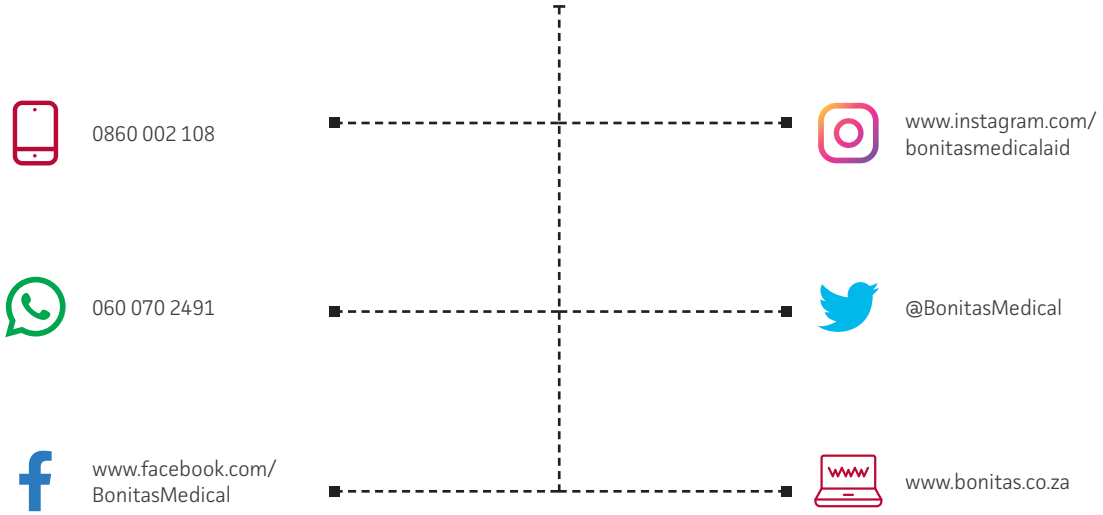
INTEGRATED REPORT 2022

REGISTRATION NUMBER 1512

Bowtex

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



MEDICAL EMERGENCY SERVICES: BONITAS SOS
call 0860 555 505

OPTICAL BENEFITS (PPN)
call 041 065 0650
email bonitas@ppn.co.za
or visit www.ppn.co.za

MENTAL HEALTH PROGRAMME
call 0860 106 155
or email mentalhealth@bonitas.co.za

DENTAL PROGRAMME (DENIS)
call 0860 336 346
or email denis@bonitas.co.za

BABYLINE AND BABY BAGS
call 0860 999 121

PHARMACY DIRECT REGISTRATION
call 0860 027 800
email care@pharmacydirect.co.za
or visit www.pharmacydirect.co.za

INTERNATIONAL TRAVEL BENEFIT
call 087 135 4795 / +27 (10) 211 4958
or email bonitas-assist@linkham.com

HIP AND KNEE PROGRAMME (ICPS)
call 011 327 2599
or visit www.icpservices.co.za

ONCOLOGY MANAGEMENT PROGRAMME (CANCER)
call 0860 100 572
or email oncology@bonitas.co.za

HIV/AIDS PROGRAMME
call 0860 100 646
please call me 083 410 9078
email afa@afadm.co.za
or visit www.afa.co.za

HIP AND KNEE PROGRAMME (JOINTCARE)
call 011 568 3334
or visit www.joint-care.co.za

DIABETES PROGRAMME
call 0860 002 108
or email diabeticcare@bonitas.co.za

BACK AND NECK PROGRAMME (DBC)
call 0860 105 104
or visit www.dbcsa.co.za

PALLIATIVE CARE PROGRAMME
email info@alignd.co.za

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ABOUT THIS REPORT

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

CONTENT SCOPE AND APPROACH

The report covers our financial and operational performance from 1 January 2022 to 31 December 2022. 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.

International Financial Reporting Standards (IFRS) Foundation's Integrated Reporting Framework, 2021 (<IR> Framework)	This report complies with the <IR> Framework. We made significant reporting improvements in the past few years, with the 2022 report including additional disclosure on material matters and an expanded description of our value creation model that includes more detail on the six capitals, their availability and impact.
King IV Report on Corporate Governance™ for South Africa, 2016 (King IV™)[1]	We apply and explain our adherence to the King IV™ principles in this report and provide detailed profiles of the members of the Board of Trustees. We also include our first remuneration report.
IFRS	Financial information in this report was compiled using 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 93.
United Nations Sustainable Development Goals (SDGs)	We are expanding our reporting focus on environmental, social and governance (ESG) aspects relevant to Bonitas. In this report we highlight our contribution to two SDGs as part of our value creation model:  Goal 3. Ensure healthy lives and promote wellbeing for all at all ages  Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

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 in 2022
- How the Board exercised and discharged its responsibility for governance

Approved on 21 April 2023 by

Mr OJ Komane

Chairperson of the Board

Mr LR Callakoppen

Principal Officer

WE WELCOME FEEDBACK

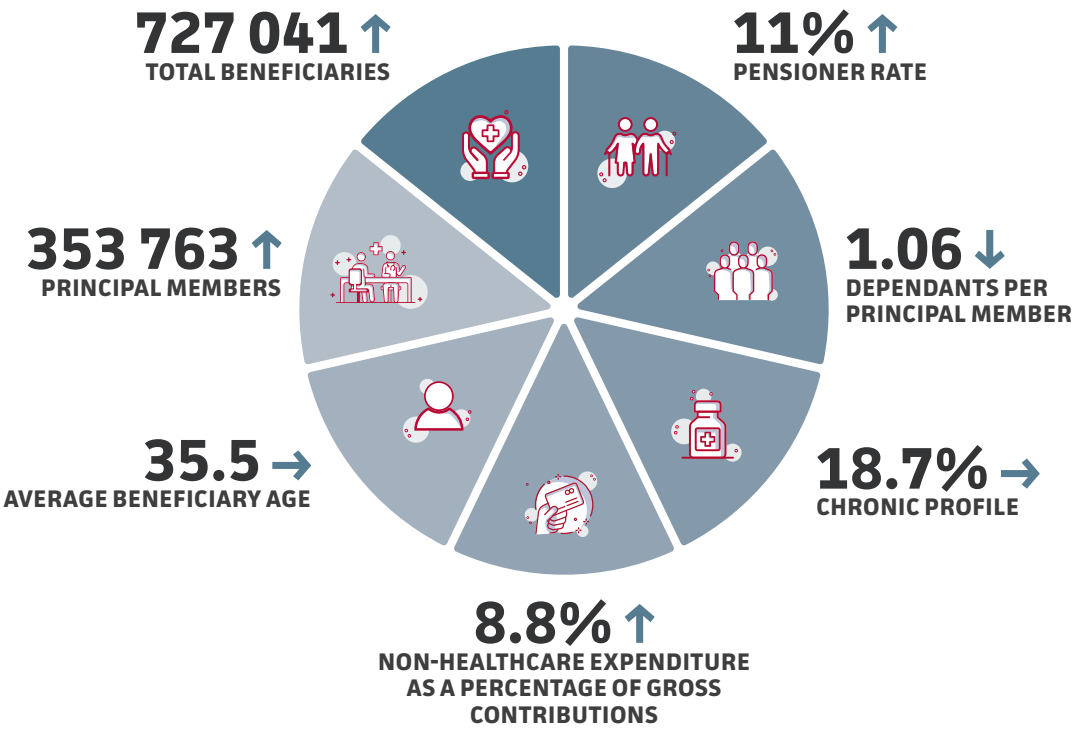
If you have suggestions to improve this report, please email annualreportqueries@bonitas.org.za.

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.

