ANNUAL REPORT

REGISTRATION NUMBER 1512

Bonitas

Medical Aid for South Africa

2021

CONTACT US

Bonitas is an open medical scheme registered in terms of the Medical Schemes Act, No 131 of 1998, as amended, under registration number 1512.

0860 002 108

@BonitasMedical

https://www.facebook.com/BonitasMedical/

www.bonitas.co.za

- **Emergency Assistance (Europ Assistance)** – call 0860 555 505 or email bonitasclaims@europassistance.co.za or visit www.europassistance.co.za
- **Pharmacy Direct Registration** – call 086 0027 800 or please call me 083 690 8934 or email care@pharmacydirect.co.za or www.pharmacydirect.co.za
- **Optical Benefits (PPN)** – call 041 065 0650 or email bonitas@ppn.co.za or www.ppn.co.za
- **Mental Health Programme** – call 0860 106 155 or email mentalhealth@bonitas.co.za
- **HIV/AIDS Programme** – call 0860 100 646 or please call me 083 410 9087 or email afa@afadm.co.za or www.aidforaids.co.za
- **Hip and Knee Programme (Jointcare)** – call 011 568 3334 or visit https://joint-care.co.za/agreements/bonitas/
- **Hip and Knee Programme (ICPS)** – call 011 327 2599 or visit www.icpservices.co.za
- **International Travel Benefit** – call 010 211 4958 or email bonitas-assist@linkham.com
- **Diabetes Programme** – call 0860 002 108 or email diabeticcare@bonitas.co.za
- **Dental Programme** – call 0860 336 346 or email denis@bonitas.co.za or claims@denis.co.za
- **Cancer Programme** – call 0860 100 572 or email oncology@bonitas.co.za
- **Back and Neck Programme (DBC)** – call 0860 105 104 or visit www.dbcsa.co.za
- **Babyline or Baby Bags** – call 086 099 9121
- **Wellness Odyssey** – www.wellnessodyssey.co.za

CONTENTS

This report is for our members, brokers, the regulator and other stakeholders. We are accountable to you for Bonitas' sustainability and performance. We keep our reporting simple and give you the facts because we know sustainable healthcare is important to you.

SCOPE AND BOUNDARY

The report covers our financial and operational performance from 1 January 2021 to 31 December 2021. We also look towards the next few years as we anticipate challenges and opportunities.

We believe the report covers all material information to enable our members to determine whether Bonitas's resources were applied efficiently and effectively. The structure of the report, data and measurements are comparable to previous reports.

In addition to the Medical Schemes Act, No 131 of 1998, as amended (MSA) requirement to produce an annual report, we took guidance from the Value Reporting Foundation's Integrated Reporting <IR> Framework and King IV™[1].

We are making progress towards full compliance with the <IR> Framework. For this report we focused on telling readers even more about Bonitas, expanded our value creation model and included an assessment of the quality of our stakeholder relationships.

Financial information in this report was compiled using International Financial Reporting Standards (IFRS) and was extracted from and agrees with the annual financial statements audited by Deloitte. The unqualified audit opinion of fair presentation and representation is on page 77.

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APPROVAL

The report was prepared by Executive Management and reviewed by the Audit and Risk Committee. The Bonitas Board and Executive Management approved the integrity of the report, with salient features including:

- A chapter on our strategy to ensure the delivery of affordable and quality healthcare to members
- Data and commentary on our performance against this strategy, with insights from the Principal Officer
- An overview of financial performance, including operational statistics
- Challenges and opportunities faced this year
- How the Board exercised and discharged its responsibility for governance

Approved on 19 April 2022 by

Mr OJ Komane
Chairperson of the Board

Mr LR Callakoppen
Principal Officer

WE WELCOME FEEDBACK

If you have suggestions to improve this report, please email annualreportqueries@bonitas.org.za.

Please look out for notices that invite members to our annual or special general meetings. Recordings and minutes of these events are available on our website.

BENEFIT BOOSTER

- **Available after completing a wellness screening or online wellness assessment**
  - GP and specialist consultations
  - Acute and over-the-counter medicine
  - Biokineticist and physiotherapist consultations and treatment
  - Paramedical services such as dietician, speech and occupational therapy consultations and treatment
  - Alternative healthcare such as homoeopathic consultations and treatment and acupuncture
  - Non-surgical procedures and tests, e.g. wart removal
  - X-rays
  - Blood tests

Child dependents can access the Benefit Booster once an adult beneficiary has completed a wellness screening or online wellness assessment (all claims are paid at the Bonitas rate)

*Find the list of **abbreviations** and **definitions for terms** used in this report on the inside back cover of this report.*

2021 PERFORMANCE AT A GLANCE

MEMBERS

Members of our medical aid for South Africa

709 881 ↓
TOTAL BENEFICIARIES

340 119 ↑
PRINCIPAL MEMBERS

35 (NO CHANGE)
AVERAGE BENEFICIARY AGE

10.3% ↑
PENSIONER RATE

1.09 ↓
DEPENDANTS PER MEMBER

18.7% ↓
CHRONIC PROFILE

8.7% ↑
NON-HEALTHCARE EXPENDITURE AS A PERCENTAGE OF GROSS

CLAIMS

Claims paid to the value of R16.0 billion

88.22% ↑
OF HOSPITAL CLAIMS PAID WITHIN SEVEN DAYS

1 300 ↓
HOSPITAL CLAIMS PROCESSED PER DAY

1 118 ↓
HOSPITAL AUTHORISATIONS PER DAY

R26.6 million ↓
GROSS RECOVERIES FROM FRAUD, WASTE AND ABUSE (FWA)

R198 million ↑
IN PROJECTED NEGOTIATED HOSPITAL SAVINGS

FINANCE

We manage financial resources with prudence

R7.4 billion ↑
IN RESERVES

36.5% ↑
SOLVENCY RATIO

R1.4 billion ↓
SURPLUS

R1.2 billion ↑
INVESTMENT INCOME

R8.32 billion ↑
TOTAL INVESTMENT PORTFOLIO VALUE EXCLUDING CASH

R1.8 billion ↓
GROSS HEALTHCARE RESULT

2021 PERFORMANCE AT A GLANCE

COVID-19

Responding to COVID-19 second, third and fourth waves
From 1 January 2021 to 31 December 2021:

298 161
PATHOLOGY TESTS PERFORMED

62 146
POSITIVE BENEFICIARY CASES

13 870
BENEFICIARY HOSPITAL ADMISSIONS

2 401
BENEFICIARY FATALITIES

257
BENEFICIARY LIVES STILL IN HOSPITAL AT 7 FEBRUARY 2022

137 811
TOTAL LIVES FULLY VACCINATED AS AT 28 FEBRUARY 2022

212 501
TOTAL LIVES VACCINATED WITH AT LEAST ONE DOSE AS AT 28 FEBRUARY 2022

8.72%
% OF LIVES INFECTED BY COVID-19

COUNTLESS
LIVES PROTECTED AND SAVED

WHAT DIFFERENTIATES US

- Bonitas is a medical aid for all South Africans, not certain segments or income groups.
- We have substantial reserves that enable us to pay claims – even under pandemic conditions.
- Our unique product design means that our members are sure to find a plan that will meet their different needs at varying stages throughout their lifespan.
- Our contributions for quality healthcare are affordable, starting from R1 274 per month.
- We continue to invest in technology that enables us to connect with members and help them manage their healthcare on-the-go.
- We have strong networks with the best healthcare providers in South Africa.
- Our core team is stable, dedicated and experienced, and supported by a strong Board of Trustees.

ABOUT BONITAS

Bonitas is the second largest open medical scheme in South Africa, based on the number of members. We aim to make quality healthcare accessible to all South Africans and offer a wide range of plans that are simple to understand and easy to use.

On 1 March 2022, Bonitas celebrated 40 years as a private healthcare scheme in South Africa. Over the four decades, we evolved and expanded our capabilities in response to the needs of a growing membership base.

We have a rich heritage and solid understanding of the South African private healthcare industry. We know the rising cost of healthcare is the top concern for our members. Therefore, our team of experts is constantly looking for innovative ways to reduce costs and increase benefits. We make strategic investments in technology, for example to ensure lifestyle diseases are identified before they become chronic.

The administration of the Scheme is outsourced to Medscheme, South Africa's largest health risk management service provider and largest medical aid administrator.

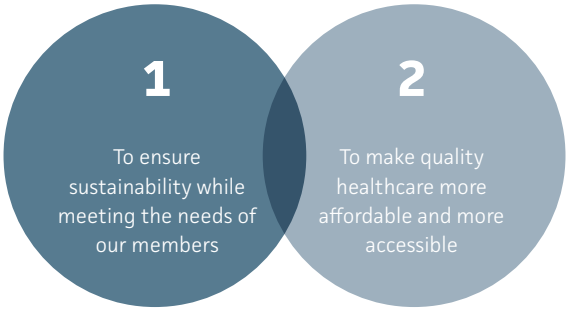
We put our members first when negotiating rates and sourcing reputable service providers. We do not believe in one-size-fits-all. We adjust our wide range of benefit options every year while keeping it simple and user-friendly.

Bonitas is there for its members, whether they are entrepreneurs, chief executive officers, newlyweds, young couples with children, retirees, or minimum wage earners who all need peace of mind when it comes to healthcare.

This is how we fulfil our aim of providing affordable, quality healthcare for all South Africans.

A BRAND THAT PROTECTS

Bonitas has two interdependent priorities:



OUR VALUE PROPOSITION

As the medical aid for South Africa, we:

Care about our members so we always act in their best interest

Partner with the best services providers so our members have access to quality care at affordable rates

Keep people healthy and assist when they are ill through a range of manage care programmes. We also make corporates healthier so they are more productive and engaged

Are financially stable so we can afford to pay out members' claims

Find innovative ways to connect with our members including our helplines, service centres, website, app, WhatsApp and social media

Offer a wide range of plans that are easy to use and understand to suit a broad variety of healthcare needs

OUR HEALTHCARE MODEL

We have an outsourced model based on quality partnerships that we continue developing and optimising. We make sure that our partners look after our members like we do.

Bonitas is an open medical scheme offering 15 benefit plans to members as of 1 January 2022.

Members join the Scheme, select plans and pay monthly contributions to Bonitas.

Internal audit services are outsourced to PwC. Deloitte has been reappointed as the external auditor following member voting at the annual general meeting.

Bonitas invests member contributions through asset managers and use RisCura Solutions as investment consultant.

ASSET MANAGERS PER STRATEGIC CATEGORY

- Prudential
- Allan Gray
- Vunani
- Sesfikile
- Fairtree
- Aluwani
- All Weather
- Catalyst
- Taquanta

*Bonitas has the **largest general practitioner network in South Africa**, a specialist network and a host of supplementary benefits paid from risk and carefully crafted managed care programmes. Our programmes include cover for chronic conditions, cancer, diabetes, HIV/AIDS and mental health. **This allows members to derive real value for money and stretch their benefits as far as possible**.*

A Board of Trustees and Board Committees provide governance oversight and ensure members' interests are protected.

Bonitas contracts actuarial services from Medscheme and NMG Consultants and Actuaries to assist with health informatics and analyses, developing plans and pricing models, to do evaluations and to assist for example with recent amalgamation.

Bonitas contracts with Medscheme to administer the Scheme. This includes managing claims, preauthorising hospital admissions, tracking benefits and much more. They are also contracted to run the managed care programmes, for example back and neck rehabilitation, HIV or oncology management.

OTHER THIRD-PARTY AGREEMENTS

- Pharmacy Direct
- Afrocentric Distribution Services
- Hospital networks
- GP networks

RISK TRANSFER AGREEMENTS

- DENIS
- PPN
- Scriptpharm
- ER24
- Europ Assistance

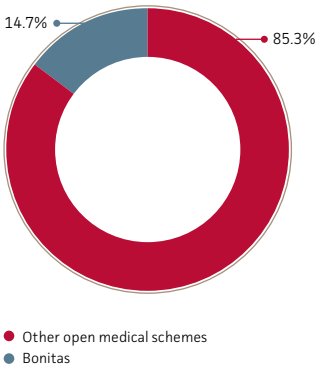
MANAGED CARE SERVICE PROVIDERS

- DENIS
- Medscheme Holdings
- Aid for Aids

A network of brokers and aggregators sign up new Bonitas members as individuals or employer groups and earn commission on their services.

BENCHMARKING BONITAS

Bonitas's market share: 14.7%
(open medical scheme beneficiaries)



Source: 2020 data from the Council for Medical Schemes Annexures to the 2020/2021 Annual Report.

Average age per beneficiary
Bonitas:
35
Average for registered open schemes: 35.3

Pensioner ratio
Bonitas:
10.3%
Average for registered open schemes: 10.8%

Solvency ratio
Bonitas:
36.5%
Average for registered open schemes: 38.7%

OUR FOOTPRINT

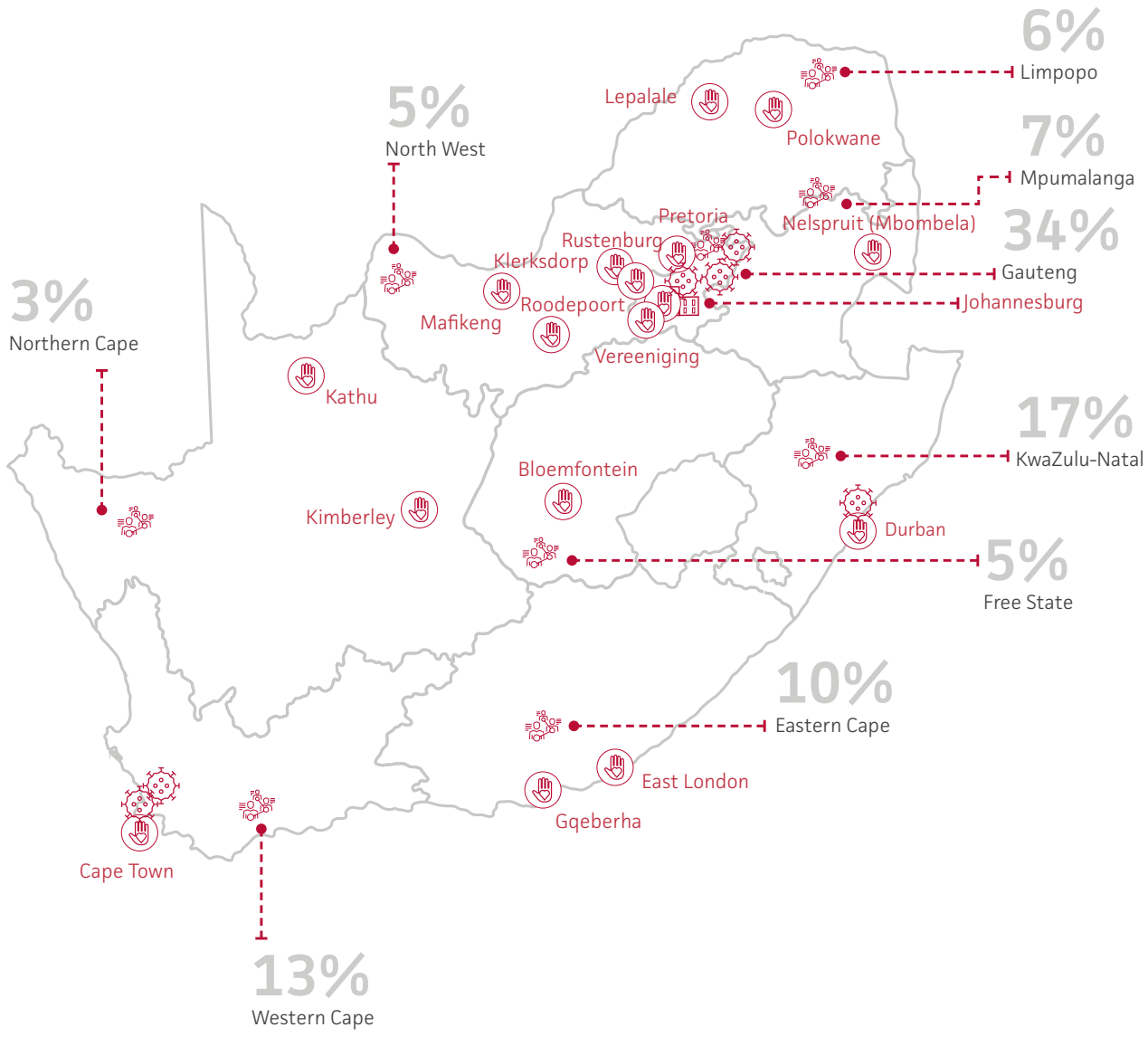
*Bonitas has the **largest general practitioner** and **specialist network** in South Africa.*

Walk-in Centres

Head Office

Vaccination Sites were offered at 6 different locations

Members



THE BONITAS PLANS

We currently offer 15 benefit plans as of 1 January 2022 to suit a range of member needs. We have traditional, savings, hospital and edge plans, all offering members more value and rich benefits.

Two traditional plans with two EDOs:	
Standard and Standard Select	A traditional option offering rich day-to-day benefits and comprehensive hospital cover **Standard Select:** A traditional option using a quality provider network to offer rich day-to-day benefits and hospital cover
Primary and Primary Select	A traditional option offering simple day-to-day benefits and hospital cover **Primary Select:** A traditional option using a quality provider network to offer simple day-to-day benefits and hospital cover
Two hospital plans with one EDO:	
Hospital Standard	A hospital plan offering extensive hospital benefits with some value-added benefits
BonEssential and BonEssential Select	A hospital plan offering rich hospital benefits with some value-added benefits **BonEssential Select:** A hospital plan using a quality provider network to offer comprehensive hospital benefits with some value-added benefits
Five savings plans:	
BonComprehensive	A first-class savings plan offering ample savings, an above-threshold benefit and extensive hospital cover
BonClassic	A generous savings option offering a wide range of medical benefits, in and out of hospital
BonComplete	A savings option offering generous savings, an above-threshold benefit and rich hospital cover
BonSave	A savings option offering savings to use as members choose for medical expenses and extensive hospital cover
BonFit Select	A savings plan offering basic cover for day-to-day medical needs and essential hospital cover
One low-income contribution plan:	
BonCap	An income-based entry-level plan offering basic day-to-day benefits and hospital cover using a network of doctors, providers and hospitals
One edge plan:	
BonStart	Driven by technology, intelligence and innovation, this plan is designed for economically active singles, living in the larger metros, with a drive to succeed
BonStart Plus*	Driven by technology, intelligence and innovation, this plan is aimed at couples intending to expand their families or for younger families.

** Bonitas launched BonStart Plus as a new option for 2022.*

OUR STRATEGIC PILLARS AND OUTCOMES

We want to be the obvious alternative leading open medical scheme in the industry.

APPLY BEST PRACTICE GOVERNANCE

- Ensured governance and compliance across all interactions
- Implemented FWA strategy to significantly reduce illegitimate claims, waste and abuse of benefits
- Continuously improved the frequency and scope of claims experience reporting to identify outlying trends for intervention in real-time

BE A STRATEGIC PURCHASER

- Value realised through managed care initiatives

BOOST BUSINESS DEVELOPMENT

- 2.1% net membership growth rate vs target of 2.1%
- 51 396 new members vs target of 47 500

OPTIMISE INVESTMENT RETURNS

- Consumer price index (CPI) +3.5% target

CONNECT WITH THE CUSTOMER

- Improved connection with all stakeholders through all platforms and touchpoints

INTEGRATE THE VALUE CHAIN

- Improve members' health status

CREATE VALUE THROUGH INNOVATION

- Improve virtual interaction and engagement and enhance offerings

HOW WE CREATE AND PROTECT VALUE

We want to proactively safeguard member interests as well as Bonitas' assets, market share, ability to pay claims and legitimacy. We also want to generate growth and increase our offering by identifying opportunities that can benefit members.

INPUTS

To provide quality healthcare cover for our members, we combine a unique set of resources and relationships.

Manufactured capital

- We have a Scheme office in Johannesburg, 17 walk-in centres in South Africa and seven vaccination sites. We use digital platforms to take the hassle out of member and broker interactions with Bonitas.
- Our broader network comprises hospitals, surgeries, clinics, pharmacies, offices, medical equipment and other necessary infrastructure to deliver healthcare services.

Financial capital

- As a medical scheme, we are a non-profit organisation.
- We maintain a solvency above the regulatory minimum of 25%.

Human capital

- Our 340 119 members, 709 881 beneficiaries and our 20 employees form a pool of human capital to maintain, serve and support Bonitas and our members.
- We use an outsourced model and partner with the best service providers to ensure our members get access to care of the highest quality.
- Our customer service agents provide one-on-one assistance to members and their beneficiaries.

Intellectual capital

- Bonitas has been operating for 40 years as a medical fund, and our management team has 97 years' combined management experience.
- Our Board members have deep experience in critical aspects of leading a medical scheme and ensuring the appropriate governance structures, processes, and controls effectively manage our outsourced administration model.
- Our core competency is in designing and pricing healthcare benefits and managed care plans. Benefits cover a range of 133 conditions including 270 diagnosis and treatment pairs (DTPs) based on the admission categories within hospital benefit management, 27 prescribed minimum benefit (PMB) chronic conditions for all options and an additional 33 conditions for certain options from a chronic medicine management perspective.
- Our protocols and formularies ensure high-quality treatment according to a list of safe and effective medicines that can be prescribed to treat certain conditions.
- Our digital channels act as resource hubs to help people understand their conditions and recommend steps they can take to remain healthy. These include virtual healthcare and self-service channels that allow members to access statements and tax certificates, submit and view claims and access electronic membership cards.
- The Bonitas brand has a strong reputation associated with specific attributes and member benefits.

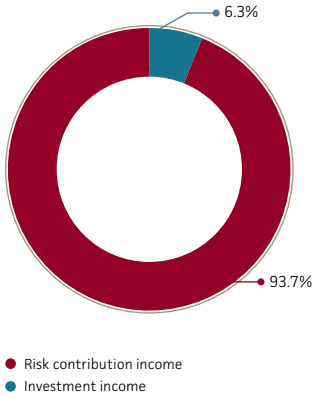
Social and relationship capital

- We operate an outsourced model that uses strategic service providers to execute a range of our activities. See detail on page 6.
- We collaborate across the healthcare value chain with industry stakeholders such as the Council for Medical Schemes (CMS), the Board of Healthcare Funders (BHF), hospital groups and healthcare practitioners to enable systemic sustainability.
- Our network of hospitals, doctors and specialists provides full cover services and managed care options to members.
- We are committed to the transformation and reform of the healthcare industry.

Natural capital

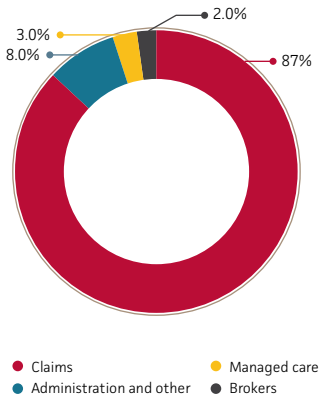
We do not rely on natural capital to create value and have an immaterial impact on natural resource use. We recognise that environmental factors potentially impact individual health through air pollution, water quality and sanitation, or natural disasters such as flooding and heatwaves.

Where our funding comes from



Members' contributions are our primary source of income. According to our Investment Strategy and Policy, these funds are invested to generate further returns. Government also supports the sustainability of this pool of funds by offering a tax credit for people paying medical scheme contributions.

How we spent these funds



We pay claims according to members' plans and benefits. Our main cost drivers are hospital, specialist and medicine claims. We do not have shareholders or investors who receive dividends. We exist and spend our funds purely for the benefit of members.

ACTIVITIES

- **We design healthcare plans** with options to suit everyone. We have different types of cover, all offering more value and rich benefits.
- **We select and negotiate service provider contracts and rates** to ensure affordable, quality healthcare.
- **We monitor the quality of care** and the treatment plans designed by medical service providers.
- **We facilitate the collection of monthly risk premiums** according to healthcare plan contributions for individuals, families or employees.
- **We invest member funds** and maintain appropriate reserves.
- **We ensure member administration is effective**, efficient and that the necessary fraud prevention and risk management measures are in place.
- **We facilitate claims payments** to members according to their plan conditions and benefits.

Our activities depend on the relationships that underpin our outsourced healthcare administration model. ***We serve our members and contribute to a more resilient society through these activities****. We keep people healthy and assist when they are ill by removing healthcare-related stress.*

OUTPUTS

For 2022, we offer 15 benefit plans to suit members' healthcare needs and provide access to discounted financial service products such as gap cover and lifestyle vouchers. Members can use various tools and services to provide clinical support, easier claims processing and access to information. Read more about our plans on page 10.

OUTCOMES

We want to improve the integration of care, enable more access to out-of-hospital services, clinical information and benefits via various solutions.

This includes simplifying healthcare, improving our members' quality of life, and creating a productive society.

Everything we do is in the best interests of our members, saving them money by making their benefits last longer and making Bonitas sustainable. This means our members can enjoy the value of private medical care while being protected against unexpected and expensive medical costs.

For this reason, we focus on continually improving the healthcare value chain.

Nett membership increased by 6 978

51 396 gross membership acquisitions

44 418 membership terminations

Solvency remained 46% above the legislated 25%

COVID-19 claims to the value of R2.6 billion were paid, up 115% on 2020

Some of our largest claim categories include, among others:

- R6.45 billion hospital
- R2.6 billion COVID-19
- R1.9 billion Medical Specialists
- R1 billion Auxiliary
- R814 million GP
- R864 million Pathology
- R977 million day-to-day

Claims of over R500 000 for the year were paid to 4 105 members

Our ultimate aim is to make quality healthcare more accessible and affordable.

Members received special COVID-19 support:

- We waived co-payments for non-network hospitals on select options.
- We paid for PCR tests and extended benefits to pay for rapid antigen tests and serology tests.
- We adjusted benefit protocols to pay for medicine.
- We committed to covering vaccines for all members.
- Our online hub provided helpful articles to help members deal with COVID-19.
- Free virtual consultations were launched for all South Africans in 2020, and were effective until December 2020. From then onwards, virtual consultations have been available to Bonitas members through the app at a low fee, with unlimited use for edge plan options.

The process of creating and protecting member value through our use of resources and relationships is dynamic and shaped by:

	Read more
Our external environment and trends in healthcare	Page 19
Progress with the implementation of our strategy	Page 26
The effectiveness of our risk management and ability to identify and capture opportunities for growth	Page 23
Ethical leadership and effective governance structures, processes and controls	Page 57
Solid financial performance	Page 43
Sustainability and prospects despite future uncertainty	Page 50

OUR KEY RELATIONSHIPS

Our members trust us with their health. To earn and maintain that trust, Bonitas nurtures a network of relationships with stakeholders that share our healthcare purpose. They give us legitimacy and ensure our sustainability.

Bonitas has a wide range of stakeholders and relationships, some extending back for decades. Our network relies on outsourced partners such as our administrator, brokers, general practitioners and specialists.

We are in the process of developing a stakeholder management framework which will map our key stakeholders, taking the full healthcare ecosystem into account. We are assessing the latter in terms of a medical scheme's relevant roles and responsibilities.

Some of our key relationships:

- Members
- Healthcare providers
- Brokers
- Administrator and managed care organisation
- Third-party stakeholders
- Regulatory stakeholders

We support and engage proactively with various stakeholders and when a query arises. Queries are captured as operating procedures and are governed by service level agreements (SLAs) with partners and service providers. Escalating a matter to Bonitas is defined in SLAs. Service providers send Bonitas monthly reports to highlight engagement interactions and matters of concern.

Internal stakeholder escalation processes allow matters to be communicated to the relevant executives. They ensure that quarterly reports to the Board highlight material stakeholder concerns.

The frequency of engagement with each stakeholder is dependent on the nature of the relationship, the method of engagement and can be daily, weekly, monthly, quarterly or *ad hoc*. To formalise and better track these relationships, we are working on a stakeholder management framework. This will include a review of our material stakeholders.

We list our material stakeholders below and provide evidence of the nature, quality and outcomes of our engagements this year.

Members form the customer base that we service. We interact with members through a variety of channels, where possible in their language of choice, and aim to be responsive and quick to address their concerns. We want to find new ways to add value for them while supporting them more effectively and efficiently.

How we engage	Topics arising during engagement	Bonitas response
• Bonitas member mobile app and internet portal • Virtual medical consultations • Surveys • Brokers • Email, SMS and WhatsApp • COVID-19 hub • Walk-in centres • General meetings	• Vaccinations • Finding a network provider • Claims and benefits queries • Role of brokers • Amalgamation queries • Membership fees • National Health Insurance (NHI) implications	• Website and app information on COVID-19 and vaccinations • Continuous training of officials who engage with members • Communication on claims, benefits, plans and fees • Invitation to general meeting and presentation on the amalgamation • Personal responses to specific queries

Members approved the NMAS amalgamation

Bonitas gained 14 585 new members in January 2022 following the amalgamation with NedGroup Medical Aid Scheme (NMAS), a restricted membership medical scheme for employees of Nedbank and Old Mutual Insurance. Bonitas members were asked to vote on the amalgamation at the annual general meeting (AGM) held on 11 August 2021. 360 members voted in favour, 37 not in favour and 46 abstained. All votes were verified by PwC, the independent oversight body, who further confirmed that the meeting was successfully concluded in line with the Scheme Rules. Although NMAS Rules did not require members to approve the amalgamation, they were invited to vote on the transaction through a ballot. Read more about the benefits and approval process for the amalgamation in the Principal Officer's report from page 37 and the Financial and operational review from page 43.

How we define the quality of our relationships:

Good relationship but needs to improve to add value to both sides

Good relationship with mutual benefit

Strong relationship of trust, collaboration and mutual understanding

Member interactions

59 859 via walk-in centres (face-to-face) *(2020: 64 511)*	**1 322 618** via call centres *(2020: 1 278 049)*	**817 313** emails *(2020: 496 944)*

"My mother went for a knee operation and Bonitas paid for the whole operation. In the previous years I was asked to make co-payment. ***I would like to commend the Bonitas team for coming up with an innovative solution*** *to cover orthopaedic surgery. Well done team."*

- **634 322** main call centre *(2020: 622 665)*
- **225 077** BonCap call centre (2020: 222 199)
- **330 950** hospital benefit management *(2020: 297 708)*
- **132 269** chronic medicine management *(2020: 135 477)*

- **477 157** main back office *(2020: 305 252)*
- **38 990** BonCap back office *(2020: 42 859)*
- **281 719** hospital benefit management authorisations created *(2020: 63 045)*
- **19 447** chronic medicine management authorisations created *(2020: 85 788)*

The Bonitas contact call centre does monthly member surveys to assess satisfaction around two indicators:

- Did the agent satisfactorily resolve or facilitate a resolution to your query? 83.68% said YES
- Was it difficult for you to get to this point where your query was resolved? 63.79% said it was EASY

This year, we sent out 170 209 surveys and had an average 18.72% response rate.

Feedback from our members

"I've been with Bonitas for 8 yrs now and they never gave me and my family headaches. I hope to be with you till my old age and I hope you remain true to your customers like you are now. Stress free medical aid so the customer can focus on their health."

"Bonitas is a good medical aid who always has your back, ***when you are with them you do not have to worry about anything****."*

*"****It's a brand for all people****, they make sure that their customers are happy."*

"There is no other simple and affordable medical aid you will get, ***if you want peace of mind join Bonitas****."*

Medscheme is our most significant outsourced partner administering Bonitas's financial, actuarial and operating activities. It is also our accredited managed care service provider. We rely on Medscheme and their service providers to provide the necessary healthcare services to our members. We have a service level agreement with penalties in place for non-delivery. Service delivery and customer satisfaction levels are evaluated regularly.

How we engage	Topics arising during engagement	Bonitas response
• Management Committee/Forum meetings • *Ad hoc* meetings	• Contracting, fees and SLA • COVID-19 responses • Healthcare expenditure • FWA exposure • Member interactions via call centre or social media • Managed healthcare value realisation initiatives • Loss-making options	• Regular reviews against the budget and market trends • Profile of membership and reviews to ensure members are on relevant managed care programmes • Review of geographic network • Review of Scheme reserves • Improved FWA process controls, detection methods and reviews

How we define the quality of our relationships:

Good relationship but needs to improve to add value to both sides

Good relationship with mutual benefit

Strong relationship of trust, collaboration and mutual understanding

Brokers and intermediaries sign up members, and advise and support them. Afrocentric Distribution Services handles the Bonitas's distribution, advertising and marketing activities. These relationships drive additional value and outputs in terms of business development, market intelligence and product development.

How we engage	Topics arising during engagement	Bonitas response
• Management Committee/Forum meetings • *Ad hoc* meetings • Strategic summit	• Contract review and renewal • Vaccine rollout arrangements • New options and benefits • Broker concerns	• Contract under review • Marketing support provided • Strategic objectives aligned

Broker engagements

One power breakfast streamed to over **657** delegates	One broker roadshow streamed to over **898** delegates	One product launch streamed to **2 727** delegates	**Two** corporate launches	**19** union engagements

RisCura Solutions manages Bonitas's portfolio of investments and cash and cash equivalents.

How we engage	Topics arising during engagement	Bonitas response
• Attendance and presentations at Board and committee meetings	• Global financial market trends and outlook • Strategic asset allocation • Investment strategy • Asset management performance • Amalgamation implications	• Updated Investment Policy Statement • Investment reallocation strategy implemented • Asset transition timeline agreed

The Board of Healthcare funders is a representative body to the healthcare funding industry and drives the sustainability of the healthcare ecosystem. Bonitas is a member and our Principal Officer is one of the BHF board members. Through this relationship we benefit from increased exposure and engagement in the healthcare sector.

How we engage	Topics arising during engagement	Bonitas response
• Forum meetings • BHF board meetings	• COVID-19 responses, including vaccines • FWA • Protection of Personal Information Act (POPIA)	• Vaccine rollout support • FWA improvements • POPIA implementation

Industry sharing initiative

Bonitas participates in CareConnect, a South African Health Information Exchange established by six of South Africa's largest private healthcare organisations. This enables a confidential electronic exchange of clinical and other information among authorised organisations. The exchange allows healthcare professionals to pull real-time patient data from a centralised hub, replacing the previously siloed, fragmented and manual approach. This promises to facilitate efficiencies across the continuum of care, from nurses and pharmacists to hospitals, doctors and specialists.

The CareConnect exchange conforms to local and international data privacy regulations to protect sensitive health information. Medical practitioners can only access information when medically necessary and only with the patient's consent.

How we define the quality of our relationships:

Good relationship but needs to improve to add value to both sides

Good relationship with mutual benefit

Strong relationship of trust, collaboration and mutual understanding

The Council for Medical Schemes acts as the regulator, responsible for the control and coordination of medical schemes, administrators, managed care organisations and brokers. Our relationship with the CMS continues to improve, particularly through regular engagement on product development. We collaborate and engage with the regulator in discharging our duties to our members and in ensuring our governance protocols remain of the highest standard.

How we engage	Topics arising during engagement	Bonitas response
• Formal correspondence • Circulars	• Requests for data/information • Inspection outcomes	• Collaboration and engagement • Compliance and adherence

CMS inspection update

Bonitas received a notice from the Registrar of Medical Schemes in 2014 indicating an intent to inspect certain issues that arose during the financial periods 2011 to 2014. After legally challenging the ordering of the inspection on procedural grounds, Bonitas resolved to co-operate with the inspection. In 2020 the Registrar extended the scope of the inspection to cover financial periods up to 2019. The inspector issued a draft report to Bonitas on 8 September 2021 for input. Bonitas provided responses to the draft report on 3 December 2021. A final inspection report is still to be issued.

The inspection itself does not impact members directly. However Bonitas may be held liable for the costs should the Registrar exercise its discretion as such. Bonitas has agreed that, should the Scheme be held liable, the costs of the expanded inspection shall be limited to an amount of R1.6 million.

Section 59 Panel

The Section 59 Investigation, launched by the CMS, examined allegations made by medical practitioners that they are being treated unfairly, and their claims are being withheld by medical schemes based on racial profiling. A panel (Section 59 Panel) was convened to investigate these claims. The Section 59 Panel released its interim report on 19 January 2021. All stakeholders were given an opportunity to make inputs into the preliminary findings contained in the interim report, and we are now awaiting the release of the final report. In the meantime, Bonitas continues to try to find ways to limit incidences of FWA.

We also demonstrate our commitment to fair treatment by ensuring that all service providers sign our Code of Ethics and Professional Conduct. We elevated reports on all controls and independent reviews to management level with direct Board oversight to ensure no action or behaviour as suggested by the Section 59 review.

Stakeholders help us ensure ethical behaviour

We encourage all stakeholders to use our whistle-blowing hotline to report any unethical behaviour that we need to be aware of. Up to now, we received most reports via our live answering service on 0800 112 811.

We continue to create awareness of all the confidential reporting options available, including the Whistle Blowers app that can be downloaded from Google Play or the Apple App Store. We also have a WhatsApp or SMS service where stakeholders can message us on 33490 in South Africa or anywhere in the world on +27 (0) 71 868 4792. Alternatively, the online reporting platform on www.whistleblowing.co.za enables stakeholders to make submissions.

Bonitas is committed to providing avenues for eligible whistle-blowers to raise concerns and receive feedback on any action taken. Eligible whistle-blowers can also take their matter further if they are dissatisfied with the response while knowing that they will be protected from reprisals or victimisation for whistle-blowing in good faith.

Examples and outcomes of whistle-blowing

- A whistle-blower alerted us to a health care practitioner who was submitting fraudulent claims and giving members cash in exchange for their medical details. This was investigated and the practitioner was found guilty of fraud by the court in Pretoria.
- We received information via the whistle-blower hotline that a member has been changing the dates on a healthcare invoice and using a receipt to gain multiple refunds. The healthcare provider picked this up on a remittance and alerted Bonitas. The member admitted fraud, membership was terminated and a police case was opened.

DIAL 0800 112 811 OR MESSAGE 33490 OR GO TO WWW.WHISTLEBLOWING.CO.ZA

450	57%	21%	15%	7%	95%
whistle-blower hotline cases reported in 2021	closed with no findings	closed with findings and the relevant claims reversed	closed with findings, relevant claims reversed and promoted for further investigation	closed with findings, no reversal but promoted for further investigation	of all cases were acknowledged, captured and reviewed within three working days from date of receipt

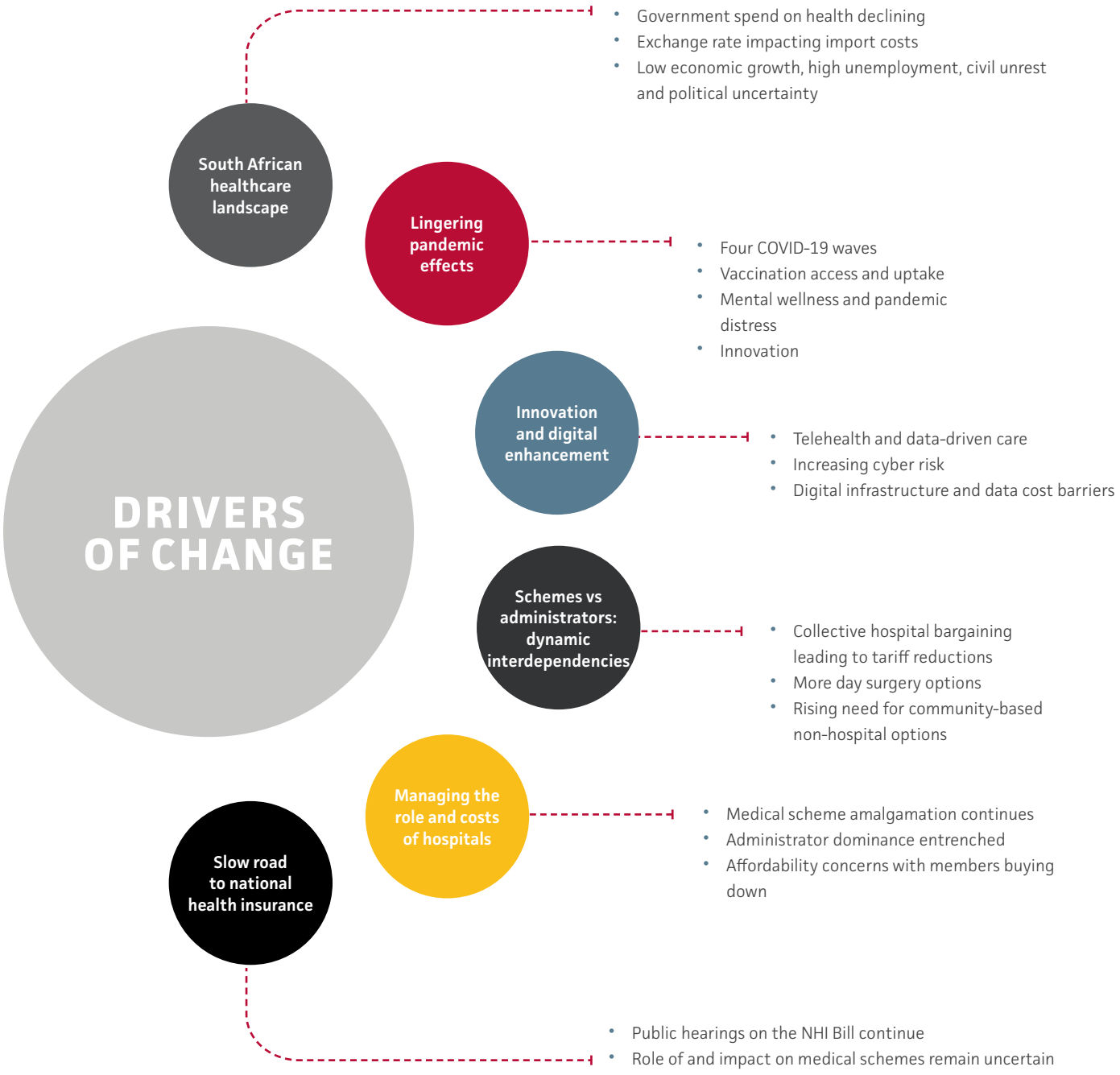
How we define the quality of our relationships:

Good relationship but needs to improve to add value to both sides

Good relationship with mutual benefit

Strong relationship of trust, collaboration and mutual understanding

EXTERNAL TRENDS SHAPING OUR WORLD



THE SOUTH AFRICAN HEALTHCARE LANDSCAPE

Affordable and accessible healthcare remains a global challenge as countries worldwide struggle with insufficient and outdated health systems and infrastructure. Even new technology and additional healthcare workforce capacity have not been able to meet the growing needs of citizens and communities – with added pandemic pressure.

South Africa faces similar challenges, compounded by severe fiscal constraints. According to Treasury's 2021 medium-term budget policy statement published in November 2021, government spending on health will decline by 0.6% up to 2025. The statement further emphasises that the public healthcare sector, burdened by COVID-19 and mounting vaccination requirements, needs to improve efficiency to sustain service delivery and alleviate backlogs. At the same time, infrastructure allocations are expected to be delayed.

The same statement indicates that the NHI policy proposal would require at least R40 billion per year in additional funding in the first five years. As there is insufficient capacity in the health sector to work substantively on national health insurance and complete the necessary regulatory process, it is unlikely that this will be implemented in the medium term.

From an economic perspective, a range of factors further impacts healthcare affordability and access. Healthcare prices tend to increase more rapidly than inflation. This is due to a weakening rand affecting the cost of imported equipment and medicine while long-term demographic trends such as an ageing population contribute to increased health expenditure. The elderly proportion of the population is projected to grow by 2.5% per year over the next two decades, reaching six million by 2040. Healthcare inflation also tended to exceed CPI inflation over the past decade.

Low economic growth and an increase in the population's average age added further pressure to the healthcare system and associated costs. Statistics South Africa expects the population to increase from 60 million in 2021 to 71 million by 2040. Only 8.9 million out of roughly 60 million individuals had access to private healthcare in 2021.

The combined impact of economic hardship, lockdown measures, COVID-19 fatalities and illness, civil unrest, high unemployment and political agitation, contributed to adverse mental health outcomes for many South Africans and their communities. Most people have been seriously affected by disease-related fears, social distancing and quarantine measures.

Bonitas strategic response:

- Be a strategic purchaser
- Boost business development
- Create value through innovation

LINGERING PANDEMIC EFFECTS

South Africa experienced four waves of COVID-19 infections since the government declared a national state of disaster on 15 March 2020. Although new variants remain a risk, the economy has slowly started on its journey of recovery as lockdown conditions are eased, and hospital admissions decline.

With the cost of vaccinations being a fraction of treating COVID-19, the vaccination rollout has been a focus for all healthcare players in 2021.

The National Department of Health, supported by the World Health Organisation and other agencies, ensured the availability of effective vaccines as a critical ingredient for the successful containment of COVID-19.

The CMS co-ordinated universal access to these vaccines and identified the following interventions in support of the rollout process:

- Declaration of the COVID-19 vaccine as a PMB
- Mobilisation of the industry to provide universal access, availability, and provision of the vaccine
- Nationally coordinated effort aimed at achieving a herd immunity of 65% and more
- Social solidarity and cross-subsidisation
- Support the central procurement of the vaccine through financial guarantees

As a PMB, COVID-19 vaccinations are covered by medical schemes for adult beneficiaries (over 15 years of age) under relevant health expenditure. Medical schemes' wholesalers procure vaccines from the central government distributor using a single exit price mechanism that includes cold chain and logistics costs.

Despite the deployment of additional healthcare workers, frontline employees dealing with COVID-19 have suffered severe distress since the pandemic outbreak. Lack of equipment, failing infrastructure, ongoing fatalities and increasing workloads caused elevated levels of depression, anxiety, insomnia, and distress.

However, COVID-19 also resulted in positive outcomes evident from public and private collaboration, levels of innovation and the reassessment of healthcare needs and benefits. The pandemic highlighted the lack of health equity and the need to address overall wellbeing for all South Africans, encompassing clinical, mental, social, emotional, physical and spiritual health.

Bonitas strategic response:

- Be a strategic purchaser
- Connect with the customer
- Create value through innovation

INNOVATION AND DIGITAL ENHANCEMENT

Remote diagnosis and treatment via telehealth, virtual consultations and the use of connected devices are becoming more pervasive. Driven by pandemic conditions and limitations, digital engagement closed gaps and provided more personalised, data-driven care. As such, technology will most likely have the largest and most continuous impact on the healthcare sector.

In South Africa, the current doctor-centred, facility-based healthcare system cannot be expanded sufficiently to achieve healthcare for all. The shift towards telemedicine and virtual care has been adopted by many stakeholders and is supported by e-scripting, which can be linked to a courier pharmacy for delivery. Medical funds that are able to control the entire service delivery chain can therefore move towards reducing healthcare expenses.

However, digital transformation in healthcare raises the levels of cyber risk and requires heightened systemic oversight and governance. This includes optimising information management and analytics, based on quality data and integration while ensuring member privacy is protected at all times.

Firstly, technology for healthcare aims to improve quality of life and then become more affordable over time. In South Africa, barriers to telemedicine include the necessary digital infrastructure in rural areas and costly data.

Bonitas strategic response:

- Integrate the value chain
- Create value through innovation
- Apply best practice governance

MEDICAL SCHEMES AND ADMINISTRATORS: DYNAMIC INTERDEPENDENCIES

Consolidation among medical schemes has been anticipated and predicted for several years, but in reality, this has been playing out at a slower rate than expected.

In 2002, the CMS regulated 144 medical schemes (47 open and 97 restricted) compared to the 75 medical schemes (20 open and 55 restricted) supervised currently. Although there are now fewer medical schemes, mainly due to amalgamations, the industry has grown in complexity[1]. South Africa currently has 25 medical scheme administrators compared to 28 in 2014, of which Medscheme is the largest.

