable from both the members and employers. Collection of arrears is as per the debt collection mandate.

Interest receivable and risk transfer receivables are of a current nature and are settled within 30 days.

Income receivable for HIV/AIDS relates to a contractual reimbursement for HIV/AIDS related costs incurred by the Society for all members who are registered on the HIV YourLife Programme. The reimbursement is made by the Employer (BPSA) on a quarterly basis.

5. CASH AND CASH EQUIVALENTS

	2017	2016
	R	R
Call accounts	13 997 891	10 962 013
Current accounts	4 581 922	11 700 429
Fixed deposits	<u>16 500 000</u>	<u>15 000 000</u>
Cash and cash equivalents per cash flow statement	<u><u>35 079 813</u></u>	<u><u>37 662 442</u></u>

The weighted average effective interest rate on short-term bank deposits was 5.23% (2016: 5.27%) per annum.

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

6. TRADE AND OTHER PAYABLES

Insurance liabilities

Debtors with credit balances	-	13 760
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Financial liabilities

Accrued expenses	448 574	279 837
Claims payable	2 744 107	448 331
Stale cheques	84 372	69 016
Provision for audit fees	<u>420 504</u>	<u>409 934</u>
	<u><u>3 697 557</u></u>	<u><u>1 220 878</u></u>

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

MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)

7. OUTSTANDING CLAIMS PROVISION

	2017	2016
	R	R
Not covered by risk transfer arrangements		
Provision for outstanding claims	<u>3 354 720</u>	<u>5 501 739</u>
Analysis of movements in outstanding claims		
Balance at beginning of year	5 501 739	4 537 842
Payments in respect of prior year	<u>(5 414 421)</u>	<u>(4 537 023)</u>
Over provision in the prior year	87 318	819
Over provision in respect of prior year written back	(87 318)	(819)
Adjustment for current year	<u>3 354 720</u>	<u>5 501 739</u>
Provision at end of year (note 9)	<u>3 354 720</u>	<u>5 501 739</u>
Covered by risk transfer arrangements		
Provision for outstanding claims for Iso Leso and Netcare 911	<u>47 066</u>	<u>38 557</u>
Analysis of movements in outstanding claims		
Balance at beginning of year	38 557	59 556
Payments in respect of prior year	<u>(38 557)</u>	<u>(59 556)</u>
Over/(under) provision in the prior year	-	-
Adjustment for current year	<u>47 066</u>	<u>38 557</u>
Provision at end of year (note 9)	<u>47 066</u>	<u>38 557</u>
Total outstanding claims provision	<u>3 401 786</u>	<u>5 540 296</u>

Process used to determine the assumptions

The process used to determine the assumptions is intended to result in neutral estimates of the most likely or expected outcome. The sources of data used as inputs for the assumptions are internal, using detailed studies that are carried out monthly. There is more emphasis on current trends and, where in earlier years there was insufficient information to make a reliable best estimate of claims development, prudent assumptions are used.

Each notified claim is assessed on a separate, case-by-case basis with due regard to the claim circumstances, information available from managed care: healthcare management services and historical evidence of the size of similar claims. The provisions are based on information currently available. However, the ultimate liabilities may vary as a result of subsequent developments. The impact of many of the items is difficult to estimate. The provision estimation difficulties also differ by category of claims (i.e. in-hospital and chronic medication benefits) due to differences in the underlying insurance contract, claim complexity, the volume of claims, the individual severity of claims, determining the occurrence date of claims and reporting lags.

The cost of outstanding claims is estimated using statistical methods. Such methods extrapolate the development of paid and incurred claims, average cost per claims and ultimate claim numbers for each benefit year based upon observed development of earlier years and expected loss ratios. Past trends are used in situations where it takes time after the treatment date until the full extent of the claims to be paid is known. It is assumed that payments will emerge in a similar way in each service month. The proportional increase in the known cumulative payments from one development month to the next can then be used to calculate payments for future development months.

MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)

7. OUTSTANDING CLAIMS PROVISION (CONTINUED)

Process used to determine the assumptions (continued)

The actual method used is consistent with prior years and considers categories of claims and observed historical claims development. To the extent that these methods use historical claims development information they assume that the historical claims development pattern will occur again in the 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 include:

- changes in processes that affect the development/recording of claims paid and incurred (such as changes in claim reserving procedures);
- economic, legal, political and social trends (resulting in different-than-expected levels of inflation and/or minimum medical benefits to be provided);
- changes in composition of members and their dependants and random fluctuations, including the impact of large losses.

Assumptions

The assumptions that have the greatest effect on the measurement of the outstanding claims provision are the expected percentages of claims settled after each of the first four months of the claims run-off period, before the claims turn stale.

The percentages used as assumptions are listed in the table below. The table also outlines the sensitivity of these percentages and the impact on the Society's liabilities if an incorrect assumption is used.

Other assumptions

- The actual demographics of the Society were used including all membership movements for the period.
- The effect of an ageing population on the utilisation of health services is automatically incorporated.

The assumed percentages of claims outstanding at the end of the period:

Claims outstanding for services rendered in:	2017	2016
December	42%	66%
November	2%	2%
October	1%	1%
September	0.3%	0.3%
August and prior	0.3%	0.3%

	2017	2016
	R	R
Effect of a 1% point increase in assumptions	1 672 023	715 756
Effect of a 2% point increase in assumptions	1 950 179	1 468 790
Effect of a 3% point increase in assumptions	2 595 519	2 262 625

The Society believes that the liability for claims reported in the Statement of Financial Position is adequate. However, it recognises that the process of estimation is based upon certain variables and assumptions that could differ when claims arise.