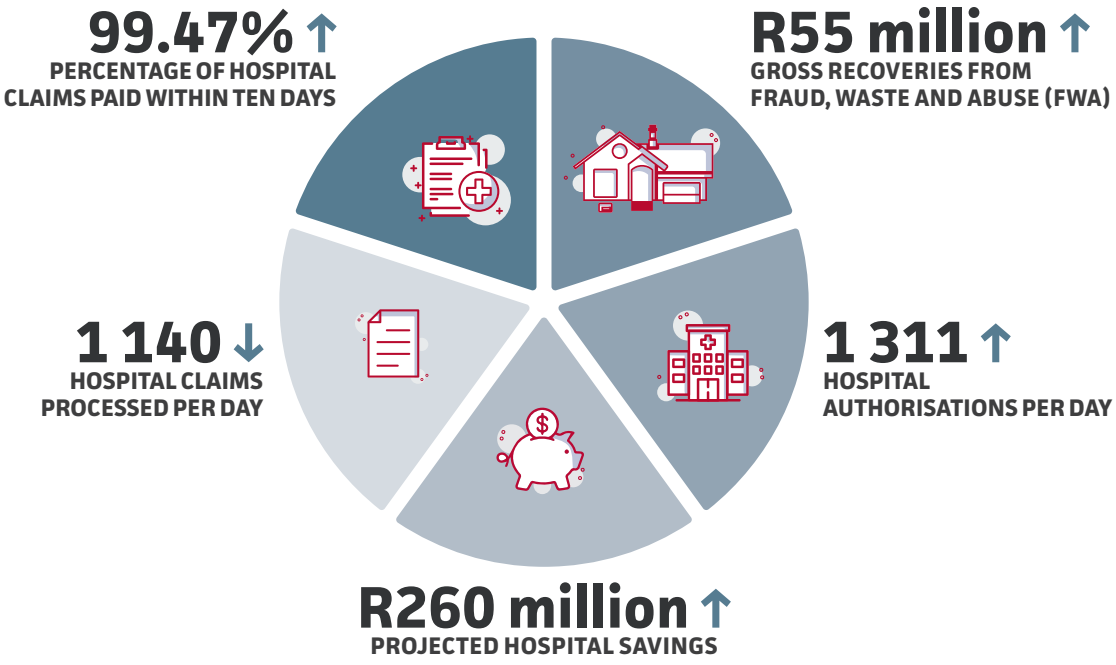
Find the list of ***abbreviations*** and ***definitions of terms*** on the inside back cover of this report.

2022 PERFORMANCE AT A GLANCE

MEMBERS OF OUR MEDICAL AID FOR SOUTH AFRICA



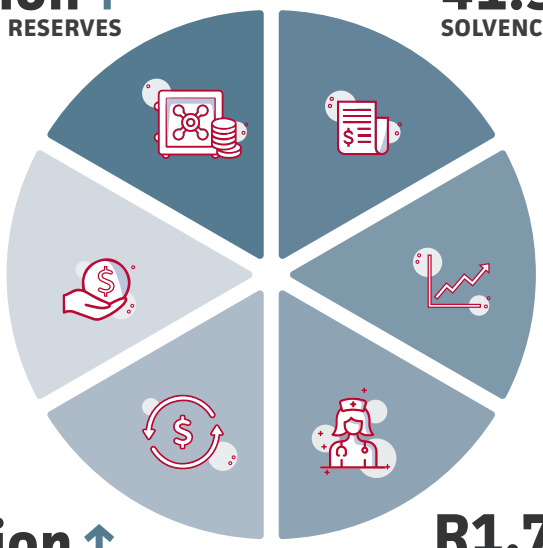
CLAIMS PAID TO THE VALUE OF R15.8 BILLION



WE MANAGE FINANCIAL RESOURCES WITH PRUDENCE

R8.8 billion ↑
RESERVES

41.3% ↑
SOLVENCY RATIO



R781 million ↓
INVESTMENT INCOME

R699 million ↓
SURPLUS

R9.97 billion ↑
TOTAL INVESTMENT PORTFOLIO VALUE EXCLUDING CASH

R1.7 billion ↓
GROSS HEALTHCARE RESULT

WHAT DIFFERENTIATES US

- Bonitas is a medical aid for all South Africans.
- We have an active presence in all market sectors and target markets.
- We have substantial reserves that enable us to pay claims – even under pandemic conditions.
- Our diversified product range meets members' health needs at their various life stages.
- We have strong networks with the best healthcare providers in South Africa.
- Our technology and multi-layered distribution channels enable us to connect with members and help them manage their healthcare on-the-go.
- Our contributions for quality healthcare are affordable, starting from R1 274 per month.
- Our operations are stable and sustainable, and we enjoy consistent membership growth.
- Our core team is dedicated and experienced and is 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 affordable and 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 that lifestyle diseases are identified before they become chronic.

Bonitas's administration 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.

Our purpose is to align our strategic intention to the 'New World' while achieving balance between growth and financial sustainability, thus securing the future of Bonitas Medical Fund.

HOW WE CARE FOR OUR MEMBERS

We provide risk assessments to allow for early detection and intervention for chronic conditions

We leverage technology to extend care through initiatives such as virtual care and online wellness assessments

We perform by using data analytics proactively

We ensure quality care in and out of hospital through extended benefits and innovations such as Hospital at Home

We extend emergency medical services to a greater pool of providers, with a dedicated line through Bonitas SOS

We provide broader access to preventative care benefits paid from risk, to proactively support members at all life stages (including childhood vaccines and vaccines for the elderly)

A BRAND THAT PROTECTS

BONITAS HAS TWO INTERDEPENDENT PRIORITIES:

1 To ensure financial sustainability while meeting the needs of our members

2 To make quality healthcare more affordable and accessible

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 managed care programmes. We also keep 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 our members' healthcare needs


Bonitas

OUR HEALTHCARE MODEL

We have a Business Process Outsourcing (BPO) model based on quality relationships that we continue developing and optimising. We make sure that our partners look after our members like we do.

Bonitas

BONITAS IS AN OPEN MEDICAL SCHEME OFFERING 15 BENEFIT PLANS TO MEMBERS AS OF 1 JANUARY 2023.

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

Internal audit services are outsourced to PricewaterhouseCoopers (PwC), and Deloitte has been reappointed as the external auditor following member voting at the annual general meeting (AGM).

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

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

ASSET MANAGERS PER STRATEGIC CATEGORY

- M & G
- Allan Gray
- Vunani
- Sesfikile
- Fairtree
- Aluwani
- All Weather
- Catalyst
- Taquanta

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 in analysing health informatics, developing plans and pricing models, conducting evaluations, and managing (for example) the recent amalgamation with the NedGroup Medical Aid Scheme (NMAS).

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

MANAGED CARE SERVICE PROVIDERS

- Aid for Aids
- Medscheme Holdings
- DENIS

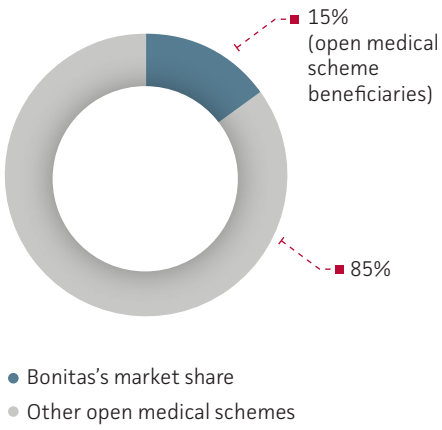
RISK TRANSFER AGREEMENTS

- DENIS
- PPN
- Scriptpharm
- ER24*
- Europ Assistance*

* *Following a Request for Proposal (RFP) tender process, the contract for ambulance and emergency services with ER24 was terminated on 30 April 2022, and Europ Assistance was appointed with effect from 1 May 2022.*

Our distribution channels consist of direct sales and a network of brokers that sign up new Bonitas members as individuals or employer groups and earn commission on their services.