Medical schemes have a declining range of choices in terms of administrators, which means that some administrators have been able to garner more market share, thus embedding dominant positions. This has resulted in medical schemes assuming greater healthcare risk as they face ageing membership, a reducing membership pool and an increase in diseases. Scheme costs (and, therefore, member premiums) are consequently highly correlated to the overall risk profile of members rather than considering optimal welfare, service quality and benefits.

The CMS has been encouraging the consolidation of schemes to improve risk pooling and affordability. However, this drives further concentration, especially among administrators, leading to lower competitiveness and the prevalence of market forces described above.

Over the last few years, there has also been a clear trend in members buying down to cheaper options. The downgrades affect medical schemes more than they affect administrators. Smaller schemes are finding themselves in a position where they cannot meet the required solvency level.

Bonitas strategic response:

- Boost business development
- Integrate the value chain

[1] *Council for Medical Schemes Annual Report 2020/2021.*

MANAGING THE ROLE AND COST OF HOSPITALS

Three private groups dominate the South African hospital facilities market: Netcare, Mediclinic and Life Healthcare. In a largely unregulated market, they can set fees and benefit from a general trend of overutilisation. For the first time in 2021, medical schemes adopted a collective bargaining strategy that led to tariff reductions. Further measures to contain these costs entail excluding some hospitals in medical scheme networks to better balance supply and demand, more stringent hospital admission requirements, managed care interventions and quality outcome criteria.

Although the number of lives covered by the private healthcare sector increased only marginally over the last decade, private hospitals continue to invest in new capacity within traditional models. This also goes against the rising importance of community-based non-hospital care in South Africa.

There is a shift towards day surgeries to support lower-cost procedures. The uptake of virtual care is also set to reduce the need for physical infrastructure.

Bonitas strategic response:

- Be a strategic purchaser
- Integrate the value chain
- Create value through innovation

SLOW ROAD TO NATIONAL HEALTH INSURANCE

The NHI has been the major unknown variable in the healthcare industry for the past five years. An overwhelming number of submissions, public debate and comment followed the release of the NHI Bill in August 2019. Public hearings by the National Assembly's portfolio committee on health started on 18 May 2021 and will continue into 2022.

The NHI Bill aims to achieve universal health coverage for all South Africans via a health financing system designed to pool funds. This will, in theory, provide access to quality affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status.

The role of the private sector within a universal health system remains unclear. This includes the role of medical schemes, which are in a position to assist the NHI administratively and in the managing of risk. In its current form, national health insurance could lead to a loss of medical scheme membership.

Bonitas strategic response:

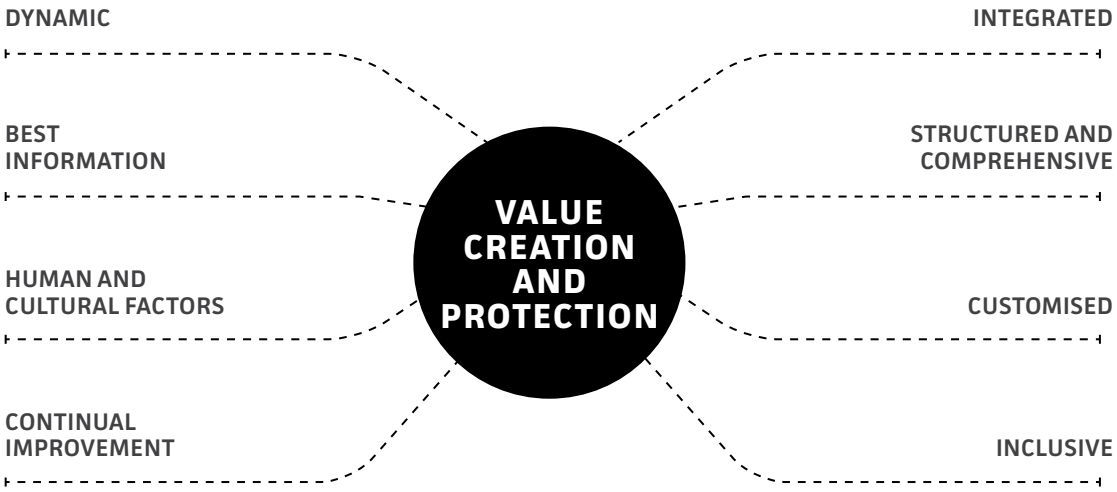
- Boost business development
- Create value through innovation
- Apply best practice governance

OUR STRATEGIC RISKS AND OPPORTUNITIES

Our focus on risk management keeps us on the forefront of redefining healthcare for a new world.

We have a Board-approved Risk Management Policy that includes a Risk Management Framework. The Framework provides guidance on identifying, evaluating, and responding to key risks and opportunities in a consistent, efficient, and effective way. Read more about risk management in the governance section on page 69.

The key risk management principles listed below aim to create and protect value for our members:



Integrated: Risk management is integrated into our planning process, from strategy setting, expectations and performance targets, tactical production and service initiatives, through to execution

Structured and comprehensive: We implement a practical framework that sets a clear policy, role definitions and requirements for reporting, i.e. registers and dashboards

Customised: The process is customised to Bonitas in proportion to our external and internal environment

Inclusive: Our stakeholders' needs and concerns are considered

Dynamic: It is adapted for changes in the external and internal factors impacting Bonitas as they appear and disappear

Best information: Inputs are based on previous knowledge (historical information), current know-how and forward-looking information based on future expectations within the industry

Human and cultural factors: Human behaviour and culture significantly influence all aspects of risk management at each level and stage. Therefore, Bonitas promotes and embraces a culture that values the importance of risk management by entrenching it in the day-to-day processes, activities and decision-making

Continual improvement: The process is continually assessed and revised to remain relevant

The Risk Management Framework includes several important elements:

- The relationship between internal audit and risk management as part of a combined assurance approach
- Clear descriptions of risk appetite and tolerances. The Framework shows tolerance levels that do not exclusively focus on the financial thresholds of acceptance; they also focus on the non-financial impacts of risk and opportunity
- Bonitas risk categories (strategic, operational, financial, legal and compliance)

We prioritise risks after considering related opportunities as well as the impact and likelihood in terms of levels: acceptable, tolerable, high or unacceptable. Our disclosure below focuses on the most strategic matters with unacceptable or high residual risk as these could have an impact – positive or negative – on our ability to create and preserve value.

Bonitas's most significant opportunity over the long term is to pursue amalgamations, and to achieve membership growth through innovative new partnerships, for example with Sanlam.

Strategic risk and opportunity	Context and causes	Our strategic response
The proposed NHI can impact the sustainability of Bonitas from a regulatory and private healthcare model perspective.	We actively engage and participate in the legislative process and provide regular updates to the Board. The Parliamentary portfolio committee invited Bonitas to present and discuss our submission on 25 January 2022. We are also working with industry bodies and groups such as the BHF to influence change. We expect NHI discussions to pick up post COVID-19, which attracts priority at the moment.	Boost business development Apply best practice governance
Increasing regulation or regulatory changes and/or the lack thereof, can impact Bonitas.	Bonitas implements the requirements set out in CMS Circulars, provides input on Bills and takes action where gaps or improvements in protecting members' interests are identified. Where necessary, we engage with our legal advisor to obtain advice and develop a response or action plan.	Boost business development Integrate the value chain Apply best practice governance
Cyber security threats and vulnerabilities can have financial, operational, strategic and reputational impacts.	We need to secure user access and ensure data protection while maturing I&T governance through oversight, management and reporting. In addition to policies and frameworks, we do penetration and vulnerability tests to ensure sufficient data management and protection. New service level agreements for administration and managed care include related clauses.	Boost business development Be a strategic purchaser Connect with the customer Integrate the value chain Apply best practice governance Create value through innovation
Bonitas's sustainability and stability relies on optimal benefit design and pricing, financial performance and mitigation of increasing healthcare costs and changes in membership risk profiles.	We assess performance against actuarial assumptions monthly. Corrective action in terms of cost containment initiatives or adjustment of assumptions, for example in our incurred but not reported (IBNR) model, is taken where necessary. A particular focus area is elective procedures, which are likely to increase in 2022. The existing underwriting policy caters for the management of high risk beneficiaries. Loss-making options are reviewed during the pricing process, and corrective measures such as adjustments to increases and benefits are considered.	Boost business development Be a strategic purchaser Connect with the customer Apply best practice governance Optimise investment returns
Bonitas relies on service provider partnerships, which can be at risk when not transacted at arm's length or where fees are not market-related or value-adding.	Deloitte provided Bonitas with transactional and relational governance assessments to inform changes to service provider contracts. In contracting, we consider measurements, outcomes and fees. An exit clause is now included in contracts allowing Bonitas to benchmark prices after one year of implementation to ensure that members receive value. Bonitas also reserves the right to renegotiate prices or terminate contracts if there is no value for members.	Integrate the value chain Be a strategic purchaser Apply best practice governance
The Bonitas brand and reputation can be affected by negative publicity and industry issues such as the Section 59 report.	Bonitas continues to engage with the regulator on potential issues and elicits ongoing guidance and input from our legal advisor and reputation management consultant. We collaborate with other schemes and the regulator as required.	Connect with the customer Apply best practice governance
Major competitors or new market entrants can disrupt and threaten Bonitas's sustainability.	Competitive products and a solid value proposition, including cost and pricing transparency, can mitigate this risk. We focus on research, reporting on product performance and ensure that our digital strategy supports our offering. We also continuously enhance benefits and implement engagement initiatives that appeal to younger people.	Apply best practice governance Boost business development

MANAGEMENT OF INSURANCE RISK

Our priority is to manage the healthcare risk exposure of our members and their dependants. Because the extent of the risk relates directly to the health of our members and beneficiaries, we have to mitigate uncertainty about the timing and severity of claims.

Bonitas uses internal risk measurement models, sensitivity and scenario analyses, and stress testing to assess and monitor risk exposure. This applies to both individual and overall risks.

We apply probability in pricing and provisioning for a portfolio of insurance contracts that cover a range of frequency and severity of claims.

Bonitas manages insurance risk through:

- Inclusion of benefit limits and sub-limits
- Approval procedures for transactions that involve pricing guidelines
- Pre-authorisation and case management
- Service provider profiling
- Monitoring of emerging issues
- Centralised management of risk transfer arrangements.

Over the past few years, there has been a steady insurance risk migration from systematic to unsystematic in terms of PMBs. This is mainly due to changing legislation, which requires Bonitas to pay PMBs at total invoice price and not according to benefit limits and sub-limits. Refer to note 14.3 of the annual financial statements for more information.

Risk transfer arrangements

Bonitas has risk transfer arrangements with the following service providers:

Service provider	Risk transfer arrangements
DENIS	Dental benefits Standard, Standard Select, BonFit Select, BonComplete, BonSave and BonClassic
Scriptpharm	Chronic medicine management All options
ER24*	Ambulance and emergency services for all options
PPN	Optometric benefit management Standard, Standard Select, Primary, Primary Select, BonClassic and BonCap
Europ Assistance	International travel benefits All members except for those on BonCap

* *Europ Assistance (EA) was appointed as the Emergency Medical Service (EMS) provider to replace ER24 effective 1 May 2022.*

Certain health risks are outsourced where it is considered beneficial to members, for example, where the cost of procurement, infrastructure and intellectual property would be disproportionate to member benefits. This would only add to rising healthcare costs and downstream costs such as hospital admissions.

In 2020, Bonitas launched a pilot on its Primary option to assess whether it may be beneficial to manage the risks in-house and not as part of the dental capitation model. However, as COVID-19 disrupted dental claims patterns, the pilot programme will continue until the end of 2022 to obtain meaningful volumes of data. Bonitas may consider moving other options in-house instead of the outsourced risk model with DENIS if the pilot is successful and there are attributable cost savings for members.

The service providers listed above have a national footprint across South Africa.

For more information on the risk transfer arrangements, refer to note 14.3 in the annual financial statements.

OUR STRATEGY FOR LEADERSHIP

Our strategic intent is to consolidate Bonitas's position as the industry's obvious leading alternative open scheme.

This year we commenced with a new three-year strategy cycle that focuses on Bonitas's positioning in the medical schemes industry, emphasising consistency and resilience in an ever-changing medical scheme environment.

We redefined our previous seven-pillar strategy to take the form of five core pillars, supported by governance and innovation which are relevant to each pillar. The particular focus on governance for all pillars is based on Bonitas's outsourced administration operating model. We need to ensure that all aspects of Bonitas service and responsibilities to members have the appropriate Board oversight and controls to ensure we meet all compliance requirements.

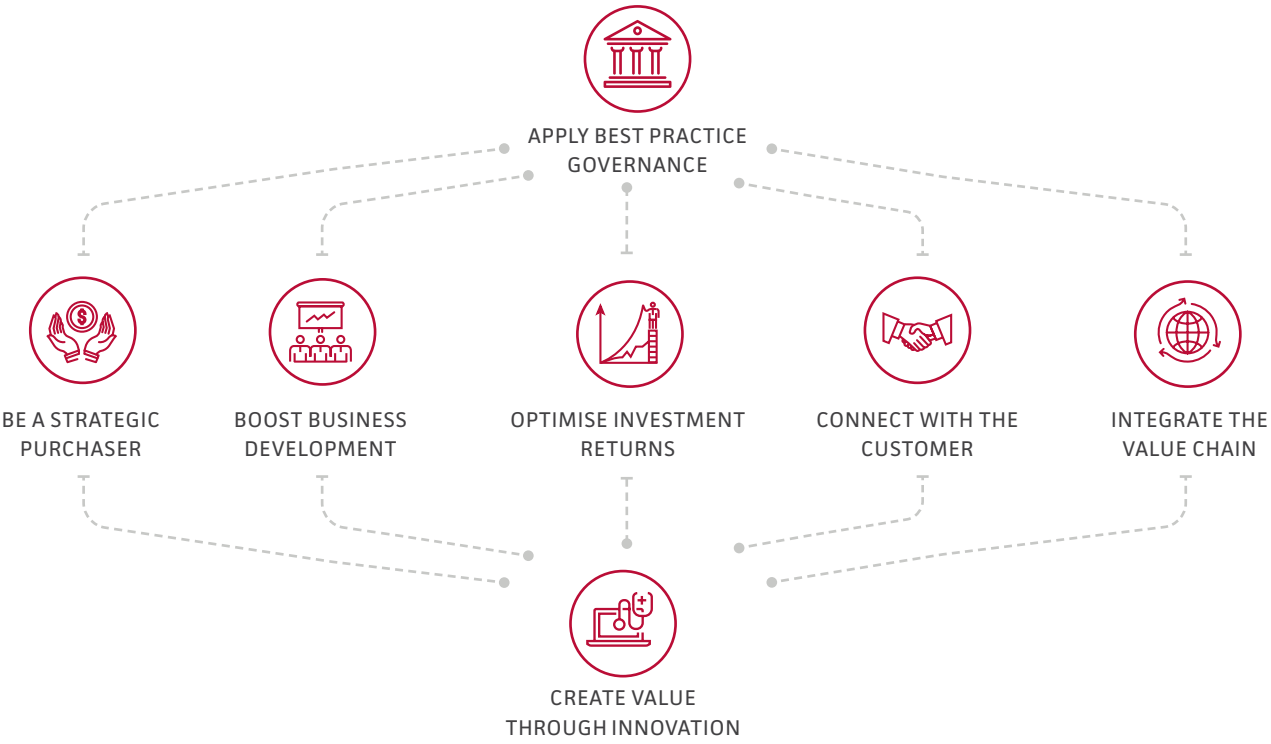
We aim to balance the need for growth with financial sustainability, thus securing the future for Bonitas over the long term.

We execute our strategy through the plans we offer. These have been designed for simplicity, flexibility, and affordability while meeting our members' varying needs at different stages throughout their lifespan. Plans were reviewed by the Board in August 2021, submitted to the CMS early September 2021 and announced to brokers and members at the product launch on 16 September 2021. The CMS approved our benefit options in October 2021.

Bonitas has financial objectives to assist in executing our strategy and to ensure that:

- Healthcare expenses, in particular, are well managed through proper financial discipline, contract management and approved budgets.
- Liabilities such as benefit payments to members regarding medical expenses are met as they become due.
- There is adequate provision for possible long-term adverse claims experiences and that we maintain a financially sound position by managing reserves responsibly.
- Benefit cover and contribution levels remain competitive compared to other market participants to retain existing members and attract new members.
- Solvency is managed according to the 25% requirement in terms of Regulation 29 to safeguard our long-term sustainability.
- The number of loss-making options is reduced through option-specific, focused strategies.
- Investment returns are maximised through cash flow management and approved strategic asset allocation.

Benefits and contribution levels are reviewed once a year to ensure that the contributions will be sufficient to meet the benefit and operating commitments as they fall due. We make allowance for expected income and fair value gains on the investment portfolio, and balance contribution levels with a low net healthcare result.



PROGRESS WITH IMPLEMENTING OUR STRATEGIC PILLARS

What this means

Be a strategic purchaser

Over the past two decades, healthcare costs have outpaced inflation. This trend is a key concern for the medical aid industry and is exacerbated by FWA and the non-regulation of other costs.

Bonitas has to make strategic purchases to maintain costs, ensure service quality, and minimise risk.

The main focus of this pillar is to:

- Contract with managed care service providers at an option level to reduce deficits.
- Define and optimise purchasing power with hospital groups.
- Build more efficient networks of service providers and enhance current networks.
- Introduce a day hospital strategy.
- Ensure preventative and primary services are available when required.
- Ensure secondary and tertiary healthcare only come in into play after the first level of relevant care has been accessed.
- Focus on reimbursement models with provider networks.
- Review existing risk transfer agreements.
- Align network hospitals and contracted healthcare providers to reduce member co-payments.

2021 progress

As the second-largest open medical aid scheme in South Africa, Bonitas has the necessary market share to effectively negotiate preferential hospital tariffs. We also enjoyed a first-mover advantage in the following:

- Bonitas was the first medical scheme in the industry to exclude several hospitals in an attempt to control the supply of hospitals in the market. Other medical schemes followed and now define networks either per option or for the overall scheme.
- Last year, we participated in the first collective negotiation process on hospital tariffs with five other medical schemes administered by Medscheme. We used our combined scale to negotiate competitive tariffs to achieve parity across the funders in the collective and parity across the hospital groups. We established a common tariff file across the schemes per hospital group and negotiated no hospital or network exclusions for the main plan options.
- We started actively encouraging the use of day hospitals and clinics for procedures such as cataract surgery, circumcisions and scopes. There is minimal disruption to members, speedier recovery times, less risk of infection, and day hospitals are a more cost-effective solution.

We saw the benefits of greater purchasing power after the amalgamation with LMS in 2016 and expect further impetus from the NMAS amalgamation in 2022. Read more about the latest amalgamation in the Principal Officer's report from page 37.

Costs are further managed strategically by efforts to eradicate FWA within the Bonitas network and the industry as a whole. We drive deterrent measures that resulted in considerable recoveries.

Claims and risk management remain strategic focus areas. Despite efforts to identify less cost-efficient hospitals, which resulted in savings, Bonitas experienced increased hospital admissions, resulting in higher utilisation, which had an adverse cost impact.

Strategic purchasing yielded savings of R407 million (2020: R346 million), mainly driven by the hospital tariff negotiations and medicine optimisation.

Read more about cost management initiatives in the financial and operational report from page 43.

Outcomes-based disease management

We introduced a process to manage disease based on outcomes rather than using a traditional transactional approach in October 2020. We use predictive modelling data to identify high-risk beneficiaries. An example is 50 000 members diagnosed with diabetes who were enrolled on the new disease management system to monitor specific outcomes. The system triggered gaps that enabled the managed healthcare team to consider possible interventions. The more we can control diabetes, the lower the number of hospital admissions that will be necessary, thus improving member experience and saving costs.

Future priorities

We plan to conduct feasibility studies into international healthcare models to help yield better quality clinical and cost outcomes. This will ensure that we maintain/improve our solvency level, increase the use of virtual care to lower hospital admissions and gain the full benefits of collective hospital bargaining.

We are also developing and implementing a strategy to promote the widespread use of generic medicine, specifically to reduce hospital medicine costs.

What this means

Boost business development

Growing our membership base is critical to Bonitas's sustainability. Corporate business growth is a focus area to counterbalance the universal trend towards more direct paying member business, which traditionally carries a higher risk.

To grow membership, Bonitas has to demonstrate value for money in our product offerings, ease of doing business in onboarding processes, and efficiency in our administration and claims handling procedures. Solvency, strong leadership and effective governance are essential components in Bonitas's overall appeal to corporate decision-makers.

Focus areas for this pillar are:

- The enhancement of distribution channels.
- Improved retention (groups and direct paying members).
- Corporate membership growth and the integration of value-add products.
- Market-orientated product development and targeted marketing to pursue growth in surplus generating options.
- Defensive product development and broker collaboration to mitigate against loss-making options.
- Increased below-the-line marketing initiatives and demand for measurable return on investment.
- Amalgamation opportunities will continue to be pursued.

2021 progress

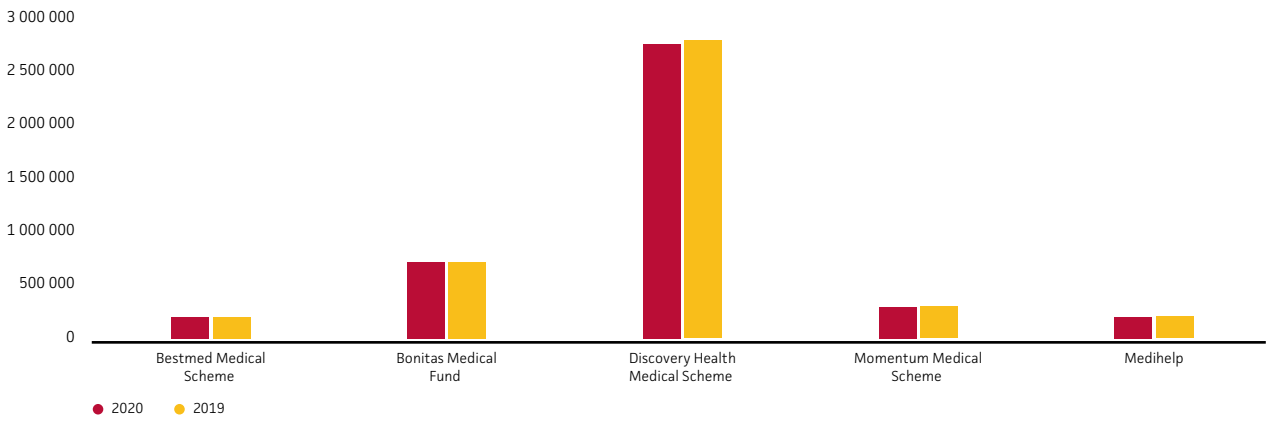
Our brand repositioning as the Medical Aid for South Africa and our engagement with stakeholders as The Everyday Hero drove organic membership growth over the past four years. We expanded our advertising and optimised sales channels. This included broker contracting and support, pay point support, the development of direct sales channels for leads processing, the contracting of leads aggregators and inroads via the tied sales forces of Liberty and Sanlam. This resulted in net membership growth of 2.1%. Bonitas acquired 51 396 new members (2020: 37 814).

A step-change in membership numbers followed from the LMS amalgamation in 2016 and the transfer of members from the Community Medical Aid Scheme in 2018. From 1 January 2022, we gained 14 585 new members as part of the amalgamation with NMAS.

Membership retention efforts led to 14 191 members retained, which is 45.39% of the controllable termination requests. Key account officers, broker consultants and brokers are continuously reminded of the vital role they play as first responders to any risks of terminations at pay points.

Our value-added offerings are an important attraction and retention mechanism and include access to discounted shopping vouchers, life-, disability- and funeral cover with built-in wealth-bonus, discounted short-term insurance, discounted gap cover and discounted membership fees to Run/Walk for Life. Available on the Bonitas mobile app is a membership behaviour influencing programme prompting members and their beneficiaries via gamified nudges to make better health and lifestyle choices. It also offers access to AVO, the largest online shopping mall in South Africa, offering multiple brands, products, discounts and bargains. Via the app, members can access their electronic membership card, membership statements, tax certificates, health risk assessments, virtual consultations with healthcare professionals, and locate network hospitals and doctors.

Largest open scheme beneficiaries



Source: *2020 data from the Council for Medical Schemes Annexures to the 2020/2021 Annual Report.*

Bonitas has been driving two growth strategies since 2020, aimed at corporates and unions. We continue to support brokers; however, we recognise that economic strain will limit the recruitment of new employees. There are still pockets of uncovered lives in large organisations.

To enhance distribution channels, we maintained close relationships with corporate brokers, forged closer relationships with smaller independent brokers, attracted more support from tied financial advisers and expanded direct sales capacity.

Our partnership with the two largest lead aggregators for the medical schemes industry ensures that potential members can get multiple quotes from a range of medical schemes, including Bonitas, at the same time. In 2021 Bonitas added Sanlam Healthcare Distribution Services as a third aggregator partner.

We expanded the capacity and capability of the Medscheme retentions department, including the accreditation of agents to provide advice during interactions with members and allowing them to get involved in group retention efforts, which previously was the sole responsibility of the key account officers.

We re-aligned our product offerings to address the specific needs of different target groups. During the 2022 product development cycle, we balanced contribution increases with the depth of benefits, focusing on loss-making options, proactive measures to protect growth options against becoming loss-making and making options more attractive to a younger audience.

In 2021 Bonitas introduced a new option called BonStart, driven by technology, artificial intelligence and innovation, exploring ways of improving access to services such as telemedicine/virtual care. The success of and learnings obtained from the launch and take-up of BonStart in both the direct paying member and group markets, and the support it receives from leads aggregators, brokers and financial advisers were considered during the 2022 product development cycle. Consequently, we developed BonStart Plus, which was submitted for approval to the CMS and approved in November 2021.

We developed and implemented a comprehensive training programme for brokers to develop proficiency in Bonitas's products and servicing regimes. Proper training is fundamental as brokers might not have the necessary product knowledge to confidently promote Bonitas within their client base; hence this initiative will continue throughout 2022.

We also produced new radio and television advertisements showcasing and unpacking various benefits that resonate with different target markets while highlighting topical concerns such as cover for COVID-19 and free virtual care consultations.

We are diversifying digital media marketing channels based on successes from 2020 and 2021. Since each digital platform serves a different function, it aims to reach potential members at either singular or multiple digital destinations. Influencer marketing will be a focus area in 2022.

We also plan to increase the use of Facebook to drive education and awareness by positioning content that highlights benefits meaningfully to drive leads.

Managed care programmes

As part of the managed care contract review this year, we considered world-class practices against the need to control costs while improving access and always assuring higher levels of quality care. Bonitas aims to meet our members' physical, emotional, and social needs while respecting their privacy and personal integrity. We also test legal compliance and competitiveness and assess whether managed care interventions deliver on our retention and growth targets.

With the rise in non-communicable diseases, such as diabetes, high blood pressure and cancer, managed care programmes can empower members to take charge of their health and support them along the way. Since the start of COVID-19, the managed care model was strengthened by:

- Reducing COVID-19 out-of-pocket expenditure for members.
- Enhancing funding approaches to various services such as pathology testing and negotiating reduced costs for those tests.
- Proactively engaging with hospitals to ensure members would be accommodated to private facilities and have access to the best private healthcare when required.
- Assisting members in need when they had medical requirements over and above the standard benefits.
- Engaging with providers and facilities in terms of personal protective equipment (PPE).
- Ensuring member co-payments/shortfalls were either reduced or eliminated to improve accessibility for members.
- Introducing free virtual healthcare to provide uninterrupted healthcare while safeguarding members.
- Enhancing our agreement with Scriptpharm to be a dedicated service provider for chronic, acute and over-the-counter medicine.

194 199 beneficiaries registered for chronic medicine	**41 977** beneficiaries on the HIV/AIDS Programme	**13 562** beneficiaries on the Cancer Programme	**63 780** beneficiaries on the Diabetes Programme	**5 022** beneficiaries were identified for the Back and Neck Programme and 4 304 were referred
27.4% ↑	**0.03% ↑**	**1.08% ↑**	**0.4% ↑**	**10% ↑** and **19.9%**

Costs saved through managed care programmes can help limit contribution increases for members. Read more about cost savings in the financial and operational report from page 43.

Future priorities

We are identifying and pursuing new opportunities for membership growth through amalgamations and by enhancing the existing distribution model. This includes implementing a segmented broker strategy to improve broker support and enhance Bonitas's broker value proposition. In addition to membership growth, we are also driving a decrease in terminations and an increased retention rate.

What this means

Optimise investment returns

Bonitas optimises the return on investments within its risk appetite. Our Investment Strategy considers regulations and the constraints imposed by the Board.

The investment portfolio is appropriately diversified, in line with the Bonitas Investment Policy Statement. Asset allocation is managed by considering our asset-liability matching to ensure sufficient liquid funds exist to meet claims and other liabilities as they fall due.

Our liabilities are short-term in nature. Because of this, a significant portion of the investment portfolio is invested in cash instruments.

The investment pillar objectives are:

- To achieve a targeted net (of fees and taxes) return in excess of CPI+3.5% per annum over a rolling 36-month period.
- To preserve capital over a rolling 12- to 18-month period.
- To be proactive and reposition Bonitas when there are opportunities to maximise returns while adhering to the set strategic asset allocation parameters.
- To manage investment risk to be within tolerable levels.

2021 progress

Our investment portfolio (excluding cash and cash equivalents) reported growth from R7.21 billion in December 2020 to R8.32 billion at the end of December 2021 – delivering an overall return of 16.15%. This is well beyond the targeted return of 8.1% (CPI+3.5% per annum).

This is evidence of the success of our strategic allocation approach, which entails a portfolio split into categories managed by asset management specialists per category. We track performance relative to market benchmarks. Industry data shows that we are one of the few schemes with consistent returns greater than CPI.

Bonitas absorbed the NMAS investment reserves into the accumulated member reserves upon completion of the amalgamation on 1 January 2022.

Read more about investment performance in the financial and operational review from page 48.

Future priorities

We will ensure that an appropriate investment strategy is in place to deliver returns that do not detract from our reserving requirement.

What this means

Connect with the customer

Bonitas focuses on providing quality and affordable healthcare to meet members' evolving needs. Communication is key to engaging with members and ensuring full value for the medical aid cover purchased.

The focus of this pillar is to:

- Implement a comprehensive customer relationship management capability, including a proper system.
- Educate and engage patients to take responsibility for their health and conditions.
- Form partnerships with doctors, health practitioners and patients.
- Align brokers' efforts with those of Bonitas in the engagement of members.
- Actively promote openness and approachability.

2021 progress

Communication is key to engaging with customers and making them feel valued and safe with the cover they purchased. This requires increased resources to ensure impact and offer value in a complex high-volume transactions environment where the permutations are seemingly endless. Members expect the same sophistication from Bonitas that they experience elsewhere in a digitally enabled world.

Bonitas was named the leader in the Medical Aid Industry category of the Ask Afrika Orange Index Awards®, the most widely referenced customer experience measurement and benchmark in South Africa. This endorsed the success of our efforts to reshape the healthcare ecosystem by bringing affordable quality care to more South Africans.

It also confirmed that members received the shift to online favourably. Following lockdown conditions and the member requirement for digital engagement, interactions on our member zone show we made it simpler and more efficient for members to track health history, payments and medicine prescriptions. The Ask Africa Orange Index® research further confirmed trust is the top customer loyalty driver, followed by reputation and relationship.

Up to the end of December 2021, 55 174 people downloaded the Bonitas app, which has become the core engagement platform with members. The uptake of the WhatsApp channel has been lively, with activity peaking in June, July and August and a total of 212 462 unique WhatsApp users. Over the year we handled:

33 780 live chat interactions	**50 650** chatbot interactions	**203 820** WhatsApp agent chats	**207 821** WhatsApp bot and self-service interactions
(2020: 21 914)	**(2020: 22 223)**	**(2020: 20 149)**	**(2020: 75 427)**

These digital tools have proven to effectively engage patients to educate and empower them. The immediate nature of communication means that members can get quick feedback or answers, such as checking if a healthcare provider is part of the network and what a co-payment will be.

In 2022 we plan to connect even more with members through various touchpoints, including webinars where we address concerns, update them on current news in the medical aid industry and explain product and benefit changes.

Members support initiatives

Marketing campaigns for 2021 focused on wellness education and knowledge sharing. We partnered with the Department of Education to support teachers and provided hand sanitisers, particularly in the mining sector. High-risk patients were a priority and received targeted communication and engagement. We provided them with advice, vitamins and sanitisers.

Our Maternity Programme was a further focus area, recognising the pressure of having a baby under pandemic conditions. We reached out through member seminars and our 24/7 helpline.

Future priorities

We plan to revise the existing communication strategy to focus on all stakeholders. To improve the customer experience, we are working on enhancements to the app and other platforms. This will improve access to information and query resolution.

What this means

Integrate the value chain

Bonitas believes the key to successful value chain integration is quality inter-organisation relationships. Value chain integration inherently aspires to improve and create value continuously. Bonitas has many partnerships and relationships with service providers built over many years, creating the ideal basis for value creation.

The focus of the pillar on the integration of the value chain is to:

- Actively move away from a relationship of client and service provider based on delivery compliance to partnerships that are co-dependent and invested in the future.
- Define and achieve common future goals for these entities.
- Brand Bonitas as the future of healthcare in South Africa.

2021 progress

Long-standing partnerships and relationships with our network of service providers are one of our competitive strengths. This enables us to continually improve and integrate with other role players to create value.

We are moving to outcomes-based contracting and exploring alternative remuneration models. We also ensure that all transactional and relational aspects in the value chain conform to governance standards.

We initiated a review of the emergency services contract and extended the DENIS pilot programme into 2022.

Vouchers with added lifestyle benefits to members are evidence of innovative partnerships that continue to evolve. 1 163 Bonitas members have MedGap cover, 1 167 use Sanlam Indie cover, and 580 hold MiWay personal insurance policies.

Future priorities

To enhance our service offering to all stakeholders, we are integrating systems between all strategic service providers. This will enable further enhancements on the member app and improve I&T governance.

What this means

Create value through innovation

Healthcare innovation aims to be preventative, promotive, therapeutic and rehabilitative while focusing on new ways to provide care. It can improve efficiency, effectiveness, quality, safety and affordability. Healthcare innovation will be driven by technology for the next decade and will involve seamless processes that enable members to optimise their health and that of their dependants. Treatment and medicine will become community-based again as drones and other technology will provide integrated healthcare at local delivery points. Medical schemes will be required to build communication and delivery systems to implement these innovations.

The focus of this pillar is to:

- Issue communication that is focused on aligning providers in Bonitas's value chain as opposed to the supply and demand of the healthcare economy.
- Educate role players to balance the triangle of affordability, quality and cost efficiencies.
- Use disruptive strategies to make healthcare technology more readily available to more people.
- Actively build a future for Bonitas to be part of the NHI in South Africa.

Innovation can be segmented into three types:

1. Strategic innovation to ensure Bonitas remains sustainable and competitive in terms of affordability for members in the current economic climate. Expanding and integrating partnerships across the value chain can be a competitive advantage in purchasing power.
2. Process innovation to improve the customer experience and ensure members are educated and empowered concerning their health and wellness needs.
3. Product innovation to respond to the needs of our members.

2021 progress

Through innovative managed healthcare programmes, we help members take control of their health and enjoy a better quality of life.

For the 2021 plans, we introduced a new BonStart option, driven by technology, intelligence and innovation. For 2022 we expanded on the success of this plan by introducing BonStart Plus as a new option.

We also launched vaccination roll-out sites, starting with Roodepoort in the middle of May 2021.

We continued exploring ways to improve accessibility through telemedicine and virtual care services. E-scripting, for example, allows members to have scripts sent to a pharmacy and the medication delivered. In some pharmacy clinics, the nurse can have a video consultation with a doctor from a mobile device and get additional assistance, saving the member time and money.

A new Bonitas member app, powered by AMP, was launched. The app empowers members to take care of their health by proactively helping them to make healthier choices. It also provides access to a range of discounts and rewards through AVO.

The Bonitas website was revamped to ensure that it follows best practice in terms of user experience. This included the dedicated COVID-19 hub, which features videos, infographics and articles on managing COVID-19, recognising its symptoms and debunking myths. We introduced a live chat facility that enables members to interact with a call centre agent via text messaging and not via traditional telephone.

We produced a comprehensive guide to recovering from COVID-19 to help empower and educate our members to beat the virus.

For the first time, continuous professional development points were offered at broker engagements to ensure that we upskill financial advisers to provide our members with the best possible independent financial advice.

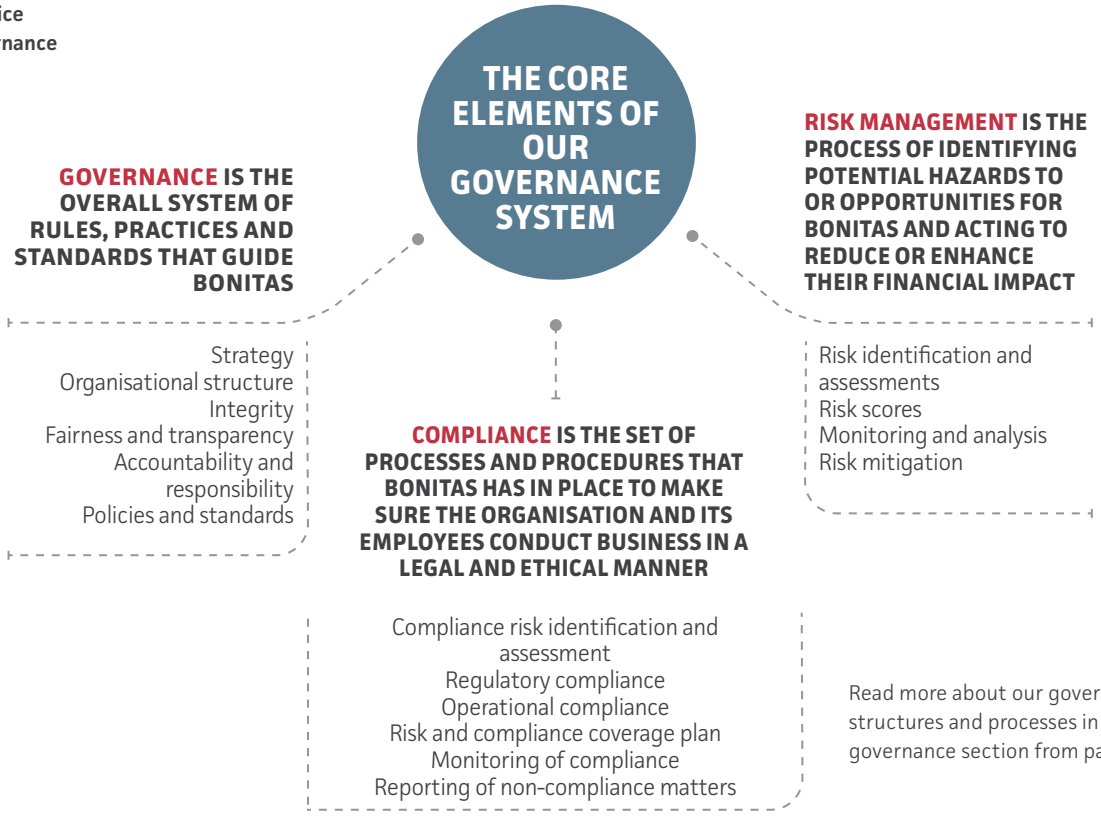
We also produced a new television campaign.

Broker portal:	Member portal:	Leads Generated:
2 426	**2 738**	**95 867**
broker registrations	member activations from website	
(2020: 228)	(2020: 7 090)	(2020: 78 057)

What this means

Bonitas has a holistic, integrated approach to organisation-wide governance, risk and compliance. This ensures that Bonitas acts ethically, correctly, and according to its risk appetite, internal policies and external regulations. It also aligns strategy, processes, technology and people, thereby improving efficiency and effectiveness.

Apply best practice governance



Read more about our governance structures and processes in the governance section from page 54.

2021 progress

Medical schemes are not-for-profit and are owned by their members. Therefore, good governance and ethical behaviour are critical to ensure Bonitas operates in members' best interests. The value of our governance structures was evident in the renegotiation of administration and healthcare contracts and the process to assess and approve the NMAS amalgamation. Read more about both processes in the Principal Officer's report from page 37.

Fraud, waste and abuse prevention

The repercussions of fraud are widespread and directly impact every Bonitas member and members of other medical schemes. When a scheme is defrauded, or money is wastefully spent, it impacts the funds available to pay claims. It also has a direct link to increased membership contributions.

FWA is one of our risk management focus areas to protect members' interests. Bonitas maintains a zero-tolerance approach to FWA.

We have an Anti-Fraud, Waste and Abuse Policy to ensure a consolidated approach in dealing with FWA while protecting Bonitas's reputation and relationships with our stakeholders, namely members, healthcare practitioners and other external parties.

The Policy's main principles are:

- Creating a culture that is intolerant to FWA.
- Awareness, detection, deterrence and prevention of FWA, which cannot be deterred.
- Investigating detected FWA.
- Taking the appropriate action in the event of FWA, e.g., disciplinary action, recovery of losses, prosecution, etc.
- Applying sanctions that include rehabilitation of identified offenders and other applicable sanctions in line with the applicable legislation.

All stakeholders with whom Bonitas interacts are expected to abide by the principles contained in the Anti-Fraud Waste and Abuse Policy. Deliberate non-compliance to this Policy resulting in fraud, waste and abuse will lead to the implementation of appropriate sanctions and the application of penalties as per the agreed SLAs on the part of the service providers.

The Bonitas FWA Forum meets monthly with the Medscheme forensics team to report and discuss operational FWA matters. Internal controls are evaluated and adjusted when needed.

We use analytical software to identify anomalies or irregularities that could indicate potential FWA and recently invested in artificial intelligence to analyse digital data.

We also invested in case management that will be implemented in 2022 to ensure that each step of the forensic process is documented, providing an auditable trail and assurance to all stakeholders. Various dashboards, automated workflows and embedded templates were designed during 2021 to support operational forensic processes.

Bonitas and Medscheme engage with service providers to drive preventative and corrective measures. These aim to change billing behaviour, leading to a decrease in healthcare costs.

This year, we started using a USSD line to verify member claims digitally. The high response rate to this initiative indicated that:

- Members want to engage based on detailed responses received and clearly want to help to resolve matters.
- Additional information obtained assisted investigations.
- Evidence collated built sufficient evidence, which increased recoveries.
- Valuable information shared by members created integration opportunities that improve members' experience.

FWA interventions are planned using a risk-based approach and incorporate the Medscheme Consortium of administered schemes. Bonitas has exposure to the majority of the providers paid in the Medscheme Consortium.

67% of the value of all Bonitas claims were submitted by practices where the forensics team intervened.

Bonitas currently has 12 active criminal cases. These cases are at various stages and are being processed at SAPS and the courts. There are several challenges to progress on cases reported to the regulatory bodies. However, we constantly engage with SAPS and the Specialised Commercial Crime Unit to provide the necessary assistance to make headway on these cases.

We initiated 5 146 interventions against healthcare practitioners from various disciplines. Bonitas applied other sanctions during the year, including reporting them to the Health Professions Council of South Africa (HPCSA) and the South African Pharmaceutical Council.

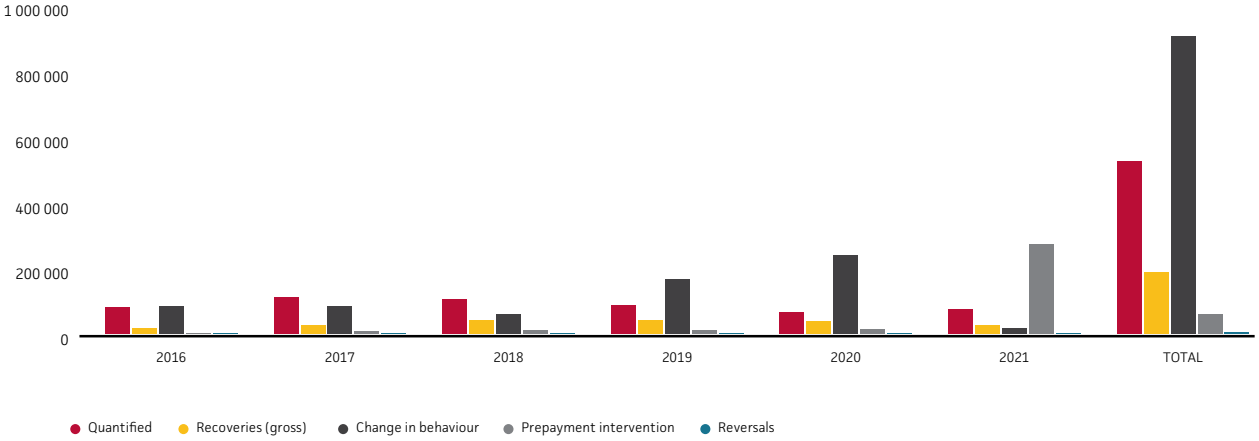
1 conviction of a healthcare practitioner	**18** civil FWA cases to the value of R19.4 million	**R524 million** quantified in FWA since 2016	**121** active cases reported to HPCSA	**450** hotline reports on FWA
(2020: 6)	**(2020: 18 cases of R19.4 million)**		**(2020: 132)**	**(2020: 370)**

In 2021, 1 478 investigations were closed with findings. As at 31 December 2021, there were 349 open investigations, 1 191 cases in recovery and 163 cases with pending existing regulatory matters or criminal sanctioning.

There are 18 open and ongoing litigation cases.

The following graph demonstrates the amounts quantified, recovered and saved because of the FWA Prevention Programme:

Fraud, waste and abuse prevention (R'000)



	2016 R'000	2017 R'000	2018 R'000	2019 R'000	2020 R'000	**2021 R'000**	TOTAL R'000
Quantified	79 559	111 612	106 208	85 881	64 920	**75 869**	524 049
Recoveries (Gross)	17 529	26 469	39 847	39 875	37 060	**26 642**	187 422
Change in behaviour	83 000	85 000	60 000	165 219	237 309	**272 710**	903 238
Prepayment intervention	729	6 521	10 942	11 338	14 216	**16 989**	60 735
Reversals	1 804	371	424	182	401	**461**	3 643

Changing the behaviour of healthcare practitioners who transgress and comparing their historical claims resulted in estimated savings of almost R903 million (calculated as the difference between the actual claims submitted against the forecasted claims over 36 months for all providers where the forensics team intervened).

POPIA implementation

Bonitas has always been committed to ethically treating members' information. POPIA now provides a legal framework and requirements for comprehensive data protection. All medical aids, including Bonitas, are legally obligated to deal with member information with far more diligence than ever before. This includes how and why information is collected, processed, shared, stored and accessed.

POPIA does not affect any member terms and conditions and only applies to how we process personal and health information. Bonitas may disclose members' personal and health information to third-party service providers when necessary to perform any service. We have agreements in place to ensure that they comply with confidentiality and privacy conditions.

Mr LR Callakoppen
Principal Officer

REPORT OF THE PRINCIPAL OFFICER

OVERVIEW

Bonitas had an exceptional start to the 2021 financial year. 28 500 new members enrolled in January 2021, and we surpassed 340 000 principal members. On top of that, 60% of new members were younger than 35.

Bonitas's performance stands out in a year that continued to reflect the pandemic conditions that characterised 2020. COVID-19 still impacted the industry as a whole, and we had to be agile and responsive to the dynamic changes in our operating landscape. However, as a Board and management, we had the advantage of learnings from the previous year to guide us when facing difficult choices. The so-called crystal ball now reflected reliable data, supported by an organisational culture and management style that had evolved over the past two years. We were all around in a better position to make confident and quick decisions in the interest of members.

