2025 VIRTUAL Annual GENERAL MEETING Questions Received

Thank you for participating in the 2025 virtual Annual General Meeting ("AGM") of Bonitas Medical Fund ("Bonitas / Scheme") held on 20 August 2025 in respect of the financial year ending 2024 and posting your questions during the meeting. Below are the questions received together with answers. It should be noted that all technical-related questions with regards to access, sound, etc. were dealt with on the day by the technical team and therefore not included below. In addition, all questions received that contained information of a personal nature or related to a specific member, will be handled with that member directly to protect their privacy and are therefore also not included below.

Should you have any further queries please contact:

- BonCap option, 0861 239 333 or email **boncap@bonitas.co.za**.
- All other options, 0860 002 108 or email **membermaint@bonitas.co.za**.

1. Would the Scheme reconsider the hospital network options? Out of 15 options, only 4 options cover all private hospitals. This does not give members a fair choice of option selection considering the high cost of living.

   Bonitas has 15 options in order that it may accommodate as many people as possible. All options allow for private hospitalization, subject to each benefit option's limits and restrictions. However, some options require members to utilize network hospitals – this is because tariffs negotiated with those hospitals provide private hospital care at cheaper rates. These savings are passed on to members in the form of either higher limits and/or lower contributions. Exceptions can be made where members live far from network hospitals or in case of emergency. We suggest that you consult your broker or the scheme for further information.

2.1 It's interesting that you don't mention the actual percentage increases - in relation to the fees of the Chair of the Board and the increase in the fees of the Trustee members.

   Percentage increases for the Chairperson of the Board as well as the Trustees are illustrated in Annexure A of the Trustee Remuneration Policy which was included as part of the AGM meeting pack. In addition, the memorandum supporting the Trustee Remuneration Policy outlines the rationale for the proposed increases above the CPI rate of 2.8% for the Chairperson of the Board and the Managed Healthcare Committee Trustee Members.

2.2 Are these remunerations per month or per year?

   Trustees receive a monthly retainer fee as well as a per-meeting fee with meetings held throughout the year but not necessarily every month.

3. Why do we have to pay additional levies when purchasing medication at pharmacies not assigned by Bonitas?

   Designated Service Providers (DSPs) are crucial for members because they ensure treatment is covered in full, especially for Prescribed Minimum Benefits (PMBs), and help control costs by providing services at contracted rates. By using a DSP, members avoid co-payments and shortfalls, ensuring their benefits and savings accounts last longer. Using a non-DSP can result in penalties, co-payments, or the member being responsible for the remaining costs because these non-DSP pharmacies are not contracted to the Scheme and do not charge the pre-determined rates. It is therefore vital to choose a DSP to maximize medical aid value.

4. What percentage of members are direct paying members (i.e. not members through their employer)?

   The percentage of direct paying members is 36,2% (as at 31 December 2024).

5. Is the savings of Members part of the investment bucket of over R10b? It would be interesting to understand how the ROI in 2024 was achieved.

   The personal medical savings are not included in the investments. They are included in Liability for incurred claims and payable on demand when a member exits the Scheme. The Return On Investment (ROI) of 13.4% was achieved by implementing an investment strategy approved by the Investment Committee annually. The strategy was to achieve a target of CPI plus 3,5% through investing in diverse asset classes.

6. Solvency ratio trend is moving in the wrong direction, although well above the legal requirement of 25 %. What is the 10-year plan?

   The Scheme aims to find an optimal balance between our members' affordability in a challenging environment and our responsibility to ensure Bonitas' sustainability through surpluses and solvency levels. From time to time, Bonitas may decide to reduce its surplus and erode some of its solvency to keep contribution increases as low as possible or, for example, by deferring price increases. While Bonitas tends to project between 3-5 years in advance, a 10-year horizon is too long, and given the dynamic nature of the healthcare landscape, it is difficult to project the scheme's solvency ratio at a 10-year horizon.

7. I'm comfortable with the AFS presented. What exactly did the auditors audit and why are the actual AFS not presented?

   The auditors audited the financial statements of Bonitas Medical Fund set out on pages 98 to 161 of the Integrated report which comprise the statement of financial position as at 31 December 2024, the statement of profit or loss and other comprehensive income, the statement of cash flows, the statement of changes in reserves for the year then ended, and notes to the financial statements, including a summary of material accounting policy information and they express their opinion on them. The AFS are included in the Integrated report which are available on the website. The AGM presentation includes a summary and highlights on the financial performance of the Scheme as at 31 December 2024. The published documents are in keeping with the regulatory requirements regarding the publishing of financial statements as required by the CMS.

8. You managed an unqualified audit opinion, and yet the auditor refers the finding on valuation of liability on incurred claim as a key audit finding. How material is this finding, i.t.o. rand value and percentage?

   Please note this was noted as a key audit matter and not a key audit finding. Key audit matters are matters, that in the auditor's professional judgement, are the most significant in the audit of the current period's financial statements. The valuation of the liability on incurred claim is derived from assumptions and other actuarial calculations and the amount at the end of the year is a significant estimated number hence the auditors highlight it as a key audit matter.

9. Why are some service providers contracted out from Bonitas as a scheme?

   Bonitas can only enter into contractual arrangements with those service providers who are willing to do so. Some of the healthcare service providers, such as specialists, prefer not to contract on pre-agreed

tariffs. Other service providers do not want to deal with the administrative requirements that may be part of the interaction with members. Therefore, Bonitas tries its utmost to be inclusive when it comes to establishing networks, but ultimately, each service provider decides whether or not to contract with Bonitas.