BENCHMARKING BONITAS



Source: 2021/22 Council for Medical Schemes annual report

AVERAGE AGE PER BENEFICIARY

Bonitas:
35.5
Average age for registered open schemes: 35.5

PENSIONER RATIO

Bonitas:
11.0%
Average ratio for registered open schemes: 10.98%

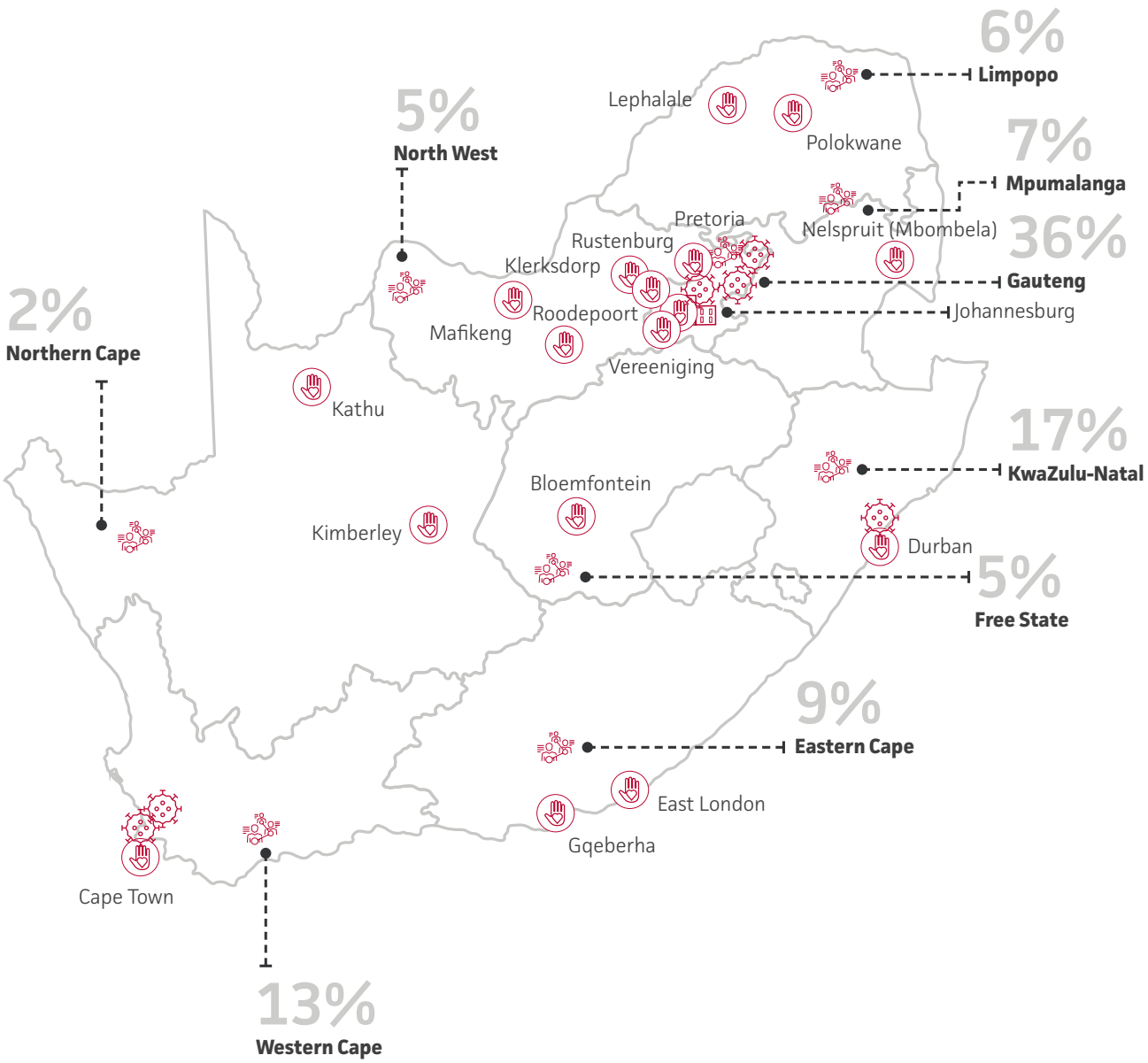
SOLVENCY RATIO

Bonitas:
41.3%
Average ratio for registered open schemes: 39.6%

OUR FOOTPRINT

Bonitas has an extensive GP and specialist network across South Africa.

	17 Walk-in Centres
	Vaccination Sites were offered at 6 different locations
	Head Office
	Members



THE BONITAS PLANS

We currently offer 15 benefit plans (12 registered benefit options and 3 efficiency discounted options) as of 1 January 2023 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 EFFICIENCY DISCOUNTED OPTIONS (EDOS):	
Standard and Standard Select	**Standard:** 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	**Primary:** 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	**BonEssential:** 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
TWO EDGE PLANS:	
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 young families and couples intending to expand their families

OUR KEY RELATIONSHIPS

Our ability to provide quality care to our members, and to make quality healthcare more affordable and accessible for all South Africans, depends on productive relationships with our stakeholders.

Bonitas operates in the South African healthcare ecosystem, which is regulated by government bodies such as the National Department of Health and the Council for Medical Schemes (CMS), as well as industry associations such as the Board of Healthcare Funders (BHF). Bonitas operates according to an outsourced model based on quality partnerships, such as with our administrator, healthcare providers and brokers.

In 2022 the Board approved a new Stakeholder Engagement and Communication Framework to represent our commitment to accountable and transparent stakeholder engagement and communication, and to direct all our stakeholder relationship management activities.

PRINCIPLES, OUTCOMES AND APPROACH

OUR ENGAGEMENT AND COMMUNICATION WITH STAKEHOLDERS ARE BASED ON SIX KEY PRINCIPLES:

Through effective engagement and communication, we aim to:

- Communicate our value proposition to our stakeholders
- Build caring, trusting, honest, ethical and open relationships that advance mutual coexistence and shared value creation
- Promote good corporate citizenship and cooperation in our stakeholder community
- Manage risk, reputation, legitimacy and relationship-building to create a sustainable future for all stakeholders
- Maintain and enhance Bonitas's governance integrity and reputation among stakeholders

STAKEHOLDER ENGAGEMENTS AND RESPONSES

Our material stakeholders are as follows:

BOARD AND EMPLOYEES

Board of Trustees
Board Committees
Employees

MEMBERS AND AGENTS

Members
Brokers
Trade unions
Employer groups and paypoints

SERVICE PROVIDERS

Administrator and managed care organisation
Managed care service providers
Healthcare providers
Asset managers
Auditors
Capitation houses (risk transfer)
Distribution, advertising and marketing providers

GOVERNMENT AND REGULATORY BODIES

National Department of Health
Council for Medical Schemes
Board of Healthcare Funders
Industry associations

How we define the quality of our relationships:

1 Poor or no relationship

2 Transactional or one-way relationship

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

4 Good relationship with mutual benefit

5 Strong relationship of trust, collaboration and mutual understanding

BOARD AND EMPLOYEES

5

Bonitas is managed by a skilled Executive Management team, supported by employees, a Board of Trustees and a number of Board Committees. These internal stakeholders are fundamental to the achievement of our value proposition and are the cornerstone of our service to members.