What was vital for us in 2021 was to guide members as they adjusted to change. By regarding members as healthcare citizens, we are increasingly using information from across the entire supply chain, which give us the advantage of data-rich decisions that can help us help our members better. This empowers members and their families to be participants and co-producers rather than merely consumers of medical services.

This is important in South Africa, where we still have significant regulatory gaps and continued uncertainty about NHI. As a medical fund, we experience growing competition from non-medical scheme providers, with pervasive questions about the role of healthcare insurance vs medical funds. We are also all affected by a bleeding economy and struggling state-owned enterprises (SOEs) that are draining the country's finances along with the challenges to address fraud and corruption.

Regardless of these challenges, we are pleased to be one of only two medical schemes seeing membership growth in the past year. Our strategic focus on connecting with customers also ensured that we successfully retained members. By engaging and educating those that were thinking about exiting, we ensured that more people in South Africa remain secured within the private healthcare system when they need care and lessened the burden on the public healthcare sector.

We are equally proud of investment returns in a slow economy. Even measured against international yields, our positive results and effective investment strategy stood Bonitas in good stead.

At the end of the year, we improved solvency to 36.5%, which speaks to a prudent approach in managing funds on behalf of our members. Bonitas is on a sustainable footing with healthy prospects.

POSITIVE AMALGAMATION OUTCOMES

The selection of Bonitas as the preferred amalgamation partner for NMAS – a restricted membership medical scheme for Nedbank and Old Mutual Insurance employees with 25 280 principal members – was a highlight for 2021. The amalgamation followed a robust process that included membership and regulatory approvals, with NMG Consultants and Actuaries providing independent actuarial services to Bonitas. The Boards of both Bonitas and NMAS considered the actuarial review of the proposed amalgamation and agreed to proceed. Independent auditors had oversight of both schemes' voting processes, and voting results were submitted to the CMS.

The amalgamation brought new members, additional reserve funds and confirmed Bonitas as an attractive and capable amalgamation partner in an industry that continues to consolidate.

Amalgamation steps and timeline

March 2021	The NMAS employers notified the Trustees of NMAS of their intention to change the Medical Scheme Membership Policy
May 2021	The NMAS Board approved the amalgamation
July 2021	The Bonitas Board approved the amalgamation in terms of Rule 30 of the Scheme Rules
July 2021	The Exposition Document was signed in terms of Section 63 of the Medical Schemes Act 131 of 1998, as amended
August 2021	At the annual general meeting (AGM), members voted on a resolution to approve the amalgamation as per the Scheme Rules
October 2021	Approval received from the Competition Commission and Tribunal
November 2021	CMS approval received
January 2022	Amalgamation effective, membership activated, and reserve funds transferred

The Board recommended the amalgamation because it increased Bonitas's membership base without adversely impacting the average age profile or pensioner ratio. It also strengthened Bonitas's solvency position.

The amalgamation is the first of its kind in that NMAS members were given a split-risk choice. Five criteria were used in selecting the preferred amalgamation partner:

- Sustainability of benefits without the need for unusually high contribution increases.
- Value-for-money and benefit fit.
- Ease of take-on.
- Future underwriting, including the treatment of new and transferring members and family post-amalgamation.
- Brand impact on how members will perceive the scheme.

Bonitas scored highest and was thus recommended as the amalgamation partner, with Medscheme acting as administrator for both NMAS and Bonitas.

Bonitas's ability to meet regulatory hurdles according to the amalgamation timeline speaks volumes about our due diligence capability and the new partners' confidence in completing an amalgamation of such size.

MEMBERSHIP GROWTH AND HEALTHCARE PLANS

Following the amalgamation, membership grew to 354 342, including organic membership growth and retention outcomes.

We pride ourselves on the Bonitas plans, which offer options to suit everyone based on their income, family size and health support requirements. We reviewed and adjusted our 2022 plans, using reserves to keep contribution increases lower. We introduced a Benefit Booster to stretch day-to-day benefits, revised the international travel benefit with payment for COVID-19 tests, and contributed to quarantine costs. We included a renewed focus on preventative care, virtual consultations and plans that enable more South Africans to access affordable, quality healthcare.

We offer a total of 15 benefit plans as of 1 January 2022 that suit a range of members' healthcare needs. Further innovations included:

- We introduced a new Edge option, called BonStart Plus.
- We introduced a new Oncology Management Programme, known as the Bonitas Oncology Network, in partnership with the South African Oncology Consortium, to improve the coordination of care.
- We launched a new electronic DBC app for our Back and Neck Programme, allowing the accessibility of home-based care to members on all options.

We commission an actuarial analysis that considers macroeconomic factors and affordability when reviewing our plans annually. The Board and committees made a conscious decision to ensure contributions are kept at the lowest possible rate without cutting member benefits. The average weighted contribution increase across all plans was 4.8%. The BonStart premium decreased by 7.9% – an industry-first based on a low cost-benefit ratio and younger membership profile.

In designing our plans, we were also mindful not to confuse members used to the traditional model built around annual contribution increases. This contrasts with other medical schemes that adopted a new model deferring increases, creating member uncertainty around planning, contributions and benefits management.

We remain committed to ensuring members are at the centre of all decisions while balancing cost with quality healthcare. We have been engaging with all service providers to up their game in customer experience and service. Our progress and success in serving members were validated by Bonitas being named the leader in the Medical Aid Industry category of the Ask Afrika Orange Index Awards® in 2021, ahead of two shortlisted competitors, Discovery and Bestmed.

We continue to respond to members' needs. Over the past two years, we have seen an increase in the importance of home-based care. Therefore, we partnered with Quro Medical to offer members who need acute level care the opportunity to receive this care in their homes rather than in a hospital. The Hospital-at-Home care delivery model is known to improve outcomes and enhance the patient experience.

We also launched the new personalised wellness and lifestyle programme, available on the Bonitas app. It allows members to access their health information digitally. In addition, through a partnership with AVO, members can enjoy great lifestyle benefits and deals.

COVID-19

With COVID-19 entrenched in our daily lives, our focus in 2021 was on vaccination. Although we respect the individual rights of members that choose not to be vaccinated, admissions data shows that people who received the vaccine had a better chance of dealing with the virus once infected. Those individuals had a better recovery rate, reduced mortality and lower intensive care unit (ICU) cases.

Wave three and four only	Not vaccinated**	Partially vaccinated	Fully vaccinated
Beneficiaries currently* hospitalised in a General Ward for Covid-19	65.1 in 100	14 in 100	20.9 in 100
Beneficiaries currently* hospitalised in a High Care or ICU ward for Covid-19	137.5 in 200	0 in 200	62.5 in 200
COVID-19 in-hospital deaths	869 per 1 000	98 per 1 000	33 per 1 000

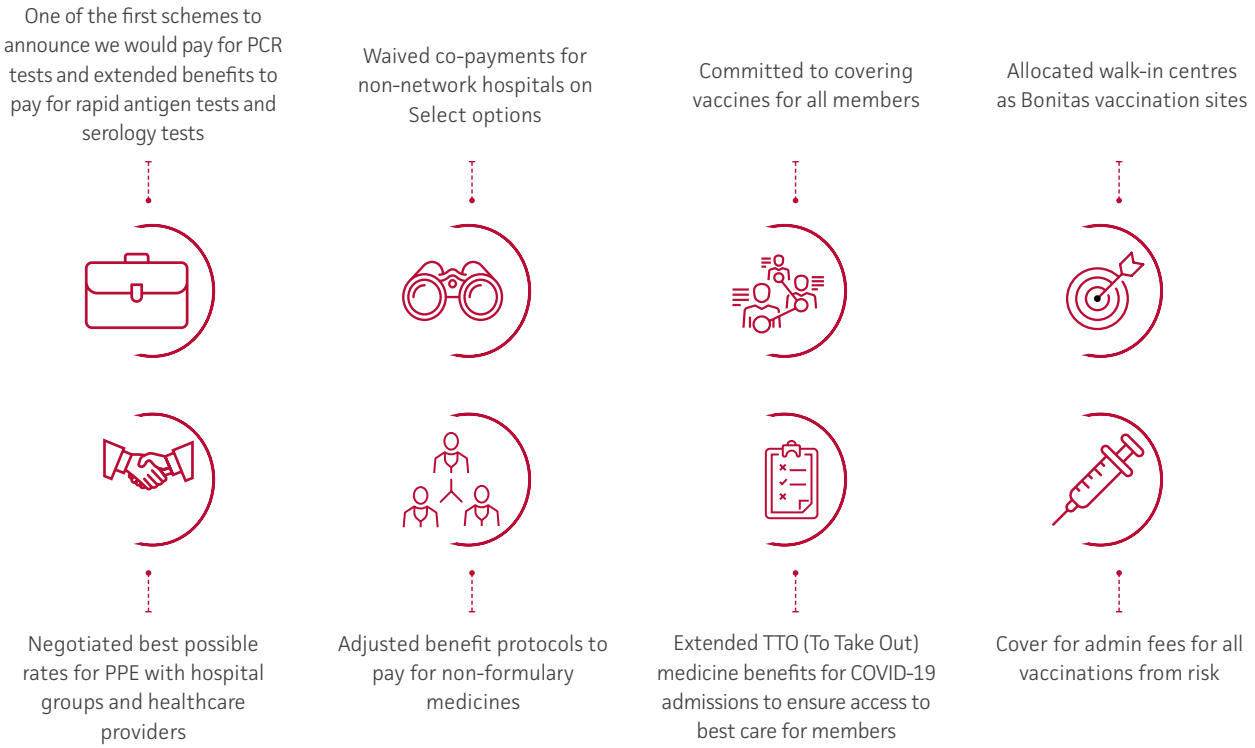
* *As at 14 March 2022.*

** *A proportion of beneficiaries in the "Not vaccinated" group may have been vaccinated, but we have not received their vaccination claim.*

Note: *The table above incorporates a broader definition for COVID-19 admissions.*

Bonitas offered vaccinations at seven operational sites and major scheme employer sites, such as Eskom. We also continuously updated the information and COVID-19 guidance on the online hub. This assisted South Africans under the National State of Disaster to still look after their health, for example, through our courier pharmacy network. Participating members had access to medicine without stepping out of their homes.

The diagram below illustrates Bonitas's proactive approach to COVID-19:



We needed to navigate other aspects of the pandemic, including increasing mental health issues and patients' deteriorating compliance with treatment regimes. Virtual care and engagements with doctors and our pharmacy courier service helped members look after their health.

Injury and trauma admission increased to the highest level since the start of the pandemic, with elective procedures approaching pre-COVID-19 levels. It is also interesting to note that the number of lives admitted to hospitals was substantially less than the pre-COVID-19 period, but costs were much higher due to the increased length of stay.

HEALTHCARE FOR ALL

Bonitas unequivocally supports the principles of universal healthcare as a fundamental, constitutional right. We made a written submission to the National Assembly's portfolio committee on health in the past year, responding to the draft NHI Bill. Our feedback highlighted the need for coverage that will be sustainable and address the risks and uncertainties in the current proposal. We requested clarity on benefit structures and the role of medical schemes. One of our primary concerns is the governance structure for managing a fund of that size, particularly given the current challenges in South Africa around corruption and fraud. It is important that there is a duality of accountability in NHI structures and that these are transparent and accountability clearly allocated.

Bonitas strongly supports healthcare reform that will address cost and quality while making healthcare widely accessible beyond the nine million people participating in medical aids. This is critical as we consider increasing warnings from the World Health Organisation and government about the growing burden of disease globally. Bonitas is tracking data related to this risk and actively taking learnings from our plans and managed care programmes that are performing well to address other areas of growing health concern.

This year, we developed an outcomes-based disease management roadmap that goes well beyond the traditional, transactional approach that uses predictive modelling data to identify high-risk beneficiaries.

An outcomes-based example is a new diabetes disease management system launched in October 2021. Early reports are pleasing and support our belief that better disease control can decrease hospital admissions and improve member experience, resulting in cost savings and a better return on investment.

We applied the same outcomes-based approach in negotiating new contracts this year.

CONTRACT RENEWALS AND NEW PARTNERSHIPS

Services for healthcare and administration are Bonitas's most significant contracts in terms of value and impact. Therefore, it is critical to follow a robust and well-governed review process and ensure that SLAs are fit for purpose, aligned to current operating processes and beneficiary needs. We also had to ensure that agreed outcomes were aligned with our strategy.

The Board had oversight of the procurement process and had specific expectations in terms of the value to be realised based on the relevant outcomes and services to be included. Costs were benchmarked against what would be fair and reasonable, with specific oversight from the Audit and Risk Committee. The process was also independently audited to ensure that members' interests were protected.

We signed a new five-year contract with Medscheme as administrator and managed care service provider, with the understanding that the contract can be terminated at any given stage. The contract contains financial penalties for performance failure, and Bonitas reserves the right to renegotiate unless value for money can be demonstrated.

A medical scheme of the size of Bonitas has to consider significant risks and unintended consequences in changing service providers, and we also recognise that we do not have many alternative service provider options in South Africa.

This year Bonitas was also approached by Sanlam to provide their clients with a more integrated offering in healthcare and insurance. This means that Sanlam's strong and wide distribution network of brokers will offer Bonitas plans, particularly for corporates. This is a mutually beneficial partnership that will widen access to private healthcare to all South Africans and alleviate the burden on the public sector.

GOVERNANCE AND CONTROLS

Our progress in maturing the governance and oversight structures for Bonitas shines the light in an ethics context where South Africa is facing low trust and confidence. This year we focused on improvements in areas such as I&T governance, with the emphasis on cyber security and cyber risk management. We made steady progress in implementing a comprehensive I&T Governance Framework to protect members' funds and data.

Our combined assurance structures continue to provide the Board and management with the comfort that risks and compliance requirements are identified, managed and monitored. These include initiatives to prevent FWA, a threat to our sustainability and member affordability. Without effective intervention and investigation, FWA could result in more people leaving medical schemes, thereby increasing the burden on the public healthcare system.

OUR HUMAN CAPITAL

We take pride in the discipline of continuous development among our Trustees and members of Senior Management. All completed the Trustee Development Programme presented by the BHF and Wits Business School. Their certificates confirm their competency in managing a scheme of our size effectively.

We made a key appointment this year. Dr Morgan Busuku Mkhatshwa, a medical doctor with extensive experience in the healthcare sector, was appointed as Head of Operations. He previously led organisational restructuring efforts within highly unionised environments, launched accelerated business expansion and improvement initiatives to maximise revenue growth. We are already benefiting from his contributions and expertise.

IMPLEMENTING A BALANCED STRATEGY

As we implement our five core strategic pillars, the importance of proactive disease management is becoming evident. We are redefining healthcare. By getting involved earlier and playing a more active role, we can help members become healthcare citizens and contribute to better outcomes for all. We want to balance prevention with treatment and not only focus on sick care. By adopting this shift, we also position Bonitas as a strong supporter of universal healthcare, working with all stakeholders towards a better and more affordable healthcare outcome for all. Read more about progress per pillar from page 27.

OUTLOOK FOR 2022

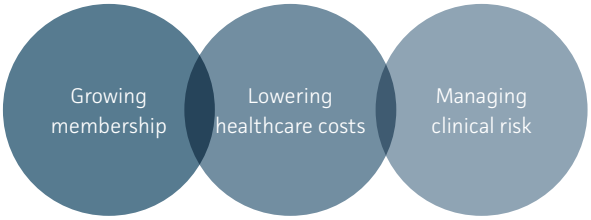
We expect the pandemic challenges to remain, whether in new waves or new variants. The potential impact is unsure, but we remain committed to promoting vaccination as an effective countermeasure. We are confident that Bonitas will continue growing membership and fostering retention, retaining the momentum gained over the past two years. However, we are mindful of the macroeconomic factors that still stifle consumer spending.

In terms of regulatory reform, we look forward to positive change that will ensure the Scheme's sustainability while meeting members' needs and making quality healthcare more affordable and more accessible to more South Africans.

Mr LR Callakoppen
Principal Officer

19 April 2022

Bonitas wants a future that makes our total population healthier by:



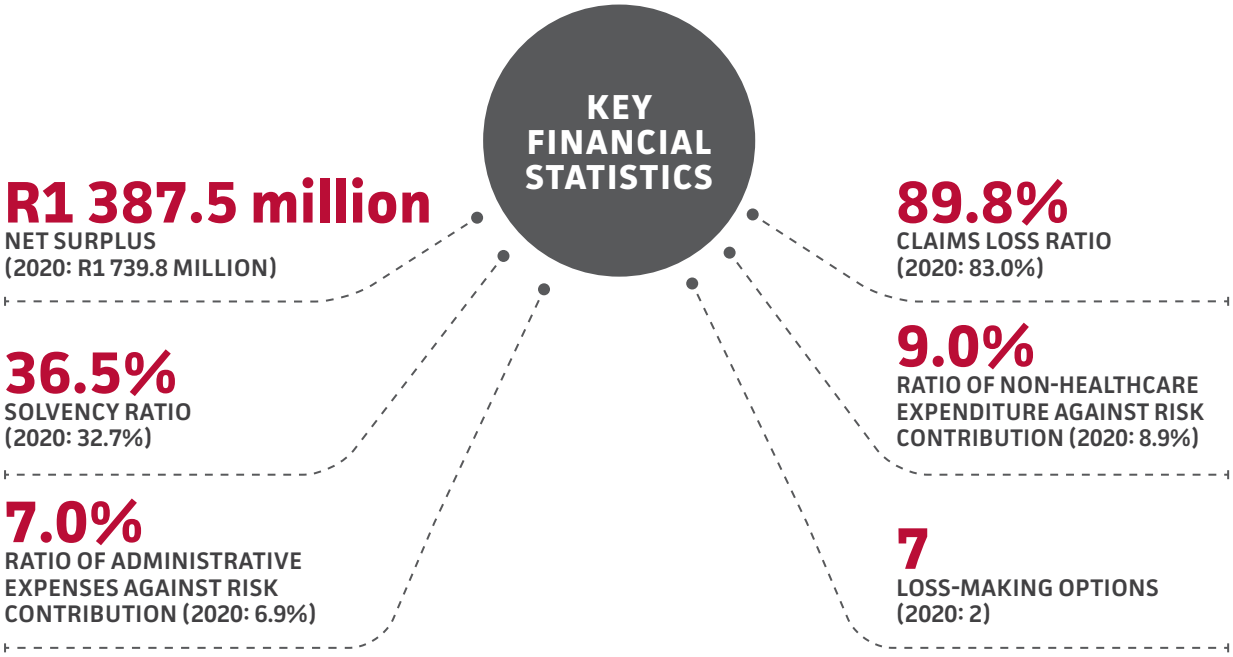
Thereby improving the quality of care for our members in a way that delivers positive wellness outcomes for more South Africans.

Mr L Woodhouse
Chief Financial Officer

FINANCIAL AND OPERATIONAL RESULTS

DRIVERS FOR FINANCIAL HEALTH

Membership growth and contributions	We met our growth target with membership exceeding 340 000 for the first time
Investment performance	Excellent yields, with our equity strategy and investment in bonds paying off
Claims trends	Higher claims, with an anticipated uptake in elective surgeries post-lockdown
Cost-saving initiatives	Significant savings impact following the collective hospital tariff negotiations in 2020
Fraud, waste and abuse	Lower recoveries due to the claims mix featuring reduced specialist compared to hospital claims
Reserves	Members funds remain healthy, enabling Bonitas to limit member contribution increases



OVERVIEW

Bonitas outperformed all expectations this year and did so in terms of most of its key indicators. Membership growth, investment performance and healthy reserves should put the minds of all members at ease, despite the pervasive uncertainty and loss caused by the COVID-19 pandemic. Strong investment performance boosted reserves, and the new Sanlam partnership puts us in a strong competitive position to gain new corporate members in the short to medium term which is vital to Bonitas's long-term sustainability.

The financial year was not without challenges. For example, COVID-19 expenditure totaled R2.6 billion. Given the significant build-up of reserves in 2020 and the challenging economic circumstances facing our members, Bonitas set historically low premium increases in 2021. Consequently we anticipated having a large number of options producing deficits. However, through focused managed care strategies we were able to reduce the projected number of loss-making options from 9 (budgeted) to 7.

The CMS defines loss-making options as those reflecting a loss in net healthcare result, which means that investment income is excluded. If we had to include investment income, almost all options would have been surplus generating. Our challenge is to reduce loss-making options while remaining competitive and ensuring members have an optimum range of plans to choose from.

FWA abuse recoveries were lower this year. This is to some extent attributable to uncertainties around the ongoing Section 59 investigation. With the administration contract renewal in 2021, we reassessed our options and elected to consolidate all services related to FWA, including profiling, analytics, prosecution and investigations. From 1 June 2021, these services were all provided by Medscheme, with a better return on investment anticipated and a significantly improved target in recoveries as a result of synergies gained across the service offerings.

We recognised that lower levels of FWA were also associated with a change in the nature of claims during COVID-19, with a decrease in the use of specialists and out-of-hospital claims.

Despite an overall strong financial year for Bonitas, we acknowledge that it was also a year of hardship, with members passing away, families dealing with loss and many people suffering from COVID-19 under challenging conditions.

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2021

	Notes	2021 R'000	2020 R'000
Risk contribution income	13	**18 138 159**	17 797 746
Relevant healthcare expenditure	14	**(16 289 636)**	(14 771 240)
Net claims incurred	14	**(15 851 053)**	(14 346 005)
Risk claims incurred		**(15 913 500)**	(14 405 261)
Third party claim recoveries		**62 447**	59 256
Accredited managed healthcare services	14	**(549 251)**	(551 530)
Net income on risk transfer arrangements	14	**110 668**	126 295
Risk transfer arrangement fees/premiums paid		**(1 531 348)**	(1 360 518)
Recoveries from risk transfer arrangements		**1 642 016**	1 486 813
Gross healthcare result		**1 848 523**	3 026 506
Broker service fees		**(360 620)**	(334 827)
Administrative expenditure	15	**(1 276 920)**	(1 221 891)
Net impairment losses on healthcare receivables	16	**(63)**	(20 281)
Net healthcare result		**210 920**	1 449 507
Other income		**1 243 833**	347 039
Investment income – Scheme	17	**1 221 652**	316 606
Change in fair value of investment property	17	**(700)**	2 900
Sundry income	18	**22 881**	27 533
Other expenditure		**(67 262)**	(56 785)
Asset management fees		**(38 675)**	(21 597)
Interest expense	11/4.2	**(24 010)**	(29 509)
Operating expenses on rental of investment property		**(4 577)**	(5 679)
Surplus for the year		**1 387 491**	1 739 761
Total comprehensive income for the year		**1 387 491**	1 739 761

MEMBERSHIP AND RISK CONTRIBUTION INCOME

Membership growth and retention are the cornerstones of Bonitas's long term sustainability and short-term performance. With good support from ADS, we had 51 396 new members joining Bonitas and retained 45.39% of controllable terminations against a target of 25%. 44 418 members terminated their membership, compared to 43 424 in 2020.

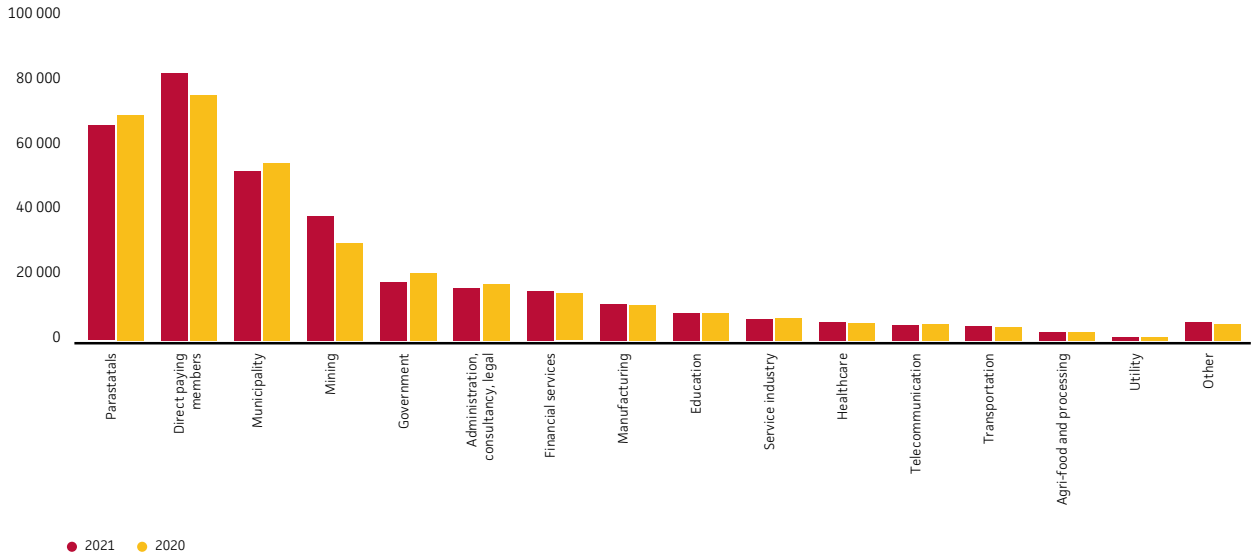
Risk contribution income increased by 1.9% to R18.1 billion (2020: R17.8 billion). Of the total lives covered by Bonitas, 10.3% (2020: 10.2%) were 65 years and older. The total number of beneficiaries decreased by 276 (2020: 12 786). Although our principal membership grew by 2.1%, our total beneficiaries (lives covered) remained stable. This is largely as a result of affordability challenges which placed financial pressure on members to maintain higher dependant ratios.

The buying down trend slowed compared to the prior year with 6 629 (2020: 10 323) members moving to lower-cost options and 4 459 (2020: 5 366) members moving to higher-cost options for the period January to December 2021.

14 585 of the 25 280 NMAS members joined Bonitas after the amalgamation. The latter positions Bonitas as a serious competitor in the conventional white-collar corporate segment and builds on our success in attracting new corporate groups seeking split risk options and amalgamations.

The new Sanlam partnership will also contribute to membership growth in the coming year, with targets set and training underway. We are starting out using an aggregator model involving a healthcare brokerage to ensure that Sanlam's vast broker network has time to obtain full accreditation for medical aid products. This model builds on the successes achieved via the Hippo and Medquote platforms. 56 new members have joined Bonitas through the Sanlam network since October 2021.

Membership distribution by industry



Plan pricing and affordability

Evaluating, developing, and pricing our annual range of healthcare plans is a core capability and critical for Bonitas's sustainability while ensuring affordability for members. We follow a rigorous process that includes broker feedback and market value analyses.

Due to the high surplus generated in 2020, we could use reserves to keep contribution increases lower. The strategic decision to use about R600 million of reserves ensured that 82% of members received a contribution increase below CPI for the 2022 benefit year. The Benefit Booster further equated to an increase in day-to-day benefits for members ranging from 16% to 32%, depending on the member's plan. The average weighted contribution increase across all plans was 4.8%.

Full-year claims for 2021 are projected	We start the process with a view of the actual 2021 year-to-date claims and then use a combination of historic claims, seasonability and budgeted claims to forecast claims cost for the rest of the year.
A claims estimation for 2022 is done	When we estimate claims for 2022, we consider the member profile, COVID-19 statistics, general utilisation trends, benefit changes, managed care interventions and work with inflationary service provider tariff increases.
Capitation fees are estimated for 2022	The capitation fee estimation is done based on providers' proposals after making allowances for benefit changes, if any.
Other expenses and income are included	Expenses, which include administration, managed healthcare fees, broker commissions and overheads, as well as other sources of income such as investment returns, are calculated.
Contribution increases for 2022 are set	To determine the final contribution increase, we consider expected membership growth to achieve an optimum balance between financial sustainability (measured by surplus and solvency at the end of the year) against member affordability and competitiveness.

HEALTHCARE EXPENDITURE

Claims trends

South Africa grappled with three COVID-19 waves in 2021, resulting in claims patterns that stood in stark contrast to 2020 and prior years. We commenced the financial year in the peak of the second wave, which saw a much higher COVID-19 hospital burden than the first wave in July 2020. During the second wave, the level of non-COVID healthcare utilisation dropped significantly relative to pre-COVID levels.

Healthcare utilisation started returning to typical levels from around March 2021, but the increasing rate of positive COVID-19 tests during April and May 2021 again resulted in reduced uptake of non-COVID healthcare services.

In May 2021 the roll-out of COVID-19 vaccinations commenced and Bonitas beneficiaries over the age of 60 were eligible to receive their first dose.

With the third wave in June and July 2021, a higher percentage of positive COVID-19 cases and hospital events were recorded due to the higher transmissibility of the Delta variant. The third wave also had a longer tail and, as a result, Bonitas saw high levels of COVID-19 hospital costs into August 2021, while non-COVID healthcare utilisation remained suppressed. The vaccination roll-out remained a top priority to protect members.

From September 2021 onwards, more typical healthcare levels were evident as the third wave came to an end. Many Bonitas members received their second COVID-19 vaccine during this time.

The combination of vaccination, natural immunity and a milder variant, saw a much milder fourth wave in December 2021. Claims patterns were therefore not altered to the same degree as during previous waves.

Overall, net claims were 4.4% and 9% higher per member per month than in 2019 and 2020 respectively. Claims included COVID-19 costs of R2.6 billion (2020: R974.7 million).

Net claims increased by 10.5% to R15.9 billion (2020: R14.3 billion) and were impacted by factors such as testing and treating COVID-19 patients, COVID-19 vaccines, as well as the levels of medical care utilisation in a post-lockdown environment. As expected, claims for elective surgeries that were postponed earlier in the pandemic, picked up.

Hospital costs dominated claims, reaching R6.45 billion, up 9.52% against 2020. COVID-19 admissions contributed to high costs, with the average cost of admission to ICU per patient at R475 371. This stands in stark contrast to the total predicted cost of vaccinations at R226.5 million, which is still our best defence against the pandemic. There is no doubt that vaccinations save lives and reduce the burden on the public healthcare system while saving members significant costs related to treating COVID-19.

The net claims ratio for the year ended on 89.8% (2020: 83.0%). Excluding COVID-19 costs, the ratio was 75.7% (2020: 76.3%) compared with 92.3% in 2019. Claims ratios are now approaching pre COVID-19 levels, and we expect it to increase beyond 94% in 2022.

Cost management interventions

Costs incurred by accredited managed healthcare services decreased by 0.4% (2020: 6.6%) as part of Bonitas's strategic investment in long-term prevention. Through a rigorous contract negotiation process, managed care fee increases were reduced to below reported inflation figures over the same financial period.

Managed care initiatives realised an estimated reduction in healthcare cost of R487 million (2020: R221 million). The most significant impact is a forecasted R197.8 million saving that resulted from the collective bargaining hospital pricing strategy initiated last year, leading to reduced hospital tariff increases.

Active Disease Risk Management (ADRM)

Through ADRM, coordinated healthcare interventions are targeted according to risk. Beneficiaries with chronic diseases are encouraged to register for the applicable chronic programme to receive ongoing coaching and support. High-intensity interventions are reserved for those beneficiaries where they will have the most significant healthcare impact. We can manage healthcare spending through interventions, based on predictive modelling.

We focus on outcomes-based frameworks to improve clinical outcomes, reduce admissions and readmissions and improve medicine adherence. These interventions achieved savings in excess of R14 million.

Alternatives to hospitalisation

In many instances, members do not need treatment in an acute facility but could, for example, receive the equivalent care, quality and health/clinical outcomes in a less costly rehab facility or day clinic. We engage with members and providers pre-admission to consider options, including home care. If the person has already been admitted to an acute hospital, the case management team negotiates transfer out of hospital as soon as they are clinically stable, with homecare support. These alternatives to hospitalisation delivered savings of R9.5 million.

Other interventions for quality and affordability

- We established a designated service provider network for alcohol and drug treatment and rehabilitation, focusing on optimising costs, coding and length of stay. We introduced bundled fees and quality of care by managing appropriately licensed facilities with qualified multi-disciplinary practitioners.
- We implemented a conservative back and neck care pathway and a managed care pathway for elective surgery patients. By using therapy, exercise, and pain management, we can effectively delay or alleviate the need for surgical intervention.
- We implemented a formulary, medicine procurement, palliative care, and an oncology care pathway for oncology patients. Beneficiaries are registered in line with their stage of disease, concomitant radiotherapy, age and metastases. This ensures cost-effective, evidence-based quality treatment across the oncology value chain.

The gross healthcare result at R1.85 billion showed a 39% decrease compared to 2020, mainly due to increased claims utilisation.

NON-HEALTHCARE EXPENSES

Administration expenses comprise operational expenses and the administration fee paid to Medscheme. Bonitas successfully managed these expenses at a level below market averages. Bonitas aims to maintain the non-healthcare expenditure as a percentage of risk contribution income at 9% or below, with 9% reported for this year. Administrator fees increased by 3.9% to R910 million (2020: R876 million) despite membership growth of 2.1%. As with managed care, the contract negotiation with Medscheme also delivered lower fees, with below CPI increases agreed. Broker fees increased by 7.7% to R360.6 million, and overhead expenses increased by 6.6%. The latter included amalgamation costs as well as marketing spend, which was slightly lower than last year.

STATEMENT OF FINANCIAL POSITION

AT 31 DECEMBER 2021

	Notes	**2021 R'000**	2020 R'000
ASSETS			
Property and equipment	4	**4 231**	9 125
Investment properties	5	**77 000**	77 700
Financial assets held at fair value through profit or loss	6	**4 784 072**	4 279 785
Non-current assets		**4 865 303**	4 366 610
Financial assets held at fair value through profit or loss	6	**3 461 898**	2 859 688
Insurance, trade and other receivables	8	**706 417**	719 066
Cash and cash equivalents	9	**766 465**	611 090
Current assets		**4 934 780**	4 189 844
Total assets		**9 800 083**	8 556 454
MEMBERS' FUNDS AND LIABILITIES			
Accumulated funds		**7 447 331**	6 059 840
Members' funds		**7 447 331**	6 059 840
Lease liability	4.2	**–**	3 047
Non-current liabilities		**–**	3 047
Outstanding risk claims provision	10	**904 350**	976 275
Personal medical savings accounts liability	11.1	**894 037**	812 078
Insurance, trade and other payables	12	**551 318**	669 731
Lease liability	4.2	**3 047**	3 605
Derivative financial instruments	7	**–**	31 878
Current liabilities		**2 352 752**	2 493 567
Total Members' funds and liabilities		**9 800 083**	8 556 454

SURPLUS

Bonitas reported another healthy surplus of R1.39 billion (2020: R1.74 billion), slightly lower than last year. The surplus was positively impacted by solid investment performance, the effective implementation of our strategic pillars, proactive risk management and prudent Board decisions. The NMAS amalgamation, which occurred on 1 January 2022, contributed a further R613 million to reserves following the transfer on 1 January 2022.

Bonitas's medium-term objective is to sustain solvency levels above 30% and to use our bolstered reserves to benefit our members, for example by limiting annual contribution increases and enhancing benefits.

INVESTMENT PERFORMANCE

2021 delivered record yields on Bonitas's investments. This was partly due to strong market performance, but also as a result of our asset managers outperforming their benchmark indices. The strategic asset allocation approach continues to pay off and is bolstering growth in the investment portfolio.

Investment market value

Bonitas reported an average return of 16.2% (2020: 4.16%) on its investment portfolio, well above target. We continued to track performance closely to determine the best strategic asset allocation for our investments. This included repurchasing equity at low values to achieve parity and implementing tactical changes to maximise opportunities. Unlike many other entities, we remained committed to our long-term investment strategy and did not opt for cash havens with short-term yields during times of uncertainty.

The market value of Bonitas's investment portfolio, excluding cash and cash equivalents was R8.32 billion at 31 December 2021 (2020: R7.22 billion), representing growth of 15%. Bonitas also used derivatives during 2021 to hedge against high levels of volatility in equity markets.

SOLVENCY RATIO

	2021 R'000	2020 R'000
Members' funds per the statement of financial position	**7 447 331**	6 059 840
Adjusted for:		
Regulation 29 exclusion of unrealised gains on remeasurement of investments and investment property to fair value*	**(558 986)**	(4 926)
Accumulated funds per Regulation 29	**6 888 345**	6 054 914
Gross contributions (note 13)	**18 887 490**	18 540 546
Solvency ratio (%)	**36.47%**	32.66%
** Cumulative net (losses)/gains on remeasurement to fair value of investments are calculated as follows:*		
At beginning of year	**(15 548)**	(35 076)
Net gains on remeasurement to fair value of financial instruments included in accumulated funds	**554 760**	19 528
At end of year	**539 212**	(15 548)
# Cumulative net gains on remeasurement to fair value of investment properties are calculated as follows:		
At beginning of year	**20 474**	17 574
Movement in unrealised gains on remeasurement to fair value of investment properties included in accumulated funds	**(700)**	2 900
At end of year	**19 774**	20 474
Cumulative net gains on remeasurement of investments and investment property at the end of the year	**558 986**	4 926

Cumulative net unrealised losses on remeasurement to fair value of investments and investment properties are excluded from the solvency calculation according to Regulation 29.

Bonitas's solvency ratio increased to 36.5% (2020: 32.7%). Our reserves remain healthy and significantly higher than the regulatory requirement of 25%. This is a good indication of fiscal stability and our continued ability to meet short and long term liabilities, including any uncertain events that may have a significant future financial impact.

OUTSTANDING CLAIMS PROVISION

The outstanding claims reserve for 2021 is R904.3 million (2020: R976.3 million), which represents 5.55% of relevant healthcare expenditure. Provisions have mainly been in the hospital, medical specialists, and pathology claims categories.

ACTUARIAL VALUATION

The independent actuary reports monthly to Bonitas on the risk status and performs an annual actuarial evaluation. Contributions and benefit levels are redesigned based on the actuary's recommendations.

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES

FOR THE YEAR ENDED 31 DECEMBER 2021

R'000	Accumulated funds R'000	Total R'000
Balance as at 31 December 2019	**4 320 079**	**4 320 079**
Total comprehensive income	**1 739 761**	**1 739 761**
Surplus for the year	**1 739 761**	**1 739 761**
Balance as at 31 December 2020	**6 059 840**	**6 059 840**
Total comprehensive income	**1 387 491**	**1 387 491**
Surplus for the year	**1 387 491**	**1 387 491**
Balance as at 31 December 2021	**7 447 331**	**7 447 331**

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2021

	Notes	**2021 R'000**	2020 R'000
Cash flows from operating activities			
Cash receipts from members and providers		**18 911 597**	18 613 087
Cash receipts from members – contribution		**18 800 873**	18 605 914
Cash receipts from members and provider – Other		**110 724**	7 173
Cash paid to providers, employees and members		**(18 773 017)**	(16 777 554)
Cash paid to providers and employees – claims		**(17 075 960)**	(15 170 531)
Cash paid to providers and employees – non healthcare expenditure		**(1 641 144)**	(1 550 092)
Cash paid to members – savings plan refunds	11	**(55 913)**	(56 931)
Cash generated by operating activities		**138 580**	1 835 533
Interest paid	11	**(23 606)**	(28 628)
Interest received	17	**4 661**	4 646
Net cash inflow from operating activities		**119 635**	1 811 551
Cash flows from investing activities			
Acquisition of property and equipment	4	**(103)**	(818)
Proceeds on disposal of property and equipment		**4**	4
Settlement of derivative financial instruments	7	**(86 373)**	–
Acquisition of financial assets held at fair value through profit or loss	6	**(1 009 999)**	(2 509 037)
Disposal of financial assets held at fair value through profit or loss	6	**842 104**	497 357
Interest received	20.1.1	**192 641**	145 492
Dividends received	20.1.2	**128 546**	68 526
Asset management fees	20.1.3	**(36 766)**	(19 914)
Rentals received	20.1.4	**9 695**	8 498
Net cash inflow/(outflow) from investing activities		**39 749**	(1 809 892)
Cashflows from financing activities			
Lease payments	4.2	**(4 009)**	(3 609)
Net cash outflow from financing activities		**(4 009)**	(3 609)
Net increase/(decrease) in cash and cash equivalents		**155 375**	(1 950)
Cash and cash equivalents at beginning of the year		**611 090**	613 040
Cash and cash equivalents at end of the year		**766 465**	611 090
Analysed as follows:			
Cash and cash equivalents	9	**766 465**	611 090
		766 465	611 090

The prior year amounts for the cash generated by operating activities have been reclassified based on the Direct method, for consistency with the current year presentation. The reclassification had no effect on the reported results of the total operating activities.

OUTLOOK

This year, Bonitas's performance exceeded expectations in terms of solvency and surplus. Hence, we endeavour to continue with competitive member contribution increases while finding innovative ways and means to improve benefits. Ultimately, we believe in giving back some of the reserves that we have built up over the last two years.

We are also focused on addressing the loss-making options and look forward to the recommendations from the loss-making options steering committee tasked with a turnaround. We established three-year financial targets, specifically for the BonCap, Primary Select and Standard Select plans. We recognise that there are always losses to absorb, as this is the nature of a medical fund. However, any cross-subsidising between plans must be acceptable relative to the overall sustainability of Bonitas.

The successful completion of the NMAS amalgamation on 1 January 2022 resulted in Bonitas acquiring R613 million of reserves from NMAS. These reserves bolstered Bonitas's solvency by approximately 1.7% in January 2022 and will assist in mitigating long-term healthcare risks associated with the 14 585 NMAS members who joined the Bonitas family.

Our intent remains to provide accessible and affordable healthcare to even more South Africans in 2022. We want to ensure a wider Bonitas family enjoys the peace of mind that comes from being protected by people who care.

Mr L Woodhouse
Chief Financial Officer

19 April 2022

OPERATIONAL STATISTICS

Bonitas Medical Fund 2021	**Consolidated total**	**Standard**	**Bon-Save**
Average number of members during the year (n)	**340 138**	**109 448**	**35 748**
Number of members at 31 December (n)	**340 119**	**107 173**	**35 618**
Average number of beneficiaries during the year (n)	**712 759**	**238 038**	**83 516**
Number of beneficiaries at 31 December (n)	**709 881**	**232 592**	**83 362**
Proportion of dependants at end of the year (n)	**1.09**	**1.17**	**1.34**
Risk contributions per average member per month (R)	**4 444**	**6 303**	**3 718**
Risk contributions per average beneficiary per month (R)	**2 121**	**2 898**	**1 591**
Healthcare expenditure per average beneficiary per month (R)	**1 905**	**2 537**	**1 359**
Non-healthcare expenditure per average beneficiary per month (R)	**191**	**209**	**191**
Relevant healthcare expenditure as a percentage of gross contributions (%)	**86.2**	**87.5**	**68.9**
Relevant healthcare expenditure as a percentage of risk contributions (%)	**89.8**	**87.5**	**85.4**
Non-healthcare expenditure as a percentage of gross contributions (%)	**8.7**	**7.2**	**9.7**
Average beneficiary age (n)	**35**	**38**	**31**
Pensioner ratio at 31 December (%)	**10.3**	**13.7**	**6.8**
Chronic profile at 31 December (%)	**18.7**	**27.2**	**13.6**

Bonitas Medical Fund 2020	Consolidated total	Standard	Bon-Save
Average number of members during the year (n)	335 425	116 755	35 843
Number of members at 31 December (n)	333 141	114 297	35 548
Average number of beneficiaries during the year (n)	714 989	256 016	83 595
Number of beneficiaries at 31 December (n)	710 157	250 255	83 150
Proportion of dependants at end of the year (n)	1.13	1.19	1.34
Risk contributions per average member per month (R)	4 422	6 085	3 553
Risk contributions per average beneficiary per month (R)	2 074	2 775	1 523
Healthcare expenditure per average beneficiary per month (R)	1 722	2 261	1 195
Non-healthcare expenditure per average beneficiary per month (R)	184	196	185
Relevant healthcare expenditure as a percentage of gross contributions (%)	79.7	81.5	63.3
Relevant healthcare expenditure as a percentage of risk contributions (%)	83.0	81.5	78.5
Non-healthcare expenditure as a percentage of gross contributions (%)	8.5	7.1	9.8
Average beneficiary age (n)	35	38	31
Pensioner ratio at 31 December (%)	10.2	14.5	6.6
Chronic profile at 31 December (%)	19.0	30.6	13.3

Primary	BonCap	Bon-Classic	Bon-Comp	BonEssential	BonFit	Hospital standard	Bon-Complete	BonStart
93 177	**55 666**	**8 576**	**4 704**	**11 725**	**6 432**	**4 934**	**8 567**	**1 161**
94 128	**56 470**	**8 337**	**4 572**	**12 138**	**6 715**	**4 782**	**8 318**	**1 868**
218 671	**81 484**	**15 082**	**8 098**	**26 480**	**14 040**	**9 219**	**16 842**	**1 289**
220 045	**82 215**	**14 571**	**7 824**	**27 301**	**14 685**	**8 929**	**16 296**	**2 061**
1.34	**0.46**	**0.75**	**0.71**	**1.25**	**1.19**	**0.87**	**0.96**	**0.10**
3 940	**1 767**	**6 617**	**9 163**	**3 110**	**2 784**	**4 084**	**5 506**	**1 570**
1 679	**1 207**	**3 763**	**5 322**	**1 377**	**1 276**	**2 186**	**2 801**	**1 414**
1 492	**1 230**	**3 613**	**5 747**	**1 308**	**1 115**	**1 963**	**2 577**	**704**
186	**131**	**233**	**254**	**184**	**198**	**234**	**228**	**236**
88.8	**101.9**	**82.5**	**87.8**	**95.0**	**73.6**	**89.8**	**78.4**	**49.8**
88.8	**101.9**	**96.0**	**108.0**	**95.0**	**87.4**	**89.8**	**92.0**	**49.8**
11.1	**10.9**	**5.3**	**3.9**	**13.3**	**13.1**	**10.7**	**6.9**	**16.7**
30	**35**	**52**	**54**	**35**	**29**	**48**	**44**	**33**
4.8	**8.2**	**35.4**	**42.3**	**10.9**	**4.8**	**27.9**	**4.8**	**2.5**
11.9	**10.7**	**48.0**	**50.7**	**11.1**	**9.6**	**20.3**	**9.6**	**4.3**

Primary	BonCap	Bon-Classic	Bon-Comp	BonEssential	BonFit	Hospital standard	Bon-Complete
88 643	48 491	9 409	5 243	10 411	5 600	5 530	9 500
89 445	48 206	9 134	5 087	11 228	5 739	5 347	9 110
209 314	75 337	16 807	9 227	23 205	12 088	10 381	19 019
211 137	74 843	16 212	8 898	25 139	12 406	10 002	18 115
1.36	0,55	0.77	0.75	1.24	1.16	0.87	0.99
3 804	1 794	6 270	8 640	2 989	2 770	3 837	5 166
1 611	1 155	3 510	4 910	1 341	1 283	2 044	2 581
1 325	1 100	3 109	4 753	1 090	921	1 708	2 183
180	123	223	239	181	195	222	216
82.3	95.3	76.1	78.7	81.3	60.5	83.5	72.1
82.3	95.3	88.6	96.8	81.3	71.8	83.5	84.6
11.2	10.7	5.5	4.0	13.5	12.8	10.9	7.1
30	34	52	54	35	30	48	43
4.8	8.7	33.7	39.6	10.5	5.0	26.6	19.2
12.2	11.2	47.1	49.5	11.2	9.6	20.0	28.4

BOARD OF TRUSTEES: PROFILES

Mr OJ Komane (56) Chairperson (Elected Trustee)

Mr Komane served as a non-executive director of the Mineworkers Investment Company until 2020. He holds a Master of Science degree in Engineering Business Management from the University of Warwick (UK). Mr Komane is currently the Managing Director of Accelerated Mining Services and served for two terms in the office as the Deputy General Secretary of the National Union of Mineworkers. He previously also held a number of positions on different boards of companies.