8. CONTRIBUTION INCOME

	2017	2016
	R	R
Members' contributions	<u>97 912 342</u>	<u>94 560 685</u>

MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)

9. RELEVANT HEALTHCARE EXPENDITURE

	2017	2016
	R	R
Claims incurred excluding claims incurred in respect of risk transfer arrangements		
Current year claims	105 821 926	96 715 780
Movement in outstanding claims provision	3 267 402	5 500 920
Over provision in prior year (note 7)	(87 318)	(819)
Adjustment for current year (note 7)	3 354 720	5 501 739
	<u>109 089 328</u>	<u>102 216 700</u>
Less:		
Discounts received on claims	(24 477)	(65 909)
	<u>109 064 851</u>	<u>102 150 791</u>
Claims incurred in respect of risk transfer arrangements		
Current year claims	2 255 495	2 075 981
Movement in outstanding claims provision	47 066	38 557
Adjustment for current year (note 7)	47 066	38 557
	<u>2 302 561</u>	<u>2 114 538</u>
	<u>111 367 412</u>	<u>104 265 329</u>
Net income on risk transfer arrangements		
Premiums/ fees paid	1 871 660	2 048 288
Recoveries	(2 302 561)	(2 114 538)
	<u>(430 901)</u>	<u>(66 250)</u>

The Society entered into a risk transfer agreement with Iso Leso Optics Ltd in 1 January 2017, whereby Iso Leso provides optometric services through a network of contracted providers to the beneficiaries on behalf of the Society.

Claims received in respect of optometric services rendered by participating and non-participating providers are processed and paid by Iso Leso. The Society pays a fixed fee in respect thereof.

The Society entered into an agreement with Netcare Hospitals (Pty) Ltd on 1 January 2017, whereby Netcare 911 facilitates emergency transport for beneficiaries on behalf of the Society. The Society pays a fixed fee in respect thereof.

MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)

10. MANAGED CARE: MANAGEMENT SERVICES

	2017	2016
	R	R
10.1 MMI HEALTH (PTY) LTD		
Disease Risk Management Programme	386 503	385 370
Eldercare Programme	-	110 692
Electronic Benefit Management Programme	560 286	238 644
General Practitioner (GP) Network	234 931	226 132
HIV YourLife Programme	174 039	147 411
Hospital Risk Management Programme	521 862	408 620
Maternity Programme	77 062	72 289
Medicine Risk Management Programme	-	293 861
Oncology Programme	91 360	87 566
Prescribed Minimum Benefits Programme	121 104	128 507
Specialist network	127 663	129 812
	<u>2 294 810</u>	<u>2 229 904</u>
10.2 ISIMO HEALTH (PTY) LTD		
Oncology Programme	<u>14 298</u>	<u>14 277</u>

11. ADMINISTRATION EXPENSES

Actuarial fees	458 204	423 063
Administrator's fees	3 223 254	3 101 917
Audit fees - current year audit services	428 978	399 239
- data warehouse review	-	26 371
- audit services	100 554	-
Bank charges	30 520	75 317
Board of Healthcare Funders subscriptions	22 265	21 446
Consulting fees	64 499	63 186
Council for Medical Schemes – levies	65 300	62 604
Fidelity cover	22 500	21 373
Multiply Wellness Rewards Programme	84 792	147 207
Printing and postage	323 446	148 115
Principal Officer costs (note 14)	460 818	429 958
Seminars	50 750	9 895
Telephone	74 100	33 569
Travelling and entertainment	51 831	38 345
Trustee/Committee member remuneration and related costs (note 11.1 and 11.2)	387 896	333 687
	<u>5 849 707</u>	<u>5 335 292</u>

**MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)**

11. ADMINISTRATION EXPENSES (CONTINUED)

11.1 BOARD OF TRUSTEES MEMBERS' REMUNERATION AND RELATED COSTS

	Services as Trustee	Trustee Training	Travelling and accommodation	Total
31 December 2017	R	R	R	R
Mr J Bush	32 430	-	-	32 430
Ms D Fortune	-	-	-	-
Ms B Hashim	-	-	-	-
Mr G McGregor	72 906	-	-	72 906
Mr C McClelland	126 850	10 995	-	137 845
Dr S Molekwa	-	-	26 533	26 533
Mr M Petersen	-	-	-	-
Mr A Stapelberg	32 303	10 995	-	43 298
	<u>264 489</u>	<u>21 990</u>	<u>26 533</u>	<u>313 012</u>

Trustees/Committee members' remuneration and related costs

	Services as Trustee	Trustee Training	Travelling and accommodation	Total
31 December 2016	R	R	R	R
Mr J Bush	73 415	-	-	73 415
Ms D Fortune	-	9 895	-	9 895
Ms B Hashim	-	-	-	-
Mr G McGregor	77 716	-	495	78 211
Mr C McClelland	112 042	9 895	-	121 937
Dr S Molekwa	-	-	11 566	11 566
Mr M Petersen	-	-	-	-
	<u>263 173</u>	<u>19 790</u>	<u>12 061</u>	<u>295 024</u>