HOW WE ENGAGE

- Meetings and forums
- Manager–team dialogues
- Formal correspondence
- Employee presentations
- Informal engagements and social activities
- Internal policies and procedures

THEIR KEY CONCERNS

- Strong and ethical leadership
- Strategic objectives and implementation
- Pay, conditions of employment, reward and recognition

BONITAS RESPONSE

- Bonitas's overall performance and sustainability are evidence of the Board's effective and ethical leadership
- Participation at the AGM confirms continued engagement between the Board, Executive Management and members; 554 members participated virtually at the AGM held on 27 July 2022, and 304 members voted through various platforms
- Bonitas ensured independent oversight at member meetings, with BDO and PwC verifying and counting votes cast during the AGM and special general meeting (SGM)
- Bonitas's internal policies and strategy documents provide guidelines on remuneration, performance management, incentives and long-service awards (see remuneration report from page 85)
- Remuneration of employees and Board members takes into account industry benchmarking and the Consumer Price Index (CPI)

MEMBERS AND AGENTS

4

Bonitas exists to create and protect value for its members. By understanding our members' needs, we are better able to deliver relevant products and services, identify growth opportunities, retain existing members and attract new members. We aim to continually find new ways to add value for our members while providing more effective and efficient support.

Our members are advised, assisted and signed up through our distribution network including brokers and direct sales. In addition to the brokers that Bonitas contracts directly, we have tied sales forces with Liberty and Sanlam, which allows us access to their wide network of brokers. Our partnership with Hippo and Medquote ensures that potential members can get multiple quotes from a range of medical schemes, including Bonitas, at the same time.

HOW WE ENGAGE

- Integrated report and annual financial statements
- Publications, websites and other material
- Meetings and forums
- Surveys, focus groups, workshops and roadshows
- Contracts and service level agreements (SLAs)
- Formal correspondence
- Walk-in centres
- Call centre
- Bonitas member app and Member Zone portal, corporate portal and brokers' portal

THEIR KEY CONCERNS

- Membership contributions
- Options and benefits
- Claims and benefit queries
- Finding a network provider
- Customer satisfaction

BONITAS RESPONSE

- The weighted average increase in membership contributions for 2023 is 4.7% compared to an inflation rate of 7.2% as at December 2022
- Bonitas communicates regularly regarding claims, benefits, plans and fees
- We provide additional benefits to members over and above their plans (see the strategy section from page 29)
- Call centre support agents are available from Mondays to Saturdays
- We engage with brokers and other intermediaries through questionnaires, power breakfasts, focus groups and roadshows
- A 2022 report by Ask Afrika revealed that 86% of members surveyed were delighted with how they were treated, and we have a higher service satisfaction level than our competitors (see the strategy section from page 29)

How we define the quality of our relationships:

1 Poor or no relationship

2 Transactional or one-way relationship

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

4 Good relationship with mutual benefit

5 Strong relationship of trust, collaboration and mutual understanding

SERVICE PROVIDERS

4

Bonitas has a BPO model, so quality partnerships with service providers are crucial to our ability to offer affordable and high-quality products and services to members.

Medscheme is Bonitas's most significant outsourced partner, and administers our financial, actuarial and operating activities. As our accredited managed care organisation, it also runs managed care programmes on our behalf – such as for chronic conditions, cancer, diabetes and mental health. Managed care services are also provided by Dental Information Systems (DENIS) and Aid for Aids (AfA).

Other key service providers include the following:

- RisCura Solutions provides advisory consulting on Bonitas's portfolio of investments, and cash and cash equivalents. We use a variety of asset managers, such as M&G, Allan Gray, Vunani and Sesfikile among others.
- Internal audit services are outsourced to PwC, while Deloitte has been reappointed as our external auditor.
- Bonitas has risk transfer arrangements in place with DENIS, Preferred Providers Negotiators (PPN), Scriptpharm and Europ Assistance. ER24 was terminated on 30 April 2022 and Europ Assistance was appointed for ambulance and emergency services with effect from 1 May 2022.
- AfroCentric Distribution Services (ADS) handles our distribution, advertising and marketing activities.

Bonitas offers its members access to a substantial network of GPs, hospital groups, specialists and pharmacies that provide wellbeing and healthcare services. Pharmacy Direct manages the dispensing and delivery of chronic medication. Through our close relationship with these stakeholders, we are able to develop plans and programmes that respond to members' real needs and incorporate the latest innovations in healthcare.

HOW WE ENGAGE	THEIR KEY CONCERNS	BONITAS RESPONSE
• Integrated report and annual financial statements • Meetings and forums • Contracts and SLAs • Formal correspondence	• Contractual roles and responsibilities • Fees and reimbursements • Financial and operational performance	• Bonitas continually monitors contracts, SLAs and agreed-upon outcomes-based measures to ensure that our network continues to create value for members • Fees and hospital reimbursement models are refined to ensure that the most appropriate level of risk is transferred • We regularly review our network of healthcare providers to ensure its optimisation for member service quality and efficiency (see the strategy section from page 29) • In 2022 we were awarded the BHF Titanium Award for Excellence in Operational Performance (see the strategy section from page 29)

How we define the quality of our relationships:

1 Poor or no relationship

2 Transactional or one-way relationship

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

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GOVERNMENT AND REGULATORY BODIES

3

The medical schemes industry is highly regulated and is governed primarily by the National Department of Health and the Medical Schemes Act (MSA). Bonitas collaborates with the following government and regulatory bodies to ensure that members' rights are protected, and that our regulatory and governance controls remain of the highest standard:

- The CMS, which acts as the regulator and is responsible for the control and coordination of medical schemes, administrators, managed care organisations and brokers.
- The BHF, which is a representative body of the healthcare funding industry that drives the sustainability of the healthcare ecosystem.
- Industry associations such as the South African Medical Association (SAMA), Health Professions Council of South Africa (HPCSA) and Hospital Association of South Africa (HASA).

HOW WE ENGAGE

- Integrated report and annual financial statements
- Publications, websites and other material
- Meetings and forums
- Formal correspondence
- Circulars

THEIR KEY CONCERNS

- Legal, regulatory and governance compliance
- FWA
- Access to healthcare
- National Health Insurance (NHI)

BONITAS RESPONSE

- A review by Deloitte Consulting found that Bonitas has a strong governance structure (refer to the governance practices and structure section on page 70)
- We monitor and implement all relevant regulatory updates, including Circulars issued by the CMS
- We monitor possible instances of FWA through our FWA Forum and collaborate with relevant stakeholders such as the South African Police Service (SAPS), Specialised Commercial Crime Unit, HPCSA and South African Pharmaceutical Council
- Through the relevant channels, we engage with government bodies on national healthcare issues such as the NHI

FEEDBACK FROM OUR MEMBERS

"I did some research on other medical aids, just to compare, but they couldn't come close to Bonitas."

Jacob

"Dialysis literally saved my life, and had Bonitas not approved and paid for the treatment and comprehensive care that goes along with it, I wouldn't be alive today."

Ronelle

"I was diagnosed with a very rare condition and had to go for many check-ups, and I was also hospitalised a lot. Bonitas sorted it all out."

Thegraj

"It's no debate that during the 40 years you've served us, you impacted us and, in the process, improved our lifestyles and habits for the better. Aluta continua to the great Bonitas, and may you grow in strength as you save and improve lives."

Tumelo

"You are my medical scheme for life. You love and care for your members. Your customer service is the best. Keep up the good work."

Khabo

"You are a part of my family."

Suzan

HOW WE CREATE AND PROTECT VALUE

We want to make quality healthcare accessible to all South Africans.

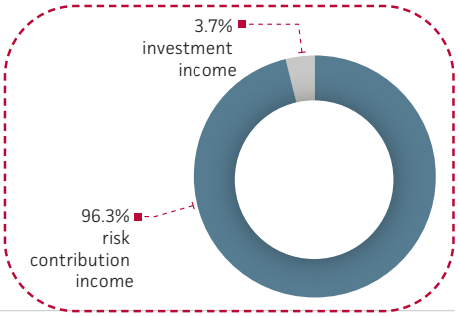
INPUTS

Our healthcare model relies primarily on relationships which, in turn, are dependent on the availability of resources set out according to the six capitals below.

FINANCIAL CAPITAL

As a medical scheme, we are a non-profit organisation.