2021 1 June 2021

First appointed as Trustee 2 January 2016; appointed Vice-Chairperson with effect from 1 October 2017; appointed Chairperson with effect from 13 March 2019 to 3 December 2020; Trustee term ended with effect 4 January 2021; Re-elected as Trustee with effect 1 June 2021 and appointed as Chairperson on 28 September 2021.

Mr J Bagg (69) Vice-Chairperson (Elected Trustee)

Mr J Bagg is a qualified actuary with over 40 years' actuarial, financial management and consulting experience. He served as Statutory Actuary for numerous life insurance companies and is a Trustee of various retirement funds. He also holds directorships at life insurance and reinsurance companies.

2016 15 October 2016

Previous Trustee of Liberty Medical Scheme (LMS). Appointed to the Bonitas Board pursuant to the amalgamation with LMS; re-appointed by the Board as a Trustee with effect from 1 April 2019 as part of a casual vacancy (appointment was approved by the members at the AGM held on 19 August 2019); appointed Vice-Chairperson with effect from 4 December 2020.

Dr PW Hill (75) (Elected Trustee)

Dr Hill, PhD, is a chronic disease self-care consultant pharmacist. He earned a doctorate in patient behaviour in Type 2 diabetes mellitus at Rhodes University. His doctoral studies included training in chronic disease self-management at Stanford University. His practice, teaching and research remain focused on helping people with chronic diseases prevention. He previously served on the Board of Trustees of Liberty Medical Scheme prior to the amalgamation with Bonitas Medical Fund.

2021 1 June 2021

Mr R Cowlin (67) (Appointed Trustee)

Mr R Cowlin has over thirty years' experience in the medical aid industry and is involved in several aspects of the industry, including administration, marketing, product design and managed care. He held various top management positions within Medscheme and was the Managing Director of Aid for Aids for ten years.

2016 2 January 2016

Appointed Vice-Chairperson with effect from 13 March 2019 to 3 December 2020; Trustee term ended with effect 4 January 2021; appointed by the Board with effect 5 January 2021.

Adv L Koch (57) (Elected Trustee)

Adv L Koch holds a BLC and LLB. She is an admitted Advocate of the High Court and is employed as a Senior State Advocate at the Specialised Commercial Crimes Unit, where she has worked since 2001. She has over 20 years' experience in the investigation and prosecution of complex commercial crimes, including medical aid fraud, money laundering and financial crimes. She has sound knowledge of corporate governance principles, frameworks and guidelines.

2017 1 October 2017, with term ended 14 October 2021

Ms M Lesunyane (67) (Elected Trustee)

Ms M Lesunyane holds a BA from the University of South Africa. She is the co-founder of Lesunyane Enterprises, with over 30 years of business experience. She worked at the Road Accident Fund (RAF) until 2017.

2012 1 September 2012 and re-elected on 1 September 2017

0000 Trustee appointment/election date

Mr MG Netshisaulu (45) (Elected Trustee)

Mr Netshisaulu holds an MCom in Taxation and LLB degree. He is a registered tax practitioner with the South African Institute of Taxation and a member of the Compliance Institute of South Africa. He has extensive experience in the tax industry from the SARS Large Business Centre, as well as corporate and non-profit organisations. He completed a Council for Medical Schemes Trustee Development Programme with GIBS. He is currently employed as a Financial Strategic Analyst at the University of South Africa. He serves as a UNISA member of the professional research fund committee. He also previously served at the Nehawu Megawatt Park Branch as Chairperson and Deputy Chairperson.

2017 1 September 2017.

Mr PJ Ribbens (50) (Elected Trustee)

Mr PJ Ribbens started his business in 1997 and has run it for the past 24 years. He has vast experience in marketing and sales and is a director of Ribbens Office National. His responsibilities include overseeing assigned accounts and monitoring and evaluating project activities. He provides guidance to the marketing department by evaluating and developing marketing strategies and planning and coordinating marketing efforts. He positions the company's brand and also develops pricing strategies with the sales department.

2019 1 July 2019

Mr JR Venter (40) (Elected Trustee)

Mr JR Venter holds a BCom from the University of Pretoria. He has extensive experience in business development, corporate governance, strategic member relationship, retention management and financial management. He is employed by the largest technology service provider in Africa with more than 15 years' ICT experience. Mr Venter is member-focused and drives SLA adherence from service providers, thorough due diligence for contracts and value creation for members.

2019 1 July 2019

Mr JD Ngwane (65) (Elected Trustee)

Mr JD Ngwane is employed by the National Union of Mineworkers as Unit Head: Social Benefits. He assisted union-negotiated retirement funds with a process involving harmonisation of benefits, resulting in consolidation of funds. His self-insurance experience on retirement funds helped to reduce repudiated permanent disability claims. This also assisted with insurance premiums no longer paid to an appointed insurance company but rather paid into an established fund account, thus accruing interest to the benefit of the fund members and those reverting to the member's fund credit. He assisted with medical aid comparisons across the mining industry, ensuring the options, benefits, and costs were favourable to members and their families during hard financial times.

2019 1 July 2019

Appointed Chairperson with effect from 4 December 2020 and stepped down as Chairperson on 28 September 2021.

Ms J Usher (62) (Elected Trustee)

Ms J Usher is a qualified Chartered Accountant with 37 years' senior executive and board experience across various industries, including medical schemes, fast-moving consumer goods, industrial manufacturing, conservation tourism and emerging economic empowerment. She is skilled in corporate governance, financial management, legal contracting, commerce, strategic growth and skills development. She is Chief Financial Officer of Great Plans Conservation Limited and Treasurer of Great Plains Foundation.

2015 7 July 2015 and re-elected on 1 September 2017

EXECUTIVE MANAGEMENT: PROFILES

Mr LR Callakoppen (45) Principal Officer

Mr LR Callakoppen holds a Master HR Professional (SA Board for People Practices) and MPhil (Human Resource) and Industrial Sociology and Information Science Honours Degree from the University of Johannesburg. He has a wealth of experience at an executive level with specialisation in human capital, transformation and operational management. He has been involved with Medscheme and the AfroCentric Group in various functions for over 13 years, including heading up the Bonitas Business Unit. He serves on the Board of Healthcare Funders (BHF) Board and the Finance and Audit Committee of BHF.

Appointment date: 1 May 2019

Mr L Woodhouse (41) Chief Financial Officer

Mr L Woodhouse is a qualified Chartered Accountant (CA)SA and holds a BCompt (Hons) Accounting Science. He has over 12 years' experience in the healthcare sector, previously heading up finance and operational roles within the AfroCentric Group. He has a wealth of practical experience when managing technical finance matters relating to the medical scheme environment.

Appointment date: 1 October 2019

MESSAGE FROM THE CHAIRPERSON

Mr OJ Komane, who has been on the Board of Bonitas in different roles since 2016, answered a few questions about the Board and governance at Bonitas.

Q&A: What are the key strengths of the Bonitas Board?

We have a Board that collectively brings extensive experience from the health sector, with great understanding of managed healthcare systems including financial, actuarial and corporate governance experience.

This is a formidable team with the ability to ask the right questions and play the rightful oversight role. We allow robust debate on all issues requiring decision. This directly contributes to the quality and the Board making the right decisions in the end.

Another key strength of the Board is the fact that we can appoint the Independent Members to the relevant Board Committees. This ensures that the Board is complemented with critical skills sets from different backgrounds namely investment, HR and remuneration, audit and risk, corporate governance etc.

The management team with their technical contributions add hugely to the strength of the Board. Led by the Principal Officer, the management team's work enables the Trustees to play their required oversight role and provide leadership.

Q&A: What gives you comfort that the Board has members' interests at heart?

What gives me comfort is the level of commitment the Board demonstrates in the work of the Scheme. The level of inputs from different Trustees towards issues related to benefits and affordability for members, is evidence that Trustees care about Bonitas members.

In all the Board and Committee meetings, Trustees declare their conflict of interest as a demonstration of good governance practice.

The Board appointed Deloitte auditors to conduct a relational and transactional governance exercise to ensure and determine the arm's length relations in the transactions as well as the value for money for the members. This will go a long way in ensuring that there's a return on investment for each rand the members invest into Bonitas's health services.

I also take comfort from the work done by our Board Committees. The Board established Committees as extensions and delegated the relevant tasks to the Committees to deliberate issues in more detail. They report back to the Board as part of accountability and present recommendations for the Board's consideration and approval. These Committees are:

- Working and Strategy Committee chaired by the Chairperson of the Board
- Audit and Risk Committee chaired by an Independent Member
- Remuneration Committee chaired by an Independent Member
- Investment Committee chaired by a Trustee
- Managed Healthcare Committee chaired by a Trustee

There are also various Management Committees and Forums in place, for example the Sales and Marketing Committee, Operations Committee, Combined Assurance Committee, Fraud, Waste and Abuse Committee, Loss-Making Options Steering Committee and the Information and Technology Steering Committee. Each of these reports into the relevant Board Committees and the Board.

The Chairpersons of all these Board Committees are required to submit reports of their Committees to the Board containing deliberations and recommendations for the Board to consider and approve where it is required. This gives me comfort as the Chairperson of the Board, and it strengthens accountability and demonstration of good governance practice.

Q&A: What are the Board's current priorities?

The Board's priorities for next year include, but are not limited to:

- Ensure that the benefits and product design process delivers attractive options.
- Ensure affordable average contribution increases.
- Transform loss-making options into surplus making options.
- Improve significantly on the Managed Healthcare programmes to secure maximum satisfaction for Bonitas members.

The Medical Schemes Act requires the Board to:

Take all reasonable steps to ensure that the interests of beneficiaries in terms of the rules of the medical scheme and the provisions of the MSA are protected at all times	Act with due **care**, **diligence**, **skill** and **good faith**	Take all reasonable steps to **avoid conflicts of interest**, and act with impartiality in respect of all beneficiaries.

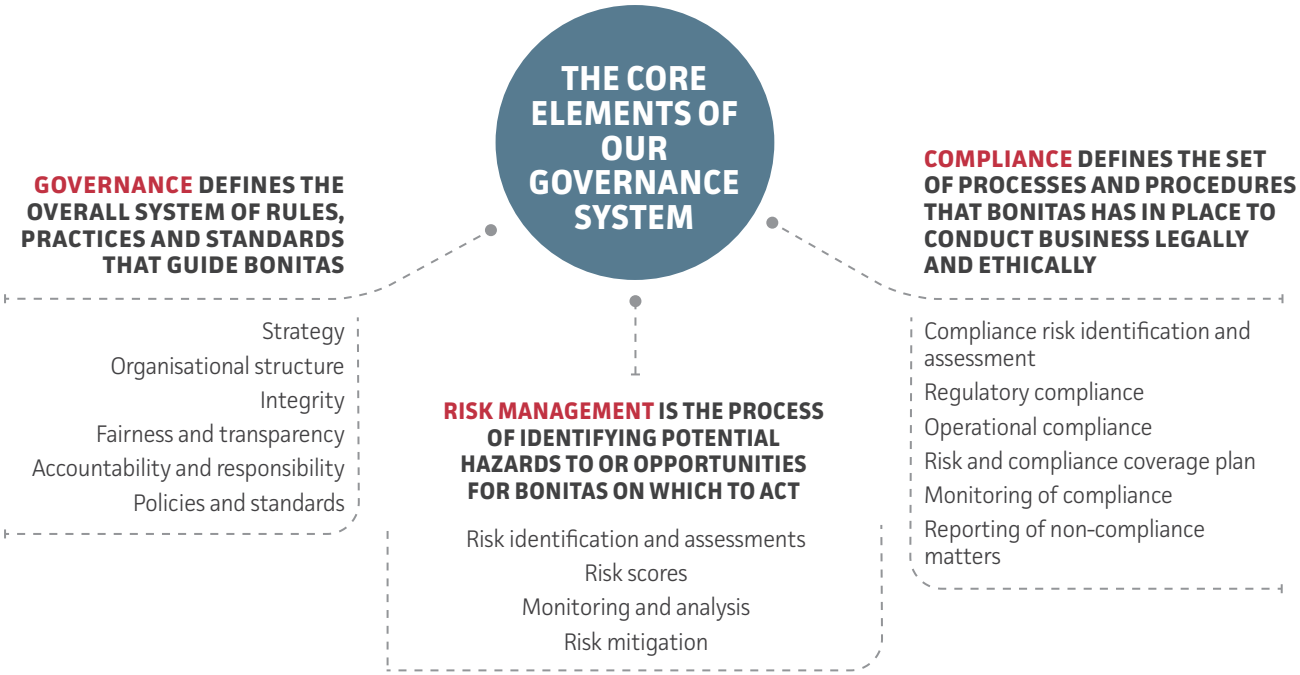
EXECUTIVE SUMMARY OF KEY GOVERNANCE DECISIONS AND DELIBERATIONS FOR 2021

COVID-19 vaccination roll-out	The Board monitored challenges related to the Department of Health's vaccination plan, vaccine roll-out logistics and slow uptake. We ensured that Bonitas responded to increased queries from members and employer groups regarding communication, education, awareness, and clarity on Bonitas's role in supporting the vaccine roll-out. To this end, we approved support measures to encourage vaccination and to educate and empower South Africans to take care of their health to avoid contracting and spreading the virus.
Amalgamation	The Board welcomed the NMAS amalgamation opportunity and provided oversight in terms of the process, governance, stakeholders and approvals. This included a detailed impact analysis to ensure that Bonitas members' interests were protected and that all consequences for benefits options and the sustainability of Bonitas were considered.
Contract renewals	The Board embarked on a number of contract negotiations such as administration, managed healthcare, FWA and HIV/Aids. These contracts were concluded during 2021 and followed an extensive contract negotiations process in line with relevant Scheme policies and independent oversight.
Policy approvals	The Board approved a range of policies and reviewed charters to ensure that these provide for ongoing process enhancements and an effective governance and control environment.
CMS inspection report	The Board considered the draft observations from the CMS report and established a task team to review the observations and provide a comprehensive response to the inspector as appointed by the CMS.
Loss-making options	With the number of loss-making options increasing during the year, the Board provided increased oversight and was kept abreast of progress with mitigation. A steering committee was established with clearly defined focus areas, objectives and timelines to address loss-making options. The Managed Healthcare Committee was presented with a framework and had oversight of operational execution.

The Board is accountable for governance and oversight at Bonitas. This includes providing direction, monitoring strategy implementation and guiding decision-making in the interests of our members.

The Board's main objective is to ensure that Bonitas acts in members' best interests while safeguarding the Scheme's long-term sustainability. Therefore, the Board is committed to leading ethically and effectively and promoting the characteristics of integrity, competence, responsibility, accountability, fairness and transparency.

The Bonitas Governance, Risk and Compliance Framework defines structures and processes in line with the requirements of the MSA, Scheme Rules and sound corporate governance principles as defined in the King IV™ Report. The Bonitas Governance, Risk and Compliance Framework is implemented according to the following three functions and accountabilities:



The Framework aims to achieve four outcomes as defined by King IV™. Initiatives related to these outcomes include:

Ethical culture

The Board is responsible to govern ethical behaviour of the Scheme through the Scheme's Code of Ethics and Professional Conduct in a way that supports the establishment of an ethical culture, as required by King IV.

Bonitas aims to maintain an ethical environment where employees, Trustees and Independent Members are encouraged to report violations, co-operate with investigations and seek advice when facing a difficult situation.

We have two codes:

1. The Code of Ethics and Professional Conduct for Trustees and Independent Members
2. The Code of Ethics and Professional Conduct for Executives and Staff

Trustees, Independent Members and all employees must acknowledge the respective Code of Conduct annually. Through this process, Trustees expressly agree to abide by specific ethical standards and to remain in good standing for their term of election or appointment.

A Gifts Policy defines business courtesy, entertainment, promotional items and invitations that can be considered gifts and describes the declaration process.

The Board follows established practices to promote ethics and effectiveness in its deliberations. These include declaring any conflicts of interest at all Board and Board Committee meetings (in line with the Conflict of Interest Policy) and ensuring transparency through its communication efforts.

Deloitte was commissioned to do a Transactional and Relational Governance engagement that included an assessment of the ethics and conflict of interest processes.

The Board has to ensure that members receive adequate and appropriate information about their rights, benefits, contributions and duties.

Read more about our whistle-blowing hotline and reporting on page 18.

Future focus areas

- Continued focus on always acting in the best interests of members

Good performance

According to the Scheme Rules, the Board is responsible for the proper and sound management of Bonitas and has to apply business principles to ensure financial and corporate governance soundness.

The Board, supported by the Audit and Risk Committee and Investment Committee, reviews Bonitas's financial performance and key performance indicators at the respective meetings, including the going concern status, solvency and investment performance.

The Board holds bi-annual strategy meetings where progress with and relevance of the strategic pillars are assessed. The Board approves targets for specific strategic indicators.

These targets form part of the approved annual Organisational Performance Matrix, including non-financial aspects. The matrix determines employee performance objectives and is implemented according to the Performance Management and Incentive Policies.

The Board further ensures regular and transparent performance reporting to members through the AGM.

Future focus areas

- Financial sustainability to ensure member healthcare costs are covered
- Membership growth
- Healthcare cost efficiency and accessibility
- Member education and empowerment in terms of healthcare

Effective control

The Scheme Rules stipulate that the Board has to have proper control systems in place. This ensures the integrity of information the Board uses to make decisions.

We have a Combined Assurance Framework that uses the four layers of defence governance model. This uses a co-ordinated approach in which assurance providers work closely, effectively and efficiently towards a control environment where the right assurance is received in the right areas.

Internal audit services are outsourced to PwC. Deloitte has been appointed as the external auditor through member voting at the AGM for the year ended 31 December 2021.

Future focus areas

Ongoing focus and consistent business operation within the:

- Strategy and risk appetite/tolerance set
- Agreed business objectives
- Agreed policies and processes
- Laws and regulations

Legitimacy

As a membership organisation, Bonitas has to maintain the trust of its members and show responsiveness to the legitimate concerns of all stakeholders. Read more about the nature of our relationships and outcomes of engagements on page 15.

As the medical aid for South Africa, we aim to enhance the healthcare ecosystem and psychosocial landscape for all South Africans. This included:

- Providing access to virtual care to all South Africans at the outset of the pandemic – at no cost
- The distribution of hand sanitiser and multivitamins to all high-risk members
- Supporting the education department with their return to school programme by providing COVID-19 educational material, sanitiser stands, face masks and virtual consultations
- Supporting the opening of the economy by introducing a return to work programme including sanitiser stands, COVID-19 posters and educational material, and corporate nurse screening
- Distribution of over 100 000 masks, 120 000 hand sanitisers and 55 000 bottles of multivitamins to various sectors including mining, parastatals, healthcare and corporates
- Providing upskilling sessions to general practitioners on our network to equip them with the skills needed to improve the service they provide to our members
- Setting up pop-up vaccine sites at various paypoints including Eskom and the City of Tshwane
- Establishing a COVID-19 hub on our website to equip South Africans with a credible source of information with regards to symptoms, treatment, preventative care measures and vaccines.

We do not sponsor political parties or entities involved in extreme sports that are controversial or disruptive. Bonitas funded two learners who completed their learnerships in December 2021, with two new NQF Level 4 Business Administration learners onboarded for 2022.

An additional three learners for the NQF Level 5 Wealth Management Learnership will be deployed at the Bonitas sales and marketing service provider, and will be hosted by a broker to ensure cross subsidisation of specialist skills and succession planning within the network and Bonitas respectively.

Future focus areas

- Ongoing focus to promote corporate responsibility, and to position Bonitas effectively as a good corporate citizen. This is achieved through the existing sponsorship strategy.
- Increased focus on the Scheme's journey to effectively incorporating ESG from an ESG investing perspective and from a Scheme perspective.

MAIN ELEMENTS OF OUR GOVERNANCE SYSTEM

The Board is responsible for the proper and sound management of Bonitas in terms of the governing legislation and regulation. These require the Board to act with due care, diligence, skill, and good faith.

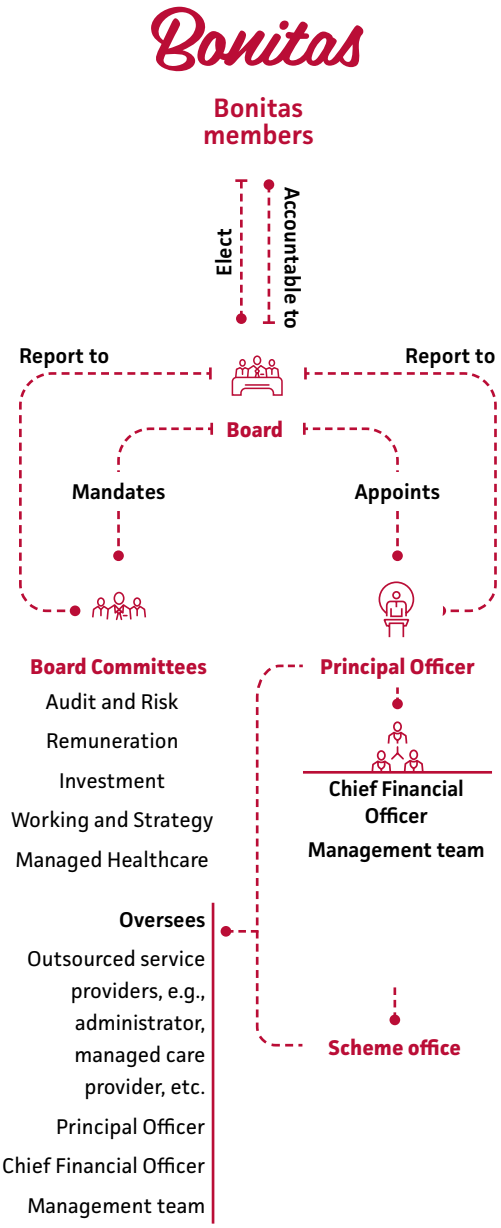
Governing legislation and regulation

The Act and regulations (including proposed Amendment Bill) – all medical schemes in South Africa are governed by the Act.

Scheme Rules – developed and maintained in accordance with the Act and approved by the CMS.

Corporate governance principles – although voluntary for medical schemes, Bonitas is committed to subscribing to King IV™ for additional governance guidance and leading practice on good governance.

Common law – relevant common law principles such as fit and proper, public funds, position of trust, etc.



Board

- Scheme governed by an independent Board
- Trustees duly elected in terms of scheme rules for a five-year term
- Fit and Proper
- Accountable to Bonitas members
- Appoints and contracts with the administrator

Board Committees

- Board supported by five Board Committees to fulfil its duties and responsibilities effectively
- Consist of Trustees and Independent Members
- Mandated through defined terms of reference/charters

Principal Officer

- Board-appointed
- Accountable for implementing strategy and any other decisions made by the Board
- Responsible for the day-to-day management of Bonitas
- Fit and proper
- Supported by Management team

BOARD COMPOSITION

During 2021, the Board consisted of ten Trustees, elected by members, and one Trustee appointed by the Board. The Board composition changed during October 2021.

According to the Scheme Rules, the Board can appoint a maximum of three Trustees who bring specific skills and diversity to the Board without undergoing elections. Such an appointed Trustee must be a member of the Scheme and must possess qualifications or belong to professions such as attorney/advocate, accountant/auditor, actuary, medical practitioner/specialist, or any other specialist expertise identified by the Board. The option to appoint specific Trustees allows the Board to source capabilities that will benefit Bonitas and improve race and gender diversity in its composition.

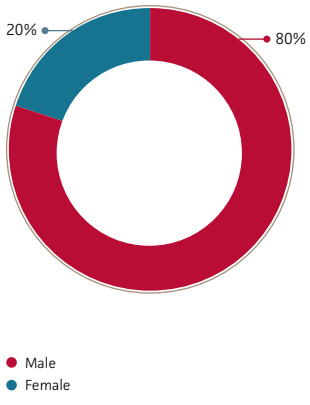
In terms of the MSA, section 57(2): "at least 50 per cent of the members of the board of trustees shall be elected from amongst members." Based on the current Scheme Rules, the composition of the Board only represents members of the Scheme whether elected or appointed.

The Board believes Bonitas has the appropriate mix of skills and experience and will aim to improve its gender diversity in future years.

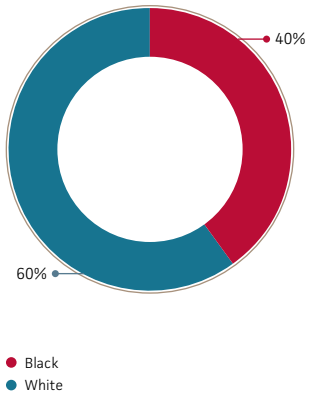
Board and Executive management skills profile

Skills	Bagg	Callakoppen	Cowlin	Hill	Komane	Lesunyane	Netshisaulu	Ngwane	Ribbens	Usher	Venter	Woodhouse
Corporate governance	✓	✓	✓	✓	✓		✓			✓	✓	✓
Medical and retirement funds	✓	✓	✓	✓				✓		✓		✓
Strategy		✓	✓		✓	✓	✓		✓	✓		✓
Financial management	✓	✓	✓				✓		✓	✓	✓	✓
Business development		✓	✓			✓			✓	✓	✓	
Law			✓				✓					
Marketing			✓						✓			
Taxation							✓			✓		✓
Skills development	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical		✓	✓	✓								
Actuarial science	✓											
Leadership	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Information technology											✓	

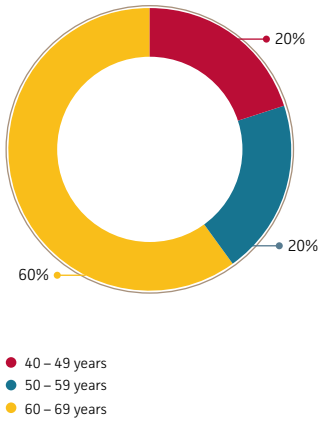
Gender profile as at 31 December 2021



Race profile as at 31 December 2021



Age profile as at 31 December 2021



Tenure as a Board member

The Board strives to always focus on having the appropriate mix of skills and experience, including gender and race diversity.

TRAINING AND EVALUATION

Trustees, Executives and Senior Management attended a Trustee Development Programme presented through BHF and the Wits Business School in March 2021. The programme is specially designed for medical schemes' leadership and focuses on health governance, roles, responsibilities, ethics, and the business landscape.

The Board also attended a managed care strategy workshop on 1 July 2021, covering focus areas that lead to better access and quality care for members.

Board members also received training on Scientrix, a management tool to track performance against strategic targets. Board members received access to the system from 7 June 2021.

Bonitas undertakes a formal evaluation process of the Board and all Board Committees every second year in line with King IV. The previous formal evaluations were independently completed by PwC in December 2020 and the final reports were distributed to the Board and the relevant Board Committees during the first quarter of 2021. Based on the results of these evaluations, the Board is satisfied that the current evaluation process is improving its performance including the performance of the Board Committees and effectiveness.

The process for the upcoming formal evaluations will be initiated towards the end of 2022, which will involve a combination of questionnaires and interviews and will be completed during 2023. Formal performance evaluations were initiated for all the management committees/forums during February 2022 through the Governance, Risk and Compliance function.

The Board continues to informally evaluate the performance of the Board and the Board Committees including the review of the membership of the various Board Committees on an annual basis in line with the Board Charter.

KEY BOARD AREAS OF OVERSIGHT

Highlights from the Board's activities in fulfilment of the Board Charter are included in this table to demonstrate how governance supports value creation and preservation.

Financial

- Evaluated financial performance, including going concern status, loss-making options, appropriateness of insurance cover and completion of year-end claims incurred but not yet reported (IBNR) provision.
- Approved annual financial statements and Board of Trustees report.
- Approved the 2022 budget.
- Renegotiated administration and managed care service contracts and fees.
- Appointed the external auditor and approved the audit fee.
- Provided oversight of the NMAS amalgamation process and considered financial impacts.
- Tracked performance and determined remuneration increases and incentives against the Organisational Performance Matrix.
- Participated in the formal Investment Committee workshop conducted in February 2021.

Operational

- Considered and approved the pricing and benefit option design for 2022.
- Considered and approved the administration and managed care contracting process which incorporated the consideration of the required service levels and outcome-based measures.
- Tracked claims history and projections, particularly given COVID-19 uncertainties.
- Considered and approved member support initiatives under COVID-19 conditions.
- Considered the impact of POPIA implementation on Bonitas operations and members.

Stakeholders

- Supervised the process of Board elections, Trustee nominations and appointments.
- Made arrangements for the special general meeting (SGM) and virtual meeting and voting at the AGM.
- Considered updates on legal proceedings and, where required, provided official responses to matters such as the CMS investigation.
- Ensured timely and targeted communication with stakeholders about the NMAS amalgamation.

Governance

- Reviewed and where relevant approved the Board Charter, Charters for the Board Committees and the Board Committee structures.
- Approved changes to the Delegation of Authority Policy.
- Approved new and revised policies
- Completed registers for declaration of interests and gifts.
- Submitted Trustee annual declaration and interest forms.
- Appointed independent advisors and an internal task team for the NMAS amalgamation.
- Appointed a negotiations task team which included the Executives and the Trustees with actuarial and managed care experience to oversee the managed healthcare and administration contract negotiation process.
- Considered the results of the Board's performance evaluation.
- Considered and approved the revised Board Charter.

Strategy, people and performance

- Considered strategy and risk alignment.
- Approved the Organisational Performance Matrix 2021.
- Considered regular updates on COVID-19 mitigation measures, actuarial impacts and special arrangements.

Risk and compliance

- Provided oversight of the key risks facing Bonitas and reviewed and monitored the effectiveness of the risk management process.
- Reviewed and monitored the effectiveness of the compliance management process.
- Participated in the formal risk workshop conducted during October 2021.

MEETING ATTENDANCE

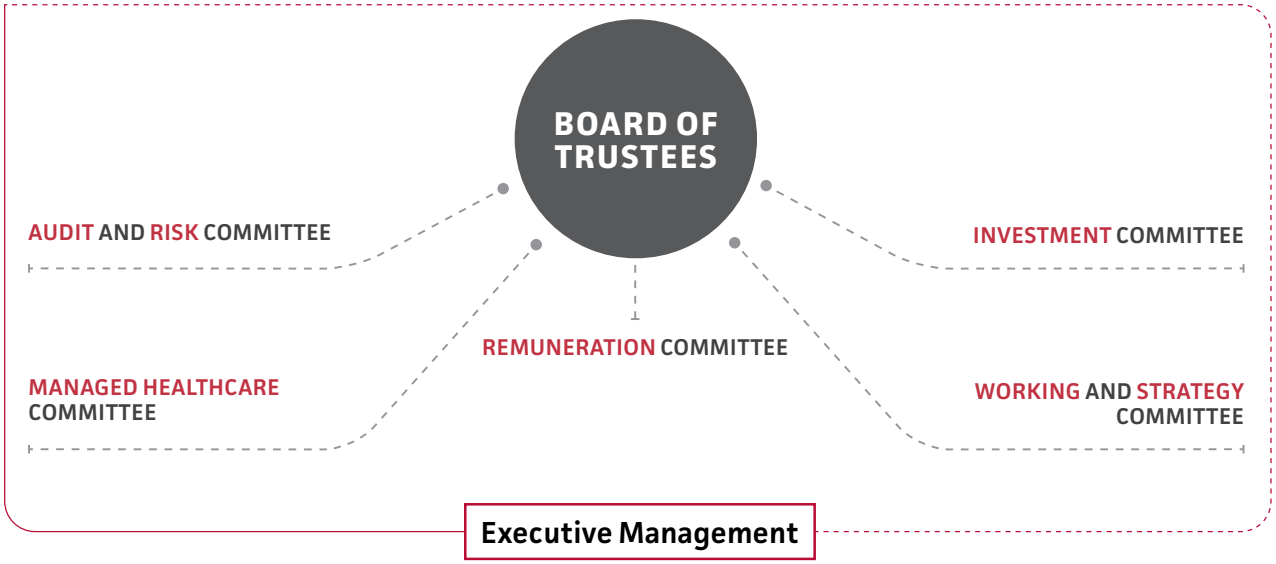
The schedule below summarises mandatory Board and Board Committee meetings held during 2021[1]. This includes special meetings and attendance by invitation.

Trustee and/ or Independent Member	Board	Audit and Risk Committee	Remuneration Committee	Investment Committee	Working and Strategy Committee	Managed Healthcare Committee
Number of meetings	10 (including 4 special meetings)	6	4 (including 1 special meeting)	5 (including 1 workshop)	13 (including 3 special and 2 ad hoc meetings)	5 (including 1 special meeting)
J Bagg	10/10	2/2**		5/5	13/13	
R Cowlin	10/10			5/5	13/13	5/5
PW Hill^	7/7					3/3
L Koch^^	7/7			1/1*^		
O Komane#^	7/7	1/1	1/1	1/1	6/6	2/2
M Lesunyane	10/10		4/4			
M Netshisaulu	10/10		4/4	1/1*^	13/13	
D Ngwane#	10/10	5/5	3/3	4/4	7/7	3/3
P Ribbens	10/10			5/5		5/5
J Usher	10/10	6/6			12/13	
J Venter	10/10	6/6		1/1*^		
J Prinsloo^*		1/1				
P Kekana	1/1*		3/4			
W Kirima				5/5		
C van Zyl			4/4	5/5		
P van der Nest	1/1*	6/6				
Y Carrim		6/6				
T Poho		6/6				

Notes

* *Independent Members attended the Board meeting by invitation.*
^ *Elected to the Board effective 1 June 2021.*
^^ *Term ended 14 October 2021.*
*^ *Attended the investment workshop by invitation.*
** *Attended ARC by invitation.*
^* *Term ended 31 January 2021.*
# *Chairperson's term ended on 28 September 2021.*
#^ *Elected to the Board effective 1 June and appointed Chairperson on 28 September 2021.*

BOARD COMMITTEES AND ACTIVITIES FOR 2021



The Board Committees reviewed their performance in terms of each Committee's mandate and were satisfied they had performed their responsibilities under the relevant charter.

[1] *Actual number of meetings attended/total number of meetings members could have attended.*

AUDIT AND RISK COMMITTEE

Mandate

In terms of section 36 of the MSA, Bonitas is obliged to have an Audit and Risk Committee. The Committee is duly constituted and functional. The Committee comprises a majority of Independent Members whose mandate is to assist the Board in discharging its duties relating to:

- Safeguarding of assets.
- Operation of adequate and effective systems, internal controls and processes.
- Preparation of annual financial statements that fairly represent Bonitas's financial position.
- Oversight of the external and internal audit appointments and functions.
- Oversight of the policies and processes for identifying and assessing business risks.
- Oversight of the governance, risk and compliance functions.
- Provision of advice on any matter referred to the Committee by the Board.

Key activities for 2021

- Assessed financial and investment performance.
- Provided oversight of risk management and compliance reporting.
- Considered reports issued by internal audit and evaluated the performance of the internal audit service provider.
- Considered Bonitas's FWA initiatives, CMS inspections and Section 59 investigation (racial profiling), including pending legal and criminal matters.
- Focused on assurance provided around cyber security and business continuity given the impact from a COVID-19 perspective.
- Monitored the implementation of the Information and Technology Governance Framework and Strategy.
- Considered and gave input on the strategic procurement contracting process relating to key contracts reaching their termination periods.
- Provided oversight of the Combined Assurance Forum feedback and the Forum's Terms of Reference.
- Considered the results of the Committee's performance evaluation.
- Participated in the formal risk workshop conducted during October 2021.Recommended to the Board for approval:
  - Updated Committee Charter
  - Reappointment of external auditors
  - External audit plan and fees
  - External auditors' report
  - Updated policies, i.e. Impairment, Credit Control, Risk Management and Combined Assurance Forum Terms of Reference
  - Audited annual financial statements and related disclosures (including the report of the Board)
  - Going concern

Disclosure statements

The Audit and Risk Committee has assessed and is satisfied that our external auditors, Deloitte, is sufficiently independent of the Scheme. The Audit and Risk Committee has recommended the appointment of the external auditor for the 2021 financial year to the Board and the AGM. Deloitte's review of their independence was also received by the Committee. The provision of non-audit services by the external auditors is limited and any such request must be approved by the Audit and Risk Committee with the required motivation and guarantees of independence. A division of Deloitte was appointed to do a non-audit transactional and relational governance engagement which is in progress and covers the 2020 and 2021 financial years as part of the scope. The division of Deloitte appointed to conduct this non-audit engagement was assessed to be sufficiently independent from the external audit partner and team. The Audit and Risk Committee is satisfied that the tenure of the external auditor and the engagement partner, does not impair independence and does not create a risk of familiarity with management.

The Audit and Risk Committee has reviewed the financial statements and received assurance on key figures, including the IBNR and the take-on of balances from the merger with NMAS.

The Audit and Risk Committee received the external audit report from Deloitte as well as the management letter. The Committee is comfortable with the assurance provided and the quality of the audit work conducted and the report.

Bonitas has an outsourced internal audit function, and the service is provided by PwC. The Committee has approved a risk-based coverage plan and the plan has been completed for the financial year. The Audit and Risk Committee is satisfied with the assurance provided by the internal auditors. The Committee receives further assurance from Afrocentric internal audit at every meeting. An annual internal audit effectiveness assessment is conducted and the results were satisfactory.

The Audit and Risk Committee has received assurance on the quality of the system of internal control. The Governance, Risk and Compliance function including management, internal and external audit contributes to the Combined Assurance Forum meetings where any possible risk and control matters are dealt with, and quarterly reports and minutes are provided to the Audit and Risk Committee as part of the assurance required. Internal and external audits have not found any material weaknesses in financial controls and Bonitas received an unqualified audit opinion. No material losses were reported resulting from a failure in internal financial controls, fraud or corruption.

The Audit and Risk committee is satisfied with the capacity and skills of the finance function and the CFO. An annual assessment of the performance of the CFO is conducted and the results were satisfactory.

Members as at 31 December 2021	Capacity	Member since
J Prinsloo**	Independent Member	1 January 2012; appointed Chairperson 1 February 2019 to 31 January 2021
J Usher*	Trustee Member	1 January 2012
D van der Nest***	Independent Member (Chairperson)	1 August 2019
YO Carrim	Independent Member	1 August 2019
T Poho	Independent Member	1 August 2019
J Venter	Trustee Member	1 August 2019

* *J Usher was an Independent Member of the Audit and Risk Committee for the period 1 January 2012 to 7 July 2015. Following her appointment as a Trustee, she became a member of the Audit and Risk Committee in her capacity as a Trustee.*
** *J Prinsloo – term as member of the Committee and Chairperson ended with effect 31 January 2021.*
*** *D van der Nest – appointed as new Chairperson of the Committee with effect 1 February 2021.*

INVESTMENT COMMITTEE

Mandate

The Investment Committee manages the investment portfolio in line with the Bonitas Investment Strategy and Policy and ensures compliance with the regulations of the MSA. The Committee advises the Board on strategic matters relating to the investment of reserves, ensuring investments are made in members' best interests.

Key activities for 2021

- Conducted an Investment Committee workshop to review the Investment Strategy.
- Monitored the performance of asset managers and reviewed their environmental, social and governance policies.
- Evaluated the delivery of services and extended the contract of the appointed investment consultant.
- Recommended the appointment of a growth asset manager to the Board.
- Allocated growth funds incrementally based on an approved implementation plan.
- Considered a policy/strategy to realise the fair value unrealised gains to bolster solvency.
- Interrogated investment reports and monitored the investment hedge.
- Considered and approved annual report disclosure on investment performance.
- Provided oversight of process for cash flow management and strategic asset balancing.
- Considered the rationale and transition timelines for the NMAS amalgamation specifically relating to the NMAS investment portfolio.
- Considered the results of the Committee's performance evaluation. Recommended to the Board for approval:
  - Updated Committee Charter
  - Updated Investment Policy Statement

Members as at 31 December 2021	Capacity	Member since
R Cowlin *	Trustee Member (Chairperson)	30 June 2016
J Bagg	Trustee Member	15 October 2016
W Kirima **	Independent Member	1 June 2014
P Ribbens	Trustee Member	16 November 2019
C van Zyl ***	Independent Member	1 July 2016

* *R Cowlin – Trustee term ended on 4 January 2021 and appointed by the Board with effect from 5 January 2021.*
** *W Kirima – Re-appointed as an Independent Member for another term effective 1 June 2020.*
*** *C van Zyl – Re-appointed as an Independent Member for another term effective 1 July 2021.*

REMUNERATION COMMITTEE

Mandate

The Remuneration Committee provides oversight of the Bonitas Remuneration Strategy and related policies and ensures compliance with these policies. The Committee oversees the remuneration of Trustees and employees.

Key activities for 2021

- Considered and approved the proposed annual employee salary increases based on oversight of employee performance management reviews.
- Considered the results of the salary benchmarking.
- Considered arrangements for employees to return to the office under COVID-19 conditions.
- Considered the financial impact of COVID-19 on Bonitas.
- Discussed succession planning.
- Discussed the revision of the LTI targets due to the amalgamation and the need for LTI payment provisions.
- Reviewed the roles and charter of the Remuneration Committee, and the need to differentiate between human capital versus remuneration reporting aspects.
- Reviewed the employment equity plan and encouraged diversity through the appointment of employment equity candidates.
- Considered training updates, which included progress with learnerships.
- Recommended new and updated policies to the Board for approval: Employment Equity and Transformation, Acting Allowance and Leave.
- Recommended Talent and Succession Frameworks to the Board for approval.
- Recommended the updated Committee Charter to the Board for approval.
- Considered the results of the Committee's performance evaluation.

Members as at 31 December 2021	Capacity	Member since
P Kekana *	Independent Member (Chairperson)	2 January 2016; appointed Chairperson 1 October 2017; re-appointed Member and Chairperson 2 January 2021
C van Zyl	Independent Member	1 March 2018
M Netshisaulu	Trustee Member	16 July 2020
M Lesunyane	Trustee Member	1 October 2017

* *P Kekana – Re-appointed as an Independent Member and the Chairperson for another term effective 2 January 2021.*

WORKING AND STRATEGY COMMITTEE

Mandate

The Working and Strategy Committee directs and monitors the implementation of the strategy and is responsible for managing procurement and contract management processes and recommending the budget to the Board for its consideration and approval.

Key activities for 2021

- Reviewed the draft CMS inspection report and initiated a comprehensive response.
- Reviewed and renewed the following contracts:
  - AfroCentric/Medscheme: Administration and Managed Healthcare
  - Emergency Management Services: Ambulance Services
  - Scriptpharm Oncology Management Contract: Medicines Management
  - Dental Information Services (DENIS): Dental Services
  - HIPPO and Optivest: Aggregators
  - Aid for Aids
- Reviewed the Sanlam partnership and financial operating model.
- Reviewed and recommended the termination of the Qhubeka Forensic Services contract and the integration of the FWA services in the administration contract.
- Considered and approved the COVID-19 member support initiative.
- Reviewed the Scheme performance against the Organisational Performance Matrix scorecard, including year-end remuneration process and timelines.
- Reviewed the Code of Ethics and Professional Conduct Policy for Executives and Staff and for Trustees and Independent Members
- Attended a strategic summit presented by AfroCentric to ensure alignment between Bonitas and the administrator.
- Considered a COVID-19 impact assessment and vaccination strategy.
- Arranged for Trustee election at the SGM.
- Monitored operational reports regarding any non-adherence to SLAs by service providers.
- Reviewed and appointed the service provider for Property Management Services at the Bonitas Office Park.
- Reviewed the professional indemnity insurance based on Bonitas' latest credit rating.
- Considered I&T Governance reports and initiated an internal audit review of the adequacy and operational effectiveness of the I&T Governance Framework.
- Considered FWA reports.
- Considered the Section 59 Task Team Review.
- Considered the results of the Committee's performance evaluation. Recommended for approval by the Board:
  - The amalgamation Transactional Document
  - 2022 plan options, pricing and benefits based on scenarios that also consider the amalgamation
  - Board and the Working and Strategy Committee Charter
  - Reviewed and updated Whistle Blowing Policy, Disciplinary Policy, Recruitment, Selection and Appointment Policy and the Delegation of Authority Policy
  - The 2021 budget

Members as at 31 December 2021	Capacity	Member since
O Komane*	Trustee member (Board Chairperson and Chairperson of this Committee)	1 June 2021
J Bagg ***	Trustee Member (Board Vice-Chairperson)	4 December 2020
R Cowlin **	Trustee Member (previous Board Vice-Chairperson)	1 October 2017
M Netshisaulu	Trustee Member	16 November 2019
J Usher	Trustee Member	28 November 2015
LR Callakoppen	Principal Officer	1 May 2019
L Woodhouse	Chief Financial Officer	1 October 2019

* *O Komane – Chairperson of the Board term ended 4 December 2020. Trustee term ended 4 January 2021. Re-elected as Trustee with effect 1 June 2021 and appointed as Chairperson on 28 September 2021.*

** *R Cowlin – Vice-Chairperson of the Board term ended 4 December 2020. Trustee term ended on 4 January 2021 and appointed by the Board with effect from 5 January 2021.*

*** *J Bagg – Re-appointed as Vice-Chairperson of the Board with effect 28 September 2021.*

MANAGED HEALTHCARE COMMITTEE

Mandate

The Managed Healthcare Committee provides direction, oversight and guidance on all strategic and operating matters relating to the Scheme's managed healthcare activities to ensure these activities are managed in the best interests of the Scheme's members. Managed healthcare is about comprehensive care, including preventative, rehabilitative, and curative care to promote appropriateness and cost.

Key activities for 2021

- Provided oversight of managed care initiatives' performance, gaps and targets while tracking progress with savings interventions.
- Considered research and data related to COVID-19 waves and hospital admissions, including an actuarial dashboard and COVID-19 scenarios.
- Considered claims trends, the health risk management feedback report and health quality assessment results.
- Considered and approved the proposed 2022 hospital strategy.
- Reviewed Aid for Aids reports.
- Considered the potential impact of the NMAS amalgamation.
- Conducted a knowledge-sharing workshop with the Board to empower them in terms of initiatives that were being driven and/or executed by the Committee, in conjunction with a robust demonstration of the value that was being realised through these interventions.

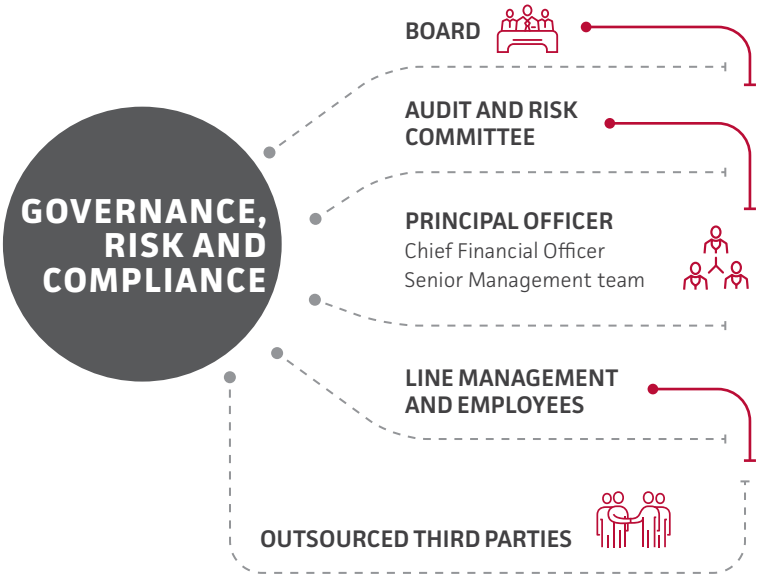
Members as at 31 December 2021	Capacity	Member since
R Cowlin *	Trustee Member (Chairperson)	16 July 2020
P Ribbens	Trustee Member	16 July 2020
P Hill	Trustee Member	7 October 2021
Vacant	Independent Member	To be confirmed

* *R Cowlin – Trustee term ended 4 January 2021 and appointed by the Board with effect from 5 January 2021.*

RISK, COMPLIANCE AND COMBINED ASSURANCE

The Board, through the Audit and Risk Committee, is responsible for the oversight and approval of risk management, compliance and combined assurance at Bonitas. The Board is also responsible for setting the risk appetite and tolerance.