11.2 SUB-COMMITTEE REMUNERATION

	Legal and Clinical Committee	Audit Committee	Total
31 December 2017	R	R	R
Adv D Mitchell	-	35 627	35 627
Mr J Bush	39 257	-	39 257
Mr N Harris	-	-	-
Ms P Khoosal	-	-	-
Mr A Rumble	-	-	-
Ms D Fortune	-	-	-
Ms B Hashim	-	-	-
	<u>39 257</u>	<u>35 627</u>	<u>74 884</u>

MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)

11. ADMINISTRATION EXPENSES (CONTINUED)

11.2 SUB-COMMITTEE REMUNERATION (CONTINUED)

	Legal and Clinical Committee	Audit Committee	Total
31 December 2016	R	R	R
Adv D Mitchell	-	38 663	38 663
Mr J Bush	-	-	-
Mr N Harris	-	-	-
Mr A Rumble	-	-	-
Ms D Fortune	-	-	-
Ms B Hashim	-	-	-
	-	38 663	38 663

12. NET IMPAIRMENT LOSSES

	2017 R	2016 R
Trade and other receivables		
Contributions that are not collectable	(129 009)	(45 101)
Movement in provision	(129 009)	(24 848)
Written off	-	(20 253)
Members' and service providers' portions that are not recoverable	(274 568)	2 809
Movement in provision	(274 568)	12 266
Written off	-	(9 457)
Less:		
Previous impairment losses recovered	-	731
	(403 577)	(41 561)

13. INVESTMENT INCOME

Available-for-sale financial assets – interest income	3 645 271	3 277 074
Available-for-sale financial assets – dividend income	1 883 164	1 459 134
Cash and cash equivalents – interest income	2 205 655	2 109 039
	7 734 090	6 845 247

14. OTHER OPERATING INCOME

Continuing financial commitment from Employer

Continuation members	24 677 643	23 286 332
HIV/AIDS refunds	1 565 770	1 751 375
Principal Officer costs refunds	460 818	429 958
	26 704 231	25 467 665
Stale cheques older than three years written back	23 786	9 397
	23 786	9 397

**MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)**

15. EVENTS POST THE REPORTING DATE

There have been no material events that have occurred subsequent to the end of the accounting period that affect the financial report.

16. RELATED PARTY TRANSACTIONS

Related party relationships

Parties with significant influence over the Society

The Employer, BP Southern Africa (Pty) Ltd, has significant influence over the Society as it has a continuing financial commitment to the Society and also appoints three Trustees, but does not control the Society.

The Administrator, MMI Health (Pty) Ltd, has significant influence over the Society as it provides financial and operational information on which policy decisions are based, but does not control the Society.

The managed care organisation, MMI Health (Pty) Ltd, a wholly-owned subsidiary of MMI Holding Ltd, has significant influence over the Society as managed care provider, but does not control the Society.

The provider of actuarial and consulting services, Alexander Forbes Health (Pty) Ltd, has significant influence over the Society, as it provides financial and operational information on which policy decisions are based, but does not control the Society.

Key management personnel and their close family members

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Society. Key management personnel include the Board of Trustees, the Principal Officer and members of sub-committees.

Close family members include dependants of the Board of Trustees, Principal Officer and members of the sub-committees.

Transactions with related parties

	2017	2016
	R	R
Statement of comprehensive income		
Gross contributions received (key personnel) – short term	438 129	474 438
Claims incurred (key personnel)	208 378	669 529
Continuing financial commitment from Employer	26 704 231	25 467 665
- Continuation members	24 677 643	23 286 332
- HIV/AIDS refunds	1 565 770	1 751 375
- Principal Officer costs refunds	460 818	429 958
Administration fees paid to MMI Health (Pty) Ltd	3 223 254	3 101 917
Managed care fees paid to MMI Health (Pty) Ltd	2 294 811	2 215 627
Consulting fees paid to Alexander Forbes Health	484 379	423 063

Statement of financial position

MMI Health (Pty) Ltd	139 663	7 206
Consulting fees payable to Alexander Forbes Health	37 962	36 252
BPSA refunds	2 238 756	1 827 167
- HIV/AIDS refunds	1 815 834	1 751 375
- Principal Officer costs refunds	422 922	75 792

Compensation to key management personnel

Remuneration and related costs – short term	326 094	295 024
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16. RELATED PARTY TRANSACTIONS (CONTINUED)

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

Contributions received (key personnel)

This constitutes the contributions paid by related parties as members of the Society, in their individual capacities. All contributions were on the same terms as applicable to other members.

Claims incurred (key personnel)

This constitutes amounts claimed by related parties, in their individual capacities as members of the Society. All claims were paid out in terms of the rules of the Society, as applicable to other members.

Administration fees

The administration agreement is in terms of the rules of the Society and in accordance with instructions given by the Board of Trustees. The duration of the agreement is indefinite but subject to the right of either party to terminate the agreement by giving not less than six months' notice.

Managed care fees

The managed care agreement is in terms of the rules of the Society and in accordance with instructions given by the Board of Trustees. The duration of the agreement is indefinite but subject to the right of either party to terminate the agreement by giving not less than three months' notice.

17. GUARANTEES AND COMMITMENTS

The Society has not given or received any guarantees or commitments as at 31 December 2017.

18. CONTINGENT ASSET

As at 31 December 2017 the Society had pending claims submitted to the Road Accident Fund (RAF) for assessment. These will only be accounted for when an amount is certain to be received from the RAF. The value at year-end amounted to R256 897 (2016: R403 506).