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.



MANUFACTURED CAPITAL

We have our head office in Johannesburg and 17 walk-in centres, as set out on the map on page 11. We also have a 24/7 helpline and a whistle-blowing hotline.

We use digital platforms to take the hassle out of member and broker interactions with Bonitas.

Our information and technology (I&T) infrastructure is integrated with that of service providers and provides us with data to effectively manage our networks and member services. We use digital tools to track performance against strategic targets, and analytical software to identify anomalies or irregularities that could indicate potential FWA.

Our broader service provider network comprises facilities such as hospitals, surgeries, clinics, pharmacies, offices, medical equipment and other necessary infrastructure to deliver healthcare services.

HUMAN CAPITAL

Our 21 employees and network of outsourced administration and health service providers form a pool of human capital to maintain, serve and support Bonitas and our members.

We offer a comprehensive training programme for brokers.

INTELLECTUAL CAPITAL

Bonitas has been operating for more than 40 years as a medical fund, and our management team has 142 years' combined management experience within the Healthcare/Medical Schemes industry.

Our Board members have extensive experience in critical aspects of leading a medical scheme and ensuring the appropriate governance structures, processes and controls to effectively manage our outsourced administration model.

Our core competency is designing and pricing healthcare benefits and managed care plans. We have several risk transfer arrangements to outsource some member health risks.

We share information on our healthcare plans, claims, tenders and performance via our website, the media, app and other channels.

SOCIAL AND RELATIONSHIP CAPITAL

We operate an outsourced model that uses strategic service providers to execute a range of our activities.

We collaborate across the healthcare value chain with industry stakeholders such as the CMS, BHF, hospital groups and healthcare practitioners to enable systemic sustainability.

We are committed to the transformation and reform of the healthcare industry.

The Bonitas brand has a strong reputation associated with specific attributes and member benefits.

NATURAL CAPITAL

We do not rely on natural capital to create value and we 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 through natural disasters such as flooding and heatwaves.

BUSINESS ACTIVITIES

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 them when they are ill by removing healthcare-related stress.

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 and employees.

We **invest member funds** and maintain appropriate reserves.

We ensure that **member administration** is effective and 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.

OUTPUTS

For 2022 we offered 15 benefit plans to suit members' healthcare needs. Members also have access to discounted financial services products such as gap cover and lifestyle vouchers with our health insurance partners. Members can use various tools and services for clinical support, easier claims processing and access to information. We offer 15 benefit plans for 2023. Detail is available on www.bonitas.co.za.

OUTCOMES

We want to improve the integration of care and 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.

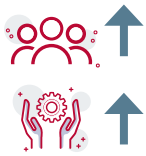
Everything we do is in the best interests of our members, saving them money by making their benefits last longer and making Bonitas sustainable. This means our members can enjoy the value of private medical care while being protected against unexpected and expensive medical costs.

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

FINANCIAL CAPITAL

Members and agents

Service providers



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.

Some of our largest claim categories in 2022 included:

- R6.9 billion hospital
- R2.3 billion medical specialists
- R1 billion auxiliary
- R895 million GPs
- R834 million pathology
- R897 million radiology
- R1 billion day-to-day benefits

Strategic purchasing strategies yielded savings of at least R441 million.

We achieved a 7.2% return on investment for members' funds.

Bonitas had six loss-making options of a total 12 registered benefit options in 2022.

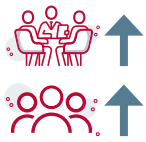
Solvency remained 16% above the legislated 25%.

R1.1 billion quantified as a drop in billing behaviour as a result of FWA since 2016, with gross recoveries due to proactive mitigation of R55 million in 2022.

MANUFACTURED CAPITAL

Board and employees

Members and agents



Read more about member interactions at walk-in and call centres on pages 36 and 37.

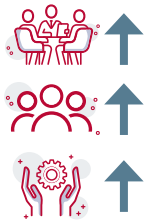
Our I&T Steering Committee oversees I&T security and ensures that disaster recovery plans are in place.

HUMAN CAPITAL

Board and employees

Members and agents

Service providers



Our 353 763 members and 727 041 beneficiaries received healthcare support according to their plans and benefits. Our customer service agents provided one-on-one assistance to members and their beneficiaries.

We partnered with the best service providers to ensure our members get access to care of the highest quality.

We expanded access to healthcare with a net membership increase of 4%. There were 47 446 gross membership acquisitions – excluding the 14 585 members acquired from the NMAS amalgamation – and 48 387 membership terminations.

We had an employee turnover of 10% and appointed three new people in key roles such as Information Technology and Governance, Risk and Compliance.

Our two new Board members received trustee training from CMS, improving their ability to provide effective leadership.

OUTCOMES

INTELLECTUAL CAPITAL

Benefits covered 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
- 33 additional conditions for certain options from a chronic medicine management perspective

Our protocols and formularies ensured high-quality treatment according to a list of safe and effective medicines that can be prescribed to treat certain conditions.

Our digital channels helped 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.

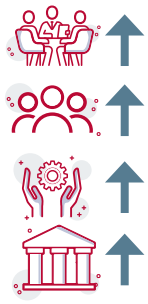
Our internal risk measurement models, sensitivity and scenario analyses, and stress testing enabled us to manage risk exposure.

Board and employees

Members and agents

Service providers

Government and regulatory bodies



SOCIAL AND RELATIONSHIP CAPITAL

Our members were covered when unexpected medical expenses arose.

Our network of hospitals, doctors and specialists provided full-cover services and managed care options to members. We contributed to better healthcare outcomes for South Africa and continued to engage on universal healthcare opportunities.

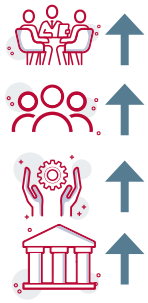
We received recognition through awards which contributed to a strong brand.

Board and employees

Members and agents

Service providers

Government and regulatory bodies



NATURAL CAPITAL

We continue to optimise the use of resources such as energy and water in our head office.

Board and employees

The outcomes of our value creation model contribute to:

Goal 3. Ensure healthy lives and promote wellbeing for all at all ages

Target 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

Target 3.b Provide access to affordable essential medicines and vaccines for all

Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Target 16.5 Substantially reduce corruption and bribery in all their forms

Target 16.6 Develop effective, accountable and transparent institutions at all levels

To deliver on our purpose, the Board has to consider:

- We exist to create and protect value for our members, but we also aim to make quality healthcare more affordable and accessible to all South Africans. Bonitas supports the principle of universal healthcare and lobbies government and regulatory bodies in this regard in a manner that benefits both members and non-members. This requires financial, human, social and intellectual resources such as time, stakeholder engagement and submissions that could have been applied otherwise in the short term. We believe the long-term outcome will be favourable to Bonitas's sustainability.
- Bonitas's efforts to increase healthcare access and maintain the affordability of our plans may lead to loss-making options. Although loss-making options are considered non-compliant with Regulation 29 of the MSA, they are common in all medical schemes. Bonitas's intent is to improve the financial viability of all our plans while continuing to meet members' healthcare needs. We do this through considered and option-specific cost management across the value chain, as well as member education and awareness.
- We must find the optimal balance between affordability for our members in a challenging economic environment, and our responsibility to ensure Bonitas's sustainability through surpluses and solvency levels. From time to time, Bonitas may decide to reduce its surpluses and erode some of its solvency to keep contribution increases as low as possible or, for example, by deferring price increases.