The governance of risk and compliance encompasses internal and external role-players:



RISK MANAGEMENT

Bonitas faces numerous risks that can disrupt our ability to implement our approved strategy. Risk management enables us to make better-informed decisions and improve the probability of achieving our objectives.

Risk management is a key, embedded component in all activities throughout Bonitas's operations and is approached in a structured and disciplined way. The Board is responsible for risk management, whereas Executive Management is responsible for the risk management process, including risk identification, assessment, measurement, monitoring and reporting to the Audit and Risk Committee.

The Risk Management Policy guides risk management principles, whereas the Risk Management Framework ensures that risk management is integrated into significant activities and functions. This ensures, for example, compliance with the MSA in providing healthcare and related services to members and enables the Board and Executive Management to discharge their fiduciary duties to Bonitas and members. This leads to the implementation of a consistent, efficient and effective risk approach that identifies, evaluates and responds to key risks that may impact our ability to achieve our strategic objectives.

The Risk Management Framework is based on the principles of the COSO Framework of the Treadway Commission, the International Guideline on Risk Management (ISO 31000:2018) and the King IV™ governance outcomes, i.e., ethical culture, good performance, effective control and legitimacy.

Read more about the strategic risks and opportunities that Bonitas is facing, as well as mitigation through our strategic pillars, from page 23.

COMBINED ASSURANCE

A Combined Assurance Framework approved by the Board is in place to ensure integration, coordination, and alignment between risk management and assurance processes. This seeks to optimise and maximise the level of governance, risk and control oversight based on Bonitas's risk appetite, taking into account the role players involved in providing assurance.

The Board provides assurance oversight. The Audit and Risk Committee is responsible for advising the Board on Bonitas's system of internal controls, risk management and governance. Key assurance role players support these bodies:

A Combined Assurance Forum was established to apply the Framework, optimise assurance activities and enable an effective control environment, awareness and discipline. The forum provides the Audit and Risk Committee with one view of all assurance efforts across the lines of defence aligned to the key risks in terms of the Scheme's risk register. This is done using a combined assurance dashboard.

COMPLIANCE

We have a Board-approved Compliance Policy that sets out the principles for compliance management and the expectations for implementing compliance procedures and provides the foundation for compliance at Bonitas.

Bonitas operates in a complex and highly regulated environment. It also uses an outsourced model for its main activities, including administration. Therefore, the Policy extends to monitoring compliance by these service providers and includes regulatory and operational compliance aspects.

A compliance function was established to assist the Board and management in delivering affordable and quality healthcare with integrity and compliance with all relevant regulatory and leading practice requirements and to the highest ethical standards.

The compliance function reports administrative matters to the Principal Officer, the custodian of the Policy, and reports functionally to the Board through the Audit and Risk Committee. The compliance function does not have any operational responsibilities that could pose a conflict of interest and impair independent reporting.

Compliance is implemented via a Compliance Programme that sets out roles, processes, activities and responsibilities.

The following were some of the key focus areas for 2021:

- The POPI Act came into effect on 1 July 2020 and organisations were granted a grace period of one year for implementation of the requirements of the Act. The grace period ended on 30 June 2020. The Information Regulator has therefore started enforcing compliance to the Act as of the 1st of July 2021. Bonitas appointed an independent service provider to assist with the implementation of the provisions of the POPI Act from a Scheme Office perspective. Bonitas furthermore appointed an Information Officer and a Deputy Information Officer.
- Ongoing compliance monitoring with regards to the MSA and MSA Regulations.
- Ongoing compliance monitoring with regards to the Scheme Rules.

The Audit and Risk Committee is responsible to monitor the effectiveness of compliance management in line with its Charter on an ongoing basis. The Audit and Risk Committee has the following key responsibilities:

- To oversee the review of a compliance management policy and process for identifying and assessing legislation, regulations and policies that the Scheme must comply with.
- To review the processes in place for ensuring that the Scheme complies with all legislation, regulatory requirements and Scheme policies.
- To obtain regular updates from management and the Governance, Risk and Compliance Function regarding compliance matters.
- To be satisfied that all regulatory compliance matters have been considered in the preparation of the financial statements.

Planned areas of future focus:

- Ongoing compliance monitoring in line with the Scheme's Regulatory Risk Profile (i.e., prioritised for the legislation identified as "primary" and rated with a "high" compliance risk exposure) such as the MSA, MSA Regulations, POPI Act, BBBEE Act and King IV from a corporate governance perspective.
- Ongoing monitoring of implementation plans with regards to non-compliance matters as reported in the next section.

NON-COMPLIANCE WITH THE MSA

The following areas of non-compliance with the MSA were identified during the financial year (refer to note 26 of the annual financial statements for more details):

Which part of the Act?

Section 33(2)

What does it say?

The registrar may withdraw the approval of such benefit options that, in its opinion, are not financially sound.

Nature and cause

Bonitas reported a net healthcare deficit on 7 (2020: two) of its benefit options for the year.

	2021 R'000	2020 R'000
BonCap	**151 006**	62 540
BonFit	**6 277**	–
BonClassic	**15 038**	–
BonComprehensive	**65 951**	9 076
BonEssential	**36 303**	–
BonComplete	**937**	–
Hospital Standard	**1 213**	–

Possible impact

Loss-making benefit options erode the solvency margin of Bonitas. However, due to historical member reserves, coupled with an efficient return on investments, Bonitas can absorb these losses.

Section 26(7)

What does it say?

Requires all subscriptions and contributions to be paid directly to a medical scheme not later than three days after payment becomes due.

Nature and cause

Bonitas has aged debtors of up to 120 days for both group and direct paying members and is thus in breach of the three-day rule.

Possible impact

Bonitas incurred bad debt write-offs of R12.5 million during 2021 (2020: R10.8 million), which equals 0.07% (2020: 0.06%) of risk contribution income. Significant members' debt could affect the liquidity of Bonitas and its ability to service members and potential non-recoverability of such debtors.

Regulation 10(6)

What does it say?

Regulation 10(6) of the Act prohibits the funding of a Prescribed Minimum Benefit (PMB) from the members' medical savings accounts.

Nature and cause

An error occurred where potential PMB claims were processed as non-PMB related claims due to system development pertaining to overriding of the Scheme Rules and paid incorrectly from members' medical saving accounts instead of being paid from the Scheme's risk reserves.

Possible impact

Non-compliances with Regulation 10(6) is the risk. This may result in escalation of member complaints whose claims were incorrectly paid from their medical savings accounts and causing the member's out-of-pocket expenses to increase.

Which part of the Act?		
Section 33(2)	**Section 26(7)**	**Regulation 10(6)**
Corrective course of action Bonitas has experienced positive performance on its largest options. In 2021, the Standard option reported a net healthcare surplus of R434.4 million. Much of the positive performance can be attributed to successful hospital negotiations and benefit design. In addition, with the easing of the lockdown restrictions, elective procedures and hospital and associated costs increased but not at the level that was expected. Bonitas continues to monitor the performance of the eight benefit options listed above every month. There are also quarterly operational meetings held with the regulator advising on the performance of these options. Bonitas has adopted a long-term strategy to correct the loss-making options into the future, in particular on the BonCap, Primary Select and Standard Select options. Bonitas has also appointed a task team to drive initiatives to reduce healthcare and non-healthcare costs over the medium term and improve health outcomes. These cost-saving measures should have a positive impact across all options.	**Corrective course of action** It is not possible to receive all contributions within three days of the due date, as there may be reasons preventing payments. In such instances, members are notified of the breach. In addition, Bonitas applies mitigating controls to address non-payment of contributions. These include the enforcement of Bonitas's Credit Control Policy. Other interventions include direct management engagement with affected groups to resolve such concerns.	**Corrective course of action** The errors were rectified when the incorrect claims process was identified. The effected members' medical saving accounts were credited with the respective amounts, where applicable. All PMB claims that are effected by the error have been rectified.

Which part of the Act?	
Section 35(8)	**Section 59(2)**
What does it say? A medical scheme may not invest any of its assets in the business of or grant loans to: • An employer group participating in the medical scheme or any administrator or any arrangement associated with the medical scheme • Any other medical scheme • Any administrator • Any person associated with any of the above.	**What does it say?** A medical scheme shall, in the case where an account was rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service any benefit owing to that member or supplier of service within 30 days after the day on which the claim for such benefit was received by the medical scheme.

Which part of the Act?	
Section 35(8)	**Section 59(2)**
Nature and cause Section 35(8) of the Act prohibits a medical scheme from investing any of its assets in the business of or granting loans to; (a) an employer group who participates in the medical scheme or any administrator or any arrangement associated with the medical scheme; (b) any other medical scheme; (c) any administrator; and (d) any person associated with any of the above.	**Nature and cause** Exceptions were noted during the year where claims were delayed when providers exceeded their monthly limit. Providers are screened first by the Forensic team prior to the limit being lifted, resulting in the claims being paid after the 30 days. Additional exceptions noted related to claims blocked in the system delaying payment and claims not routing for manual intervention after the 30 day period had lapsed.
Possible impact Bonitas invested with various entities associated with its administrator and Bonitas's employer groups during the financial year.	**Possible impact** Providers not settled timely should be communicated with appropriately to avoid non-compliance.
Corrective course of action Bonitas obtained an exemption in terms of Section 35(8) of the Act from the CMS in respect of this non-compliance.	**Corrective course of action** A communication strategy was implemented at the end of 2020 to inform providers and members of any delays in claims payments outside the 30 days and was subsequently reviewed to ensure all claims in the environment are identified and communicated proactively within the 30-day window period to reduce the risk of non-compliance. Claims system scheduling jobs are being monitored by the system maintenance to avoid further delays and constant monitoring of exception reporting to identify any issues proactively and ensure corrective measures are taken.

INFORMATION AND TECHNOLOGY

Information and technology governance structures

The Board is responsible for the governance of information and technology. It has mandated the executive team to implement the Bonitas I&T Governance Charter and Framework and reporting system to monitor the risks and effective control of IT. An I&T Steering Committee was established and will commence in March 2022 as a Management Committee, reporting to the Principal Officer, who is accountable to the Board. The Committee will operate according to a terms of reference.

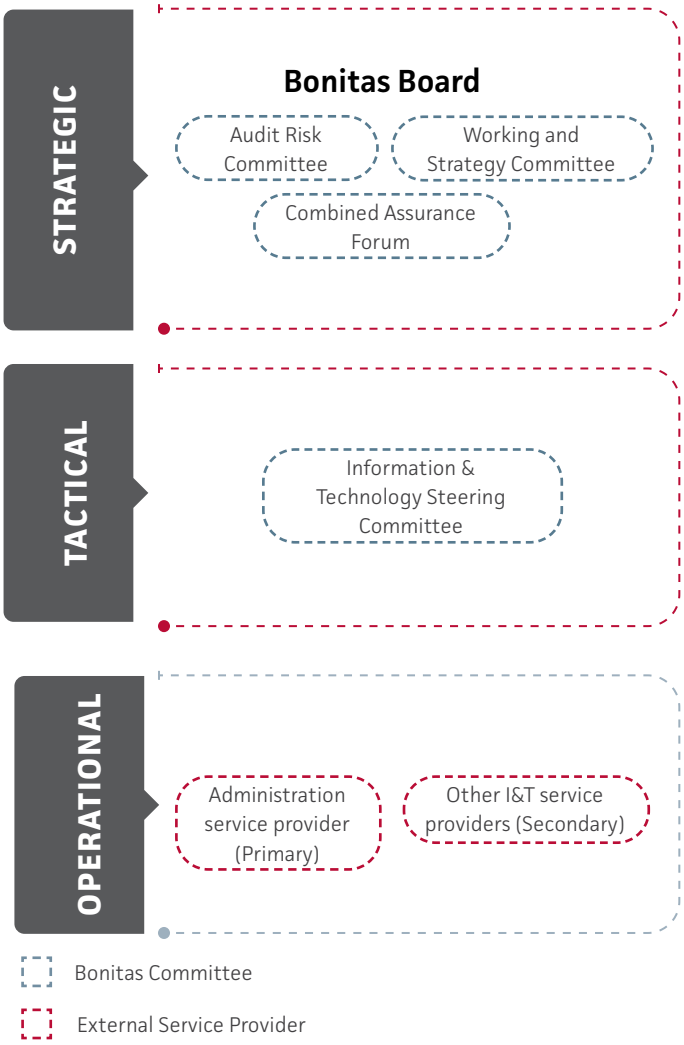
As the custodian of the I&T Governance Charter and Framework, the I&T Steering Committee provides oversight, governance, risk identification and monitoring for all Bonitas IT-related functions, inclusive of contracted primary service providers. It also ensures compliance with the Framework, adherence to IT requirements and SLAs. The oversight role also includes updates from primary service providers on matters such as penetration testing, vulnerability assessments, IT-related audits, disaster recovery plans and testing, business continuity plans and testing, as well as major IT-related projects.

The I&T Governance Charter and Framework includes the requirements set out in King IV, Control Objectives for Information and Related Technology (COBIT) 2019 and the ISO/IEC 38500:2016 Standard for Information Governance. The practices set out in the latest version IT Infrastructure Library (ITIL) were also considered.

COBIT 2019 is used as the primary guiding framework, since it covers IT-related governance areas addressed by King IV and ISO 38500, and links to other commonly used frameworks like ITIL, PMBOK and InfoSec.

Information and technology operating model

Bonitas implements I&T governance across all levels and structures, including service providers.



- Set the strategy for I&T
- Approve I&T policies
- Approve I&T budgets
- Generate awareness of governance standards and guide change
- Monitor effectiveness of I&T services in meeting Bonitas strategic objectives

- Continuously monitor I&T initiatives and services
- Ensure alignment between Bonitas business and I&T objectives
- Define working groups or projects for specific objectives
- Facilitate cross-functional I&T initiatives and include third-party providers as required

- Manage and monitor service delivery and ensure strategic alignment
- Ensure SLA and policy compliance
- Identify pain points and improvement areas
- Recommend and manage change
- Deal with incidents

Information and technology progress in 2021

We established the I&T Steering Committee this year, and embedded I&T reporting to Executive Management, the Audit and Risk Committee, the Working and Strategy Committee and the Board.

We developed and/or revised and approved the following IT Policies:

- Information Security and Acceptable Usage Policy
- Security Incident Management Policy including Data Breach Response Process Document
- General Access Management (including Passwords) Policy
- I&T Change Management Policy and Procedure
- Backup Policy

PwC conducted internal audit reviews on the adequacy and effectiveness of I&T governance processes. PwC also completed a Cybersecurity: National Institute of Standards and Technology (NIST) Assessment Review with no major concerns noted.

No external data breaches were reported for the year.

An internal user cyber awareness training course was completed in September 2021. Bonitas initiated a simulated phishing exercise in December 2021. Only two users clicked on links and were automatically enrolled on a training course.

Future focus areas

- Ongoing focus to embed the I&T Governance Charter and Framework and reporting system to monitor the risks and effective control of IT.
- Ongoing cyber awareness.
- Enforcement of IT policies.

STATEMENT OF RESPONSIBILITY OF THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2021

Annual financial statements

The Board is responsible for ensuring that Bonitas Medical Fund ("the Scheme") maintains accurate accounting records; the preparation, integrity and fair presentation of the annual financial statements of the Scheme. The annual financial statements comprise the statement of financial position as at 31 December 2021, the statements of comprehensive income, changes in funds and reserves and cash flows for the period ended; and the notes to the financial statements which include a summary of significant accounting policies and other explanatory notes. The annual financial statements presented on pages 81 to 140 have been prepared in accordance with International Financial Reporting Standards ("IFRS") and in a manner required by the Medical Schemes Act of South Africa, No 131 of 1998, as amended.

In the preparation of the annual financial statements, the Board considers that the most appropriate accounting policies have been used, consistently applied and supported by reasonable and prudent judgements and estimates in line with IFRS. The Board is satisfied that the information contained in the annual financial statements fairly represents the results of operations for the year and the financial position of the Scheme as at year-end. The Board also prepares other information included in the annual report and is responsible for its accuracy and consistency with the annual financial statements.

Going concern

The going concern basis has been adopted in preparing these financial statements.

The Board has reviewed detailed impact analyses and stress scenarios to determine the financial impact of COVID-19 on its reserves, profitability and liquidity and has determined that the Scheme has the sufficient reserves and liquidity in place to manage the associated financial risk.

The Scheme's forecasts support the long-term viability of the Scheme.

Accounting records and control environment

The Board is responsible for the Scheme's system of internal controls which includes risk management and internal control procedures that are designed to provide reasonable, but not absolute assurance that assets are safeguarded and the risks facing the business are being monitored and controlled. Furthermore, the internal controls are designed to enable the preparation of annual financial statements that are free from material misstatement, whether due to fraud or error, and maintaining adequate accounting records and an effective system of risk management.

To the best of its knowledge and belief, based on the above, the Board is satisfied that no material breakdown in the operation of the systems of internal control and procedures has occurred during the year under review.

External auditor's responsibility

The external auditor, Deloitte, is responsible for reporting on whether the annual financial statements fairly represent the financial position of the Scheme in accordance with the applicable financial reporting framework, and their unqualified audit report is presented on page 77. Deloitte had unrestricted access to all financial records and related data. The Board believes that all representations made to the external auditor during their audit were accurate and appropriate.

Approval of the annual financial statements

The annual financial statements of the Scheme were approved by the Board on 19 April 2022.

Mr OJ Komane
Chairperson of the Board
19 April 2022

Mr LR Callakoppen
Principal Officer
19 April 2022

J Bagg
Vice-Chairperson of the Board
19 April 2022

STATEMENT OF CORPORATE GOVERNANCE

FOR THE YEAR ENDED 31 DECEMBER 2021

Board

The Scheme is committed to the principles and practices of fairness, transparency, responsibility and accountability in all dealings and engagements with its stakeholders. The Trustees are nominated and elected by the members of the Scheme in terms of the Rules of the Scheme and in accordance with the Medical Scheme Act of South Africa, No. 131 of 1998, as amended ("the Act"). The Trustees are required to act with due care, diligence and good faith in the best interests of the Scheme and its members. In pursuit of this, the Trustees conduct themselves in accordance with the Rules of the Scheme, the Act and terms of reference of the Board. Although voluntary for medical schemes, Bonitas is committed to subscribing to King IV™ for additional guidance and best practice on good governance.

The Board meets regularly and monitors the performance of the Scheme, the administrator and other third-party service providers. The Trustees address a range of key issues and ensure that engagements, review and assessment of policy, governance, strategy and performance are critical, informed and constructive.

The Board further monitors its performance and that of the Board Committees against an agreed charter and performance targets.

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

Risk management and internal controls

The Board, through the Audit and Risk Committee, remains ultimately responsible for oversight and approval of risk management within the Scheme. The governance, risk and compliance function is responsible for co-ordinating, facilitating, monitoring and reporting risk within the Scheme. These roles are executed based on an established risk management policy.

The Board is responsible for overseeing the establishment of effective systems of internal controls in order to provide reasonable assurance as to the integrity and reliability of the annual financial statements and to adequately safeguard the Scheme's assets, mainly through an outsourced model (i.e. administrator). The Scheme's internal controls are based on established policies and procedures and are implemented and exercised by trained personnel with the appropriate segregation of duties.

PricewaterhouseCoopers provides an outsourced internal audit function to the Scheme with a direct functional reporting line to the Audit and Risk Committee of the Scheme. In addition, an in-house internal audit function exists within the administrator with regular reporting to Executive Management including the Audit and Risk Committee of the Scheme. PricewaterhouseCoopers confirmed in an Assessment of the systems of Internal Control, Risk Management and Governance Management Report issued to the Audit and Risk Committee (dated 5 April 2022) for the year ended 31 December 2021 that: "Notwithstanding the fact that there were internal audit findings reported, PricewaterhouseCoopers do not have significant concerns about the control environment in the areas reviewed (based on specific scope and results of sample testing) including the risk management control environment, should the areas raised be addressed by management in a timely manner. Although a formal governance assessment was not performed for the year ended 31 December 2021, to the extent that the individual reviews considered governance areas, PricewaterhouseCoopers concluded that no significant concerns were noted in this regard."

Mr OJ Komane
Chairperson of the Board

19 April 2022

Mr LR Callakoppen
Principal Officer

19 April 2022

J Bagg
Vice-Chairperson of the Board

19 April 2022

Private Bag X6
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South Africa

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INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF BONITAS MEDICAL FUND

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Bonitas Medical Fund (the Scheme) set out on pages 81 to 140, which comprise the statements of financial position as at 31 December 2021, and the statement of comprehensive income, the statements of changes in equity and the statements 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 financial statements present fairly, in all material respects, the financial position of the Scheme as at 31 December 2021, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes No 131 of 1998.

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 the Scheme in accordance with the Independent Regulatory Board for Auditors' Code of Professional Conduct for Registered Auditors (IRBA Code) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the corresponding sections of the International Ethics Standards Board for Accountants' (IESBSA) International Code of Ethics for Professional Accountants (including International Independence Standards) (IESBA code). 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 judgement, 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.

INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF BONITAS MEDICAL FUND

Key Audit Matter	How the matter was addressed in the audit
Outstanding claims provision	
As disclosed in Note 10, the carrying amount of the Outstanding Claims Provision ("IBNR") at year end was R904.4 million (2020: R976.3 million). The determination of the IBNR requires the Scheme's Trustees to make assumptions in the valuation thereof, which is determined with reference to an estimation of the ultimate cost of settling all claims incurred but not yet reported at the Statement of Financial Position date. The IBNR calculation is 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, • Variations in the nature and average cost per claim, and • Other factors such as expectations of future events that are believed to be reasonable to be taken into account in the valuation of the IBNR at year end. Certain of the above mentioned factors require judgement and assumptions to be made by the Scheme's Trustees and therefore accordingly, for the purposes of our audit, we identified the valuation of the IBNR as representing a key audit matter.	In evaluating the valuation of the IBNR, we audited the calculations approved by the Board of Trustees and performed various procedures which included: • Considering the design and implementation of the Scheme's controls relating to the preparation of the IBNR calculation, • Testing the integrity of the information used in the calculation of the IBNR by performing substantive procedures to test the accuracy and completeness of data used in the valuation of IBNR, • With the assistance of our internal actuarial specialists, performed an independent calculation of the estimate of the provision using historical claims data and trends, and using this estimate as a basis of assessing the reasonableness of the Board of • Trustees' estimate of the provision, • Testing a sample of claims paid in the current year against the related IBNR reserve held to assess the reasonability of assumptions used to calculate the IBNR estimate, • Performing tests of detail on the current year IBNR including testing actual claims paid subsequent to year end to determine if these have been appropriately reserved for at balance sheet date, and • Assessing the presentation and disclosure in respect of the IBNR and considered the adequacy of these disclosures. • Considering the validity and completeness of any out of model adjustments made to adjust the IBNR for matters not included in the historical data set and therefore not incorporated in the actuarially determined reserve. The assumptions applied in the IBNR calculation are appropriate and we are satisfied that the movement of the IBNR in the Statement of Comprehensive Income and the related disclosure of the IBNR balance and assumptions are appropriate.

INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF BONITAS MEDICAL FUND

Other Information

The Scheme's Trustees are responsible for the other information. The other information comprises the Statement of responsibility by the Board of Trustees, the Statement of corporate governance by the Board of Trustees and the Report of the Board of Trustees as required by the Medical Schemes Act No 131 of 1998, which we obtained prior to the date of this report. The other information does not include the financial statements and our auditor's 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 on the other information obtained prior to the date of this auditor's report, 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 for the Financial Statements

The trustees are responsible for the preparation and fair presentation of the financial statements in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act No 131 of 1998, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the Scheme'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 the trustees either intend to liquidate the Scheme or to cease operations, or have no realistic alternative but to do so.

INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF BONITAS MEDICAL FUND

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives 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.

As part of an audit in accordance with ISAs, we exercise professional judgement and maintain professional scepticism throughout 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 Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the trustees.
- Conclude 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 Scheme'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 Scheme 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 entities or business activities within the Scheme to express an opinion on the consolidated financial statements. We are responsible for the direction, supervision and performance of the Scheme 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

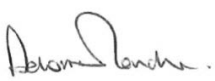
Non-compliance with the Medical Schemes Act No 131 of 1998

As required by the Council for Medical Scheme, we report that all material instances of non-compliance with the requirements of the Medical Schemes Act No 131 of 1998, has been adequately disclosed in the notes to the financial statements (Note 26 Non-Compliance with the Act).

Audit tenure

In terms of CMS Circular 38 of 2018 Audit tenure, we report that Deloitte & Touche has been the auditor of Bonitas Medical Fund for 5 years.

The engagement partner, Penny Binnie, has been responsible for Bonitas Medical Fund audit for 5 years



Deloitte & Touche
Per Penny Binnie
Partner

19 April 2022

STATEMENT OF FINANCIAL POSITION

AT 31 DECEMBER 2021

	Notes	**2021 R'000**	2020 R'000
ASSETS			
Property and equipment	4	**4 231**	9 125
Investment properties	5	**77 000**	77 700
Financial assets held at fair value through profit or loss	6	**4 784 072**	4 279 785
Non-current assets		**4 865 303**	4 366 610
Financial assets held at fair value through profit or loss	6	**3 461 898**	2 859 688
Insurance, trade and other receivables	8	**706 417**	719 066
Cash and cash equivalents	9	**766 465**	611 090
Current assets		**4 934 780**	4 189 844
Total assets		**9 800 083**	8 556 454
MEMBERS' FUNDS AND LIABILITIES			
Accumulated funds		**7 447 331**	6 059 840
Members' funds		**7 447 331**	6 059 840
Lease liability	4.2	**–**	3 047
Non-current liabilities		**–**	3 047
Outstanding risk claims provision	10	**904 350**	976 275
Personal medical savings accounts liability	11.1	**894 037**	812 078
Insurance, trade and other payables	12	**551 318**	669 731
Lease liability	4.2	**3 047**	3 605
Derivative financial instruments	7	**–**	31 878
Current liabilities		**2 352 752**	2 493 567
Total Members' funds and liabilities		**9 800 083**	8 556 454

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2021

	Notes	2021 R'000	2020 R'000
Risk contribution income	13	**18 138 159**	17 797 746
Relevant healthcare expenditure	14	**(16 289 636)**	(14 771 240)
Net claims incurred	14	**(15 851 053)**	(14 346 005)
Risk claims incurred		**(15 913 500)**	(14 405 261)
Third party claim recoveries		**62 447**	59 256
Accredited managed healthcare services	14	**(549 251)**	(551 530)
Net income on risk transfer arrangements	14	**110 668**	126 295
Risk transfer arrangement fees/premiums paid		**(1 531 348)**	(1 360 518)
Recoveries from risk transfer arrangements		**1 642 016**	1 486 813
Gross healthcare result		**1 848 523**	3 026 506
Broker service fees		**(360 620)**	(334 827)
Administrative expenditure	15	**(1 276 920)**	(1 221 891)
Net impairment losses on healthcare receivables	16	**(63)**	(20 281)
Net healthcare result		**210 920**	1 449 507
Other income		**1 243 833**	347 039
Investment income – Scheme	17	**1 221 652**	316 606
Change in fair value of investment property	17	**(700)**	2 900
Sundry income	18	**22 881**	27 533
Other expenditure		**(67 262)**	(56 785)
Asset management fees		**(38 675)**	(21 597)
Interest expense	11/4.2	**(24 010)**	(29 509)
Operating expenses on rental of investment property		**(4 577)**	(5 679)
Surplus for the year		**1 387 491**	1 739 761
Total comprehensive income for the year		**1 387 491**	1 739 761

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES

FOR THE YEAR ENDED 31 DECEMBER 2021

R'000	Accumulated funds R'000	Total R'000
Balance as at 31 December 2019	**4 320 079**	**4 320 079**
Total comprehensive income	**1 739 761**	**1 739 761**
Surplus for the year	**1 739 761**	**1 739 761**
Balance as at 31 December 2020	**6 059 840**	**6 059 840**
Total comprehensive income	**1 387 491**	**1 387 491**
Surplus for the year	**1 387 491**	**1 387 491**
Balance as at 31 December 2021	**7 447 331**	**7 447 331**

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2021

	Notes	2021 R'000	2020 R'000
Cash flows from operating activities			
Cash receipts from members and providers		**18 911 597**	18 613 087
Cash receipts from members – contribution		**18 800 873**	18 605 914
Cash receipts from members and provider – Other		**110 724**	7 173
Cash paid to providers, employees and members		**(18 773 017)**	(16 777 554)
Cash paid to providers and employees – claims		**(17 075 960)**	(15 170 531)
Cash paid to providers and employees – non healthcare expenditure		**(1 641 144)**	(1 550 092)
Cash paid to members – savings plan refunds	11	**(55 913)**	(56 931)
Cash generated by operating activities		**138 580**	1 835 533
Interest paid	11	**(23 606)**	(28 628)
Interest received	17	**4 661**	4 646
Net cash inflow from operating activities		**119 635**	1 811 551
Cash flows from investing activities			
Acquisition of property and equipment	4	**(103)**	(818)
Proceeds on disposal of property and equipment		**4**	4
Settlement of derivative financial instruments	7	**(86 373)**	–
Acquisition of financial assets held at fair value through profit or loss	6	**(1 009 999)**	(2 509 037)
Disposal of financial assets held at fair value through profit or loss	6	**842 104**	497 357
Interest received	20.1.1	**192 641**	145 492
Dividends received	20.1.2	**128 546**	68 526
Asset management fees	20.1.3	**(36 766)**	(19 914)
Rentals received	20.1.4	**9 695**	8 498
Net cash inflow/(outflow) from investing activities		**39 749**	(1 809 892)
Cashflows from financing activities			
Lease payments	4.2	**(4 009)**	(3 609)
Net cash outflow from financing activities		**(4 009)**	(3 609)
Net increase/(decrease) in cash and cash equivalents		**155 375**	(1 950)
Cash and cash equivalents at beginning of the year		**611 090**	613 040
Cash and cash equivalents at end of the year		**766 465**	611 090
Analysed as follows:			
Cash and cash equivalents	9	**766 465**	611 090
		766 465	611 090

The prior year amounts for the cash generated by operating activities have been reclassified based on the Direct method, for consistency with the current year presentation. The reclassification had no effect on the reported results of the total operating activities.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2021

1. GENERAL INFORMATION

The Scheme is a registered non-profit, open medical scheme in terms of the Medical Schemes Act 131 of 1998 ("the Act") and is domiciled in the Republic of South Africa. The Scheme is administered by Medscheme Holdings Proprietary Limited.

2. SIGNIFICANT ACCOUNTING POLICIES

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

2.1 Basis of preparation

2.1.1 Statement of compliance

The annual financial statements are prepared in accordance with International Financial Reporting Standards ("IFRS") and interpretations issued by the IFRS Interpretations Committees, as applicable in South Africa, and in the manner required by the Act.

2.1.2 Basis of measurement

These annual financial statements have been prepared on the going concern principle and using the historical cost basis except for fair value through profit or loss financial instruments and investment properties that are held at fair value.

Historical cost is generally based on the fair value of the consideration given in exchange for goods and services.

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date, regardless of whether that price is directly observable or estimated using another valuation technique.

In estimating the fair value of an asset or liability, the Scheme takes into account the characteristics of the asset or liability if market participants would take these characteristics into account when pricing the asset or liability at the measurement date. Fair value for measurement and/or disclosure purposes in these financial statements is determined on such a basis except for leasing transactions that are within the scope of IFRS 16.

2.1.3 Functional and presentation currency

The annual financial statements are prepared in Rand which is the Scheme's functional and presentation currency. All financial information presented has been rounded to the nearest thousand, unless otherwise stated.

2.1.4 New standards, amendments to published standards and interpretations

(a) New standards, amendments and interpretations issued and not yet effective in 2021 and relevant to the Scheme

Standard	Details of amendment	Effective date Periods beginning on or after
IFRS 17 Insurance Contracts	IFRS 17 will impact the measurement of the contracts with members in the scheme's financial statements. The scheme will qualify for the premium allocation approach which requires the scheme to recognise a liability for remaining coverage (with reference to the premiums received) and a liability for incurred claims (calculated as the expected cash outflows and a risk adjustment). The scheme expects that the boundary of the contracts with members will be one year. The scheme will be required to assess for onerous contracts at the point members elect the benefit option for the following year. The standard should be applied retrospectively. The Scheme is in the process of assessing the impact of the new standard with the following initial assessment results: The Scheme's adoption of the premium allocation approach as the optional measurement simplification method offered by the Standard is informed by the alignment of the contract coverage to the financial reporting period. The MSA has been assessed to be a legislative framework that acts as a barrier to set a price that fully reflects the risk of an insured member, resulting in the Scheme applying the level of aggregation at the broadest grouping and taking the view that all 11 of its benefit options are managed together as a single portfolio of contracts that display similar risks. The risk of the portfolio of contracts becoming onerous will further be evaluated based on the fulfilment cash flow expectations as determined in the Pricing and Budgeting cycles of each year. The MSA Regulation 29 currently defines the accumulated funds ratio with reference to gross contribution income and makes no allowance for the revised definitions of the new Standard. As a result, the new Standard will have no impact on the Scheme's solvency determination, with the exception of onerous contract accounting. Should the Pricing and Budgeting assess the portfolio of contracts to be onerous in the upcoming year, an additional expense and liability will be recognised in the year preceding the actual loss.	1 January 2023

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.1 Basis of preparation continued

2.1.4 New standards, amendments to published standards and interpretations continued

Standard	Details of amendment	Effective date Periods beginning on or after
Reference to the Conceptual Framework (Amendments to IFRS 3)	The amendment updates a reference in IFRS 3 to the Conceptual Framework for Financial Reporting without changing the accounting requirements for business combinations. Reporting, in order to determine what constitutes an asset or a liability in a business combination. In addition, the Board added a new exception in IFRS 3 for liabilities and contingent liabilities. The exception specifies that, for some types of liabilities and contingent liabilities, an entity applying IFRS 3 should instead refer to IAS 37, 'Provisions, Contingent Liabilities and Contingent Assets', or IFRIC 21, 'Levies', rather than the 2018 Conceptual Framework. The Board has also clarified that the acquirer should not recognise contingent assets, as defined in IAS 37, at the acquisition date.	1 January 2022
IAS 1 Presentation of Financial statements	*Classification of Liabilities as Current or Non-current:* Under existing IAS 1 requirements, companies classify a liability as current when they do not have an unconditional right to defer settlement of the liability for at least twelve months after the end of the reporting period. As part of its amendments, the Board has removed the requirement for a right to be unconditional and instead, now requires that a right to defer settlement must have substance and exist at the end of the reporting period. There is limited guidance on how to determine whether a right has substance and the assessment may require management to exercise interpretive judgement. The existing requirement to ignore management's intentions or expectations for settling a liability when determining its classification is unchanged. *Disclosure of Accounting Policies:* The amendments require schemes to disclose their material accounting policy information rather than their significant accounting policies, with additional guidance added to the Standard to explain how an entity can identify material accounting policy information with examples of when accounting policy information is likely to be material.	1 January 2023
Definition of Accounting Estimates (Amendments to IAS 8)	The amendments clarify how companies should distinguish changes in accounting policies from changes in accounting estimates, by replacing the definition of a change in accounting estimates with a new definition of accounting estimates. Under the new definition, accounting estimates are "monetary amounts in financial statements that are subject to measurement uncertainty". The requirements for recognising the effect of change in accounting prospectively remain unchanged.	1 January 2023
IAS 37 – Onerous Contracts: Cost of Fulfilling a Contract	Amendments to IAS 37, clarify that the 'costs of fulfilling a contract' when assessing whether a contract is onerous comprise both: • the incremental costs – e.g. direct labour and materials; and • an allocation of other direct costs – e.g. an allocation of the depreciation charge for an item of property, plant and equipment used in fulfilling the contract.	1 January 2022

2.2 Events after reporting date

Recognised amounts in the annual financial statements are adjusted to reflect events arising after reporting date that provide evidence of conditions that existed at the reporting date. Events arising after the reporting date, that are indicative of conditions that arose after the reporting date, are dealt with by way of a note disclosure.

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.3 Property and equipment

Property and equipment is measured at historical cost less accumulated depreciation and accumulated impairment losses.

Costs include expenditure that is directly attributable to the acquisition of the asset.

Depreciation is calculated using the straight-line method to allocate the cost of items of property and equipment to their residual values over their estimated useful lives.

The depreciation rates applicable to each category of property and equipment for the current and comparative periods are as follows:

- Motor vehicles – 5 years
- Leasehold improvements – 5 years
- Computer equipment – 1 to 5 years
- Office equipment – 1 to 5 years
- Furniture and fittings – 1 to 5 years
- Right of use asset – Amortised over Lease term

Depreciation methods, residual values and useful lives are reviewed at each reporting date and adjusted where appropriate. If the carrying amount of the asset is greater than its estimated recoverable amount, the carrying amount is written down immediately to its recoverable amount.

Subsequent costs are included in an asset's carrying amount or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the Scheme and the cost of the item can be measured reliably. All other repairs and maintenance costs are recognised in profit or loss during the financial period in which they are incurred.

Gains and losses on disposals are determined by comparing the proceeds from the disposal with the carrying amount of the relevant asset and these are recognised in profit or loss during the financial period.

2.4 Investment properties

Investment properties are initially measured at cost and subsequently measured using the fair value model.

Land and buildings that constitute investment properties are not depreciated. The fair value of investment properties is determined annually by independent external professional valuators using the comparable sales and income capitalisation approaches. The fair value movement is recognised in profit or loss during the financial period.

Any gain or loss on disposal of investment property (calculated as the difference between the net proceeds from disposal and the carrying amount of the item) is recognised in profit or loss.

2.5 Impairment of non-financial assets

The carrying amounts of the Scheme's property and equipment are reviewed at each reporting date to determine whether there are events or changes in circumstances that indicate that the carrying amount may not be recoverable. If any such indication exists, then the affected asset's recoverable amount is estimated.

The recoverable amount of an asset is the higher of its value in use and its fair value less costs to sell. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset.

An impairment loss is recognised if the carrying amount of an asset exceeds its estimated recoverable amount. Impairment losses are recognised in profit or loss.

Impairment losses recognised in prior periods are assessed at each reporting date for any indications that the loss has decreased or no longer exists. An impairment loss is reversed if there has been a change in the estimates used to determine the recoverable amount. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation, if no impairment loss had been recognised.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.6 Financial instruments

2.6.1 Classification, recognition and measurement

Regular-way purchases and sales of financial assets and liabilities are recognised on trade date, being the date that the Scheme becomes a party to the contractual rights or obligations of the instrument. The Scheme has the following financial instrument categories: Fair value through profit or loss; Loans and receivables; and Financial liabilities. The Scheme has classified its financial instruments into the following classes:

- Financial assets held at fair value through profit or loss;
- Derivatives;
- Insurance, trade and other receivables;
- Cash and cash equivalents;
- Insurance, trade and other payables; and
- Personal member savings accounts liability.

The classification and measurement of the financial instruments depend on the objective of the Scheme's business model whether it is to hold assets only to collect cash flows, or to collect cash flows and to sell and whether the contractual cash flows of an asset give rise to payments on specified dates that are solely payments of principal and interest on the principal amount outstanding. Management applies this assessment on financial instruments at initial recognition and re-evaluates this for Financial assets when the objective of the Scheme's business model changes.

Financial instruments are initially measured at fair value plus transaction costs that are directly attributable to acquisition or issue of the financial asset or liability. Subsequent to initial recognition, these instruments are measured as set out below.

i) Financial assets held at fair value through profit or loss

These financial assets are initially recognised at fair value excluding transaction costs, which are immediately expensed.

These financial assets are subsequently measured at fair value. The fair value adjustments are recognised in the statement of profit or loss during the financial period.

Derivative financial instruments are carried at fair value through profit or loss and these are recognised as either current or non-current assets/liabilities based on the contractual period and fair value movement.

ii) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market other than those that the Scheme intends to sell in the short term. Insurance receivables are classified in this category and are reviewed for impairment as part of the impairment review of loans and receivables. They are included in current assets, except for maturities greater than 12 months after the end of the reporting period. These are classified as non-current assets.

Loans and receivables comprise of 'Insurance, trade and other receivables' (excluding prepayment) and 'Cash and cash equivalents'.

Loans and receivables are subsequently measured at amortised cost using the effective interest method, less impairment losses.

a) Insurance, trade and other receivables

Insurance, trade and other receivables with members (insurance receivables) and these balances are reviewed for impairment as part of the impairment review conducted on loans and receivables.

b) Cash and cash equivalents

Cash and cash equivalents comprise cash on hand, deposits held at call with banks, other short-term liquid investments that are readily convertible to a known amount of cash and are subject to an insignificant risk of change in value, and have an original maturity of 90 days or less.

iii) Financial liabilities

A financial liability is a liability that is a contractual obligation to deliver cash or another financial asset to another entity or to exchange financial assets or financial liabilities with another entity under conditions that are potentially unfavourable to the entity. They are included in current liabilities, except for maturities greater than 12 months after the end of the reporting period. These are classified as non-current liabilities.

Financial liabilities comprise Insurance, trade and other payables and personal member savings accounts liability.

Financial liabilities are recognised initially at fair value less any directly attributable transaction costs. Subsequent to initial recognition, financial liabilities are measured at amortised cost, using the effective interest method.

Derivative liabilities include liabilities that exist at year end as a result of marked-to-market losses accrued on derivative instruments. A derivative with a positive fair value is recognised as a financial asset whereas a derivative with a negative fair value is recognised as a financial liability.

a) Insurance, trade and other payables

Insurance, trade and other payables include payables relating to healthcare insurance contracts and amounts owing to South African Revenue Services.

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.6 Financial instruments continued

2.6.2 Impairment of financial assets

i) Loans and receivables

The Scheme's loans and receivables do not contain a significant financing component and therefore the loss allowance is measured at initial recognition as the expected the credit losses that result from all possible default events over the expected life of a financial instrument (ECL) in accordance with IFRS 9. As a practical expedient, IFRS 9 allows a provision matrix to be used to estimate ECL for these financial instruments.

The provision matrix is based on historical observed default rates, adjusted for forward looking estimates. At every reporting date, the historical observed rates are updated. Objective evidence that a financial asset or group of assets is impaired includes observable data that comes to the attention of the Scheme about the following events: the Scheme is unable to collect all amounts due according to the original terms of the receivables; significant financial difficulty of the issuer or debtor; a breach of contract, such as a default or delinquency in payments by the debtor; the disappearance of an active market for that financial asset because of financial difficulties; or national or local economic conditions that correlate with defaults on the assets in the Scheme.

It is in respect of contributions receivable, member and service provider debit balances and advances from savings plan accounts recoverable by management. The Scheme utilises readily available economic information such as consumer price index, healthcare inflation, national credit rating and unemployment indicators as a basis for determining the future expectations of the observable data.

If it is determined that a possible impairment loss will be incurred on loans and receivables measured at amortised cost, the amount of the loss is measured as the difference between the present value of the cash flows due under the contract and the present value of the cash flows that the entity expects to receive. These losses are recognised at initial recognition in profit or loss and reflected in an allowance account.

If in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised (such as improved credit rating), the previously recognised impairment loss is reversed directly to profit or loss.

2.6.3 Derecognition of financial instruments

Financial assets are derecognised when the rights to receive cash flows from the assets have expired, the right to receive cash flows has been retained but an obligation to pay them in full without material delay has been assumed or the right to receive cash flows has been transferred together with substantially all the risks and rewards of ownership.

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

Where the Scheme neither transfers nor retains substantially all the risks and rewards of ownership of the financial asset, the Scheme determines whether it has retained control of the financial asset. If the Scheme has not retained control, it derecognises the financial asset and recognises separately as assets or liabilities any rights and obligations created or retained in the transfer; and if the Scheme has retained control, it continues to recognise the financial asset to the extent of its continuing involvement in the financial asset.

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

2.6.4 Offset

Financial assets and liabilities are offset and the net amount reported in the statement of financial position only when there is a legally enforceable right to offset the recognised amounts and there is an intention to settle on a net basis, or to realise the asset and settle the liability simultaneously.

2.7 Insurance contracts

Contracts under which the Scheme accepts significant insurance risk from another party ("the member") by agreeing to compensate the member or other beneficiary if a specified uncertain future event ("the insured event") adversely affects the member or other beneficiary are classified as insurance contracts. The contracts issued compensate the Scheme's members for healthcare expenses incurred. Refer note 2.12 for the accounting policies relating to risk transfer arrangements.

2.8 Outstanding claims provision

Outstanding claims comprise provisions for the Scheme's estimate of the ultimate cost of settling all claims incurred but not yet reported ("IBNR") at the reporting date. Outstanding claims are actuarially 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, variations in the nature and average cost incurred per claim, and other factors such as expectations of future events that are believed to be reasonable to be taken into account in the valuation of the IBNR at year end.

Estimated co-payments and payments from savings plan accounts are deducted in calculating the outstanding claims provision. The Scheme does not discount its provision for outstanding claims, since the effect of the time value of money is not considered material. The estimation of claims to be paid by the Scheme is up to four months after reporting date.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.9 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, including related cash flows, and comparing this amount to the carrying value of the liability. Where a shortfall is identified, an additional provision is made and the Scheme recognises the deficiency in profit or loss for the year.

2.10 Personal Medical Savings Account ("PMSA") liability

The PMSA Liability is managed by the Scheme on behalf of its members. It represents PMSA contributions, which are a deposit component of the medical insurance contracts and accrued interest thereon, net of any PMSA claims paid on behalf of members in terms of the Scheme's rules. The deposit component has been unbundled since the Scheme can measure the deposit component separately and its accounting policies do not otherwise require it to recognise all obligations and rights arising from the deposit component. The medical insurance component is recognised in accordance with IFRS 4, Insurance Contracts.

Member unused savings at year-end are retained in the members' PMSA. In terms of the Act, balances standing to the credit of members are refundable in accordance with the Scheme Rules.

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

The PMSA Liability, i.e. deposit component, is recognised in accordance with IFRS 9 and is initially measured at fair value (i.e. the amount payable on demand) because it has a demand feature and subsequently measured at amortised cost.

PMSA contributions are credited on the deposit basis and withdrawals on a cash basis, i.e. no provision is made for outstanding claims at year-end.

2.11 Risk contribution income

Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably certain. Risk contributions represent the gross contributions per the registered rules after the unbundling of savings contributions. The earned portion of risk contributions received is recognised as revenue. Risk contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis. Risk contributions are shown before the deduction of broker service fees.

2.12 Relevant healthcare expenditure

Relevant healthcare expenditure consists of net claims incurred and net income or expenses from risk transfer arrangements and accredited managed care services as per circular 56 of 2015.