19. CONTINGENT LIABILITIES

There were no potential liabilities contingent on the outcome of litigation, claims, guarantees, suretyships or the like at 31 December 2017.

20. FINANCIAL RISK MANAGEMENT REPORT

The Society is exposed to a range of financial risks through its financial assets and financial liabilities. In particular, the key financial risk is that the Society's investment performance is not sufficient to maintain the current reserve ratio, or that the Society may have to increase member contributions due to insufficient investment performance. The most important components of these financial risks are interest rate risk, equity price risk, credit risk and liquidity risk.

These risks arise from open positions in interest rate and equity risk products, both of which are exposed to general and specific market movements. The risks that the Society primarily faces due to the nature of its investments and liabilities are interest rate risk and equity price risk.

The Board of Trustees appointed an Investment Committee to focus on the Society's investment strategy, risk management and asset allocation. Risk management and investment decisions are made under the guidance and policies approved by the Board of Trustees. The Audit, Investment and Risk Committees assist the board with the formulation of these policies.

The Society'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 which the Society holds to meet its obligations to its members.

MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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20. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

The following summary represents the major asset classifications held by the Society which is exposed to the financial risks as discussed:

Asset allocation summary	2017	2016
	R	R
Available-for-sale investments (note 3)	112 635 710	97 590 379
Cash and cash equivalents (note 5)	35 079 813	37 662 442
Trade and other receivables (note 4)	4 044 436	3 763 946
	<u>151 759 959</u>	<u>139 016 767</u>

Risk management and investment decisions are carried out by the Board of Trustees. The Board of Trustees identifies and evaluates risks associated with the Society's investment portfolios with the assistance of the Investment Committee.

The Society appointed a professional asset management company (Alexander Forbes Health) with an established track record to manage the Society's investment portfolios. These investments are held via linked policies of insurance. The approach of the asset manager is to construct portfolios of diversified asset classes in order to obtain an optimal risk/return mix. The strategy is to focus on strategic asset allocation rather than on timing the market. This will mitigate the risk of volatile markets.

Acsis Ltd has a mandate to maximise cash returns by investing in call and fixed deposits for durations not exceeding twelve months.

LIQUIDITY RISK

Liquidity risk is the risk that the Society may be in a position where it cannot settle claims and other obligations as they fall due. This could occur when the Society's assets are tied up in investments that cannot be readily converted into cash.

Prudent liquidity risk management implies maintaining sufficient cash and marketable securities through liquid holding cash positions with various financial institutions. This ensures that the Society has the ability to fund its day-to-day operations.

At year end 29.2% (2015: 25.2%) of the Society's assets were invested in cash products to ensure that the Society can meet its short-term liabilities. The table below illustrates the prudent liquidity position of the Society:

As at 31 December 2017					
Category	Total	Less than 1 month	Between 1 and 3 months	Between 3 months and 1 year	Over 1 year
	R	R	R	R	R
Trade and other payables	3 697 557	3 697 557	-	-	-
Outstanding claims provision	3 401 786	1 741 863	1 659 923	-	-
	7 099 343				
Trade and trade receivables	4 505 355	1 730 501	68 077	2 706 777	-
Cash and cash equivalents	35 079 813	35 079 813	-	-	-
Available-for-sale investments	112 635 710	21 244 367	-	-	91 391 343
	152 220 878				
Excess liquidity	145 121 535				

MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
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20. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

LIQUIDITY RISK (CONTINUED)

As at 31 December 2016					
Category	Total	Less than 1 month	Between 1 and 3 months	Between 3 months and 1 year	Over 1 year
	R	R	R	R	R
Trade and other payables	1 220 878	1 220 878	-	-	-
Outstanding claims provision	5 540 296	1 547 378	2 156 740	3 724 703	-
	6 761 174				
Trade and trade receivables	3 776 527	738 252	2 875 670	162 605	-
Cash and cash equivalents	37 662 442	37 662 442	-	-	-
Available-for-sale investments	91 513 078	18 455 050	-	-	73 058 028
	132 952 047				
Excess liquidity	126 190 873				

CREDIT RISK

The Society has exposure to credit risk, which is the risk that a counterparty will be unable to pay amounts in full when due. Key areas where the Society is exposed to credit risk are:

- amounts due from members and service providers; and
- interest and capital due from financial institutions.

Impairment of financial assets

The Society assesses, at each reporting date, whether there is objective evidence that contribution debtors are impaired. An impairment exists if one or more events that has occurred since the initial recognition of the debtors (an incurred 'loss event'), has an impact on the estimated future cash flows from the debtors that can be reliably estimated. The Society adheres to debt management practice notes to assess the impairment of claims debtors and contributions debtors. The practice notes detail debt collection procedures and write-off requirements requiring the Board of Trustees' approval.

The table below illustrates the quality of the Society's receivables in order to assess the credit risk:

As at 31 December 2017	R	R	R	R
Class	Fully performing	Past due	Impaired	Total
Insurance receivables	2 446 212	923 762	509 871	3 879 845
Interest receivables	627 394	-	-	627 394

As at 31 December 2016	R	R	R	R
Class	Fully performing	Past due	Impaired	Total
Insurance receivables	2 835 520	227 409	118 875	3 181 804
Interest receivables	662 460	-	-	662 460

**MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)**

20. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

CREDIT RISK (CONTINUED)

Impairment of financial assets (continued)

The table below provides an age analysis of the credit that is past due, but not yet impaired:

As at 31 December 2017	R	R	R	R
Class	30 – 60 days	60 – 90 days	90 – 120 days	Total
Insurance receivables	158 895	254 995	-	413 890

As at 31 December 2016	R	R	R	R
Class	30 – 60 days	60 – 90 days	90 – 120 days	Total
Insurance receivables	69 903	51 212	-	121 115

The table below illustrates the quality of the Society's cash and cash equivalents.