FUTURE AVAILABILITY AND RISK TO THE CAPITALS

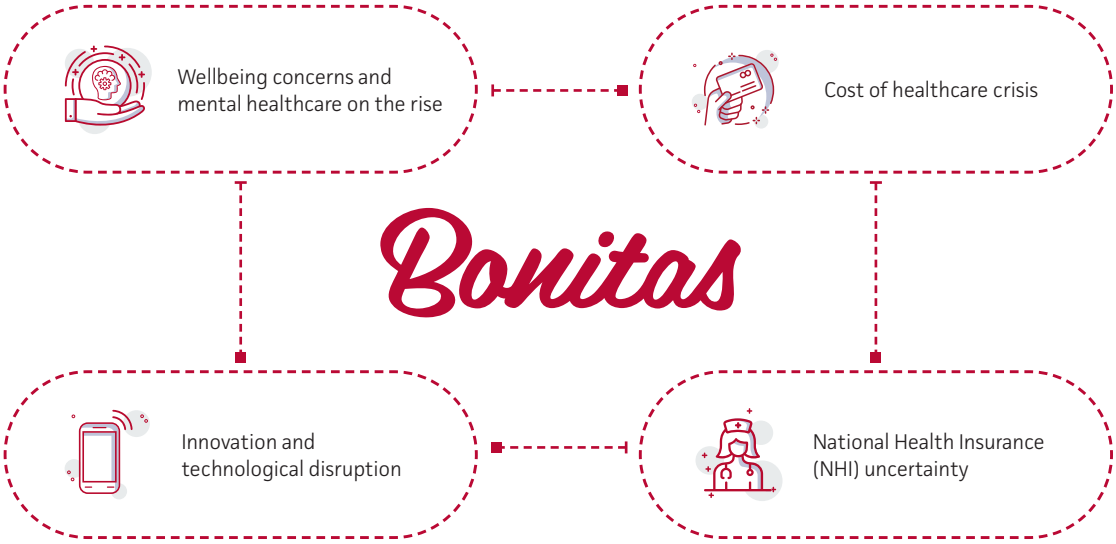
FINANCIAL CAPITAL	This capital relies on membership growth, investment returns and strategic purchasing to be sustainably available.
MANUFACTURED CAPITAL	This capital relies on national infrastructure and services, such as electricity, with loadshedding affecting the optimal functioning of Bonitas's network of service providers.
HUMAN CAPITAL	This capital relies on Bonitas's ability to attract and retain talent, as well as ensure high performance.
INTELLECTUAL CAPITAL	Cyber risk can affect the availability, quality and integrity of data.
SOCIAL AND RELATIONSHIP CAPITAL	Cyber risk can impact our ability to ensure member privacy. 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. The Bonitas brand and reputation can be affected by negative publicity and industry issues such as the Section 59 report.
NATURAL CAPITAL	Climate change impacts might increase risks, costs and the ability to serve members due to physical events or pandemics.

OUR VALUE CREATION MODEL CONTEXT

Our external environment and trends in healthcare	**PAGE 23**
Progress with the implementation of our strategy	**PAGE 31**
The effectiveness of our risk management, and ability to identify and capture opportunities for growth	**PAGE 45**
Ethical leadership and effective governance structures, processes and controls	**PAGE 70**
Solid financial performance	**PAGE 55**
Sustainability and prospects despite future uncertainty	**PAGE 52**

TRENDS SHAPING OUR WORLD

The South African healthcare sector is one of the most dynamic and complex in the world, and although it faces many of the same risks and opportunities as its foreign counterparts, there are some unique trends.



COST OF HEALTHCARE CRISIS

Health insurance inflation is one of a number of CPI components, with medical inflation rates persistently above the midpoint of the target range. Over the past decade, medical scheme contribution increases have outpaced inflation by around 4%. This is according to a study by the South African Reserve Bank, which identified the drivers of high inflation in this category as ageing, shrinking membership pools as well as sub-optimal regulations. Health insurance inflation slowed during COVID-19 as medical schemes accumulated large surpluses, but is expected to show a steep rebound as reserves are used and structural drivers of high medical insurance increase in line with higher interest rates, rising debt and loadshedding costs.

In the current economic environment, consumers are under severe pressure, and most members are not able to afford above-inflation contribution increases. Accordingly, the CMS recommended in July 2022 that medical aid contribution increases for 2023 should be limited to 5.7%, in line with the South African Reserve Bank's average inflation rate for the year. It also recommended that schemes in a strong financial position should implement increases lower than the recommendation.

Most schemes announced lower-than-usual contribution increases for 2021 and 2022 but as medical aid claims – including hospitalisations – begin to escalate, higher medical aid premiums are once again becoming the norm. Some schemes are continuing the practice of price freezes or contribution deferrals as a means to alleviate cost pressure for members.

Fortunately, the pandemic accelerated the movement of care from high-cost, high-traffic sites such as hospitals, to lower-cost facilities such as pharmacies, clinics and homes. Virtual healthcare and home-based care became attractive options for both healthcare practitioners and patients, and while adoption rates may decline as countries loosen their COVID-19 restrictions, these options will likely continue to gain ground as a result of convenience and affordability.

BONITAS STRATEGIC RESPONSE:

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

NATIONAL HEALTH INSURANCE UNCERTAINTY

The World Health Organization (WHO) states that the highest attainable standard of health is a fundamental right of every human being. This places obligations on governments to support universal healthcare that does not discriminate on the grounds of race, age, ethnicity or any other factor.

In South Africa, the right to access healthcare services is guaranteed in the Constitution.

The South African government and healthcare stakeholders continue engaging on establishing a health financing system that is designed to pool funds to provide access to quality affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. There is wide support for the principle, but complex challenges remain in terms of funding, governance, risk and capacity.

The process to agree on the aspects set out in the NHI Bill, as well as the role of medical funds, continues. The NHI Bill proposes that healthcare costs for all South Africans be covered by a single national NHI Fund, which will be funded from general taxes and employee contributions. The government has stated that once the NHI is fully implemented, the role of medical schemes will change: An effective NHI will mean that citizens no longer need to contribute to a medical scheme to obtain quality healthcare, and medical schemes will only provide cover for services that are not reimbursable by the NHI Fund.

In January 2022, key role players in the medical schemes sector were asked to provide feedback on the NHI Bill to the Parliamentary portfolio committee, and the industry eagerly awaits feedback.

BONITAS STRATEGIC RESPONSE:


Be a strategic purchaser


Integrate the value chain


Create value through innovation

INNOVATION AND TECHNOLOGICAL DISRUPTION

As with many industries, the healthcare sector is experiencing severe disruption – caused primarily by the rapid development of new technology.

- The WHO predicts that the proportion of South Africa's population aged 60 years or older will double from 7.7% to 15.4% by 2050. Increased investment in research and development is required to develop innovative health and wellness solutions for this ageing population.
- Virtual healthcare – such as telemedicine, live virtual chats, emails and instant messaging – holds the promise to significantly impact some of the most challenging problems currently facing the South African healthcare system, including access to quality healthcare, cost-effective delivery, and addressing the disparate distribution of a limited number of healthcare providers.
- Artificial intelligence (AI) is set to revolutionise healthcare provision. For example, AI is being used to predict the outcomes of clinical trials and the potential side effects of new drugs, analyse medical imagery to spot early warning signs of disease in X-rays and magnetic resonance imaging (MRI) scans, and collect and process clinical information from at-home patients through remote monitoring.
- The concept of personalised healthcare is slowly becoming a reality. This includes precision medicine, where medication and other treatments are tailored to a specific person or group of people based on factors such as their age, pre-existing conditions and genetics.
- As technology becomes better able to capture and process colossal volumes of data, mechanisms need to be developed to analyse this data to examine trends, make predictions and identify areas for improvement. Data analytics can be particularly useful when it comes to preventative care.
- As organisations create, manage and analyse more data, the need to protect that data increases. The healthcare sector is particularly attractive to cyber attackers due to a perception that healthcare providers pay handsomely if patient data or healthcare systems are compromised.