10. What does monitor members trends means under operational?

    Monitoring members' trends refers to monitoring healthcare trends and consumer behaviour trends. For example, if we note an increase in admissions for respiratory illnesses, we provide proactive communication to members to educate them on ways to protect themselves from contracting these illnesses.

11. With regards to the claims, many medical services fail the members by using incorrect codes with claims that do not get approved, also medical services do not advise the member as to what is covered by the fund and what is not, this burdens the member of covering the cost of which is supposed to be covered by medical aid. How is Bonitas going to resolve this?

    Please note: We reached out to this member who advised that their concern was primarily focussed on co-payments for networks and formularies. The response below is based on this.

    Some Bonitas options are formulary and network-based options – by making use of network doctors you can avoid shortfalls and co-payments. The medicine lists (also known as formularies) are available on our website for members. Members can also use the customer service platforms to request the relevant formularies. Providers have access to formularies via the provider portal relating to the relevant options. Bonitas engages regularly with providers and will reiterate the same to ensure alignment.

12. When did they last get an increase and how much was the previous increase?

    Trustees including the Chairperson of the Board received a CPI increase of 5.2% which represented the headline CPI as published by Stats SA for April 2024. The increased fees were effective 1 September 2024.

13. Why do we have only one audit firm to choose from or otherwise?

    The process of appointing the auditor is done in terms of the Scheme's procurement policy and the required governance processes. Under the Medical Schemes Act ("MSA"), the ultimate authority to appoint the auditor lies with the Registrar. The Board (in terms of Rule 25.1 of the Bonitas Rules) embarks on the appointment process and then engages with the Registrar to ensure that the appointment of the auditor is properly made in terms of the statute. Within the context of the AGM, members are advised of the outcome of the above process, and for this reason, members are not given a choice of which auditor to appoint, but rather to be able to interrogate the process to ensure compliance with the above.

14. For your graphs on Bonitas versus industry, I suggest that, in future, you use different types of lines, e.g., a continuous line versus a dashed line. Sometimes the colours used do not have sufficient contrast.

    Thank you for your suggestion.

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15. What is the reason for my general practitioner having to obtain an authorisation for specialist appointments, and not only a referral letter to the specialist?

In order to ensure that members' benefits are optimized, the Scheme, through its Managed Healthcare interventions, tries to ensure that members are only sent to specialists where it is absolutely necessary. Often members can be treated by their GPs without needing a specialist - this is better for both the member and the scheme as it is more cost-effective, and also, access to GPs is much quicker. Therefore, we require a letter of referral from the GP if the GP is of the view that the member needs specialist treatment.

16. Has it been considered that, upon appeal, a member could use their local pharmacist as their preferred pharmacy for chronic medication at no extra cost? The local small one-man pharmacist knows his client and through years of service is up to date on the member's medical condition, on a personal level.

Designated Service Providers (DSPs) are crucial for members because they ensure treatment is covered in full, especially for Prescribed Minimum Benefits (PMBs), and help control costs by providing services at contracted rates. By using a DSP, members avoid co-payments and shortfalls, ensuring their benefits and savings accounts last longer. Using a non-DSP can result in penalties, co-payments, or the member being responsible for the remaining costs, so it's vital to choose a DSP to maximise medical aid value.

17. Will chronic management be reviewed for 2026 to include ADHD on Primary Select? And thank you for Benefit Booster!

Thank you for your suggestion. We evaluate all benefits and consider claiming patterns, option performance, and member feedback annually as part of our product development process.

18.1 What is the Bonitas BBBEE profile of service providers? Is it possible to get a breakdown by service category?

The Scheme makes a concerted effort to appoint providers with the lowest rating in number (i.e. level 1). The Board is committed to continue to improve the Scheme's BBBEEE scorecard.

18.2 Can we also get this view by spend?

The Scheme can confirm that approximately 90% of spend is in terms of level 1 providers.

19. In trying to provide quality services to members, has the board considered the high co-payments that we are expected to pay, specifically pensioners, I am drowning and end up sometimes not going for services due to these high costs.

The Scheme consistently looks at reducing the financial burden on its members however, certain co-payments are unavoidable due to the nature of the procedure and the costs associated with it. Members can take the following steps to limit co-payments:

- Ensure that your service providers are part of the Bonitas network where possible.
- Use medicine on the formulary for your plan or generic medicine.
- Talk to your doctor or pharmacist to help you make informed choices to stretch your healthcare rand further.

- If you have any doubts, contact our call centre and seek advice regarding the co-payment to ensure that you have followed the correct processes.

20. It is interesting that you segment the elderly/retirees in your member profile, yet there seem to be no concessionary payments, when it comes to distinguishing a two-member family of retirees, and full complement family of two parents and dependent children?

    We show our pensioner ratio as this forms part of the industry standard in terms of reporting criteria. However, all adult dependants pay the same rates.

21. Please briefly explain Bonitas stand with regards to the National Health Insurance and possible effects to members?

    We support the concept of universal healthcare and are committed to making quality healthcare more affordable and more accessible to all South Africans. However, we firmly believe that there will always be a role for medical schemes to play. At present, there are no effects to members as the operational rollout elements for National Health Insurance have not been finalised.

22. Bonitas does ask members to comment on interaction with Bonitas employees. This is a positive. Therefore, a positive step to review service providers but do you intend to ask members for their experiences?

    We conduct voice of the customer surveys regularly to evaluate the services our members received. We also commission independent research across all stakeholder groups including members, brokers and corporates to evaluate various aspects such as benefits, value for money and service experience. This helps to inform our offering and our operations so that we can improve where possible.