Fitch National Long-Term Rating

Financial institution	2017	2016	Credit rating	
	R	R	2017	2016
Standard Bank	11 441 994	11 700 429	BB+	BBB-
ABSA	4 529 707	7 522 698	BB+	BBB-
Rand Merchant Bank	1 500 000	1 500 000	BB+	BBB-
Investec	10 590 283	8 946 494	BB+	BBB-
Nedbank	7 017 829	7 992 821	BB+	BBB-

The credit risk on liquid funds is limited because the counter party is a financial institution with a high credit rating.

The exposure to individual counter parties is also managed by other mechanisms, such as the right of offset, where a legally enforceable right exists.

Management information reported to the Society includes details of provisions for impairment on receivables and subsequent write-offs. The table below provides an analysis of the receivables that were impaired:

	2017	2016
	R	R
Insurance receivables	509 871	118 875

MARKET RISK

The Society has exposure to market risk, which is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in market prices. Market price risk comprises three types of risks: currency risk, interest rate risk and other price risk which includes equity price risk.

CURRENCY RISK

The Society is not exposed to foreign exchange risk arising from its investment in the Investment Solutions portfolio. At 31 December 2017 and 31 December 2016 the Society had no exposure to offshore cash.

MEDICAL AID SOCIETY
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
for the year ended 31 December 2017 (continued)

20. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

CURRENCY RISK (CONTINUED)

The Trustees manage this risk by ensuring that the asset manager complies with the Regulations of the Act. The maximum exposure to foreign cash is 10% of assets available for investment.

INTEREST RATE RISK

The Society is exposed to interest rate risk, as it places funds at both fixed and floating interest rates. The risk is managed by maintaining an appropriate mix between fixed and floating rate placings within market expectations.

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

2017	Up to 1 month	1 – 3 months	3 –12 months	1 – 5 years	Total
	R	R	R	R	R
Cash and cash equivalents	35 079 813	-	-	-	35 079 813
Available-for-sale investments					
- Bonds and debentures	-	-	-	29 129 357	9 129 357
- Cash	21 244 367	-	-	-	21 244 367
Total	56 324 180	-	-	29 129 357	85 453 537

The cash and cash equivalents are subject to floating interest rates, linked to the repo rate. Bond investments are subject to fixed interest rates. The cash portion in the available-for-sale investment contains exposure to floating interest rates and exposure to fixed interest rates.

2016	Up to 1 month	1 – 3 months	3 –12 months	1 – 5 years	Total
	R	R	R	R	R
Cash and cash equivalents	37 662 442	-	-	-	37 662 442
Available-for-sale investments					
- Bonds and debentures	-	-	-	23 571 141	23 571 141
- Cash	18 455 050	-	-	-	18 455 050
Total	56 117 492	-	-	23 571 141	79 688 633

Sensitivity analysis

The sensitivity analysis for interest rate risk illustrates how changes in the fair value of future cash flows of a financial instrument will fluctuate because of changes in market interest rates at the reporting date.

A decrease in 100 basis points in interest yields for a full year would result in an increase in reserves and other comprehensive income of R468 358 (2016: R478 256). An increase in 100 basis points in interest yields for a full year would result in a decrease in reserves and other comprehensive income of R468 358 (2016: decrease of R478 256) .

This sensitivity analysis is based on a change in an assumption while holding all other assumptions constant. In practice this is unlikely to occur and changes in some of the assumptions may be correlated; for example the effect of interest rates on the equity market.

20. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

EQUITY PRICE RISK

The Society is exposed to equity price risk as it invested funds in South African equities through an asset manager. The Society's equity portfolio is a long-term investment and the funds invested in this portfolio are not needed in the short to medium term. This mitigates the risk for short-term fluctuations in the equity market. The Society appointed a reputable asset manager with a good track record in terms of performance.

The Society is also exposed to equity price risk, as the asset manager deals in equities via derivative trading. The equity investment strategy is to protect capital by limiting any loss in exposed capital. This is achieved by hedging exposures with other derivative instruments. The equity price risk is thus limited by strategic actions by the asset manager.

Sensitivity analysis

The sensitivity analysis for equity price risk illustrates how changes in the fair value of future cash flows of a financial instrument will fluctuate because of changes in the equity market at the reporting date.

An increase of 5% in the JSE All Share Index would result in an increase in reserves of R1 040 453 (2016: R941 561). This full amount would be recognised in the Society's revaluation reserve and will not affect the Society's reserve ratio. The Society's sensitivity to equity prices has not changed significantly from the prior year.

This sensitivity analysis is based on a change in an assumption while holding all other assumptions constant. In practice this is unlikely to occur and changes in some of the assumptions may be correlated, for example the effect of interest rates on the equity market.

The Trustees monitor the equity portfolio movements on a regular basis, and the Investment Committee has regular meetings to review the Society's strategy and asset allocation.