BONITAS STRATEGIC RESPONSE:


Be a strategic purchaser


Connect with the customer


Create value through innovation


Apply best practice governance

WELLBEING CONCERNS AND MENTAL HEALTHCARE ON THE RISE

More than 970 million people across the globe suffer from a mental health or substance abuse disorder. A study by the Global Happiness Council found that mental illness is the main ailment among people of working age.

Prior to the pandemic, one in six South Africans suffered from anxiety, depression or substance abuse disorder. However, over the last two years, the prevalence of anxiety and depression disorders has increased by 36.4% and 38.7% respectively, according to the South African Depression and Anxiety Group.

A 2022 study by the Wits Medical Health Research Unit indicated that more than 25% of South Africans suffer from probable depression, which is much higher than the data collected in comparative surveys in the United States, Germany, Australia and Brazil.

This has a significant impact on workforce productivity and performance, compounded by economic uncertainty, political instability and poor socioeconomic conditions. A further challenge in South Africa is the fact that up to 80% of South Africans who require mental health support are unable to access it easily, according to South Africa's National Mental Health Policy Framework.

As a result, more medical schemes are increasing their mental health offerings, and corporates are investing in healthcare services and support.

BONITAS STRATEGIC RESPONSE:


Connect with the customer

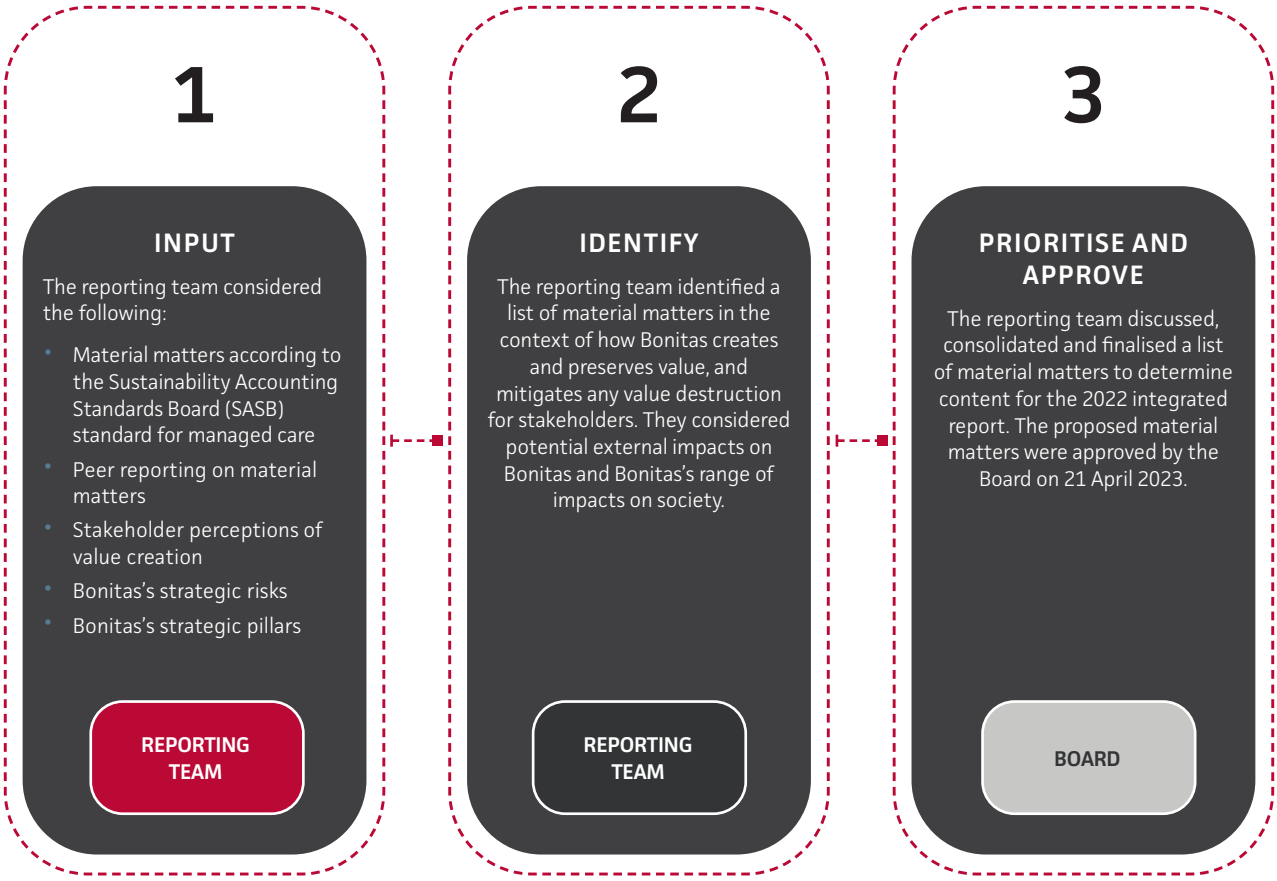

Create value through innovation

MATERIAL MATTERS

In 2022, the Bonitas team identified those matters that can substantively affect our ability to create value over the short, medium and long term. The Board approved our basis for determining materiality and the final list of material matters.

OUR MATERIALITY PROCESS

The reporting team followed a structured and facilitated process in October 2022 to identify material matters for Bonitas:



OUR MATERIAL MATTERS

	**Successful and efficient healthcare reform**
	**Trust and confidence in our ability to protect stakeholders' interests**
	**Thought leadership in functional, clinical and specialist areas**
	**Making it easy for members to look after their health**

	**Leveraging our bargaining power, footprint and networks**
	**Protecting our financial sustainability**
	**Preventing fraud, waste and abuse**
	**Cyber and information resilience**

SUCCESSFUL AND EFFICIENT HEALTHCARE REFORM

Read more in the strategy section from page 29.

Bonitas unequivocally supports the principle of universal healthcare as a fundamental, constitutional right. We support healthcare reform that will address cost and quality while making healthcare widely accessible in South Africa.

The implications of the NHI Bill for medical schemes and their role remain unclear but can have a significant impact on the future of Bonitas. Once there is more clarity on our potential role and benefit structures, we will be able to identify future opportunities to ensure sustainability.

Relevant stakeholders:

Board and employees

Members and agents

Service providers

Government and regulatory bodies

Related external trend:

National Health Insurance (NHI) uncertainty

Strategic pillar response:

Create value through innovation

Boost business development

Related strategic risk:

NHI's impact on Bonitas's sustainability and structure

Impact of increasing regulation or regulatory changes and/or lack thereof

TRUST AND CONFIDENCE IN OUR ABILITY TO PROTECT STAKEHOLDERS' INTERESTS

Read more in the strategy section from page 29.

We are committed to stakeholder relationships that are purposeful, relevant, open and honest, inclusive and responsive. For our members, this means having peace of mind that their claims and bills will be paid.

We protect members' contributions through due care and due diligence. We build trust by ensuring that we understand and include the needs of stakeholders in developing our strategy. This helps us increase insights, work collaboratively through partnerships, and take action to achieve maximum benefits for our members and other stakeholders.

We know Bonitas creates value through lower cost, better access, quality, speed of refunds, and meeting medical needs efficiently while managing our funds responsibly.

Relevant stakeholders:

Board and employees

Members and agents

Service providers

Government and regulatory bodies

Related external trend:

Cost of healthcare crisis

Innovation and technological disruption

Strategic pillar response:

Connect with the customer

Apply best practice governance

Related strategic risk:

Negative media publicity and potential loss of stakeholder confidence and brand and/or reputational damage

THOUGHT LEADERSHIP IN FUNCTIONAL, CLINICAL AND SPECIALIST AREAS

Read more in the strategy section from page 29.

Since we have access to specialist skills – including actuarial and clinical skills – we are able to design plans, develop managed care programmes, and select the most appropriate service providers for our networks.