2.12.1 Risk claims incurred

Risk claims incurred comprise the total estimated cost of all claims arising from healthcare events that have occurred in the year and for which the Scheme is responsible in terms of its registered rules, whether or not reported by the end of the year. Net risk claims incurred represent claims incurred net of discounts received, recoveries from members for co-payments, PMSA and recoveries from third parties.

2.12.2 Risk transfer arrangements

The risk transfer arrangements comprise the provision of medical services that are outsourced to third parties of the Scheme. A risk transfer arrangement is defined by IFRS 4 as an insurance contract issued by one insurer ("the reinsurer") to compensate another insurer ("the cedant") for losses on one or more contracts issued by the cedant. The cost the Scheme would have incurred to deliver the specified benefits had it not entered into the capitation agreement, represents the Scheme's exposure to its members, as the capitation agreement cannot absolve the Scheme from its responsibility towards its members. This cost is determined by the claims paid out for members on options that are not included in the capitation agreements taking into account adjustments for differences in the benefit thresholds. Only contracts that give rise to a significant transfer of insurance risk are accounted for as risk transfer arrangements. Risk transfer fees are recognised as an expense over the indemnity period on a straight-line basis. Where applicable, a portion of risk transfer fees is treated as pre-payments.

Capitation fees relating to risk transfer arrangements are calculated on a per member per month basis.

Risk transfer claims and benefits reimbursed are presented in profit or loss and the statement of financial position on a gross basis. Amounts recoverable under such contracts are recognised in the same year as the related claim.

Claims recoveries relating to risk transfer arrangements represent a recovery in kind of the amount that the Scheme would have incurred in claims, had the risk transfer arrangement not been in place.

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 each 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 Scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the Scheme will receive under the risk transfer arrangement.

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.13 Employee benefits

2.13.1 Defined contribution plans

A defined contribution plan is a post-employment benefit plan under which an entity pays fixed contributions into a separate entity and will have no legal or constructive obligation to pay further amounts. Obligations for contributions to defined contribution pension plans are recognised as an employee benefit expense in profit or loss when they are due. Prepaid contributions are recognised as an asset to the extent that a cash refund or a reduction in future payments is available.

2.13.2 Short-term benefits

Short-term employee benefit obligations are measured on an undiscounted basis and are expensed in profit or loss during the period in which the employee renders the related service.

A liability is recognised for the amount expected to be paid under short-term cash bonus plans if the Scheme has a present legal or constructive obligation to pay this amount as a result of past service provided by the employee and the obligation can be estimated reliably.

2.14 Leases

The Scheme leases property which is accounted for under IFRS 16. The contracts contains a lease as defined because it conveys the right to control the use of the identified asset for a period of time in exchange for consideration.

The Scheme as a lessee:

For contracts for which the Scheme is a lessee the initial measurement requires the recognition of a right of use asset and lease liability recognised at commencement date.

The right of use asset is initially recognised at cost which includes the initial amount of the lease liability adjusted for any lease payments made on or before commencement date plus initial direct costs incurred.

The right of use asset is subsequently depreciated on a straight line basis over the useful life which is the same basis as the lease period. Additionally the right of use asset is periodically reduced by impairments if any and adjusted for changes in the remeasurement of the lease liability.

The lease liability is initially measured at the present value of lease payments that are not paid at the commencement date discounted at the interest rate if that rate can be readily determined. If that rate cannot be readily determined, the Scheme uses the lessee's incremental borrowing rate.

Lease payments included in the measurement of the lease liability comprise fixed payments including in substance fixed payments less any incentives receivable.

The lease liability is subsequently measured by increasing the carrying amount to reflect interest on the lease liability (using the effective interest method) and by reducing the carrying amount to reflect the lease payments made.

The Scheme as a lessor:

Contracts wherein the Scheme is a lessor, are either classified as an operating lease or a finance lease based on an overall assessment to determine whether substantially all the risks and rewards are transferred or retained by the Scheme. Payments made under operating leases are recognised in profit or loss on a straight-line basis over the period of the lease.

2.15 Investment income

Investment income comprises: interest on call accounts, current accounts, bonds and money market instruments; dividend income; rental income from investment properties; net fair value gains on financial assets at fair value through profit or loss; changes in the fair value of investment property and gains/losses on disposal of investment properties.

2.15.1 Interest income

Interest income 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 Scheme.

2.15.2 Dividend income

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

2.15.3 Rental income

Assets leased to third parties are included in investment property in the statement of financial position. Lease income from operating leases is recognised in profit or loss on a straight-line basis over the lease term.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

2. SIGNIFICANT ACCOUNTING POLICIES CONTINUED

2.16 Allocation of income and expenses to benefit options

The following items are directly allocated to benefit options:

- Risk contribution income;
- Net claims incurred;
- Net income on risk transfer arrangements;
- Net impairment losses;
- Administration fees;
- Managed care: management services;
- Broker service fees; and
- Interest on savings plan liability.

The remaining non-healthcare costs are apportioned based on the number of members per option divisible by total membership on the Scheme for the financial period.

- Other administrative expenditure;
- Net impairment losses;
- Investment income;
- Sundry income; and
- Asset management fees.

3. USE OF ESTIMATES AND JUDGEMENTS

The preparation of the annual financial statements in conformity with IFRS requires management to make judgements, estimates and assumptions that affect the application of the accounting policies and the reported amounts of assets, liabilities, income and expenses. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the annual financial statements, are disclosed below.

Estimates and underlying assumptions are continually evaluated and reviewed on an ongoing basis and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. Revisions to accounting estimates are recognised in the period in which the estimates are revised and in any future periods affected.

The annual financial statements are prepared in Rand which is the Scheme's functional and presentation currency. All financial information presented has been rounded to the nearest thousand, unless otherwise stated.

3.1 Determination of outstanding claims provision

The provision for outstanding risk claims has been calculated using an actuarial valuation. The method used by the actuary, including information about significant areas of estimation, uncertainty and critical judgements applied, is discussed in note 10, Outstanding risk claims provision.

3.2 Determination of fair values

Investment properties, fair value through profit or loss financial instruments and derivative financial instruments are measured at fair value and include an estimation component. Fair values have been determined for measurement and/or disclosure purposes based on the methods listed below. Where applicable, further information about the assumptions made in determining fair values is disclosed in the notes specific to that asset or liability.

3.2.1 Investment properties

An independent valuation company, having appropriate recognised professional qualifications and recent experience in the location and category of property being valued, values the Scheme's investment property portfolio annually.

Valuations reflect, when appropriate the type of tenants actually in occupation or responsible for meeting lease commitments or likely to be in occupation after letting vacant accommodation, and the market's general perception of their creditworthiness; the allocation of maintenance and insurance responsibilities between the Scheme and the lessee; and the remaining economic life of the property.

3.2.2 Fair value through profit or loss financial assets

Financial assets classified as level 2 are valued using a discounted cash flow method. For unlisted equity financial assets, fair value was determined by the Board of Trustees using the net asset value valuation approach.

The unlisted property holding is valued based on the fair value of the underlying property. The property is valued using the net income of the property and applying a capitalisation rate to the net income. The capitalisation rate applied is based on an assumed average commercial property yield simulating the risk characteristics of a similar investment. The majority of investments held within the portfolio are subject to various assumptions based on valuation techniques not supported by observable market data.

3. USE OF ESTIMATES AND JUDGEMENTS CONTINUED

3.3 Discount rates

The discount rates used are the appropriate pre-tax rates that reflect the current market assessment of the time value of money and the risks specific to the assets and liabilities being measured for which the future cash flow estimates have not been adjusted.

3.4 Unconsolidated investment structures

The Scheme has involvement with investment funds in which it invests but it does not consolidate. The investment funds meet the definition of structured entities because:

- The voting rights in the funds are not dominant rights in deciding who controls them because they relate to administrative tasks only;
- Each fund's activities are restricted by prospectus; and
- The funds have narrow and well-defined objectives to provide investment opportunities.

3.5 Investment in associate

The investment of 26% in Louis Pasteur Hospital Holding Proprietary Limited has not been accounted for as an investment in associate as the Scheme is not actively involved and does not have significant influence over the entity. The investment was accounted for as an unlisted investment and classified as a financial asset held at fair value through profit or loss.

4. PROPERTY AND EQUIPMENT

Property and equipment comprise owned and leased assets that do not meet the definition of investment property.

	Note	**2021 R'000**	2020 R'000
Property and equipment	4.1	**2 269**	3 881
Right of use asset	4.2	**1 962**	5 244
		4 231	9 125

R'000	**Motor Vehicles R'000**	**Leasehold improvements R'000**	**Computer Equipment R'000**	**Office Equipment R'000**	**Furniture and Fittings R'000**	**Total R'000**
4.1 Property and equipment						
Cost						
Balance at 31 December 2019	359	4 339	5 444	1 161	4 558	15 861
Additions	–	–	110	–	708	818
Disposals/scrappings	–	–	(40)	–	–	(40)
Balance at 31 December 2020	359	4 339	5 514	1 161	5 266	16 639
Additions	**–**	**–**	**103**	**–**	**–**	**103**
Disposals/scrappings	**–**	**–**	**(77)**	**–**	**–**	**(77)**
Balance at 31 December 2021	**359**	**4 339**	**5 540**	**1 161**	**5 266**	**16 665**
Accumulated depreciation						
Balance at 31 December 2019	216	1 873	4 913	130	3 825	10 959
Disposals/scrappings	–	–	(38)	–	–	(38)
Depreciation for the period	71	894	368	219	283	1 837
Balance at 31 December 2020	287	2 767	5 243	349	4 108	12 758
Disposals/scrappings	**–**	**–**	**(77)**	**–**	**–**	**(77)**
Depreciation for the period	**72**	**890**	**224**	**218**	**310**	**1 715**
Balance at 31 December 2021	**359**	**3 657**	**5 390**	**567**	**4 418**	**14 396**
Carrying amount						
Balance at 31 December 2020	72	1 572	271	812	1 158	3 881
Balance at 31 December 2021	**–**	**682**	**150**	**593**	**848**	**2 269**

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

4. PROPERTY AND EQUIPMENT CONTINUED

4.2 Lease

The Scheme leases the building from which it operates its head office. The remaining lease term on 31 December 2021 was determined to be nine months. Depreciation charge is determined on a straight line basis over the remaining lease term. Information about the lease for which the Scheme is the lessee is presented below:

Right of use asset

	Building R'000	Total R'000
Balance at 1 January 2021	**5 244**	**5 244**
Depreciation charge for the year	**(3 282)**	**(3 282)**
Balance at 31 December 2021	**1 962**	**1 962**
Lease liabilities		
Maturity Analysis – contractual undiscounted cashflows:		
Not later than one year	**4 009**	**4 009**
Later than one year and not later than five years	**3 149**	**3 149**
Total undiscounted lease liabilities as at 31 December 2020	**7 158**	**7 158**
Not later than one year	**3 149**	**3 149**
Later than one year and not later than five years	**–**	**–**
Total undiscounted lease liabilities as at 31 December 2021	**3 149**	**3 149**

Included in the Statement of Financial Position is the lease liability for the remaining lease term of 9 months as at 31 December 2021:

	2021 R'000	2020 R'000
Current lease liability	**3 047**	3 605
Non-current lease liability	**–**	3 047
	3 047	6 652

The Scheme's interest rate per the lease contract of 8% was used to discount the cashflows to the present value of the lease liability from which the interest expense is derived. The variable costs relating to the lease were expensed in profit or loss and largely relate to the utility bill which is driven by utilisation. These expenses comprise 32% of the fixed lease payments and are excluded in the determination of the lease liability and related right of use asset.

Included in the Statement of profit or loss and other comprehensive income at 31 December 2021:

	2021 R'000	2020 R'000
Interest on lease liability	**(404)**	(670)
Rental costs – variable in nature	**(1 858)**	(1 852)
	(2 262)	(2 522)

Total cash outflow with respect to the head office lease for 31 December 2021 is as follows:

	2021 R'000	2020 R'000
Lease liability cashflows	**(4 009)**	(3 609)
Rental costs – variable in nature	**(1 858)**	(1 852)
	(5 867)	(5 461)

Details of the property and equipment are recorded in an asset register which may be inspected at the registered office of the Scheme. No assets have been pledged as security.

	2021 R'000	2020 R'000
5. INVESTMENT PROPERTIES		
Balance at the beginning of the year	**77 700**	74 800
Fair value (decrease)/increase in investment property	**(700)**	2 900
Balance at the end of the year	**77 000**	77 700
Direct operating expenses incurred in the generation of rental income applicable to investment properties	**4 577**	5 679

Investment properties comprise commercial properties that are leased to third parties. The properties are leased for various periods. Subsequent renewals are negotiated with the lessee. No contingent rents are charged. Refer to note 23 of the financial statements for minimum future lease rental receivables from lessees. Lease rental receipts amounting to R9.8 million (2020: R9.2 million) relating to the lease of investment properties are included in profit or loss, refer to note 17 of the financial statements.

The estimated open market value for developed commercial property leased to third parties was determined by independent property valuators DDP Valuations & Advisory Services (Pty) Ltd using an Income capitalisation approach. The capitalisation rate used in determining the open market value was 9.25% (2020: 9%).

	2021 R'000	2020 R'000
6. FINANCIAL ASSETS HELD AT FAIR VALUE THROUGH PROFIT OR LOSS		
Balance at the beginning of the year	**7 139 473**	5 008 926
Additions/reinvestments	**1 009 999**	2 509 037
Withdrawals	**(842 104)**	(497 357)
Interest income reinvested	**102 801**	87 897
Dividend income reinvested	**1 203**	7 998
Asset management fees capitalised to investments	**(1 909)**	(1 683)
Net fair value gains on fair value assets through profit or loss (note 17)	**836 507**	24 655
Balance at the end of the year	**8 245 970**	7 139 473
Non-current	**4 784 072**	4 279 785
Current	**3 461 898**	2 859 688
	8 245 970	7 139 473
Comprises:		
Listed equities	**3 154 282**	2 332 973
Unlisted equities	**–**	22 000
Bonds	**3 684 494**	3 633 929
Money market instruments	**1 407 194**	1 148 983
Unlisted property holding	**–**	1 588
	8 245 970	7 139 473

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

	2021 R'000	2020 R'000
7. DERIVATIVE FINANCIAL INSTRUMENTS		
Financial liabilities held at fair value through profit or loss		
Current liabilities		
– Derivative financial instruments	**–**	31 878
Derivative financial liability at the end of the year	**–**	31 878
Reconciliation of the balance at the end of the year:		
Derivative financial liability at the beginning of the year	**31 878**	–
Losses on revaluation of derivative financial instruments to fair value		
Fair value losses on derivative financial instruments		
– Zero-cost equity fences	**54 495**	31 878
Settlement of derivative financial instruments	**(86 373)**	–
Derivative financial liability at the end of the year	**–**	31 878

In September 2020 Bonitas Medical Fund entered into a contractual agreement with Khumo Capital (Pty) Ltd to act as an agent for the Scheme and enter into derivative agreements with counterparty banks on the Scheme's behalf. The Scheme signed a trade instruction before any trade was implemented.

The Scheme is exposed to market risk resulting from equity price fluctuations. The Scheme implemented 85%_97.5% Zero Cost Fence structures to protect a portion of the Scheme's equity portfolio from market declines. The structures also limited the potential upside from market increases. These derivatives were both entered into in September 2020 and expired in September 2021. Refer to note 22.4.3 for further detail.

	2021 R'000	2020 R'000
8. INSURANCE, TRADE AND OTHER RECEIVABLES		
8.1 Insurance receivables		
Contributions outstanding	**646 822**	618 752
Recoveries due from members for co-payments	**6 545**	6 474
Service provider receivables	**5 745**	6 556
Amounts owing from Managed care organisation	**3 631**	2 262
Amounts owing from related entities	**9 492**	55 545
Receivables under risk transfer arrangements	**39 194**	43 787
Savings plan account advances (note 11)	**1 333**	1 448
Allowance for impairment losses	**(15 523)**	(24 556)
Balance at 1 January	**(24 556)**	(11 006)
Decrease/(increase) in provision charged to profit or loss (note 16)	**9 033**	(13 550)
Total insurance receivables	**697 239**	710 268
8.2 Trade and other receivables		
Prepaid expenses	**5 714**	4 923
Other receivables	**3 464**	3 875
Interest receivables	**12**	26
Rent receivables	**564**	615
Rent deposit	**1 533**	1 533
Sundry receivables	**1 355**	1 701
Total trade and other receivables	**9 178**	8 798
Total insurance, trade and other receivables	**706 417**	719 066

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

The prior year comparatives have been reclassified. Receivables under risk transfer arrangements associated with a related entity have been reclassified from 'Receivables under risk transfer arrangements' to 'Amounts owing from related entities'.

	2021 R'000	2020 R'000
9. CASH AND CASH EQUIVALENTS		
Cash with investment managers	**128 472**	197 937
Call accounts with investment managers	**90 739**	57 697
Current accounts with banks	**547 254**	355 456
Total cash and cash equivalents	**766 465**	611 090

The carrying amount of the cash and cash equivalents approximates the fair values due to the short-term nature of the investments. The weighted average effective interest rate was 4.6% (prior year: 5.8%) on call account balances.

	2021 R'000	2020 R'000
10. OUTSTANDING RISK CLAIMS PROVISION		
Covered by risk transfer arrangements	**39 194**	43 787
Not covered by risk transfer arrangements	**865 156**	932 488
Outstanding risk claims provision – incurred but not yet reported (IBNR)	**904 350**	976 275

	Covered by risk transfer arrangements R'000	Not covered by risk transfer arrangements R'000
2021		
Analysis of movements in outstanding risk claims		
Balance at 1 January	**43 787**	**932 488**
Payments in respect of prior year claims	**(43 787)**	**(875 632)**
Over provision in prior year*	**–**	**56 856**
Adjustment for current period	**39 194**	**808 300**
Balance at 31 December	**39 194**	**865 156**
Net exposure in respect of outstanding risk claims		
Gross outstanding risk claims		**904 350**
Less: Estimated risk transfer arrangements recoveries		**(39 194)**
Net outstanding risk claims		**865 156**
2020		
Analysis of movements in outstanding risk claims		
Balance at 1 January	41 061	728 047
Payments in respect of prior year claims	(41 061)	(709 919)
Over provision in prior year	–	18 128
Adjustment for current period	43 787	914 360
Balance at 31 December	43 787	932 488
Net exposure in respect of outstanding risk claims		
Gross outstanding risk claims		976 275
Less: Estimated risk transfer arrangements recoveries		(43 787)
Net outstanding risk claims		932 488

* *The over provision of R57 million in the prior year was as a result of faster run-off speeds observed for 2020 treatments when compared to earlier years' trends, on which these assumptions were based. This was mainly as a result of faster run-off speeds associated with specialists costs as illustrated below.*

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

10. OUTSTANDING RISK CLAIMS PROVISION CONTINUED

Month	Specialists	
	Actual run-off observed	Assumed run-off
0	58%	48%
1	89%	82%
2	95%	91%
3	97%	94%
4	99%	96%
5	99%	97%
6	99%	98%
7	100%	98%
8	100%	99%
9	100%	99%
10	100%	99%
11	100%	99%
12+	100%	100%

Data, methodology and assumptions

10.1 Data

The primary source of data used in this exercise was the Medscheme data warehouse. This contained the necessary contributions, risk claims and other data of the Scheme. The data used included all claim payments and membership movements up to the end of February 2022.

Data was compared to the Scheme's December 2021 management accounts and found to be consistent after adjusting for manually paid claims.

10.2 Process used to determine the assumptions

The process used to determine the assumptions is intended to result in estimates of the most likely or expected outcome. The sources of data used as inputs for the assumptions are generated internally, using detailed studies that are carried out regularly (at least annually).

The general methodology involves increasing the claims paid so as to estimate the total claim amounts expected for treatments occurring up to 31 December 2021. The difference between the total expected risk claims and the paid risk claims is the outstanding risk claims provision.

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 affecting the ultimate costs of the risk claims is difficult to estimate. The provision estimation difficulties also differ by category of risk claims (i.e. in-hospital, chronic and above threshold benefits) due to differences in the underlying medical insurance contract, claim complexity, the volume of risk claims, the individual severity of risk claims, determining the occurrence date of a claim and reporting lags.

Run-off factors are most reliable as a predictive tool where outstanding claims are relatively small and the payment pattern is stable over time. Actuarial run-off triangle techniques are applied to estimate the total expected claims. In particular, run-off factors (development factors) are used to calculate the remaining outstanding claims with respect to a particular treatment month, as it takes several months for all claims to be paid, due to delays in receiving or processing claims. Members must submit all claims for payment within four months of seeking medical treatment. However, some claims do take significantly longer than four months to settle. One would expect the most recent month to have a significant proportion of claims still to be paid. This proportion would decrease each preceding month, with all claims assumed to have been fully paid about nine months after treatment. These run-off factors are calculated by considering the Scheme's recent experience on the pattern of when claims occur and when they are paid. It is assumed that payments will emerge in a similar way in each treatment month. In determining run-off factors, claims are categorised into groups for which one can expect a homogenous run-off pattern to emerge.

10. OUTSTANDING RISK CLAIMS PROVISION CONTINUED

Data, methodology and assumptions continued

10.2 Process used to determine the assumptions continued

The above method uses historical risk claims development information and assumes that the historical risk 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 risk claims paid and incurred (such as changes in claim reserving procedures).
- Economic, political and social trends.
- Changes in composition of members and their dependants.
- Random fluctuations, including the impact of large losses.

The calculations are based on treatment dates rather than payment dates. Treatment dates are the dates on which treatment of the member actually occurs, whilst payment date refers to the date on which the health practitioner was actually paid.

10.3 Assumptions

The assumptions that have the greatest effect on the measurement of the outstanding risk claims provision are the run-off factors for the 2019, 2020 and 2021 benefit years.

Changes in assumptions and sensitivities to changes in key variables

The table below outlines the sensitivity of the outstanding risk claims provision to reasonable possible movements in assumptions used in the estimation process. It should be noted that this is a deterministic approach with no correlations between the key variables.

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

An analysis of sensitivity around various scenarios for the general medical insurance business provides an indication of the adequacy of the Scheme's estimation process. Information from the managed healthcare provider on pre-authorised but unpaid hospital accounts was used as an independent source of information to assess the reasonability of the projected hospital claims and to modify the estimate where necessary. Hospital claims are the largest claims category by value and are also one of the slowest categories of claims to be paid. Thus, an independent estimate of the expected hospital cost is particularly valuable in estimating the total expected claims costs for the Scheme.

The Scheme believes that the liability for claims reported in the statement of financial position is adequate. However, it recognises that the process of estimation is based on certain variables and assumptions which could differ when claims arise.

The change in the outstanding risk claims provision also represents the absolute change in net surplus/(deficit) for the year. It should be noted that increases in provisions will result in decreases in surplus and vice versa. These reasonable possible changes in key assumptions do not result in any changes directly in reserves.

Impact on surplus reported caused by reasonable possible changes in key variables

	Total claims R'million	Outstanding risk claims provision# R'million	Change in outstanding risk claims provision R'million
2021			
As at 31 December	**14 189**	**865**	**–**
Run-off factors 20% faster than assumed	**14 155**	**831**	**(34)**
Run-off factors 20% slower than assumed	**14 220**	**896**	**31**
2020			
As at 31 December	13 538	932	–
Run-off factors 20% faster than assumed	13 416	810	(122)
Run-off factors 20% slower than assumed	13 662	1 056	124

 # Not covered by risk transfer arrangements.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

11. PERSONAL MEDICAL SAVINGS ACCOUNT MONIES MANAGED BY THE SCHEME ON BEHALF OF ITS MEMBERS

11.1 Personal medical savings account liability

	2021 R'000	2020 R'000
Balance of Personal medical savings account liability at 1 January	**812 078**	678 857
Less: Personal medical savings plan advances	**(1 448)**	(3 790)
Balance of Personal medical savings account liability at 1 January	**810 630**	675 067
Add: Savings account contributions received	**749 331**	742 800
Savings plan liabilities transferred to the scheme from other Schemes in terms of Regulation 10 (4)	**1 914**	3 334
Net interest paid on savings plan account	**23 606**	28 628
Interest paid	**24 338**	29 324
Investment expenses/fees	**(732)**	(696)
Less: Claims paid on behalf of members	**(627 388)**	(566 192)
Refunds on death or resignation in terms of Regulation 10 (5)	**(55 913)**	(56 931)
Savings used to fund contributions	**–**	(1 151)
Personal medical savings plan advances (note 8)	**1 333**	1 448
Advances on savings accounts written off	**68**	56
Unclaimed Personal medical savings account liability written off to scheme funds	**(9 544)**	(14 981)
Balances due to members on Personal medical savings accounts held at 31 December	**894 037**	812 078

The BonSave, BonClassic, BonComprehensive, BonComplete and BonFit benefit options allow members the facility to pay a percentage of their gross contributions into a savings account, to assist members in managing their healthcare costs to their own requirements. The percentage per option varies from 14.1% on BonClassic, 16.0% on BonFit, 15.0% on BonComplete, 19.5% on BonSave, and 18.9% on BonComprehensive. Savings are capped at a maximum of 25.0% of the gross contributions.

The personal medical savings account (PMSA) liability contains a demand feature in terms of Regulation 10 of the Act that any credit balance on a member's PMSA must be taken as a cash benefit when the member terminates his or her membership of the Scheme or benefit option, and then enrols in another benefit option or medical scheme without a PMSA, or does not enrol in another medical scheme.

It is estimated that the claims to be paid out of members' PMSA in respect of claims incurred in 2021 but not reported will amount to R9.2 million (2020: R5.9 million). Advances paid on personal medical savings accounts are funded by the Scheme and are included in trade and other receivables (refer to note 8).

The Scheme obtained exemption from Regulation 10(3) of the Medical Schemes Act, 131 of 1998, personal medical savings account, which prohibits the medical savings funds to be used to offset contributions unless to settle the Scheme upon termination of membership. Thus R1.2m of accumulated savings balances were used to offset contributions in 2020 and there were no savings balances used in 2021 as these reliefs expired 31 December 2020. The exemption from the Council for Medical Schemes was provided to the Scheme as part of a contribution relief measure to assist members who were in financial difficulty following the economic challenges driven by COVID-19 and the ensuing financial crisis. The exemptions were to provide temporary relief to Bonitas Medical Fund members and expired 31 December 2020.

The following Scheme Rules were adopted from 1 January 2020:

- Interest would still be paid to members on PMSA monies at the rate achieved by the Scheme's cash portfolio net of administration costs. An effective 0.125% return achieved for a particular month (1.5% annual) is deducted for investment expenses from the return allocated to the PMSA, relating to administration costs associated with managing the members PMSA.
- Interest would be applied to members accumulated fund balances. Net interest is not allocated to current savings balances. The effective interest rate earned was 4,7% (2020: 5.9%) and 3.2% was allocated to the PMSA balances.

	2021 R'000	2020 R'000
12. INSURANCE, TRADE AND OTHER PAYABLES		
12.1 Insurance payables		
Contributions received in advance	**420 116**	495 497
Dorbyl contributions received in advance	**(0)**	1
Reported claims not yet paid (note 12.3)	**74 874**	104 787
Credit balances due to members – overpayments	**7 037**	13 804
Total insurance payables	**502 027**	614 089
12.2 Trade and other payables		
Accrual of external audit fees	**2 277**	2 667
Accrual of internal audit fees	**581**	571
Amounts owing to administrator	**7 322**	3 115
Amounts owing to related entities (including marketing costs)	**15 414**	34 493
South African Revenue Service	**225**	243
Broker fees payable	**10 000**	–
Accrual for advertising and marketing expenses (excluding related entity)	**1 377**	4 953
Sundry payables	**12 095**	9 601
Total trade and other payables	**49 291**	55 642
Total insurance, trade and other payables	**551 318**	669 731

The carrying amount of trade and other payables approximate their fair values due to the short-term maturities of these liabilities.

	2021 R'000	2020 R'000
12.3 Reported claims not yet paid		
Balance at 1 January	**104 787**	83 073
Net movement – members and providers	**(29 913)**	21 714
Claims received	**14 036 589**	13 297 111
Claims paid	**(14 066 502)**	(13 275 397)
Reported claims not yet paid	**74 874**	104 787

Reported claims not yet paid comprise claims that have been received and processed for payment. These claims have been accounted for in the claims cost expense for the current financial year. Payment of these claims will only occur during the next financial year.

	2021 R'000	2020 R'000
13. RISK CONTRIBUTION INCOME		
Gross contributions per registered rules#	**18 887 490**	18 540 546
Less: Personal medical savings account contributions received*	**(749 331)**	(742 800)
Risk contribution income	**18 138 159**	17 797 746

 # Gross contribution income in 2020 includes concessions granted for contribution relief measures. Refer to note 27.3.

** The savings contributions are received by the Scheme in terms of Regulation 10 (1) and the Scheme Rules. Refer to note 11 of the financial statements for details of how these funds were applied.*

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

	2021 R'000	2020 R'000
14. RELEVANT HEALTHCARE EXPENDITURE		
Net claims incurred (14.1)	**15 851 053**	14 346 005
Accredited managed healthcare services (14.2)	**549 251**	551 530
Net income on risk transfer arrangements (14.3)	**(110 668)**	(126 295)
Total relevant healthcare expenditure	**16 289 636**	14 771 240
14.1 Net claims incurred		
Claims incurred excluding claims incurred in respect of risk transfer arrangements	**14 271 484**	12 918 448
Current year claims per registered rules	**14 966 204**	13 280 199
Movement in outstanding claims provision	**(67 332)**	204 441
Provision in prior year	**(932 488)**	(728 047)
Provision for the current year	**865 156**	932 488
Claims paid from Personal Medical Savings Account**	**(627 388)**	(566 192)
Claims incurred in respect of risk transfer arrangements	**1 642 016**	1 486 813
Current year claims incurred in respect of risk transfer arrangements	**1 646 609**	1 484 087
Movement in outstanding claims provision (note 10)	**(4 593)**	2 726
Third party claims recoveries (note 14.4)	**(62 447)**	(59 256)
Net claims incurred	**15 851 053**	14 346 005

** *Claims are paid on behalf of the members from their PMSA in terms of Regulation 10 (3) and the Scheme's registered benefits. Refer to note 11 to the financial statements for a breakdown of the movement in these balances.*

14.2 Accredited managed healthcare services

	2021 R'000	2020 R'000
Hospital benefit management	**191 595**	203 061
Medicine benefit management	**88 732**	87 916
Disease management	**123 051**	118 679
HIV/AIDS management	**54 601**	53 525
Provider network management	**74 020**	72 155
Dental risk management	**17 252**	16 194
	549 251	551 530

Managed care fees reduced following the negotiations of a new managed care contract effective 1 June 2021. Fees for the period 1 January 2021 to 31 May 2021 remained at 2020 rates.

	2021 R'000	2020 R'000
14. RELEVANT HEALTHCARE EXPENDITURE CONTINUED		
14.3 Risk transfer arrangements		
Premiums/fees paid	**1 531 348**	1 360 518
Dental Information Systems Proprietary Limited	**360 163**	307 861
Scriptpharm Risk Management Proprietary Limited*	**771 362**	703 422
Preferred Provider Negotiators Proprietary Limited	**258 672**	217 111
ER24 EMS Proprietary Limited#	**128 842**	122 171
Europ Assistance Worldwide Services (South Africa) Proprietary Limited	**12 309**	9 953
Recoveries received	**(1 642 016)**	(1 486 813)
Claims recoveries	**(1 642 016)**	(1 486 813)
Net income on risk transfer arrangements	**(110 668)**	(126 295)

* *Given the reduction of utilisation as a result of the COVID-19 pandemic, the Scheme obtained a refund of capitation fees relating to Scriptpharm Risk Management Proprietary Limited, R9m. These are to be settled to the Scheme at the beginning of the second quarter of 2022 as the utilisation during 2021 was lower than expected due to the ongoing impact of COVID-19. From a claims aspect utilisation pertaining to the other risk transfer arrangements normalised and no additional refunds were negotiated on these agreements. In 2020 refunds of capitation fees were received from Dental Information Systems Proprietary Limited and Preferred Provider Negotiators Proprietary Limited, for the amounts of R56m and R46m respectively. These were as a result of lower utilisation due to COVID-19.*

\# *Fees and benefits were agreed up until 30 April 2022 with the extension of the contract. See note 21.*

The net (income)/loss of the risk transfer arrangements for the current financial year per third party service provider is as follows:

	2021 R'000	2020 R'000
Dental Information Systems Proprietary Limited	**(25 615)**	(61 113)
Scriptpharm Risk Management Proprietary Limited*	**(37 864)**	(21 791)
Preferred Provider Negotiators Proprietary Limited	**(22 856)**	(36 504)
ER24 EMS Proprietary Limited	**(34 910)**	(15 639)
Europ Assistance Worldwide Services (South Africa) Proprietary Limited	**10 577**	8 752
Net income on risk transfer arrangements	**(110 668)**	(126 295)

Risk transfer arrangements are entered into in respect of the provision of medical services that are outsourced to third parties by the Scheme. These services comprise:

- Dental benefits provided by Dental Information Systems Proprietary Limited;
- Chronic medicine benefits provided by Scriptpharm Risk Management Proprietary Limited;
- Optical benefit management provided by Preferred Provider Negotiators Proprietary Limited;
- Ambulance and emergency services provided by ER24 EMS Proprietary Limited; and
- International travel benefits provided by Europ Assistance Worldwide Services (South Africa) Proprietary Limited.

The service providers noted above have a national footprint across South Africa, providing access to all members.

Refer to note 21 to the financial statements for nature, terms and conditions of the risk transfer arrangements.

Dental Information Systems Proprietary Limited ("DENIS")

The Scheme has appointed DENIS to attend to all aspects of dental claim administration, including payments of all claims and to provide the SMILE programme. The Scheme pays DENIS a fixed fee on a monthly basis for members on the Standard, BonSave, BonComplete, BonFit and BonClassic Options.

Scriptpharm Risk Management Proprietary Limited ("Scriptpharm")

The Scheme has entered into a risk transfer arrangement with Scriptpharm to provide Chronic medicine benefits for the members with an effective date of 1 February 2020. The Scheme pays Scriptpharm a monthly fixed fee per beneficiary on the BonComprehensive, BonClassic, Standard, BonComplete, BonSave, Primary, BonFit, Hospital Standard, BonEssential, BonCap and BonStart Options.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

14. RELEVANT HEALTHCARE EXPENDITURE CONTINUED

14.3 Risk transfer arrangements continued

Preferred Provider Negotiators Proprietary Limited ("PPN")

The Scheme has entered into a risk transfer arrangement with PPN for optometric benefit management services and pays a monthly fee per member per month on the Standard Option, Primary Option, Classic Option and BonCap Option. Included in the contract is an arrangement whereby if a defined surplus, comprised of premiums less claims paid less expenses, is reported at the end of the benefit or contract cycle then 100% of the defined surplus, up to a maximum of 10% of the total of the premiums paid, is due to the Scheme.

ER24 EMS Proprietary Limited ("ER24")

The Scheme re-appointed ER24 to render emergency medical services whereby they will maintain a twenty-four (24) hour a day professionally staffed contact centre to provide general medical advice, appropriate rapid response vehicle services with the necessary life saving support equipment and care as well as medical transportation to the most appropriate medical facility for providing adequate care for all members of the Scheme.

Europ Assistance Worldwide Services (South Africa) Proprietary Limited ("EASA")

The Scheme has entered into a risk transfer arrangement with EASA for the provision of international travel benefits for members who travel overseas for a period of not more than 90 days at a fixed fee per member per month with an effective date of 1 January 2020. This contract applies to all members of the Scheme except for those on the BonCap Option. Note 28 provides additional information on EASA's appointment to provide emergency medical services.

14.4 Third party claim recoveries

Third party claim recoveries of R62.4 million (2020: R59.3 million) are included in net claims incurred. Included in this are third party recoveries for motor vehicle accident ("MVA") and injury on duty ("IOD") claims of R32 million (2020: R27.3 million). The timing and consideration of MVA or Road Accident Fund recoveries is uncertain. These claims are currently being administered by Gildenhuys Malatji Attorneys and Batsumi Claims Management Solutions Proprietary Limited. The net claims recoveries in the current year includes R25.3 million (2020: R27.1 million) in relation to forensic recoveries pertaining to the fraud waste and abuse services provided by the Administrator, R0.4 million (2020: R0.3 million) in relation to diabetes clawbacks and R4.7 million (2020: R4.6 million) in recoveries from Mediclinic and Life Healthcare related to settlement discounts.

15. ADMINISTRATIVE EXPENDITURE

	2021 R'000	2020 R'000
Accredited Administrator service fees (15.1)	**818 006**	786 210
Other administration services provided by Accredited Administrator (15.2)	**92 122**	90 251
Actuarial services	**3 833**	3 712
Annual general meeting costs	**2 079**	1 520
Audit remuneration – external	**3 032**	2 942
Audit fees	**3 027**	2 667
Prior year under provision	**5**	275
Audit remuneration – internal	**4 403**	3 649
Audit fees	**4 380**	3 728
Prior year under/(over) provision	**23**	(79)
Bank charges	**3 434**	3 421
Benefit management services	**19 839**	20 908
Communication expenses	**126**	175
Consulting fees	**2 977**	2 286
Council for Medical Schemes levies	**14 426**	13 025
Committee fees – Independent members	**1 198**	1 831
Audit and risk committee fees	**701**	1 051
Investment committee fees	**250**	372
Remuneration committee fees	**247**	408
Computer maintenance	**3 402**	3 046
Depreciation	**4 997**	5 194
Fidelity, professional indemnity and other insurance premiums	**1 523**	868
Forensic fees	**3 129**	8 275
Hire of equipment	**176**	176
Human resourcing and payroll management fees	**111**	962
Legal fees and inspection costs	**4 209**	6 558
Marketing and advertising expenses	**200 656**	187 256
Meeting venue and catering costs	**63**	104
Office expenses	**309**	371
Postage and courier service	**148**	233
Principal Officer short-term employee benefits	**6 826**	5 614
Principal Officer remuneration	**5 021**	4 522
Performance bonus	**1 439**	777
Defined contribution benefits	**239**	213
Other disbursements	**127**	102
Printing and stationery	**1 111**	596
Professional services	**2 047**	2 288
RAF administration expense	**11 676**	11 612
Rental costs	**1 858**	1 852
Repairs and maintenance	**18**	20
Staff short-term employee benefits	**25 229**	21 495
Staff remuneration	**19 679**	16 015
Performance bonus	**3 432**	1 750
Termination benefit	**–**	1 934
Defined contribution benefits	**1 056**	800
Other disbursements	**1 062**	996
Subscription fees	**2 803**	2 782
Sundry expenses	**569**	863
Travel, accommodation and conferences	**68**	78
Trustee elections	**7 106**	–
Trustees' remuneration and other disbursements (15.3)	**6 067**	5 635
Trustees' remuneration	**5 868**	5 536
Other disbursements	**199**	99
Wellness expenses	**27 344**	26 083
	1 276 920	1 221 891

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

		2021 R'000	2020 R'000
15.	**ADMINISTRATIVE EXPENDITURE** CONTINUED		
15.1	**Accredited Administrator service fees**		
	Member record management	**114 107**	109 943
	Contribution management	**43 893**	42 291
	Claims management	**195 594**	188 455
	Financial management	**35 124**	33 843
	Information management and data control	**122 869**	118 385
	Broker remuneration management	**87 779**	84 350
	Customer services	**218 640**	208 943
	Total Accredited Administrator service fees	**818 006**	786 210
15.2	**Other administration services provided by Accredited Administrator**		
	Internal audit services	**28 262**	27 230
	Forensic investigations and recoveries	**33 134**	33 416
	Governance and compliance services rendered	**30 726**	29 605
	Total other administration services provided by Accredited Administrator	**92 122**	90 251

15. ADMINISTRATIVE EXPENDITURE CONTINUED

R	Fees for meeting attendance[1]	Fees for holding of office[2]	Fees for other meeting attendance[3]	Total remuneration	Accommodation, travel and meals	Training and annual subscription fees	Total
15.3 Trustees' remuneration and considerations							
2021							
Mr OJ Komane	**149 756**	**158 640**	**181 449**	**489 845**	**69 542**	**–**	**559 387**
Adv L Koch*	**92 252**	**169 260**	**21 861**	**283 373**	**–**	**14 721**	**298 094**
Mr J Bagg	**176 911**	**227 328**	**310 619**	**714 858**	**–**	**2 068**	**716 926**
Mr MG Netshisaulu	**229 087**	**227 328**	**102 044**	**558 459**	**–**	**16 221**	**574 680**
Mr R Cowlin	**355 785**	**227 328**	**155 433**	**738 546**	**–**	**14 721**	**753 267**
Ms J Usher	**309 088**	**227 328**	**44 155**	**580 571**	**–**	**14 721**	**595 292**
Ms MP Lesunyane	**159 350**	**227 328**	**–**	**386 678**	**–**	**14 721**	**401 399**
Mr JD Ngwane	**365 872**	**293 152**	**242 470**	**901 494**	**2 189**	**14 721**	**918 404**
Mr JR Venter	**185 370**	**227 328**	**57 994**	**470 692**	**–**	**14 721**	**485 413**
Mr P Ribbens	**159 134**	**227 328**	**89 031**	**475 493**	**–**	**14 721**	**490 214**
Dr PW Hill	**93 551**	**133 638**	**40 649**	**267 838**	**5 920**	**–**	**273 758**
	2 276 156	**2 345 986**	**1 245 705**	**5 867 847**	**77 651**	**121 336**	**6 066 834**
2020							
Mr OJ Komane	500 644	342 416	365 814	1 208 874	17 524	2 215	1 228 613
Adv L Koch	140 151	218 952	8 400	367 503	1 692	2 215	371 410
Mr J Bagg	190 895	218 952	50 658	460 505	–	2 215	462 720
Mr MG Netshisaulu	253 429	218 952	34 217	506 598	3 192	2 215	512 005
Mr R Cowlin	343 899	218 952	168 007	730 858	26 440	2 215	759 513
Ms J Usher	348 188	218 952	–	567 140	428	2 215	569 783
Ms MP Lesunyane	178 209	218 952	–	397 161	2 472	2 215	401 848
Mr JD Ngwane	140 151	225 299	27 558	393 008	3 816	2 215	399 039
Mr JR Venter	241 468	218 952	8 400	468 820	1 590	2 215	472 625
Mr P Ribbens	190 895	218 952	25 888	435 735	19 160	2 215	457 110
	2 527 929	2 319 331	688 942	5 536 202	76 314	22 150	5 634 666

* *Term ended 14 October 2021.*

1 *Fees for meeting attendance refers to remuneration payable to Trustees for attending meetings of Board of Trustees.*

2 *Fees for holding office refers to remuneration payable to individuals to act in their capacity as Trustee, including carrying out their fiduciary duty.*

3 *Fees for other meeting attendance refers to remuneration payable to Trustees for attendance of other meetings at which their attendance is required to act in the interest of the Scheme.*

16. IMPAIRMENT LOSSES ON INSURANCE, TRADE AND OTHER RECEIVABLES

	2021 R'000	2020 R'000
(Decrease)/increase in provision for healthcare receivables (note 8)	**(9 033)**	13 550
Bad debts written off	**12 549**	10 797
Contributions	**3 614**	2 436
Members portion	**8 493**	8 045
Other receivables	**442**	316
Previous impairment losses recovered	**(3 453)**	(4 066)
	63	20 281

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

	2021 R'000	2020 R'000
17. INVESTMENT INCOME		
Cash and cash equivalents interest income	**4 661**	4 646
Financial assets held at fair value through profit or loss	**425 191**	309 913
Interest income	**295 442**	233 389
Dividend income	**129 749**	76 524
Net fair value gains on financial assets held at fair value through profit or loss	**836 507**	24 655
Net fair value losses on derivative instruments	**(54 495)**	(31 878)
Rentals received	**9 788**	9 270
Contractual rental	**9 644**	8 913
Straight-lining of lease accrual	**144**	357
Investment income – Scheme	**1 221 652**	316 606
Change in fair value of investment properties	**(700)**	2 900
	1 220 952	319 506
18. SUNDRY INCOME		
Profit on sale of property and equipment	**4**	2
Forensic recoveries	**1 020**	1 776
Sundry income	**21 857**	25 755
Unclaimed personal medical savings account write backs (note 11.1)	**9 544**	14 981
Recovery of personal medical savings account investment and administration expense	**11 423**	9 563
Other income	**890**	1 211
	22 881	27 533

Claim recoveries from Healthcare practitioners are offset against claims paid. Forensic recoveries comprise financial recoveries from members and healthcare providers arising from irregularities due to fraud and abuse as these members and healthcare providers were thoroughly investigated and either legally prosecuted by the Scheme, or have signed an acknowledgement of debt, thereby committing to pay back the Scheme the amounts claimed erroneously. See note 14.1 third party claims recoveries which includes recoveries as a result of fraud, waste and abuse services provided by the Administrator.

19. SURPLUS/(DEFICIT) PER BENEFIT OPTION

For management purposes the traditional Scheme is organised into the following eleven benefit options: Standard, BonSave, Primary, BonCap, BonFit, BonClassic, BonComprehensive, BonEssential, BonComplete, Hospital Standard and BonStart. The features of the benefit options are disclosed in the Annual Report.