Risk management of the investment portfolio

The asset manager's approach is to construct a portfolio of diversified asset classes, after determining the long-term relationship or correlation of these asset classes, in order to obtain an optimal risk/return mix. The asset manager uses strategic asset allocation rather than market timing strategies to manage risk. Quantitative analysts ensure appropriate risk exposure.

Fair value estimation

The fair value of publicly traded financial instruments and available-for-sale investments is based on quoted market prices at the reporting date.

The table below provides the carrying amounts of financial assets and liabilities per category:

	2017	2016
	R	R
Available-for-sale investments	112 635 710	91 513 078
Cash and cash equivalents	35 079 813	37 662 442
Trade and other receivables	4 044 436	3 776 527
- Insurance receivables	3 369 975	3 075 510
- Other receivables	627 395	662 460
- Risk transfer arrangements	47 066	38 557
Trade and other payables	(3 602 809)	(1 220 878)

The carrying amounts of these financial assets and liabilities approximate their fair values.

The fair value of available-for-sale investments is based on quoted bid-market prices at the year-end date.

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20. FINANCIAL RISK MANAGEMENT REPORT (CONTINUED)

EQUITY PRICE RISK (CONTINUED)

Fair value estimation (continued)

The table below illustrates the fair values of financial assets by hierarchy level.

As at 31 December 2017	Level 1	Level 2	Level 3	Reclassification
	R	R	R	R
Available-for sale-investments				
Bonds and debentures	29 129 357	-	-	-
Property	6 372 976	-	-	-
Equities with primary listing on the JSE	55 889 010	-	-	-
Local cash	21 244 367	-	-	-
Total	112 635 710	-	-	-

As at 31 December 2016	Level 1	Level 2	Level 3	Reclassification
	R	R	R	R
Available-for sale-investments				
Bonds and debentures	23 571 141	-	-	-
Property	5 924 187	-	-	-
Equities with primary listing on the JSE	43 562 700	-	-	-
Local cash	18 455 050	-	-	-
Total	91 513 078	-	-	-

The hierarchy levels are defined as follows:

Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities. These are readily available in the market and are normally obtainable from multiple sources.

Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly (i.e. as prices) or indirectly (i.e. derived from prices).

Level 3: Inputs for the asset or liability that are not based on observable market data (unobservable inputs).

The face values less any estimated credit adjustments for financial assets and liabilities with a maturity of less than one year are assumed to approximate their fair values. The fair value of financial liabilities is estimated by discounting the future contractual cash flows at the current market interest rate available to the Society for similar financial instruments.

Capital management

The Society's objective is to manage its capital in such a way that the annual contribution increase to members is as low as possible.

Capital adequacy risk is the risk that there may be insufficient reserves to provide for adverse variations on actual and future experience.

The accumulated funds ratio was 132.67% at 31 December 2017 and 124.27% at 31 December 2016 and compares favourably to the accumulated funds ratio of 25%, as prescribed by the Medical Schemes Act.

21. INSURANCE RISK MANAGEMENT

NATURE AND EXTENT OF RISKS ARISING FROM INSURANCE CONTRACTS

The Society issues contracts that transfer insurance risk. This section summarises these risks and the way the Society manages them.

Insurance risk – description of benefits

- In-hospital benefits cover all costs incurred by members, whilst they are in hospital to receive pre-authorised treatment for certain medical conditions.
- Chronic medication benefits cover the cost of certain prescribed medicines consumed by members for chronic conditions/diseases, such as high blood pressure, cholesterol and asthma.
- Day-to-day benefits cover the cost of out-of-hospital medical attention (subject to certain sub-limits), such as visits to general practitioners and dentists, as well as prescribed, non-chronic medicines.
- The treatment of prescribed minimum benefits is covered at cost.

Risk management objectives and policies for mitigating insurance risk

The primary insurance activity carried out by the Society assumes the risk of loss from members and their dependants that are directly subject to the risk. These risks relate to the health of the Society's members. As such the Society is exposed to the uncertainty surrounding the timing and severity of claims under the contract. The Society also has exposure to market risk through its insurance and investment activities.

The Board of Trustees has developed and approved documented policies and practices for the acceptance and management of insurance risk to which the Society is exposed. Reference has also been made to the requirements of the Medical Schemes Act in compiling the insurance risk management policy. These policies are reviewed annually and the benefit option provided to members is structured to fall within the acceptable insurance risk levels specified. The Board of Trustees also determines the policy for entering into risk transfer arrangements. The annual business plan is structured around the insurance risk management policy.

The Society manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, as well as the monitoring of emerging issues, and network arrangements through the appointment of designated and preferred service providers. Certain risks are mitigated by entering into a risk transfer arrangement.

The Society uses several methods to assess and monitor insurance risk exposures both for individual types of risks insured and overall risks. These methods include analysing detailed claims information with the assistance of the Society's actuarial consultants.

The Trustees also appointed managed care providers to focus on specific areas where the Society is exposed to insurance risk. These programmes include the following:

- HIV YourLife Programme
- Hospital Risk Management Programme
- Medicine Risk Management Programme
- Electronic Benefit Management Programme
- Disease Risk Management Programme
- Prescribed Minimum Benefits Programme
- Oncology Programme
- Maternity Programme
- General Practitioner and Specialist Network

The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and severity of claims is greater than expected.

Insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated using established statistical techniques.