R'000	Standard	BonSave	Primary	BonCap	BonFit	BonClassic	Bon Compre-hensive	Bon Essential	Bon Complete	Hospital Standard	BonStart	Scheme Total
2021												
Gross contribution income	8 277 605	1 975 464	4 405 187	1 180 156	255 018	792 509	636 357	437 567	663 925	241 826	21 876	18 887 490
Less : Savings contributions	–	(380 638)	–	–	(40 108)	(111 529)	(119 161)	–	(97 895)	–	–	(749 331)
Risk contribution income	8 277 605	1 594 826	4 405 187	1 180 156	214 910	680 980	517 196	437 567	566 030	241 826	21 876	18 138 159
Relevant healthcare expenditure	(7 246 397)	(1 361 946)	(3 913 804)	(1 202 917)	(187 815)	(653 834)	(558 508)	(415 525)	(520 837)	(217 155)	(10 898)	(16 289 636)
Net claims incurred	(7 125 091)	(1 302 774)	(3 784 879)	(1 136 368)	(176 015)	(646 302)	(546 500)	(398 596)	(513 924)	(211 351)	(9 250)	(15 851 053)
Claims incurred	(7 145 116)	(1 309 333)	(3 802 011)	(1 146 622)	(177 204)	(647 869)	(547 360)	(400 760)	(515 490)	(212 252)	(9 483)	(15 913 500)
Third party recoveries	20 025	6 559	17 132	10 254	1 189	1 567	860	2 164	1 566	901	230	62 447
Managed healthcare services	(205 540)	(52 111)	(155 260)	(67 455)	(10 301)	(12 933)	(8 787)	(15 664)	(13 134)	(6 745)	(1 321)	(549 251)
Net income on risk transfer arrangements	84 234	(7 061)	26 335	906	(1 499)	5 401	(3 221)	(1 265)	6 221	941	(324)	110 668
Risk transfer arrangement fees/premiums paid	(873 234)	(118 100)	(228 791)	(82 758)	(11 536)	(80 165)	(56 705)	(19 615)	(47 772)	(12 012)	(660)	(1 531 348)
Recoveries from risk transfer arrangements	957 468	111 039	255 126	83 664	10 037	85 566	53 484	18 350	53 993	12 953	336	1 642 016
Gross healthcare result	1 031 208	232 880	491 383	(22 761)	27 095	27 146	(41 312)	22 042	45 193	24 671	10 978	1 848 523
Broker service fees	(126 336)	(42 615)	(107 345)	(37 503)	(6 755)	(6 602)	(5 128)	(11 574)	(10 569)	(5 522)	(671)	(360 620)
Administrative expenditure	(470 418)	(148 358)	(380 028)	(90 745)	(26 615)	(35 581)	(19 510)	(46 765)	(35 560)	(20 361)	(2 979)	(1 276 920)
Net impairment losses on healthcare receivables	(17)	(7)	(27)	3	(2)	(1)	(1)	(6)	(1)	(1)	(3)	(63)
Net healthcare result	434 437	41 900	3 983	(151 006)	(6 277)	(15 038)	(65 951)	(36 303)	(937)	(1 213)	7 325	210 920
Other income	393 051	136 705	334 061	199 381	23 813	37 646	20 070	42 068	35 201	17 735	4 102	1 243 833
Investment income – Scheme	385 928	134 375	327 981	195 741	23 392	37 088	19 764	41 302	34 644	17 414	4 023	1 221 652
Sundry income	7 344	2 403	6 274	3 756	435	575	315	791	574	331	83	22 881
Change in fair value of investment property	(221)	(73)	(194)	(116)	(14)	(17)	(9)	(25)	(17)	(10)	(4)	(700)
Other expenditure	(13 984)	(13 018)	(11 989)	(7 169)	(1 588)	(7 926)	(3 771)	(1 516)	(5 506)	(629)	(166)	(67 262)
Interest on savings plan liability – PMSA		(8 434)	–	–	(755)	(6 832)	(3 171)	–	(4 414)	–	–	(23 606)
Interest expense	(130)	(42)	(110)	(66)	(8)	(10)	(6)	(14)	(10)	(6)	(2)	(404)
Asset management fees	(12 380)	(4 061)	(10 626)	(6 354)	(739)	(968)	(531)	(1 344)	(967)	(556)	(149)	(38 675)
Operating expenses on investment property	(1 474)	(481)	(1 253)	(749)	(86)	(116)	(63)	(158)	(115)	(67)	(15)	(4 577)
Net surplus/(deficit) for the year	813 504	165 587	326 055	41 206	15 948	14 682	(49 652)	4 249	28 758	15 893	11 261	1 387 491
Average number of members (n)	109 448	35 748	93 177	55 666	6 432	8 576	4 704	11 725	8 567	4 934	1 161	340 138

19. SURPLUS/(DEFICIT) PER BENEFIT OPTION CONTINUED

For management purposes the traditional Scheme is organised into the following ten benefit options: Standard, BonSave, Primary, BonCap, BonFit, BonClassic, BonComprehensive, BonEssential, BonComplete and Hospital Standard. The features of the benefit options are disclosed in the Annual Report.

R'000	Standard	BonSave	Primary	BonCap	BonFit	BonClassic	Bon Comprehensive	Bon Essential	Bon Complete	Hospital Standard	Scheme Total
2020											
Gross contribution income	8 525 114	1 892 851	4 046 174	1 043 753	220 877	823 861	668 964	373 439	690 844	254 669	18 540 546
Less : Savings contributions	–	(364 853)	–	–	(34 743)	(115 976)	(125 335)	–	(101 893)	–	(742 800)
Risk contribution income	8 525 114	1 527 998	4 046 174	1 043 753	186 134	707 885	543 629	373 439	588 951	254 669	17 797 746
Relevant healthcare expenditure	(6 947 016)	(1 198 835)	(3 329 204)	(994 827)	(133 605)	(627 121)	(526 224)	(303 502)	(498 153)	(212 754)	(14 771 240)
Net claims incurred	(6 786 586)	(1 151 376)	(3 222 211)	(953 052)	(124 958)	(619 289)	(497 998)	(289 463)	(494 693)	(206 379)	(14 346 005)
Claims incurred	(6 807 224)	(1 157 708)	(3 237 859)	(961 620)	(125 946)	(620 953)	(498 925)	(291 295)	(496 373)	(207 358)	(14 405 261)
Third party recoveries	20 638	6 332	15 648	8 568	988	1 664	927	1 832	1 680	979	59 256
Managed healthcare services	(217 524)	(53 493)	(152 324)	(60 748)	(8 245)	(14 163)	(8 315)	(14 177)	(14 848)	(7 694)	(551 530)
Net income on risk transfer arrangements	57 094	6 034	45 331	18 973	(402)	6 331	(19 911)	138	11 388	1 319	126 295
Risk transfer arrangement fees/premiums paid	(806 741)	(99 062)	(184 709)	(64 261)	(8 634)	(75 125)	(49 445)	(15 846)	(44 707)	(11 988)	(1 360 518)
Recoveries from risk transfer arrangements	863 835	105 096	230 040	83 234	8 232	81 456	29 534	15 984	56 095	13 307	1 486 813
Gross healthcare result	1 578 098	329 163	716 970	48 926	52 529	80 764	17 405	69 937	90 798	41 915	3 026 506
Broker service fees	(126 679)	(39 363)	(95 113)	(31 188)	(5 461)	(6 685)	(5 158)	(9 174)	(10 733)	(5 273)	(334 827)
Administrative expenditure	(467 827)	(143 850)	(351 080)	(77 356)	(22 466)	(37 693)	(21 004)	(40 503)	(38 078)	(22 034)	(1 221 891)
Net impairment losses on healthcare receivables	(7 083)	(2 172)	(5 348)	(2 922)	(336)	(573)	(319)	(608)	(582)	(338)	(20 281)
Net healthcare result	976 509	143 778	265 429	(62 540)	24 266	35 813	(9 076)	19 652	41 405	14 270	1 449 507
Other income	107 024	42 779	87 779	45 736	6 424	17 411	8 899	11 785	14 290	4 912	347 039
Investment income – Scheme	96 435	39 528	79 731	41 340	5 915	16 557	8 424	10 838	13 429	4 409	316 606
Sundry income	9 594	2 942	7 269	3 976	459	774	431	849	782	457	27 533
Change in fair value of investment property	995	309	779	420	50	80	44	98	79	46	2 900
Other expenditure	(9 781)	(11 703)	(7 462)	(4 067)	(1 128)	(9 787)	(4 649)	(886)	(6 859)	(463)	(56 785)
Interest on savings plan liability – PMSA	–	(8 695)	–	–	(656)	(9 000)	(4 211)	–	(6 066)	–	(28 628)
Interest expense	(306)	(94)	(233)	(127)	(15)	(25)	(14)	(28)	(25)	(14)	(881)
Asset management fees	(7 494)	(2 307)	(5 731)	(3 119)	(363)	(602)	(335)	(684)	(606)	(356)	(21 597)
Operating expenses on investment property	(1 981)	(607)	(1 498)	(821)	(94)	(160)	(89)	(174)	(162)	(93)	(5 679)
Net surplus/(deficit) for the year	1 073 752	174 854	345 746	(20 871)	29 562	43 437	(4 826)	30 551	48 837	18 719	1 739 761
Average number of members (n)	116 755	35 843	88 643	48 491	5 600	9 409	5 243	10 411	9 500	5 530	335 425

20. CASH FLOW NOTES

20.1 Returns on financial assets at fair value through profit or loss

The bulk of investment income on investments is held as cash and cash equivalents and not reinvested by the fund managers into financial instruments.

	2021 R'000	2020 R'000
20.1.1 Interest received		
Finance income (note 17)	**295 442**	233 389
Interest capitalised in investments	**(102 801)**	(87 897)
	192 641	145 492
20.1.2 Dividends received		
Dividend income (note 17)	**129 749**	76 524
Dividends capitalised in investments	**(1 203)**	(7 998)
	128 546	68 526
20.1.3 Asset management fees		
Asset management fees per statement of comprehensive income	**(38 675)**	(21 597)
Fees capitalised in investments	**1 909**	1 683
	(36 766)	(19 914)
20.1.4 Rentals received		
Rentals received (note 17)	**9 788**	9 270
Straight-lining of lease receivables	**(144)**	(357)
Decrease/(increase) in rent receivables	**51**	(415)
	9 695	8 498

21. INSURANCE RISK MANAGEMENT

21.1 Risk management objectives, policies and strategies to mitigate insurance risk

The primary insurance activity carried out by the Scheme assumes the risk of loss from members and their dependants that are directly subject to the risk. This risk relates to the health of the Scheme members. As such, the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract.

The Scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, service provider profiling, centralised management of risk transfer arrangements and the monitoring of emerging issues. Certain risks are mitigated by entering into risk transfer arrangements.

The Scheme uses several methods to assess and monitor insurance risk exposures both for individual types of risks insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing. 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.

This variation could be due to adverse experience for example an unexpected pandemic, unanticipated demographic movements e.g. a substantial number of young members leaving the Scheme, changes in the health profile of the membership, unexpected price increases and the cost of new technologies or drugs.

A major risk affecting the future sustainability of the Scheme is the possibility of deterioration in the risk profile of members. Schemes with a better member risk profile can offer the same benefits at a lower contribution rate than other schemes, as their members will be claiming less.

If a scheme charges higher contribution rates than the market, it is at risk of losing members and not replacing them. It is typically easier for younger, healthier members to move to another scheme. Should this happen, the member risk profile would deteriorate, resulting in even higher contribution rates being required.

One of the Scheme's key objectives, therefore, is to keep contribution rates as competitive and affordable as possible given the increases in claims costs. It is important that the Scheme maintains or improves its member risk profile, by attracting lower risk members and retaining healthy members in the Scheme.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

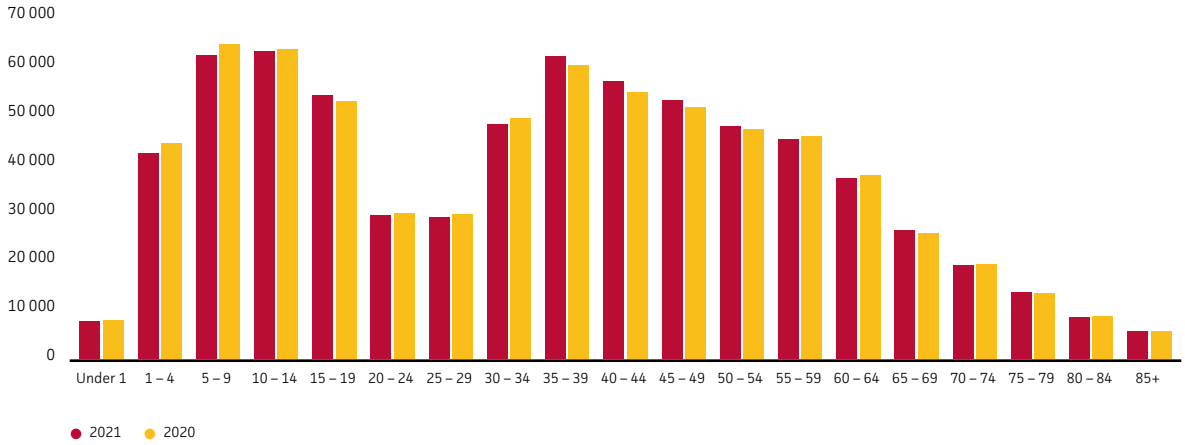
FOR THE YEAR ENDED 31 DECEMBER 2021

21. INSURANCE RISK MANAGEMENT CONTINUED

21.1 Risk management objectives, policies and strategies to mitigate insurance risk continued

The chart below provides an overview of the Scheme's beneficiaries demographic profile:

Beneficiary demographic profile (age)



The Scheme's strategy seeks diversity to ensure a balanced portfolio approach. This approach is based on having a large portfolio of similar risks over a number of years, which is believed to reduce the variability of the outcome.

The strategy is set out in the annual business plan, and specifies the benefits to be provided by each option, the expected number of members per option and their expected demographic profile.

All the benefit option contracts are annual in nature and the Scheme has the right to change the terms and conditions of the contracts at renewal. Management information including contribution income, claims ratios, target market and demographic split profile per option is reviewed periodically. There is also an underwriting review programme that reviews a sample of contracts periodically, to ensure adherence to the Scheme's objectives.

It is important to note that the Scheme's insurance risk management strategy focuses primarily on the management of systematic risk factors, which are risks within the control of the Scheme. Conversely, limited focus is placed on the management of unsystematic risk factors as these factors are uncontrollable in nature and are inherent to the medical industry as a whole.

The Scheme has noted the steady migration of insurance risk pertaining to Prescribed Minimum Benefits ("PMBs"), from systematic to unsystematic risk over the past four years. This is mainly attributable to change in legislation associated with PMBs, which requires the Scheme to pay for PMBs at full invoice price and no longer at set benefit limits and sub-limits.

21. INSURANCE RISK MANAGEMENT CONTINUED

21.2 Concentrations of insurance risk

The Scheme's concentrations of insurance risk can be split into the following three benefit categories:

- **Out-of-hospital benefits**

The out-of-hospital benefits include both the PMSA and an insurance risk element, dependent on the elected benefit option. These benefits cover the cost of out-of-hospital healthcare services, such as visits to general practitioners and dentists as well as prescribed acute medicines.

- **In-hospital benefits**

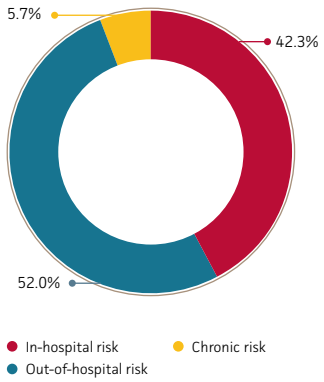
The hospital benefit covers medical expenses incurred due to admission to hospital.

- **Chronic illness benefit**

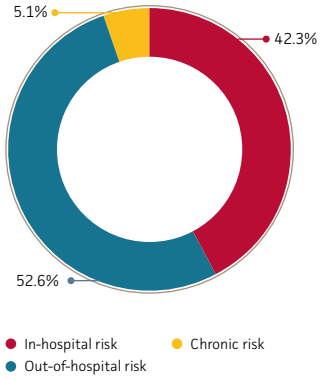
The Chronic Illness Benefit (CIB) covers approved medication for listed conditions, including the 27 PMB chronic conditions.

The following charts summarise the concentrations of insurance risk in relation to the type of risk covered/benefits provided:

Concentration of insurance risk: 2020



Concentration of insurance risk: 2021



NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

21. INSURANCE RISK MANAGEMENT CONTINUED

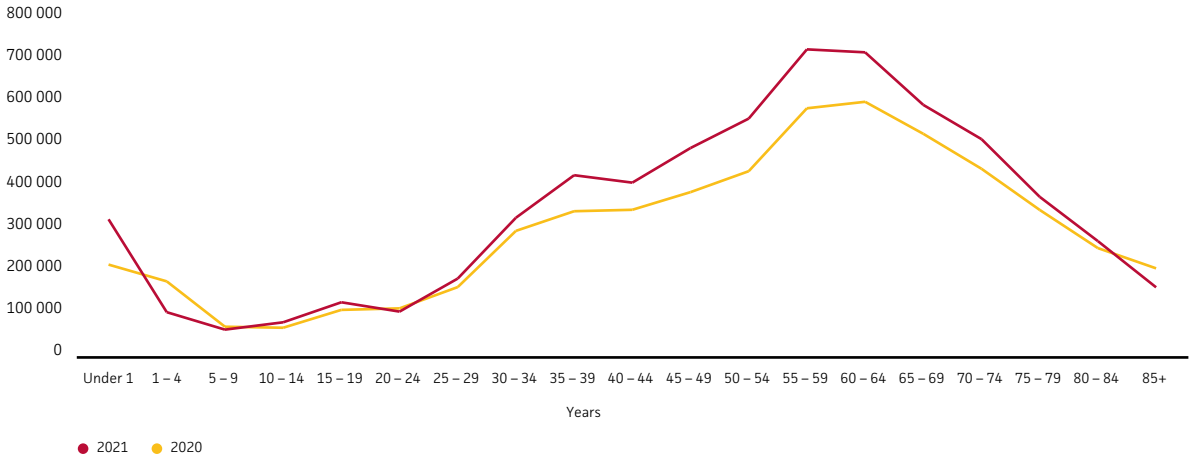
21.2 Concentrations of insurance risk continued

The following graphs summarise the concentrations of insurance risk, with reference to the carrying amount of the insurance claims incurred (before risk transfer arrangements), by age category in years of the Scheme and in relation to the benefit category.

The health status of the membership is a primary determinant of demand for health services which subsequently affects total cost of care. Therefore mitigation strategies are focused on positively influencing the utilisation and price of such services, to ensure overall system-wide cost-containment of quality care. These strategies for each benefit category are also summarised below.

21.2.1 In-hospital risk

Concentration of insurance risk: In-hospital risk (R'000)



Hospital and major medical expenses make up a significant part of overall expenditure and require close management. Therefore there is a strong focus on ensuring appropriate treatment during the hospital stay (including level of care and length of stay), as well as post-discharge, which improves patient outcomes and reduces the likelihood of readmission for high risk admissions.

Initiatives used by the Scheme include:

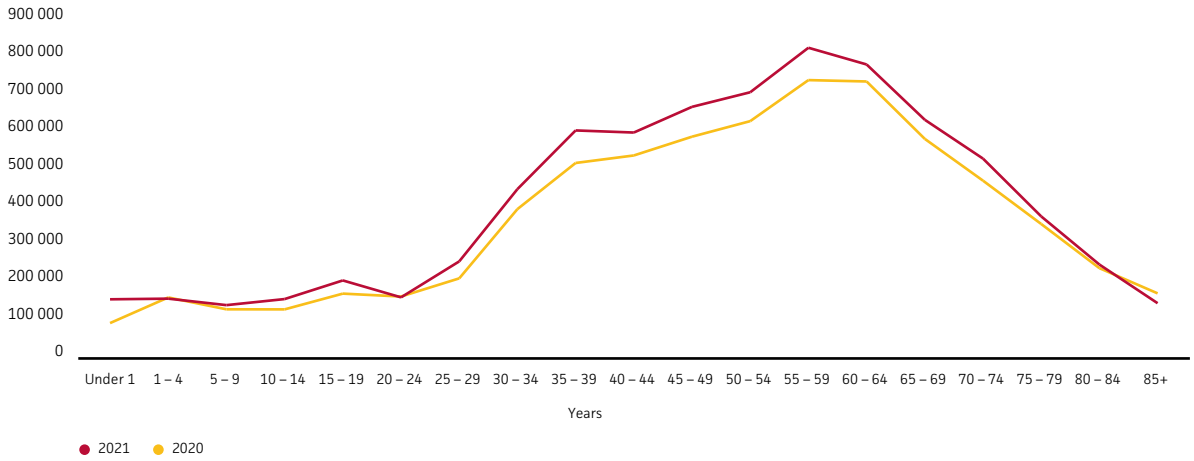
- Hospital Benefit Management Programme – focusing on patient care co-ordination, from pre-admission to six weeks post-discharge, in order to ensure best and appropriate care.
- Reviewing and updating of clinical funding protocols as well as criteria for recognising specific healthcare professionals as being able to perform certain procedures.
- Health technology assessments (HTA) on existing and new technologies entering the market, within a framework of clinical validity and economic appropriateness of the healthcare intervention, based on a systematic review of the evidence base and costing considerations.
- Specialised case management – providing a dedicated focus on psychiatric cases, neonates, high cost cases and cases involving alternatives to hospitalisation (e.g. step down facilities).
- "Call-me-back" functionality to promote treating Doctor and/or Medical Advisor engagement in answering questions and offering choice in terms of funding alternatives.
- Monitoring compliance to care pathways to reduce the risk of readmission. This involves a follow-up process where, in the case of non-compliance, support is provided to assist the beneficiary to return to the care pathway.
- Innovative reimbursement models with hospitals/hospital groups to ensure the most appropriate level of risk is transferred through reimbursement such as;
  - Efficiency gain share
  - Claims increase protection
  - Rewarding providers for efficiency and quality care
- Entering into risk-based contracting with specialists where specific risks within the member population can be addressed e.g. arthroplasty (global fee).
- Contracting of a specialist network at agreed reimbursement rates.
- Clinical audit and re-pricing of claims to ensure that claims are paid against the contracted hospital rates and the pre-authorised level of care.

21. INSURANCE RISK MANAGEMENT CONTINUED

21.2 Concentrations of insurance risk continued

21.2.2 Out-of-hospital risk

Concentration of insurance risk: Out-of-hospital risk (R'000)



Managing claims expenditure is not only about negotiating lower rates but also about curtailing preventable hospital utilisation and cost. Initiatives focused on coordinating care for segments of the population who are likely to present for medical care, with associated high claim costs, have been implemented. Such initiatives include:

- Active Disease Risk Management Programme – An integrated care coordination programme enabling high and emerging risk beneficiaries to improve their health and quality of life by empowering the beneficiary through information sharing and counselling, to take responsibility for his or her own health and wellness.
- Back Rehabilitation Programme – An evidence-based physiotherapy and active rehabilitation programme that concentrates primarily on back and neck ailments, thus reducing the need for surgical intervention.
- High Risk Maternity Case Management – Pregnant mothers with potentially high risk pregnancies are supported and additional benefits are provided where this is deemed necessary to reduce the risk of high-cost hospitalisation and premature deliveries.
- Oncology Disease Management – Complex or unusual patient-specific requirements are managed on a case-by-case basis ensuring that beneficiaries access funding for appropriate and cost-effective oncology therapy before, during and after active treatment.

Other initiatives include:

- Pathology Programme – Application of clinical protocols and utilisation rules to prevent wasteful utilisation of pathology benefits.
- Contracting of a GP network at agreed reimbursement rates.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

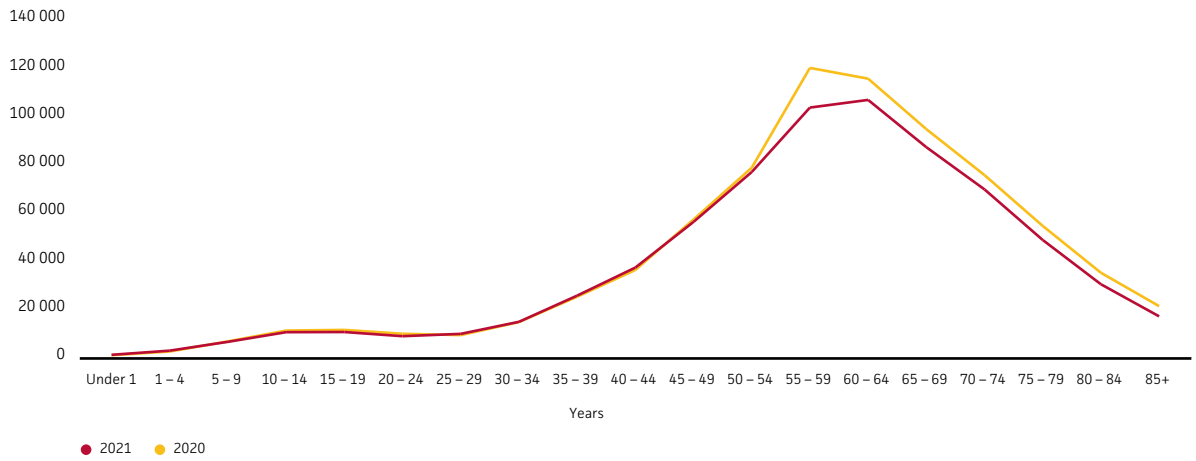
FOR THE YEAR ENDED 31 DECEMBER 2021

21. INSURANCE RISK MANAGEMENT CONTINUED

21.2 Concentrations of insurance risk continued

21.2.3 Chronic Illness Risk

Concentration of insurance risk: Chronic risk (R'000)



Chronic risk may, if not managed appropriately, have a significant impact on both out-of-hospital and in-hospital risks.

Initiatives in this regard include:

- Diabetes Management Programme – The programme is made up of a combination of care co-ordination including risk stratification, adherence and pathology management and health coaching. The programme also includes family practitioner up-skilling and payment for prolonged consultations for diabetic patients through enhanced care plans. There is also an arrangement for acute diabetic hospitalisations where the diabetic beneficiaries are registered on the chronic programme.
- A chronic medicine pre-authorisation process which ensures access to appropriate treatment and the management of the chronic medicine benefit through a formal drug utilisation review.
- Generic reference pricing and formularies incentivise cost-effectiveness.
- Medicine exclusions eliminate products with no clinical benefit or which may be harmful.
- Real-time drug utilisation evaluation to alert against potential contraindications and drug interactions as well as excessive utilisation.
- Processing of claims in real-time against all Scheme Rules and benefit limits.
- Sophisticated analytical capabilities to identify medicine trends and potential fraud.

21. INSURANCE RISK MANAGEMENT CONTINUED

21.3 Risk transfer arrangements

The Scheme makes use of risk transfer arrangements as an alternative insurance risk management strategy to mitigate specified risks associated with the provision of certain in-hospital and out-of-hospital benefits. Currently risk transfer arrangements approximate 9.3% of the Scheme's Relevant Healthcare Expenditure.

The Scheme entered into capitation agreements directly with DENIS, Scriptpharm, PPN, ER24, and Europ Assistance. The capitation agreements involve a transfer of risk however the Scheme remains ultimately liable to its members with respect to ceded risks if any supplier fails to meet the obligations it assumes.

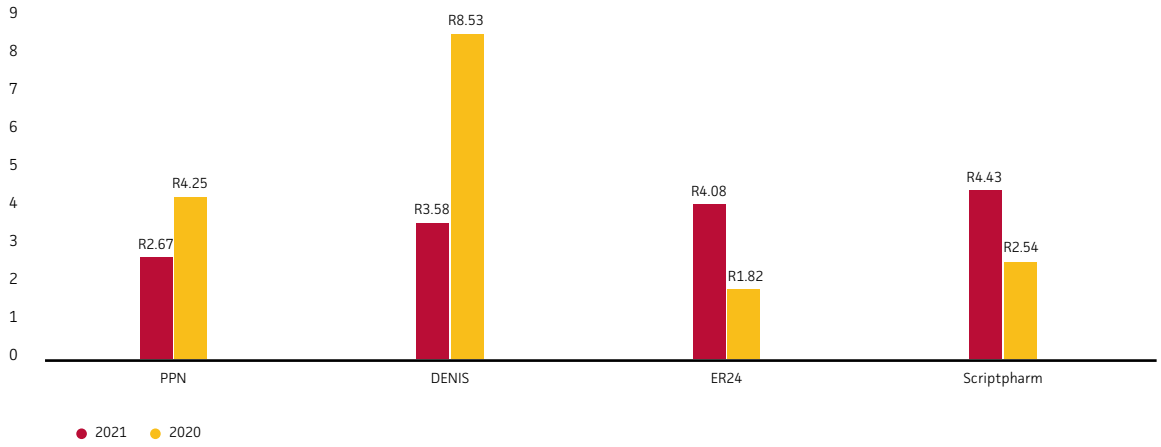
These risk transfer arrangements spread the insurance risk and minimise the effect of losses. The amount of each risk retained depends on the Scheme's evaluation of the specific risk, subject in certain circumstances, to maximum limits on the basis of characteristics of coverage. According to the terms of the capitation agreements, the suppliers provide certain minimum benefits to all Scheme members, as and when required by the members.

When selecting a supplier, the Scheme considers its relative security and ability to deliver the relevant service.

Management renegotiates the agreed fees and benefits of the capitation agreements annually.

The graph below outlines the net income (i.e. capitation premiums less cost recoveries) incurred per beneficiary relevant to services provided in accordance with the capitation agreements.

Average net income per beneficiary per month



21.3.1 Dental Information Systems Proprietary Limited ("DENIS")

The Scheme contracts DENIS to manage all aspects of dental claims administration, including the payment of all approved claims from service providers. Services rendered by DENIS are limited to all aspects of dental benefits including related hospitals, clinic and anaesthetist cost and any claim administration related to such dental and related services excluding services, benefits and claims classified under PMB as defined by the Medical Scheme Act, or amendments of the Act applicable to PMBs. DENIS also provides the Scheme with monthly financial reports reflecting all transactions related to fees paid by the Scheme and services rendered by DENIS.

The Scheme pays DENIS a monthly fixed fee, in advance of R93.80 (2020: R88.43) for beneficiaries on the Standard Option, R50.83 (2020: R46.59) for beneficiaries on the BonSave Option, R93.57 (2020: R86.87) for beneficiaries on the BonClassic Option, R102.80 (2020: R92.10) for beneficiaries on the BonComplete Option and R18.13 (2020: R29.40) for beneficiaries on the BonFit Option.

The current contract took effect from 1 January 2017 for a period of 5 years. Fees and benefits have been agreed for the 2022 benefit year.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

21. INSURANCE RISK MANAGEMENT CONTINUED

21.3 Risk transfer arrangements continued

21.3.2 Scriptpharm Risk Management Proprietary Limited ("Scriptpharm")

The Scheme contracted Scriptpharm as an accredited managed care organisation, to provide Chronic medicine benefits to beneficiaries of the Scheme on a capitated basis. Scriptpharm creates and provides the Scheme with a Network of Providers which shall ensure the delivery of chronic medicines to the beneficiaries of the Scheme. Scriptpharm pays all valid medicine claims which shall be submitted to Scriptpharm by any pharmacy that is a Designated Service Provider and any General Practitioner or Specialist. Scriptpharm will provide the Scheme with all information, data and reports as required.

The Scheme pays Scriptpharm a monthly fixed fee per beneficiary, in advance of R531.43 (2020: R464.46) for beneficiaries on the BonComprehensive Option, R277.75 (2020: R251.39) for beneficiaries on the BonClassic Option, R141.44 (2020: R132.95) for beneficiaries on the Standard Option and R178.50 (2020: R166.28) for beneficiaries on the Standard EDO Option, R124.08 (2020: R106.65) for beneficiaries on the BonComplete Option, R51.72 (2020: R47.13) for beneficiaries on the BonSave Option, R43.58 (2020: R39.27) for beneficiaries on the Primary Option, R50.59 (2020: R49.04) for beneficiaries on the Primary EDO Option, R35.05 (2020: R32.39) for beneficiaries on the BonFit Option, R95.24 (2020: R85.04) for beneficiaries on the Hospital Standard Option, R51.79 (2020: R47.10) for beneficiaries on the BonEssential Option, R47.00 (2020: R45.11) for beneficiaries on the BonEssential EDO Option and R37.34 (2020: R34.92) for beneficiaries on the BonCap Option and R42.00 (2020: R0) for beneficiaries on the BonStart Option.

The contract commenced on 1 February 2020 and endured for an initial period of 11 (eleven) months, and was renewed for a period of 24 (twenty four) months. Fees for the 2022 financial year have been agreed.

21.3.3 Preferred Providers Negotiators Proprietary Limited ("PPN")

The Scheme has contracted PPN for optometric benefit management services and pays a monthly fee of R50.98 (2020: R46.75) for members on the Standard Option, R26.22 (2020: R24.49) for members on the Primary Option, R58.51 (2020: R54.33) for members on the BonClassic Option and R21.99 (2020: R20.24) for members on the BonCap Option. Included in the contract is an arrangement whereby if a defined surplus, comprised of premiums less claims paid less expenses, is reported at the end of the benefit or contract cycle then 100% of the defined surplus, up to a maximum of 10% of the total of the premiums paid, is due to the Scheme.

The contract commenced on 1 January 2019 and will remain in force for four years until 31 December 2022. Fees and benefits have been agreed for the 2022 financial year.

21.3.4 ER24 EMS Proprietary Limited ("ER24")

The Scheme contracted ER24 for the provision of emergency medical and international travel services. ER24 conducts its business as an emergency response, assistance and transportation company. ER24 ensures that all telephonic requests for medical assistance received from members are dealt with in accordance with the contract. ER24 maintains and updates its database to continuously reflect the most recently available data and information relating to the provision of services.

The Scheme pays ER24 a standard fee of R33.65 (2020: R32.36) per member per month.

The contract terminated on 31 December 2018. Through a request for proposal exercise ("RFP"), ER24 was reappointed as the provider for emergency medical evacuation services and the contract commenced on 1 January 2019 and remained in force for three years until 31 December 2021. Fees and benefits were agreed up until April 2022 following the extension of the contract. From May 2022 the provision of emergency medical and international travel services has been awarded to Europ Assistance Worldwide, as further detailed in note 28.

21.3.5 Europ Assistance Worldwide Services (South Africa) Proprietary Limited ("EASA")

The Scheme has entered into a risk transfer arrangement with EASA for the provision of international travel benefits for members who travel overseas for a period of not more than 90 days at a fee of R2.46 per member per month. This contract applies to all members of the Scheme except for those on the BonCap Option.

The contract commenced on the effective date of 1 January 2020 and remained in force up until 31 December 2021. Fees and benefits were agreed up until April 2022 following the extension of the contract. Refer note 28 for further detail.

21. INSURANCE RISK MANAGEMENT CONTINUED

21.4 Claims sensitivity analysis

The table below outlines the sensitivity of claims and solvency to the major insurance risks, i.e. tariff inflation, ageing and utilisation being higher than expected. Each change in the criteria is quantified in the form of an expected claims and solvency impact on the Trustee-approved 2022 Budget.

Claims category	Change in variable	Estimated impact on expected 2022 claims R'000	Estimated impact on expected 2022 solvency %
Inflation assumptions			
Represents the increase in the price of service units rendered			
In-hospital claims (ward/theatre/consumables)	Tariff inflation 1% higher	69 132	(0.34%)
Ageing assumptions			
Represents the expected claims increase due to members getting older on average			
In-hospital claims (ward/theatre/consumables)	Average member age 0.5 years higher	71 345	(0.35%)
Acute Medicine claims	Average member age 0.5 years higher	6 061	(0.03%)
Utilisation assumptions			
Represents expected claims increases over and above what is explained by inflation, ageing and benefit changes			
In-hospital claims (ward/theatre/consumables)	Utilisation rate 1% higher	69 481	(0.34%)
Specialist costs	Utilisation rate 1% higher	22 218	(0.11%)

22. FINANCIAL RISK MANAGEMENT

22.1 Financial risk management principles

The Scheme's activities expose it to the following financial risks:

- Credit risk;
- Liquidity risk; and
- Market risk from equity market prices (price risk) and interest rate risk.

The Scheme's overall risk management programme focuses on the unpredictability of financial markets and seeks to minimise potentially adverse effects on the financial performance of the investments that the Scheme holds to meet its obligations to its members.

Financial risk management and investment decisions are made under the guidance and policies approved by the Board of Trustees, together with the Scheme's Executive Management, who have overall responsibility for the establishment and oversight of the Scheme's financial and non-financial risk management framework.

The Investment Committee is responsible for assisting the Board to manage the investment portfolio in accordance with the agreed policies of the Scheme and ensure compliance with the regulations of the Act. Refer to page 65 of the Annual Report for further details on the Scheme's investment strategy.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

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22. FINANCIAL RISK MANAGEMENT CONTINUED

22.2 Credit risk

Credit risk is the risk that the Scheme will suffer a financial loss if a customer (insurance or trade receivable) or other counterparty to a financial instrument fails to meet their current obligations to the Scheme. Credit risk arises principally from the Scheme's investment securities (excluding the equity instruments), cash and cash equivalents and insurance, trade and other receivables.

22.2.1 Exposure to credit risk

The carrying amounts of financial assets represents the maximum credit exposure. The maximum exposure to credit risk at the reporting date was:

	2021 R'000	2020 R'000
Investments (current and non-current)	**8 245 970**	7 139 473
Insurance, trade and other receivables (excluding prepayments)	**700 703**	714 144
Cash and cash equivalents	**766 465**	611 090
	9 713 138	8 464 707

22.2.2 Investments

The credit risk is managed by limiting exposure as well as the quality of instruments that the Scheme's assets can be invested in, limiting the impact of a default on the overall portfolio. The following guidelines provide the current limits on each instrument:

Domestic equity investments

- Domestic Equity Investments shall be restricted to securities that are actively traded on the Johannesburg Stock Exchange (JSE) and readily marketable.
- Not more than 5% of the Investment Portfolio of the Scheme may be invested in the share instrument of any one company.
- Not more than 2.5% of the total Scheme's accumulated reserves shall be invested in a company with market capitalisation less than R5 billion at any point in time.
- In cases of investments into a pooled fund, the Scheme may invest in accordance with Regulation 30 requirements, in which case the Scheme may waive strict adherence to the guidelines above.

Domestic fixed-income and cash investments

- An important element of credit risk management is the establishment of exposure limits on single counterparties and groups of connected counterparties. Limits should also be established for industries or economic sectors, geographic regions, etc. Risk ratings are an important tool in monitoring and controlling credit risk. In order to facilitate early identification of changes in risk profiles, the Scheme's risk rating system should be responsive to indicators of potential or actual deterioration in credit risk. The credit limits set out below shall apply to all debt securities:

	Per Issuer Limit:
Credit category (Fitch/S&P or equivalent)	**Per Issuer limit as % of total bond and cash allocation**
RSA bonds	Up to 100%
AAA (including sovereign & Government-guaranteed bonds)	Not more than 25%
Below AAA but not lower than AA-	Not more than 20%
Below AA- but not lower than A	Not more than 15%
Below A but not lower than BBB	Not more than 10%
Below BBB	Not more than 5%

In addition to the per issuer limits, a minimum of ninety percent of the debt securities held by the Scheme must be investment grade (AAA to BBB- or equivalent) credit rating.

Derivatives

- Derivative instruments are used for the purposes of hedging or protecting the Scheme's investment portfolio, rebalancing or facilitating cash flows in order to enhance the Scheme's investment returns. The mark-to-market value of investments are limited to 2.5% of the investment portfolio. Refer to note 7.

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.2 Credit risk continued

22.2.3 Insurance, trade and other receivables

The Scheme's exposure to credit risk is influenced by the individual characteristics of each member. The demographics of the Scheme's membership base, including the default risk of the industry in which the member operates, has less of an influence on credit risk. The Scheme's revenue streams are evenly spread thereby reducing credit risk exposure.

The majority of the Scheme's members have been loyal to the Scheme for many years, resulting in infrequent losses occurring. Credit risk is actively managed by suspending members accounts on non-receipt of contributions.

Age analysis of insurance, trade and other receivables

	2021 R'000	2020 R'000
Not past due	**689 004**	703 038
Past due 1 – 30 days	**8 428**	8 032
Past due 31 – 60 days	**1 165**	1 942
Past due 61 – 90 days	**126**	727
Past due more than 90 days	**1 980**	405
Trade and other receivables (excluding prepayments)	**700 703**	714 144

With respect to the insurance assets that are neither impaired nor past due, there are no indications as of the reporting date that the debtors will not meet their payment obligations based on, the nature of the counterparty, the historical information about the counterparty default rates and other information used to assess credit quality.

22.2.4 Cash and cash equivalents

Cash transactions are limited to high credit quality financial institutions. The Scheme has a policy of limiting the amount of credit exposure to any one financial institution and only uses the reputable banks.

22.2.5 Concentrations of credit risk

The Scheme establishes an allowance for impairment that represents its estimate of incurred losses in respect of trade and other receivables. The collective loss allowance is determined based on a set policy, while bearing in mind historical data of payment statistics for similar financial assets.

22.2.6 Impairment allowances

The Scheme establishes an allowance for impairment that represents its estimate of expected credit losses (IFRS 9) in respect of insurance receivables. The collective loss allowance is determined based on a set policy, while bearing in mind historical data of payment statistics for similar financial assets.

The movement in the allowance for impairment in respect of insurance receivables during the year was as follows:

	2021 R'000	2020 R'000
Balance at the beginning of the year	**24 556**	11 006
Impairment loss recognised/(reversed)	**(9 033)**	13 550
Balance at the end of the year	**15 523**	24 556

The provision for impairment at 31 December 2021 was determined in accordance with the guidelines of the simplified approach (life time expected losses) of the expected credit loss model as required by IFRS 9. It is in respect of contributions receivable, member and service provider debit balances and advances from savings plan accounts recoverable by management. In order for the Scheme to determine life time expected losses, a provision matrix was used. The provision matrix is based on historical observed default rates, adjusted for forward looking estimates. At every reporting date, the historical observed rates are updated.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.2 Credit risk continued

22.2.6 Impairment allowances continued

The provision matrix is split for the following categories:

a) Group debtors
b) Direct paying members
c) Members portion debtors
d) Savings debtors
e) Provider debtors

The expected credit loss estimates were updated to account for future economic conditions, relative to historic conditions, given the severity of the economic impacts of COVID-19. In the prior year the Beta risk factors were increased from 15% to 25% as cash flows were impacted due to contribution relief granted to defer contribution payments for the period 1 June 2020 to 31 August 2020 and 1 October 2020 to 31 December 2020. Members who qualified per the stipulated criteria, considering credit risk, utilised accumulated savings balances to offset contribution debt up to a maximum period of 3 months and Employer Groups, as well as Small and Medium Enterprises less than 200 employees, who qualified, were granted deferred contribution payment relief for 30 days. Payment defaults were managed according to the Credit Policy. Refer note 27 for the financial impact of the relief measures granted.

22.3 Liquidity risk

Liquidity risk is the risk that the Scheme will not be able to meet its financial obligations as they fall due. The Scheme's approach to managing liquidity is to ensure, as far as possible, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Scheme's reputation.

The Scheme manages its cash flows on a daily basis to ensure sufficient liquidity to cover daily requirements of which the rental costs make up a non-significant portion of cash flow requirements on a monthly basis. Furthermore, the Scheme has appointed asset managers to manage its liquidity requirements in the short, medium and long-term.

The Scheme has strategically allocated 25% of its total investment assets to be invested in cash which provides a high degree of liquidity on investments. Additionally, the other asset managers are keeping cash in their portfolios at no more than 5% of total investments.

As part of the Scheme's liquidity risk management on market linked investments, the following categories are specifically excluded from the investment portfolio unless the Board of Trustees provides prior written approval for these investments:

- Private equity funding including venture capital and direct property investments;
- Physical commodities or physical commodity contracts; and
- Unregistered and/or restricted instruments which are unlisted and/or not freely traded.

The contractual maturities of the financial liabilities at reporting date are tabled below. The amounts are gross and undiscounted:

	Within three months R'000	Three to twelve months R'000	Total R'000
2021			
Financial liabilities			
Personal medical savings account liability	**(58 375)**	**(835 662)**	**(894 037)**
Insurance, trade and other payables (excluding VAT)	**(551 093)**	**–**	**(551 093)**
Outstanding risk claims provision	**(859 133)**	**(45 218)**	**(904 351)**
	(1 468 601)	**(880 880)**	**(2 349 481)**
2020			
Financial liabilities			
Personal medical savings account liability	(51 762)	(760 316)	(812 078)
Insurance, trade and other payables (excluding VAT)	(669 488)	–	(669 488)
Outstanding risk claims provision	(927 461)	(48 814)	(976 275)
Derivative financial instruments	–	(31 878)	(31 878)
	(1 648 711)	(841 008)	(2 489 719)

Liquidity analysis assumptions:

i) The carrying amount of the financial liabilities equals the undiscounted contractual values of these instruments due to the short period to maturity.

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.4 Market risk

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

22.4.1 Currency risk

Currency risk is the risk that the value of a financial instrument will fluctuate in Rands due to changes in foreign exchange rates. The Scheme had no material exposure to currency risk during the year under review as no material foreign currency-denominated investments were held.

22.4.2 Interest rate risk

The Scheme is exposed to interest rate risk on its money market investments (debt investments), cash and cash equivalents. The money market and cash and cash equivalents are managed on a net returns basis by the Scheme's asset managers. The balance of fixed and variable instruments being held in these portfolios is adjusted in response to movements in market interest rates to maintain an acceptable level of risk as well as returns. The net returns are benchmarked against the SteFi Composite index.

The carrying amounts of fixed-rate instruments in these portfolios approximate their fair values due to the short period to maturity, and no fair value adjustments are processed to the statement of profit or loss in respect of these instruments. Variable-rate instruments are not linked to one specific market interest rate. The reported returns on these investments will vary in response to movements in market rates.

The Scheme does not discount insurance, trade or other receivables or payables as they are all settled or fall due within one year.

	2021 R'000	2020 R'000
Interest-bearing instruments		
Financial assets	**5 858 153**	5 394 002
Investments – interest-bearing assets (note 6)	**5 091 688**	4 782 912
Cash and cash equivalents	**766 465**	611 090
Financial liabilities		
Personal medical savings account liability	**(894 037)**	(812 078)
	4 964 116	4 581 924

Interest rate sensitivity analysis

At the end of December 2021, the Scheme earned interest income of R300 million (2020: R238 million) from its investments in bonds, cash and money market instruments. The following tables illustrates the impact of negative and positive market returns to the overall Scheme as a result of the current interest rate exposure, assuming all other variables remain constant:

Decrease	**(2.5%)**	**(2.0%)**	**(1.5%)**	**(1.0%)**	**(0.5%)**	**(0.25%)**	**0.0%**
2021							
Scheme impact (surplus) (R'000)	**(141 551)**	**(113 240)**	**(84 930)**	**(56 620)**	**(28 310)**	**(14 155)**	**–**
Solvency impact	**(0.75%)**	**(0.60%)**	**(0.45%)**	**(0.30%)**	**(0.15%)**	**(0.07%)**	**–**
2020							
Scheme impact (surplus) (R'000)	(112 275)	(89 820)	(67 365)	(44 910)	(22 455)	(11 227)	–
Solvency impact	(0.61%)	(0.48%)	(0.36%)	(0.24%)	(0.12%)	(0.06%)	–

Increase	**0.0%**	**0.25%**	**0.5%**	**1.0%**	**1.5%**	**2.0%**	**2.5%**
2021							
Scheme impact (surplus) (R'000)	**–**	**14 155**	**28 310**	**56 620**	**84 930**	**113 240**	**141 551**
Solvency impact	**–**	**0.07%**	**0.15%**	**0.30%**	**0.45%**	**0.60%**	**0.75%**
2020							
Scheme impact (surplus) (R'000)	–	11 227	22 455	44 910	67 365	89 820	112 275
Solvency impact	–	0.06%	0.12%	0.24%	0.36%	0.48%	0.61%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.4 Market risk continued

22.4.3 Market price risk

Market price risk arises from fair value through profit or loss in equity securities held for partially meeting the Scheme's financial obligations although this downside risk was partly managed through an equity hedge (derivative). The Scheme's assets are managed by various asset managers on behalf of the Scheme. All buy and sell decisions are measured in terms of the investment mandate of the Scheme.

The following guidelines provide the current limits on each instrument:

Domestic equity investments

- Domestic Equity Investments shall be restricted to securities that are actively traded on the Johannesburg Stock Exchange (JSE) and readily marketable.
- Not more than 5% of the Investment Portfolio of the Scheme may be invested in the share instrument of any one company.
- Not more than 2.5% of the total Scheme's accumulated reserves shall be invested in a company with market capitalisation less than R5 billion at any point in time.
- In cases of investments into a pooled fund, the Scheme may invest in accordance with Regulation 30 requirements, in which case the Scheme may waive strict adherence to the guidelines above.

Domestic fixed-income and cash investments

The credit limits set out below shall apply to all debt securities:

	Per Issuer Limit:
Credit category (Fitch/S&P or equivalent)	**Per Issuer limit as % of total bond and cash allocation**
RSA bonds	Up to 100%
AAA (including sovereign & Government-guaranteed bonds)	Not more than 25%
Below AAA but not lower than AA-	Not more than 20%
Below AA- but not lower than A	Not more than 15%
Below A but not lower than BBB	Not more than 10%
Below BBB	Not more than 5%

In addition to the per issuer limits, a minimum of ninety percent of the debt securities held by the Scheme must be investment grade (AAA to BBB- or equivalent) credit rating.