21. INSURANCE RISK MANAGEMENT (CONTINUED)

NATURE AND EXTENT OF RISKS ARISING FROM INSURANCE CONTRACTS (CONTINUED)

Risk management objectives and policies for mitigating insurance risk (continued)

Experience shows that the larger the portfolio of similar insurance contracts, the smaller the relative variability about the expected outcome will be. In addition, a more diversified portfolio is less likely to be affected across the board by a change in any subset of the portfolio. The Society has developed its insurance underwriting strategy to manage the type of insurance risk accepted and within each of these categories to achieve a sufficiently large population of risks to reduce the variability of the expected outcome.

Frequency and severity of claims

For insurance contracts issued, climatic and seasonal changes, as well as the spread of pandemics give rise to more frequent and severe claims.

Source of uncertainty in the estimation of future claims payments

The Society reviews the contributions and benefits annually to ensure that the necessary underwriting surplus is maintained relative to the risk exposure. It is relatively easy to assess the future claim payments since the large majority is lodged soon after year-end, before the four-month expiration of claims period comes into effect.

All the contracts are annual in nature and the Society has the right to change the terms and conditions of the contracts at renewal. Management information including contribution income and claims ratios, target market and demographic split, is reviewed monthly.

The insurance risk management strategy is set out in the annual business plan, which specifies the benefits to be provided. Management information including contribution income and claims ratios is reviewed monthly.

Concentration of insurance risk

The following table summarises the concentration of insurance risk, with reference to the number of beneficiaries by age group.

2017		2016	
Age grouping (in years)	Total	Age grouping (in years)	Total
<= 25	1 043	<= 25	1 069
26 – 35	324	26 – 35	314
36 – 50	616	36 – 50	644
51 – 64	680	51 – 64	747
=> 65	1 096	=> 65	1 073
Total	3 759	Total	3 847

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21. INSURANCE RISK MANAGEMENT (CONTINUED)

NATURE AND EXTENT OF RISKS ARISING FROM INSURANCE CONTRACTS (CONTINUED)

Concentration of insurance risk (continued)

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

2017

Age grouping	General practitioners	Medical specialists	Dentistry	Medicines	Hospital	Other	Optometry	Total
	R	R	R	R	R	R	R	R
<= 25	994 223	1 657 560	431 177	1 170 907	2 284 853	620 026	-	7 158 746
26 – 35	532 470	1 099 095	282 591	993 445	1 668 932	591 043	-	5 167 576
36 – 50	1 010 883	2 780 835	516 014	2 295 892	4 156 746	1 618 944	-	12 379 314
51 – 64	1 102 424	5 807 296	866 571	4 547 364	8 565 465	3 244 205	-	24 133 325
=> 65	1 998 321	14 926 063	1 193 078	9 249 377	23 614 404	5 977 245	-	56 958 488
Iso Leso	-	-	-	-	-	-	1 897 163	1 897 163
Netcare 911	-	-	-	-	-	405 398	-	405 398
	5 638 321	26 270 849	3 289 431	18 256 985	40 290 400	12 456 861	1 897 163	108 100 010
IBNR – current year								3 354 720
IBNR – prior year over provision								(87 318)
TOTAL								111 367 412

MEDICAL AID SOCIETY
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21. INSURANCE RISK MANAGEMENT (CONTINUED)

NATURE AND EXTENT OF RISKS ARISING FROM INSURANCE CONTRACTS (CONTINUED)

Concentration of insurance risk (continued)

2016

Age grouping	General practitioners	Medical specialists	Dentistry	Medicines	Hospital	Other	Optometry	Total
	R	R	R	R	R	R	R	R
<= 25	27 167	75 394	40 562	31 484	52 711	19 529	-	246 847
26 – 35	456 377	988 009	280 419	592 902	1 076 647	183 087	-	3 577 441
36 – 50	1 495 601	3 820 227	993 236	3 286 975	4 096 624	764 211	-	14 456 874
51 – 64	1 120 743	6 780 503	1 195 509	5 270 614	6 206 522	2 271 268	-	22 845 159
=> 65	1 760 483	16 419 016	1 412 868	10 042 811	20 484 986	5 403 386	-	55 523 550
PPN	-	-	-	-	-	-	1 350 547	1 350 547
ER24	-	-	-	-	-	763 991	-	763 991
	4 860 371	28 083 149	3 922 594	19 224 786	31 917 490	9 405 472	1 350 547	98 764 409
IBNR – current year								5 501 739
IBNR – prior year over provision								(819)
TOTAL								104 265 329

The insurance risk management strategy is reviewed annually and specifies the benefits to be provided, as well as the contribution payable.

The Other category includes: radiology, pathology, renal care, blood services, etc.

Claims development

Claims development tables are not presented since the uncertainty regarding the amount and timing of claims payments are typically resolved within one year.

21. INSURANCE RISK MANAGEMENT (CONTINUED)

NATURE AND EXTENT OF RISKS ARISING FROM INSURANCE CONTRACTS (CONTINUED)

Concentration of insurance risk (continued)

Risk transfer arrangements

The Society entered into capitation agreements with an optical service provider and an emergency transport provider.

However, the Society remains liable to its members with respect to these services, should the capitation provider fail to meet its obligation.

The amount of each risk retained depends on the Society's evaluation of the specific risk, subject in certain circumstances to maximum limits on the basis of characteristics of coverage. According to the terms of the risk transfer arrangements, the third party agrees to reimburse the ceded amount in the event the claim is paid. According to the terms of the capitation agreement, the supplier provides certain minimum benefits to all Society members, as and when required by the members.