Derivatives

- The Scheme is permitted to invest into derivative structures as per Annexure B of the Medical Schemes Act. Annexure B of Regulation 30 Section 7 a(ii) allows for an allocation of no more than 2.5% of Scheme's assets towards any other local assets not referred to in Annexure B and derivative instruments are not referred to anywhere in Annexure B. Therefore, this provision qualifies derivatives as "other" among other assets not referred to in Annexure B.
- The Regulation 30 limitation would therefore permit the Scheme to invest in derivative instruments not exceeding 2.5% of the Scheme's assets. For clarity, the 2.5% would relate to the value of the derivative asset/liability recognised and not the value of the underlying assets held by the Scheme.

The Scheme strives to minimise market risk as follows:

- The Scheme has established an investment strategy and in line with this strategy, the Scheme diversifies its investment portfolio by investing in domestic equities, domestic bonds, derivative instruments and domestic cash to achieve a balanced investment portfolio.
- The Scheme invests across domestic listed equities, domestic bonds, domestic listed and fixed property as well as domestic cash portfolios.
- Investments are limited to the types of securities listed in the Investment Policy Statement. Furthermore, the following categories of securities are excluded and may only be considered with written approval from the Board of Trustees:

  a) Private equity funding including venture capital and direct property investments;

  b) Physical commodities or physical commodity contracts; and

  c) Unregistered and/or restricted instruments which are unlisted and/or not freely traded.

- Diversifying the management of the Schemes investment portfolio to specific specialised mandates thus mitigating the risk through diversification. The Scheme, in addition to this, has one asset manager responsible for managing the Scheme's cash.
- Structuring the investment portfolio so that sufficient cash and cash-like securities are available to meet cash requirements for ongoing cash flow needs, thereby avoiding the need to sell securities on the open market during periods of market volatility.

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.4 Market risk continued

22.4.3 Market price risk continued

Sensitivity analysis

The analysis presented below assumes all other factors remain constant and is performed on the same basis for 2021 and 2020, incorporating the impact of the new derivative arrangements entered into in September 2020 (in the prior year).

Listed equities

At the end of December 2021, the Scheme had 37.9% (2020: 32.3%) of its investment portfolio (excluding cash) invested in listed equity instruments. The following tables illustrates the impact of negative and positive market returns to the overall Scheme as a result of the current equity exposure, assuming all other variables remain constant before zero cost fence derivatives:

Decrease	**(35.0%)**	**(25.0%)**	**(15.0%)**	**(10.0%)**	**(5.0%)**	**(2.0%)**	**0.0%**
2021							
Scheme impact (surplus) (R'000)	**(1 103 999)**	**(788 571)**	**(473 142)**	**(315 428)**	**(157 714)**	**(63 086)**	**–**
Solvency impact	**(5.85%)**	**(4.18%)**	**(2.51%)**	**(1.67%)**	**(0.84%)**	**(0.33%)**	**–**
2020							
Scheme impact (surplus) (R'000)	(816 541)	(583 243)	(349 946)	(233 297)	(116 649)	(46 659)	–
Solvency impact	(4.40%)	(3.15%)	(1.89%)	(1.26%)	(0.63%)	(0.25%)	–

Increase	**0.0%**	**2.0%**	**5.0%**	**10.0%**	**15.0%**	**25.0%**	**35.0%**
2021							
Scheme impact (surplus) (R'000)	**–**	**63 086**	**157 714**	**315 428**	**473 142**	**788 571**	**1 103 999**
Solvency impact	**–**	**0.33%**	**0.84%**	**1.67%**	**2.51%**	**4.18%**	**5.85%**
2020							
Scheme impact (surplus) (R'000)	–	46 659	116 649	233 297	349 946	583 243	816 541
Solvency impact	–	0.25%	0.63%	1.26%	1.89%	3.15%	4.40%

Solvency figures are calculated on the assumption that all cumulative unrealised fair value reserves have been realised.

Equity derivative financial instrument (Zero-cost equity fence)

In September 2020 the Scheme entered into zero-cost equity fence arrangements to hedge the exposure to changes in market prices for investments in the equity portfolios. The contracts provided downside protection against market decline of between 2.5% and 15%. To achieve this, the Scheme agreed to forego upside benefit from an increase in equity prices above 10.1% for contract 1 and 11.2% for contract 2. These contracts as listed below expired in September 2021.

2021 CONTRACTS (Expired September 2021)

	Index level	**Nominal Value R'000**	**Index level at trade date**	**Index level at expiry date**	**Expiry date**	**Settlement value R'000**	**Losses on derivative financial instruments R'000**
1	**CAPPED SWIX40, BBG: J430PR Index**	**500 000**	**14 597**	**18 193**	**06-Sep-21**	**72 705**	**38 170**
2	**CAPPED SWIX40, BBG: J430PR Index**	**148 000**	**14 619**	**17 646**	**13-Sep-21**	**13 668**	**16 325**
						86 373	**54 495**

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FOR THE YEAR ENDED 31 DECEMBER 2021

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.5 Fair value

For financial assets held at fair value, disclosure is required of a fair value hierarchy which reflects the significance of the inputs used to make the measurements. Fair value disclosures are based on the level within which an instrument falls in the fair value hierarchy. The inputs are categorised into three levels, with the highest priority given to unadjusted quoted prices in active markets for identical assets or liabilities and the lowest priority given to unobservable inputs.

The three fair value hierarchy levels are:

- Level 1 inputs are unadjusted quoted prices in active markets for identical assets or liabilities;
- Level 2 inputs are inputs other than quoted prices included within Level 1 that are either directly or indirectly (that is, derived from prices) observable for the asset or liability;
- Level 3 inputs for the asset or liability that are not based on observable market data (that is, unobservable inputs).

The following table presents the Scheme's assets held at fair value:

	Level 1 R'000	Level 2 R'000	Level 3 R'000	Total R'000
at 31 December 2021				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	**3 154 282**	**–**	**–**	**3 154 282**
Unlisted equities*	**–**	**–**	**–**	**–**
Bonds	**3 684 494**	**–**	**–**	**3 684 494**
Unlisted property holding*	**–**	**–**	**–**	**–**
Money market instruments*	**–**	**1 407 194**	**–**	**1 407 194**
Investment properties*	**–**	**–**	**77 000**	**77 000**
Total assets	**6 838 776**	**1 407 194**	**77 000**	**8 322 970**
at 31 December 2020				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	2 332 973	–	–	2 332 973
Unlisted equities*	–	–	22 000	22 000
Bonds	3 633 929	–	–	3 633 929
Unlisted property holding*	–	–	1 588	1 588
Money market instruments*	–	1 148 983	–	1 148 983
Investment properties*	–	–	77 700	77 700
Total assets	5 966 902	1 148 983	101 288	7 217 173

* *Movements and valuation techniques relating to Level 2 and Level 3 category items are disclosed in notes 5, 6 and 7.*

There were no changes in levels noted in the current year.

Financial assets held at fair value through profit or loss held by the Scheme categorised as Level 1 were invested in listed preference shares, equities, bonds and priced with reference to published price quotations (unadjusted) in an active market.

Financial assets held at fair value through profit or loss held by the Scheme categorised as Level 2:

- unlisted money market instruments and valued using discounted cash flows based on applicable interest rates

Financial assets held at fair value through profit or loss held by the Scheme categorised as Level 3 were invested in:

- Unlisted equity investment of 26% in Louis Pasteur Holdings Proprietary Limited (sold in February 2021);
- Investment properties leased to third parties valued annually by independent property valuators;
- An unlisted property holding and valued with reference to commercial property yields on the existing average income stream received; and
- Unlisted insurance policy and valued based on underlying Funds investments (fully impaired in 2021).

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.5 Fair value continued

The following table presents the Scheme's liabilities held at fair value:

	Level 1 R'000	Level 2 R'000	Level 3 R'000	Total R'000
at 31 December 2021				
Liabilities				
Financial liabilities held at fair value through profit or loss				
Derivative instruments	–	–	–	–
	–	–	–	–
at 31 December 2020				
Liabilities				
Financial liabilities held at fair value through profit or loss				
Derivative instruments	–	31 878	–	31 878
	–	31 878	–	31 878

Financial liabilities held at fair value through profit or loss held by the Scheme categorised as Level 2:

- Derivative financial instruments measured using inputs other than quoted prices included within Level 1 that are observable for the liability, either directly or indirectly. The derivative contracts expired in September 2021 and therefore no liability was reported as at 31 December 2021.

The following table shows a reconciliation of the movement during the year for fair value measurements for investments through profit and loss in Level 3 of the fair value hierarchy of the Scheme for 2021:

	Investment property R'000	Unlisted equity R'000	Unlisted property holding R'000	Total R'000
Opening balance	**77 700**	**22 000**	**1 588**	**101 288**
Fair value adjustment	**(700)**	**–**	**(1 588)**	**(2 288)**
Disposal	**–**	**(22 000)**	**–**	**(22 000)**
Closing balance	**77 000**	**–**	**–**	**77 000**

Although the Scheme believes that its estimates of fair value are appropriate, the use of different methodologies or assumptions could lead to different measurements of fair value.

Key inputs and assumptions used in the model at 31 December 2021 include:

Investment property

Refer to note 5 for the details regarding key inputs and assumptions used in the valuation at 31 December 2021.

The property value is based on the fair value of the underlying property. The property is valued using the net income of the property and applying a capitalisation rate to the net income.

The capitalisation rate applied is based on an assumed average commercial property yield simulating the risk characteristics of a similar investment.

Unlisted equity

Refer to note 22.6 for details as this investment was sold in February 2021.

Unlisted property holding

The unlisted property holding relates to a debenture held in Nova Property Group (Nova) which is linked to the Waterglen Shopping Centre. The discounted syndication value, which is the capital repayment that the debenture holder is entitled to, under current market conditions using a risk adjusted discount rate, was used in the valuation at 31 December 2021 and determined the debenture value to be R3.7 million.

Due to a number of factors namely: Nova's financial distress in 2021, the auditor's highlighted going-concern issues and adverse opinion on the financial statements and worsening market conditions as the market capitalisation of Real Estate Investment Trusts (REITs) has declined, the debenture was impaired 100% and thus the value as at 31 December 2021 is nil.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.5 Fair value continued

Unconsolidated investment structures

The asset managers invest the Scheme's monies in reputable funds which target returns to the Scheme. The Scheme views these funds as unconsolidated structured entities. The Scheme monitors the performance of the funds closely to ensure the Scheme earns high returns without unnecessary exposure to risk.

The Scheme has investments in pooled investment products and collective investment schemes (the Funds) as listed in the table below. The exposure the Scheme has to these funds is listed in the table below in terms of Regulation 30 of the Act. The Scheme's maximum exposure to loss from its interests in the fund is limited to the total fair value of its investments as detailed below:

	at 31 December 2021		at 31 December 2020	
Fund	**Fair value R'000**	**% exposure in terms of Regulation 30**	Fair value R'000	% exposure in terms of Regulation 30
Nedgroup Structured Life Taquanta EIF	**405 377**	**5%**	278 579	4%
Nedgroup Investments Money Market Fund Class C4	**100 551**	**1%**	314 500	4%
27four Life: QML8 SRI Low Liquidity Funding Portfolio	**1 952**	**0%**	2 650	0%
	507 880	**6%**	595 729	8%

22.6 Unlisted investments

Unlisted equities comprised a 26.0% investment in Louis Pasteur Hospital Holdings Proprietary Limited (Louis Pasteur). The investment in Louis Pasteur was valued at fair value and sold, the settlement was received on 2 February 2021.

	2021 R'000	2020 R'000
Reconciliation of fair values		
Balance at 1 January	**22 000**	22 000
Disposal	**(22 000)**	–
Balance at 31 December	**–**	22 000

22. FINANCIAL RISK MANAGEMENT CONTINUED

22.7 Capital management

The Board of Trustees' policy is to maintain a strong capital base so as to maintain investor, creditor and market confidence and to sustain future growth of the business. RisCura Solutions (Pty) Ltd manages the Scheme's portfolio of investments and cash and cash equivalents to achieve this objective.

The Board of Trustees monitors the solvency ratio of the Scheme. The Scheme is required to maintain a minimum level of accumulated funds in terms of Regulation 29 of the Act. Accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review may not be less than 25.0%. "Accumulated funds" is defined as the net asset value of the Scheme, excluding funds set aside for specific purposes and unrealised non-distributable reserves.

	2021 R'000	2020 R'000
Members' funds per the statement of financial position	**7 447 331**	6 059 840
Adjusted for:		
Regulation 29 exclusion of unrealised gains on remeasurement of investments and investment property to fair value*	**(558 986)**	(4 926)
Accumulated funds per Regulation 29	**6 888 345**	6 054 914
Gross contributions (note 13)	**18 887 490**	18 540 546
Solvency ratio (%)	**36.47%**	32.66%
** Cumulative net (losses)/gains on remeasurement to fair value of investments are calculated as follows:*		
At beginning of year	**(15 548)**	(35 076)
Net gains on remeasurement to fair value of financial instruments included in accumulated funds	**554 760**	19 528
At end of year	**539 212**	(15 548)
# Cumulative net gains on remeasurement to fair value of investment properties are calculated as follows:		
At beginning of year	**20 474**	17 574
Movement in unrealised gains on remeasurement to fair value of investment properties included in accumulated funds	**(700)**	2 900
At end of year	**19 774**	20 474
Cumulative net gains on remeasurement of investments and investment property at the end of the year	**558 986**	4 926

Cumulative net unrealised losses on remeasurement to fair value of investments and investment properties are excluded from the solvency calculation according to Regulation 29.

23. COMMITMENTS

	2021 R'000	2020 R'000
23.1 Lessee operating lease commitments		
The future aggregate minimum lease payments under non-cancellable operating leases are as follows:		
Not later than one year	**3 149**	4 009
Later than one year and not later than five years	**–**	3 149
	3 149	7 158
23.2 Lessor operating lease commitments		
The future aggregate minimum lease receipts under non-cancellable operating leases are as follows:		
Not later than one year	**5 358**	8 185
Later than one year and not later than five years	**3 382**	8 739
	8 740	16 924

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

24. RELATED PARTY TRANSACTIONS

24.1 Related party relationships

24.1.1 Key management personnel and their close family members

Key management personnel are those persons who have authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the Chairman of the Board, the Board of Trustees, the Principal Officer and the Chief Financial Officer.

Close family members include direct family members of the Chairman of the Board, the Board of Trustees, the Principal Officer and the Chief Financial Officer.

24.1.2 Key service provider

Medscheme Holdings Proprietary Limited is a key service provider for the Scheme as it has a significant role in the administering of Scheme's financial, actuarial and operating activities.

Medscheme Holdings Proprietary Limited is also the accredited managed care service provider.

Afrocentric Distribution Services Proprietary Limited, is a key service provider as it handles the Scheme's advertising and marketing activities. It is a fellow subsidiary of the Scheme's administrator.

Aids for Aids Management Proprietary Limited, is a key service provider for the Scheme as it participates in providing managed care services to the Scheme's members. It is a fellow subsidiary of the Scheme's administrator.

Afrocentric Technologies Proprietary Limited, is a key service provider as it handles the IT support services. It is a fellow subsidiary of the Scheme's administrator.

Pharmacy Direct Proprietary Limited, is a key service provider as it handles the Scheme's dispensing and delivery of chronic medication. It is a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of the Scheme's administrator.

Dental Information Systems Proprietary Limited, is a key service provider as it handles the Scheme's dental claims management. It is a fellow subsidiary of the Scheme's administrator.

Scriptpharm Risk Management Proprietary Limited, is a key service provider as it handles the Scheme's chronic risk management. It is a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of the Scheme's administrator.

Wellness Odyssey Proprietary Limited, is a key service provider as it handles the Scheme's wellness programmes. It is a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of the Scheme's administrator.

Tendahealth Proprietary Limited, is a service provider that provides the Scheme's members with brokerage services. It is a subsidiary of Afrocentric Distribution Services, a fellow subsidiary of the Scheme's administrator.

24.1.3 Other related parties

The Scheme had a 26% ordinary shareholding in Louis Pasteur Hospital Holdings Proprietary Limited. The members of the Scheme utilise the facilities of the Louis Pasteur Hospital on an ongoing basis, for medical services. The investment was sold in February 2021.

24. RELATED PARTY TRANSACTIONS CONTINUED

24.2 Transactions with related parties

All transactions with related parties are at arms-length.

	2021 R'000	2020 R'000
24.2.1 Parties with significant influence over the Scheme		
Medscheme Holdings Proprietary Limited – Scheme administrator		
Statement of comprehensive income		
Administration fees paid		
The administration agreement between Medscheme Holdings Proprietary Limited and the Scheme stipulates that Medscheme Holdings Proprietary Limited administers the Scheme in terms of the rules of the Scheme and in accordance with the instructions given by the Board of Trustees.	**910 128**	876 461
Claim recoveries for service failures		
As part of the administration agreement, the Scheme is entitled to recoveries due to service failures if services as per the agreements are not satisfied.	**(7 512)**	–
Third party recoveries		
As part of the administration agreement, the Administrator was entitled to a 30% fee until 31 May 2021 and 25% from June 2021 on fraud, waste and abuse recoveries.	**9 021**	10 386
Statement of financial position		
Balances payable to related party		
The balances payable bear no interest, are unsecured and are due within 30 days.	**(7 322)**	(3 115)
Medscheme Holdings Proprietary Limited – Managed care provider		
Statement of comprehensive income		
Managed care fees		
The managed care agreement between Medscheme Holdings (Pty) Ltd and the Scheme stipulates that Medscheme Holdings (Pty) Ltd renders managed healthcare services to the Scheme in terms of the rules of the Scheme and in accordance with the instructions given by the Board of Trustees.	**481 513**	481 811
Statement of financial position		
Balances owed by related party		
The balances owed bear no interest, are unsecured and are owed upon presentation of an approved invoice (managed care).	**3 631**	2 262
Medscheme Holdings Proprietary Limited – Actuarial service provider		
Statement of comprehensive income		
Actuarial consulting fees		
The actuarial consulting agreement between Medscheme Holdings (Pty) Ltd and the Scheme stipulates that Medscheme Holdings (Pty) Ltd renders actuarial consulting services and technical marketing services to the Scheme in accordance with the instructions given by the Board of Trustees.	**2 639**	2 552
Statement of financial position		
Balances owed to related party		
The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice.	**(440)**	–

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

24. RELATED PARTY TRANSACTIONS CONTINUED

24.2 Transactions with related parties continued

24.2.1 Parties with significant influence over the Scheme continued

	2021 R'000	2020 R'000
Afrocentric Distribution Services Proprietary Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
Sales and marketing fees	**112 086**	109 391
Statement of financial position		
Balances payable to related party		
The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice.	**(9 340)**	(8 738)
Aid for Aids Management Propriety Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
Managed care fees		
The managed care agreement between Aid for Aids Management Proprietary Limited and the Scheme stipulates that Aid for Aids Management Proprietary Limited renders management services to the Scheme in terms of the rules of the Scheme and in accordance with the instructions given by the Board of Trustees.	**54 601**	53 525
Statement of financial position		
Balances payable to related party		
The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice.	**(4 584)**	(4 492)
Afrocentric Technologies Proprietary Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
Software licence agreement		
IT management and support services agreement		
The IT management and support services agreement in place is to provide the Scheme with IT support services.	**216**	597
Statement of financial position		
Balances (payable)/receivable from related party		
The balance receivable bears no interest, is unsecured and is due within 30 days.	**–**	–
Pharmacy Direct Proprietary Limited (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
Claims paid during the year	**333 312**	400 176
Wellness costs incurred during the year	**11 405**	–
Statement of financial position		
Balances payable to related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**(755)**	–

24. RELATED PARTY TRANSACTIONS CONTINUED

24.2 Transactions with related parties continued

24.2.1 Parties with significant influence over the Scheme continued

	2021 R'000	2020 R'000
Scriptpharm Risk Management (Pty) Ltd (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
Risk transfer arrangement premiums/fees paid		
The capitated risk management agreement between the Scheme and Scriptpharm Risk Management (Pty) Ltd, as an accredited managed care organisation, stipulates that Scriptpharm Risk Management (Pty) Ltd renders Chronic medicine benefits to beneficiaries of the Scheme on a capitated basis.	**780 854**	703 422
Refund of capitation fees as a result of COVID-19	**(9 492)**	–
Statement of financial position		
Balances owing by/(payable) to related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**9 492**	(13 397)
Dental Information Systems Proprietary Limited		
In December 2019, AfroCentric Investment Corporation Limited (AfroCentric Group), reached an agreement through one of its subsidiaries to acquire 100% of the shareholding of DENIS for R250 million. The Competition Commission approved the deal and allowed for finalisation of the details of this acquisition which came into full effect on 01 October 2020.		
Statement of comprehensive income		
Risk transfer arrangement premiums/fees paid		
The capitated risk agreement between Dental Information Systems Holdings Proprietary Limited and the Scheme stipulates that Dental Information Systems Holdings Proprietary Limited renders dental risk management to the members of the Scheme.		
Capitation fees payable (including fees for wellness and administration costs)	**377 932**	93 427
Refund of capitation fees negotiated as a result of COVID-19	**–**	(55 545)
Managed care services		
The managed care agreement between Dental Information Systems Holdings Proprietary Limited and the Scheme stipulates that Dental Information Systems Holdings Proprietary Limited renders managed care services for Primary and Primary EDO options of the Scheme.		
Dental risk management	**17 252**	4 117
Statement of financial position		
Balances (payable to)/owing by related party		
The balance (payable)/owing bears no interest, is unsecured and is due within 30 days, as the Scheme negotiated a refund of capitation fees due to a reduction in utilisation as a result of the COVID-19 pandemic.	**(177)**	55 545
Wellness Odyssey (Pty) Ltd (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
Wellness costs paid during the year*	**4 611**	18 261
Statement of financial position		
Balances payable to related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**(118)**	(7 866)

* *Wellness costs paid reduced as these are now included in the Managed care contract payable to Medscheme Holdings Proprietary Limited (Managed Care Provider), effective 1 June 2021.*

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

24. RELATED PARTY TRANSACTIONS CONTINUED

24.2 Transactions with related parties continued

24.2.1 Parties with significant influence over the Scheme continued

	2021 R'000	2020 R'000
Tendahealth (Pty) Ltd (a subsidiary of Afrocentric Distribution Services (Pty) Ltd, a fellow subsidiary of Medscheme Holdings (Pty) Ltd)		
Statement of comprehensive income		
Broker fees paid	**14 984**	10 196
Statement of financial position		
Balances payable to related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**–**	–

24.2.2 Key management personnel and their close family members

Key management compensation		
Trustee's remuneration and other disbursements (note 15)	**6 067**	5 635
Principal Officer's remuneration and other disbursements (note 15)	**6 826**	5 614
Executive remuneration and other disbursements	**3 222**	4 456
	16 115	15 705
Statement of comprehensive income		
Contributions received		
This constitutes the contributions paid by the Executive Management and Trustees as members of the Scheme, in their individual capacity. All contributions were at the same terms as applicable to third parties.	**925**	886
Claims paid		
This constitutes amounts claimed by the Executive Management and Trustees, in their individual capacity as members of the Scheme. All claims were paid out in terms of the rules of the Scheme, as applicable to third parties.	**301**	280
Trustee savings balances		
This constitutes savings balances held by the Scheme on behalf of the trustees.	**2**	2

24.2.3 Other related parties

Louis Pasteur Hospital Holdings Proprietary Limited		
Statement of comprehensive income		
Claims paid during the year*	**1 377**	23 808
Statement of financial position		
Unlisted equity held by the Scheme in the entity at fair value*	**–**	22 000
Balance payable to related party*		
The balance payable in the prior year bears no interest, is unsecured and is due within 30 days.	**–**	(280)

* *The Louis Pasteur Holdings Proprietary Limited investment was sold on 2 February 2021 and therefore claims paid were recorded up until 31 January 2021 and no fair value unlisted equity or balance payable is reported as at the financial year end.*

25. CONTINGENCIES

The Scheme has contingent assets in respect of the Road Accident Fund claim recoveries for members that are or may be involved in a motor vehicle accident of R453 million (2020: R454 million). Management is confident that the contingent assets will be recoverable, should they arise.

26. NON-COMPLIANCE WITH THE ACT

The following areas of non-compliance with the Medical Schemes Act were identified during the course of the financial year:

26.1 Contravention of Section 33(2) of the Act

26.1.1 Nature and cause

In terms of Section 33(2) of the Act, the Registrar may withdraw the approval of such benefit options which, in his opinion, are not financially sound. For the year ended 31 December 2021 the Scheme reported a net healthcare deficit on seven (2020: two) of its benefit options:

	2021 R'000	2020 R'000
BonCap	**151 006**	62 540
BonFit	**6 277**	–
BonClassic	**15 038**	–
BonComprehensive	**65 951**	9 076
BonEssential	**36 303**	–
BonComplete	**937**	–
Hospital Standard	**1 213**	–

26.1.2 Possible impact

Loss-making benefit options erode the solvency margin of the Scheme. However, due to historical member reserves coupled with an efficient return on investments, the Scheme is able to absorb these losses.

26.1.3 Corrective course of action

The Scheme has experienced positive performance on its largest option. In 2021 Standard has reported a net healthcare surplus of R434.4 million. Much of the positive performance can be attributed to successful hospital negotiations and benefit design. In addition, with the easing of the lockdown restrictions, elective procedures and hospital and associated costs increased but not at the level that was expected. The Scheme continues to monitor the performance of the seven benefit options listed above on a monthly basis. There are also quarterly operational meetings held with the regulator advising on the performance of these options. The Scheme has adopted a long-term strategy to correct the loss-making options into the future. The Scheme has also appointed a task team to drive initiatives which will reduce both healthcare and non-healthcare costs over the medium term and improve health outcomes. These measures should have a positive impact across all options.

26.2 Contravention of Section 26(7) of the Act

26.2.1 Nature and cause

Section 26(7) of the Act, requires that all subscriptions and contributions be paid directly to a Medical Scheme not later than three days after payment thereof becomes due. The Scheme has aged debtors of up to 120 days for both group and direct paying members and is thus in breach of the three day rule.

26.2.2 Possible impact

There is a risk of non-compliance with Section 26(7) of the Act. Significant debt with members could affect the liquidity of the Scheme and its ability to service members and potential non recoverability of such debtors. For the 2021 financial period the Scheme incurred bad debt write offs of R12.5 million (2020: R10.8 million) which equals 0.07% (2020:0.06%) of risk contribution income.

26.2.3 Corrective course of action

It is not possible to receive all contributions within three days of becoming due, as there may be economic circumstances whereby contributions cannot be paid as per Section 26(7). In such instances members are notified of the breach. In addition, the Scheme has mitigating controls in place to address the non-payment of contributions, which include the enforcement of the Scheme's Credit Control Policy. Other interventions include, direct management engagement with affected groups to resolve such concerns.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

26. NON-COMPLIANCE WITH THE ACT CONTINUED

26.3 Exemption of Section 35(8) of the Act

26.3.1 Nature and cause

Section 35(8) of the Act prohibits a medical scheme from investing any of its assets in the business of or granting loans to; (a) an employer group who participates in the medical scheme or any administrator or any arrangement associated with the medical scheme; (b) any other medical scheme; (c) any administrator; and (d) any person associated with any of the above.

26.3.2 Possible impact

The Scheme has invested with various entities associated with its administrator and the Scheme's employer groups during the financial year.

26.3.3 Corrective course of action

The Scheme obtained an exemption in terms of Section 35(8) of the Act from the Council for Medical Schemes in respect of the non-compliance noted.

26.4 Contravention of Section 59 (2) of the Act

26.4.1 Nature and cause

Section 59(2) of the Act states that: "A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme."

Exceptions were noted during the year where claims were delayed when providers exceeded their monthly limit. Providers are screened first by the Forensic team prior to the limit being lifted, resulting in the claims being paid after the 30 days. Additional exceptions noted related to claims blocked in the system delaying payment and claims not routing for manual intervention after the 30 day period had lapsed.

26.4.2 Possible impact

Providers not settled timely should be communicated with appropriately to avoid non-compliance.

26.4.3 Corrective course of action

A communication strategy was implemented at the end of 2020 to inform the providers and members of any delays in claims payments outside the 30 days and was subsequently reviewed to ensure all claims in the environment are identified and communicated with proactively within the 30 window period to reduce the risk of non-compliance. Claims system scheduling jobs are being monitored by the System Maintenance to avoid further delays and the constant monitoring of exception reporting to identify any issues proactively and ensure corrective measures are taken.

26.5 Contravention of Regulation 10 (6) of the Act

26.5.1 Nature and cause

Regulation 10(6) of the Act prohibits the funding of a Prescribed Minimum Benefit ("PMB") from the members' medical savings accounts. An error occurred where potential PMB claims were processed as non-PMB related claims due to system development pertaining to overriding of the Scheme Rules and paid incorrectly from members' medical saving accounts instead of being paid from the Scheme's risk reserves.

26.5.2 Possible impact

Non-compliances with Regulation 10(6) is the risk. This may result in escalation of member complaints whose claims were incorrectly paid from their medical savings accounts and causing the member's out-of-pocket expenses to increase.

26.5.3 Corrective course of action

The errors were rectified when the incorrect claims process was identified. The effected members' medical saving accounts were credited with the respective amounts, where applicable. All PMB claims that are effected by the error have been addressed.

27. FINANCIAL IMPACT OF CORONAVIRUS (COVID-19) DURING THE 2021 YEAR

In 2021 the Scheme outperformed most of its targets, achieving a positive membership growth of 2.1% and a surplus of R1.4 billion in comparison to a budgeted surplus of R663 million, bolstered by strong investment performance. The year was not without financial challenges as COVID-19 costs of R2.6 billion were incurred and elective procedures and hospital and associated costs gradually increased, but not at the rate that was expected.

The financial relief measures offered in 2020 namely, utilisation of accumulated Personal Medical Savings account and deferred contribution granted to Small and Medium Enterprises Groups who qualified according to the stipulated criteria, discontinued in 2021.

The tables below represent the membership and financial impact experienced by the Scheme during the 2021 financial period.

27.1 COVID-19 Membership impact

Despite South Africa grappling with three COVID-19 waves in 2021 the Scheme was able to make growth targets as, with the roll-out of the vaccine campaign from May 2021 and easing of the lockdown conditions, the economy has slowly started its journey of recovery. Affordability challenges remained a continuing trend as terminations tracked closely to the previous year and buy downs, in terms of members moving to lower cost options, remained high although not to the same extent.

The following table represents the membership statistics:

	2021	2020
Average number of members during the year	**340 138**	335 425
Total number of membership losses for the year	**44 418**	43 424
Total number of new members joining the Scheme for the year	**51 396**	37 814
Average net membership (loss)/growth for the year (%)	**2.1%**	(1.7%)
Total number of members moving to lower cost options	**6 629**	10 323
Total number of members moving to higher cost options	**4 459**	5 366

27.2 COVID-19 and Non-COVID-19 Claims

27.2.1 COVID-19 Claims impact

The following table represents the COVID-19 claims financial impact using data as at February 2022:

	2021	2020
Total lives infected by COVID-19	**62 146**	33 952
% of total lives infected by COVID-19	**8.72%**	4.7%
Total lives recovered from COVID-19	**59 740**	30 142
Total deaths from COVID-19	**2 401**	1 123
Total lives vaccinated	**137 811**	–
Total vaccine costs in Rands*	**139 229 672**	–
Total COVID-19 related claims (including outstanding risk claims provision) in Rands	**2 563 383 093**	1 189 827 999

- Both the second wave in January 2021 and the third wave in July 2021 saw a much higher COVID-19 hospital burden than the first wave in July 2020;
- The increasing rate of COVID-19 testing during 2021 also resulted in a higher level of pathology outgo than 2020 for COVID-19;
- In May of 2021 the roll-out of COVID-19 vaccinations to the South African public began and Bonitas beneficiaries over the age of 60 were eligible to receive their first dose as part of the COVID-19 PMB benefits; and
- Due to the combination of vaccination, natural immunity and a milder variant, December 2021 saw a much milder fourth wave in terms of hospitalisation than the previous waves in the year.

27.2.2 Non-COVID-19 Claims

The claims ratio excluding COVID-19 claims was at 76.3% in 2020 and 75.7% in 2021 due to:

- Similar to 2020, members tried to avoid physical contact in 2021 during COVID-19 waves;
- Various discretionary ("elective") procedures were postponed during 2021 by practitioners, facilities and members;
- Many facilities dealt with capacity constraints where the focus had to be on COVID-19 treatment, especially during the peak of the second and third waves;
- Reduced local and international travel, as well as members practising social distancing and mask-wearing, also helped to reduce the spread of other infectious diseases; and
- More members staying home also reduced the number of injury and trauma cases.

The future impact of COVID-19 on claims values is detailed in note 28.

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FOR THE YEAR ENDED 31 DECEMBER 2021

27. FINANCIAL IMPACT OF CORONAVIRUS (COVID-19) DURING THE 2021 YEAR CONTINUED

27.3 Types of COVID-19 contribution relief measures granted to members

The relief measures were only available to members and groups up to 31 December 2020.

27.3.1 COVID-19 relief granted via the Personal Medical Savings Account (PMSA) utilisation to offset contribution

The following table represents the COVID-19 relief measures granted via the PMSA utilisation:

	2021	2020
Total members utilising PMSA for COVID-19 relief	**–**	155
Total Rand amount of PMSA COVID-19 relief utilised to offset contributions granted	**–**	1 151 442
Total Rand amount of the PMSA Liability of the Scheme (before relief granted)	**n/a**	813 229 787

27.3.2 COVID-19 relief granted via deferred contribution payment of a 30-day term to SMEs less than 200 employees

The following table represents the COVID-19 relief measures granted via the deferred contribution payment of a 30-day term to SMEs:

	2021	2020
Total number of members of the SMEs who were granted contribution deferrals	**–**	183
Total number of SMEs of less than employees who were granted contribution deferrals	**–**	2
Total Rand amount of contribution deferrals granted to SMEs	**–**	608 178
Total Rand amount of deferrals recovered/paid back by SMEs	**–**	608 178
Total accounts receivable balance of the scheme	**n/a**	719 065 940

28. EVENTS AFTER STATEMENT OF FINANCIAL POSITION DATE AND EXPECTED IMPACT OF COVID-19

28.1 Outstanding claims provision

The outstanding claims provision is expected to have a run-off period of four months after the date of the statement of financial position date, thereafter the stale claims mandate will apply which will assess each claim on merit.

28.2 COVID-19 Impact Assessment for 2022

28.2.1 Impact of COVID-19 on claims values for 2022

During 2021, the Scheme saw the non-COVID healthcare utilisation of Bonitas members return to more typical pre-COVID levels as the third wave came to an end in September. Many Bonitas members received their second COVID-19 vaccine during this time. Due to the combination of vaccination, natural immunity and a milder variant, December 2021 saw a much milder fourth wave than the previous waves in the year. Claims patterns were therefore not altered to the same degree as during previous waves.

Medical experts have predicted a fifth wave towards May 2022 which is expected to be milder based on the ongoing vaccination uptake as well as natural/herd immunity. New variants are expected to emerge for a while going forward, and there is a strong likelihood that COVID-19 will become an endemic disease.

With the information available as at the time of writing (noting that research is ongoing), there are three main categories of COVID-19 related financial uncertainties for 2022:

1) Postponed Elective Surgeries

2) Burden of Disease (Long-COVID)

3) COVID-19 Booster Vaccines

28. EVENTS AFTER STATEMENT OF FINANCIAL POSITION DATE AND EXPECTED IMPACT OF COVID-19 CONTINUED

28.2 COVID-19 Impact Assessment for 2022 continued

28.2.1 Impact of COVID-19 on claims values for 2022 continued

The table below shows a subset of the sensitivities performed to assess the potential impact of COVID-19 on 2022 claim levels.

Category of COVID-19 Related Event	Event description	Estimated impact on expected 2022 claims	Estimated impact on expected 2022 solvency
Postponed Elective Surgeries	Discretionary procedure pent-up demand: hospital claims 4% higher than expected	288 418 962	(1.42%)
	Discretionary procedure pent-up demand: hospital claims 4% lower than expected	(288 418 962)	1.42%
Burden of Disease (Long-COVID)	Acute Medicine and Specialist Costs: 3% higher than expected	68 459 749	(0.34%)
	Acute Medicine and Specialist Costs: 3% lower than expected	(68 459 749)	0.34%
COVID-19 Booster Vaccines	Price of Booster Vaccine increases by 20%, take-up assumption unchanged	43 520 751	(0.21%)
	Price of Booster Vaccine reduces by 20%, take-up assumption unchanged	(43 520 751)	0.21%
Estimated claims upper-end impact relative to Budget		**400 399 462**	**(1.97%)**
Estimated claims lower-end impact relative to Budget		***(400 399 462)***	***1.97%***

The table below represents the impact on 2022 Solvency levels:

	Solvency	Increase/ (decrease) in solvency
Budgeted Solvency for 2022	**35.10%**	
Budgeted 2022 Solvency after COVID-19 upper-end claims impact	**33.13%**	**(1.97%)**
Budgeted 2022 Solvency after COVID-19 lower-end claims impact	**37.07%**	**1.97%**

The sensitivities considered show that the Scheme is suitably positioned to absorb the projected healthcare impact relating to the 2022 COVID-19 infections and have sufficient cash reserves to meet the R400 million claims outgo. The expected solvency of 33.13% exceeds the minimum level of accumulated funds in terms of Regulation 29 of the Act of 25%.

The assessment has not evaluated the impact of investment performance in 2022, nor the possibility of any market crashes and the impact therefore on any significant changes to membership numbers and profile. Management believe the likelihood and/or probability of another market crash is highly unlikely and for that reason, the impact thereof has not been factored into the COVID-19 impact assessment. However, note 22.4 does illustrate the impact of both negative and positive market movements on the Scheme's reserves and solvency for reference.

28.3 Amalgamation with Nedgroup Medical Aid Scheme

Subsequent to the financial year end and with effect from 1 January 2022 Nedgroup Medical Aid Scheme (NMAS), a restricted medical scheme for employees of Nedbank and Old Mutual Insurance, amalgamated with Bonitas Medical Fund as approved by the Competition Commission and Tribunal on 26 October 2021 and Council for Medical Schemes on 17 November 2021.

This transaction was duly undertaken as Nedbank adjusted their Human Resources Policy effective from 1 January 2022, offering employees and retirees compulsory medical scheme membership with the choice of selecting one of three open medical schemes namely Bonitas Medical Fund, Bestmed or Discovery Health. Thus the NMAS Scheme Board of Trustees resolved to consider an amalgamation with one of these three medical schemes with the intent to amalgamate effective 1 January 2022. After finalising a Request for Information process Bonitas Medical Fund was selected as the preferred amalgamation partner.

As at 31 December 2021, of the 25 280 impacted NMAS members, 14 585 members transitioned to Bonitas Medical Fund on 1 January 2022 whilst 10 695 members joined either Discovery Health or Bestmed or resigned from NMAS Scheme.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS CONTINUED

FOR THE YEAR ENDED 31 DECEMBER 2021

28. EVENTS AFTER STATEMENT OF FINANCIAL POSITION DATE AND EXPECTED IMPACT OF COVID-19 CONTINUED

28.3 Amalgamation with Nedgroup Medical Aid Scheme continued

As this is deemed an amalgamation in terms of the Medical Schemes Act, 100% of the Assets and Liabilities of NMAS Scheme were also transferred 1 January 2022 based on the reported figures presented in NMAS Management Accounts as at 31 December 2021 prior to any fair value adjustment.

The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of asset and liabilities was:

	R'000
Consideration at 1 January 2022	
Members Funds	612 791
Total Consideration Transferred	**612 791**
Recognised amounts of identifiable assets acquired and liabilities assumed	
Current Assets	757 393
Available-for-sale investments	666 487
Insurance, trade and other receivables	14 180
Cash and cash equivalents	76 726
Current Liabilities	144 602
Outstanding risk claims provision	56 346
Personal medical savings accounts liability	67 920
Insurance, trade and other payables	20 336
Total identifiable net assets	612 791

As a result of the amalgamation, the Scheme acquired the following receivables:	**Gross Receivables**	**Allowance for impairment losses**	**Total Insurance, trade and other receivables**
Insurance, trade and other receivables	15 610	(1 430)	**14 180**
Contributions outstanding	13 790	(523)	**13 267**
Recoveries due from members for co-payments	375	(274)	**101**
Service provider receivables	1 029	(567)	**462**
Savings plan advances	154	(66)	**88**
Receivables under risk transfer arrangements	53	–	**53**
Other debtors	209	–	**209**

The net assets transferred of R613 million bolstered Bonitas' solvency by approximately 1.7% in January 2022. In addition, with the take-on of the assets and in line with the Bonitas investment strategy, the NMAS investments were disposed of, with the exception of R2.5 million relating to LandBank Holding within the Prescient segregated portfolio, and transferred to the Bonitas investment portfolio.

The estimated annual contribution income amounts to R805 million.

28.4 Appointment of Europ Assistance as the Emergency Medical Service (EMS) Provider

Through a request for proposal exercise ("RFP"), Europ Assistance Worldwide Services (South Africa) Proprietary Limited (EASA) was appointed as the service provider for emergency medical services and the contract will be effective from 1 May 2022, for a three year period. EASA will continue to provide international travel cover in addition to the emergency medical service.

29. PRIOR YEAR CLASSIFICATION RESTATEMENT

Circular 52 of 2021 issued by the Council for Medical Schemes (CMS) on 27 September 2021 concluded that Schemes, in terms of section 37(2), are required to report cash flows from operating activities using the direct method in the Statement of Cash Flows of the annual financial statements for the year ended 31 December 2021 onwards. This is aligned to Paragraph 19 of IAS 7 which encourages entities to report cash flows from operating activities using the direct method and is also aligned to the CMS annual statutory returns as it was deemed to provide the most useful information to members.

Therefore in 2021 the Scheme has reported the cash flow from operating activities using the direct method in the Statement of Cash Flows for the year ended 31 December 2021. This required a restatement of the comparative figures reported in 2020. This had no impact on the 2020 figures reported in the Scheme's Statement of comprehensive income, Statement of financial position and for the Statement of Cash flows the net cash inflows from operating activities remained unchanged at R1.8 billion before and after the disclosure change using the direct method.

OUR CONTACT DETAILS

Officers of the Scheme

Principal Officer	Chief Financial Officer
LR Callakoppen	**L Woodhouse**
Physical address 2nd Floor 34 Melrose Boulevard Melrose Arch Johannesburg 2076	**Physical address** 2nd Floor 34 Melrose Boulevard Melrose Arch Johannesburg 2076
Postal address PO Box 3496 Cramerview 2060	**Postal address** PO Box 3496 Cramerview 2060

Registered office and postal address of the Scheme

	Administrator Medscheme Holdings Proprietary Limited Accreditation number MCO53	Managed care provider Medscheme Holdings Proprietary Limited Accreditation number MCO53
Physical address 2nd Floor 34 Melrose Boulevard Melrose Arch Johannesburg 2076	**Physical address** 37 Conrad Drive Florida North 1709	**Physical address** The Boulevard Building F Searle Street Woodstock 7925
Postal address PO Box 3496 Cramerview 2060	**Postal address** PO Box 1101 Florida Glen 1708	**Postal address** PO Box 38632 Pinelands 7430

Asset/Investment managers

Taquanta Asset Management Proprietary Limited Financial service provider number: 618	Allan Gray Investment Managers Financial service provider number: 40592	M&G Investments (Prudential Portfolio Managers) Financial service provider number: 615	Fairtree Investment Manager Financial service provider number: 25917
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Postal address PO Box 23450 Claremont 7700		**Postal address** PO Box 44813 Claremont 7735	

Asset/Investment managers

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All Weather Capital (Pty) Limited
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NMG Consultants and Actuaries Proprietary Limited
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Postal address

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NOTES

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ABBREVIATIONS AND DEFINITIONS

the administrator or Medscheme	Medscheme Holdings Proprietary Limited
AfA	Aid for Aids
ADS	AfroCentric Distribution Services Proprietary Limited
AGM	Annual general meeting
Board	Board of Trustees
BHF	Board of Healthcare Funders
Bonitas or the Scheme	Bonitas Medical Fund
Bryte	Bryte Insurance Company Limited
CAGR	Compound annual growth rate
COVID-19	Coronavirus disease (COVID-19) is an infectious disease causing respiratory illness (like the flu) with symptoms such as a cough, fever, and in more severe cases, difficulty breathing
CMS	Council for Medical Schemes
CPI	Consumer Price Index
CSI	Corporate social investment
Deloitte	Deloitte & Touche
DENIS	Dental Information Systems Proprietary Limited
DoA	Delegation of Authority
EDO	Efficiency discounted option
ER24	ER24 EMS Proprietary Limited
Europ Assistance	Europ Assistance Worldwide (South Africa) Services Proprietary Limited
FWA	Fraud, waste and abuse
GDP	Gross domestic product
GP	General practitioner
HBM	Hospital benefit management
HMI	Health Market Inquiry
HPCSA	Health Professions Council of South Africa
IBNR	Incurred but not reported
ICPS	Improved Clinical Pathway Services
IFRS	International Financial Reporting Standards
IMF	International Monetary Fund
IPS	Investment Policy Statement
IR	Integrated Reporting
I&T	Information and technology
King IV™	King Report on Corporate Governance™ for South Africa, 2016
LPHH	Louis Pasteur Hospital Holdings Proprietary Limited
LTI	Long-term incentive
MSA or the Act	Medical Schemes Act, No 131 of 1998, as amended
NHI	National Health Insurance
NMAS	NedGroup Medical Aid Scheme
PCR	Polymerase chain reaction
PMB	Prescribed minimum benefits
PMSA	Personal medical savings account
POPIA	Protection of Personal Information Act, No 24 of 2013
PPE	Personal Protection Equipment
PPN	Preferred Providers Negotiators Proprietary Limited
PWC	Pricewaterhouse Coopers
the report	2021 Annual Report
RisCura Solutions	RisCura Solutions (Pty) Ltd
SAPC	South African Pharmacy Council
SAPS	South African Police Service
SCCU	Specialised Commercial Crime Unit
Scriptpharm	Scriptpharm Risk Management Proprietary Limited
SLA	Service level agreement
WEF	World Economic Forum
the year	Financial year ended 31 December 2021

Bonitas

Medical Aid for South Africa

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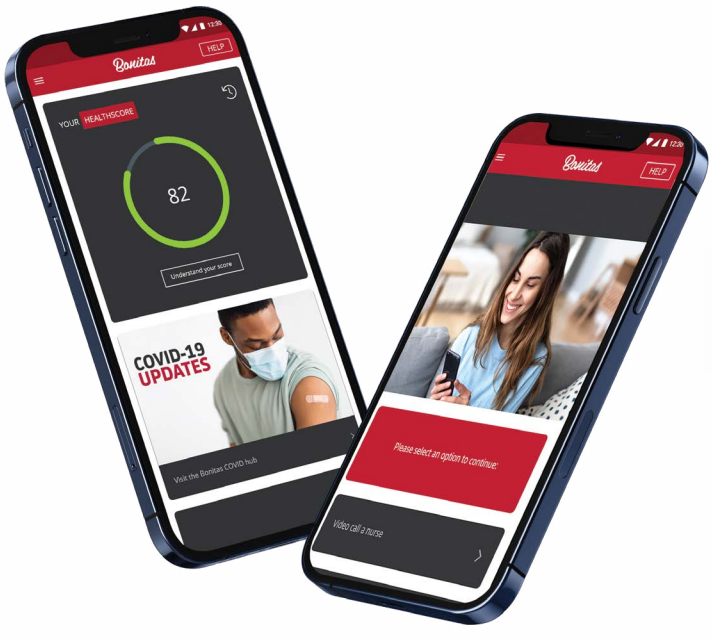

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