When selecting a capitation provider the Society considers its relative security. The security of the capitation provider is assessed from public rating information and from internal investigations, such as considering capital adequacy, solvency, capacity and appropriate resources.

22. CRITICAL ACCOUNTING JUDGEMENTS AND AREAS OF KEY SOURCES OF ESTIMATION UNCERTAINTY

In the process of applying the Society's accounting policies, management has made the following judgements that have the most significant effect on the amounts recognised in the financial statements.

A key assumption concerning the future that has a significant risk of causing a material adjustment to the carrying amounts of liabilities in the next financial year is that used to determine the provision for outstanding claims (refer note 7).

When arriving at this provision it is assumed that the reporting and settlement trend of claims incurred but not reported will be similar to that of the previous financial period. The provision is calculated based on percentages derived from the previous financial period and is adjusted as the claims are reported and settled.

Although the assumption is considered critical, post year-end settlements against the provision have been monitored to ensure reasonability of the original provision.

23. NON-COMPLIANCE MATTERS

23.1 CONTRAVENTION OF SECTION 35(8)(C) OF THE MEDICAL SCHEMES ACT

Nature and impact

The Society holds shares in MMI Holdings Ltd, Sanlam limited and Discovery Group Ltd. This is in contravention of Section 35(8) of the Act, as the Society is not allowed to hold shares in the holding company of any administrator.

Causes for the failure

The Society invests in a pooled portfolio and does not have control over the underlying assets.

Corrective action

The Society received an open-ended exemption in October 2012 from the Council for Medical Schemes from complying with Section 35(8)(c), insofar as it relates to investments placed with asset managers who invest on behalf of the Society and where such investment choices are not influenced by the Society.

23. NON-COMPLIANCE MATTERS (CONTINUED)

23.2 CONTRAVENTION OF SECTION 26(7) OF THE MEDICAL SCHEMES ACT

Nature and impact

In terms of Section 26(7) of the Act, contributions should be received in accordance with the rules of the Society. The rules indicate that contributions should be received no later than three days after they become due. As at 31 December 2017, there were contribution debtors outstanding for more than 30 days to the value of R574 598 (2016: R204 744). This amount represents 0.58% of the total contributions received during the year, but the delay in receipt is in contravention of Section 26(7) of the Act.

Causes for the failure

Delays were experienced in respect of receipt of payment from some employer groups.

Corrective action

This non-compliance is a result of the following:

Section 26(7) does not adequately provide for circumstances where member contributions are remitted from other countries of residence and the Society has pensioner members who reside outside South Africa.

Retirees of the BPSA Provident Fund pay their contributions via monthly debit order. Timely receipt of these contributions is dependent upon factors beyond the control of the Society. Established processes of pursuing responsible parties are followed when member contributions are not received.

23.3 CONTRAVENTION OF REGULATIONS TO MEDICAL SCHEMES ACT 131 OF 1998, CHAPTER 2, SECTION 3(1)(B)

Nature and impact

In terms of the rules of the Society, all members registered must have valid identity numbers. There are currently 12 members and 44 dependants of the Society who do not have valid identity numbers. This constitutes non-compliance with the rules of the Society.

Causes for the failure

Historically, identity numbers were not a requirement to register on the Medical Scheme. This is a legacy problem as these relate to beneficiaries taken on prior to 2015.

Corrective action

Management will on a continual basis review the data integrity of membership details and endeavour to comply with requisite legislation.

23.4 CONTRAVENTION OF SECTION 59(2) OF THE MEDICAL SCHEMES ACT

Nature and impact

A number of claims were settled outside the statutory 30-day timeframe. These claims were not erroneous or unacceptable for payment.

Causes for the failure

A change in the operating system used by the administrator in December 2016 resulted in claims being settled outside of the 30-day timeframe

23. NON-COMPLIANCE MATTERS (CONTINUED)

23.4 CONTRAVENTION OF SECTION 59(2) OF THE MEDICAL SCHEMES ACT (CONTINUED)

Corrective action

The settlement of claims that might fall outside the statutory timeframe was prioritised to ensure future claims received are paid within the 30-day timeframe.

23.5 NON-COMPLIANCE WITH REGULATION 30 – EQUITY

Nature and impact

In terms of Regulation 30 of the Act, a Scheme is prohibited from investing more than 40% of its investments in equity instruments.

Causes for the failure

The Scheme has equities invested in managed portfolios above the limit of 40% specified in category 4(a) of Annexure B to the Medical Scheme Regulations.

Corrective action

A motivation was sent in December 2015 to the Council for Medical Schemes to hold equities above the specified limit of 40% in category 4(a) of Annexure B to the Medical Scheme Regulations.

23.6 CONTRAVENTION OF REGULATION 8(1) OF THE MEDICAL SCHEME ACT 101 OF 1998

Nature and impact

Regulation 8(1) of the Medical Scheme Act 131 of 1998 states that, any benefit option that is offered by the Medical Scheme, must pay in full without co-payment costs of prescribed minimum benefits (PMBs). PMBs were not paid in full as per the Medical Scheme Act and Society's rules.

Causes for the failure

An assessor error resulted in claims not being reprocessed correctly.

Corrective action

Management continues to monitor abuse relating to PMBs in order to intervene and reduce the Society's financial exposure. Management ensures compliance with the Society's rules and legislation. These claims were reworked and paid as per the PMB mandate.