We remain at the forefront of healthcare management through clinical and behavioural stratification of beneficiaries to ensure that those who need support receive it at the right time.

We use data and analytics to support our reputation, drive innovation and optimise benefit plans while developing and enhancing our internal talent pool of future thought leaders.

Relevant stakeholders:

Board and employees

Members and agents

Service providers

Government and regulatory bodies

Related external trend:

Innovation and technological disruption

Wellbeing concerns and mental healthcare on the rise

Strategic pillar response:

Connect with the customer

Create value through innovation

Related strategic risk:

Major competitors or new entrants take actions to establish and sustain competitive advantage over Bonitas or threaten our sustainability

MAKING IT EASY FOR MEMBERS TO LOOK AFTER THEIR HEALTH

Read more in the strategy section from page 29.

We focus on preventative and primary services being available when required to drive positive member experiences. Bonitas offers wellness and preventative care benefits on all our plans to help members lead healthier and happier lives. This includes a free annual screening check, flu vaccine and HIV test, and mammograms with designated service providers. These benefits are in addition to savings and day-to-day benefits.

We offer a free wellness screening for each member, once a year, on all our plans. The wellness screening is made up of carefully selected tests to help members get a clear picture of their health. These tests are the first step in detecting serious chronic conditions such as hypertension, heart disease and diabetes. Once a member has completed the wellness screening, they can access the Benefit Booster, which can be used to pay for out-of-hospital day-to-day services or a programme to stop smoking.

In 2022 Bonitas introduced Panda, a mental health and wellness mobile app that allows users to objectively measure their mental wellbeing, and access professional and peer support.

Relevant stakeholders:

Board and employees

Members and agents

Service providers

Government and regulatory bodies

Related external trend:

Wellbeing concerns and mental healthcare on the rise

Innovation and technological disruption

Strategic pillar response:

Integrate the value chain

Connect with the customer

Related strategic risk:

Changes to benefit design and pricing are not optimal to support the achievement of our strategic objectives

LEVERAGING OUR BARGAINING POWER, FOOTPRINT AND NETWORKS

Read more in the strategy section from page 29.

Our commitment to cost-effective preventative care interventions ensures that we make quality healthcare more affordable and accessible to South Africans. Our intent is to protect members from future 'price shocks' and higher increases in the long term.

We use an outsourced model and partner with the best service providers to ensure our members get access to care of the highest quality. For our service providers and third-party suppliers, this also means that they benefit from ease of doing business and can focus on quality healthcare rather than administration.

Relevant stakeholders:

Board and employees

Members and agents

Service providers

Government and regulatory bodies

Related external trend:

Cost of healthcare crisis

Innovation and technological disruption

Strategic pillar response:

Integrate the value chain

Be a strategic purchaser

Related strategic risk:

Failure of third parties to deliver against contracts, SLAs and outcomes-based measures

PROTECTING OUR FINANCIAL SUSTAINABILITY

Read more in the strategy section from page 29.

Our financial sustainability depends on membership growth, a balanced membership profile, responsible investment, solvency and stability. We follow a prudent, dependable approach in terms of contribution increases, and invest responsibly to protect our members' funds.

The uncertainty around the role of medical schemes and the NHI funding model requires that we remain agile and future-focused to ensure Bonitas's sustainability.

Relevant stakeholders:	Related external trend:	Strategic pillar response:	Related strategic risk:
Board and employees Members and agents Service providers Government and regulatory bodies	Cost of healthcare crisis National Health Insurance (NHI) uncertainty	Optimal investment returns	NHI's impact on Bonitas's sustainability and structure Poor financial performance

PREVENTING FRAUD, WASTE AND ABUSE

Read more in the strategy section from page 29.

We have an integrated approach to prevent FWA across our value chain. This includes efforts to increase awareness, the use of analytics, early detection and disciplined action.

We improve outcomes by focusing on recoveries, practice vetting and billing behaviour.

Relevant stakeholders:	Related external trend:	Strategic pillar response:	Related strategic risk:
Board and employees Members and agents Service providers Government and regulatory bodies	Innovation and technological disruption	Apply best practice governance	Poor financial performance

CYBER AND INFORMATION RESILIENCE

Read more in the strategy section from page 29.

We are committed to securing members' health information, records and data. New technology, increasing volumes of data and an expanding user base all contribute to a higher risk of cyber attacks. Healthcare systems are particularly vulnerable to ransom attacks as compromised data and systems can cost lives.

Our industry is experiencing increased incidents, including system failures resulting in core systems being unavailable. This means that services such as pharmacy claims and chronic medicine dispensation could potentially cause disruption to members.

Cyber and information resilience received specific attention from the Board this year.

Relevant stakeholders:	Related external trend:	Strategic pillar response:	Related strategic risk:
Board and employees Members and agents Service providers Government and regulatory bodies	Innovation and technological disruption	Apply best practice governance	Cyber and information security threats and vulnerabilities Inadequate and/or insufficient I&T change control and incident management Impact on system stability and/or accessibility of the administrator or managed care organisation Lack of sufficient focus on I&T governance

Bonitas wants a future in which our total population will be healthier. We focus on growing and retaining membership, lowering healthcare costs and managing clinical risk, thereby improving the quality of care for our members in a way that delivers positive wellness outcomes for more South Africans.

OUR STRATEGY FOR LEADERSHIP

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

OUR FIVE-PILLAR STRATEGY AND PERFORMANCE

STRATEGY REVIEW PROCESS

To ensure that we deliver on our purpose, Bonitas has a detailed and robust strategy based on five core pillars. The Board's Working and Strategy Committee is responsible for directing and monitoring the implementation of the strategy. Progress is evaluated during meetings and workshops conducted by the five Board Committees, and is presented to the Board during Board meetings.

A formal strategy review process takes place once a year. The Board, together with Executive Management, review the strategy against the current healthcare environment, trends and anticipated future changes. The process includes identifying new risks and changes to risk ratings, and assessing progress in strategy execution. Based on the results of this review, the Board in June 2022 confirmed that no changes were required to the current strategy.

We reaffirmed our commitment to our financially prudent and customer-focused approach:

- To drive long-term sustainability and financial stability, we aim to manage contribution increases in a way that prevents future 'price shocks' while protecting our members in the long term. Although our contributions increase in line with systemic medical inflation, our intention is that these increases should remain lower than the industry average.
- To continue meeting the needs of our members, our focus is on improved solvency, and using our reserves to ensure affordability and continued innovation in terms of our plans and value-added benefits. This approach supports affordability and ensures that we grow our membership base.

Strategic alignment
In May 2022 Bonitas embarked on an exercise to compare our own strategic objectives with those of our key stakeholders – in particular Medscheme, CMS and the rest of the industry – to identify possible gaps.

One of the recommendations following this exercise was to develop a Stakeholder Engagement and Communication Framework to ensure consistency across the value chain on issues relating to stakeholder interests and engagement. This framework was approved by the Board in July 2022 and is discussed in the section that details our key relationships (from page 13).

Remuneration is linked to progress with implementing the strategy. The performance of members of the Executive and Senior Management team is evaluated against an Organisational Performance Scorecard that is linked to the strategic pillars. The scorecard includes key performance indicators, together with related targets and success criteria. The key performance indicators relate to:

- Net healthcare results
- Loss-making options
- Solvency and investment returns
- Membership growth and retention
- Governance, risk and compliance
- Strategy implementation

Read more in the Remuneration Report from page 85.

FIVE STRATEGIC PILLARS

The Bonitas strategy has five core pillars, supported by governance and innovation – which are relevant to each pillar.

- The focus on governance is based on Bonitas's outsourced administration operating model. To ensure that we meet compliance requirements, our Board must have the appropriate oversight and control over all aspects of our services and responsibilities to members.
- The focus on innovation is based on our intention to make quality healthcare more affordable and accessible to all South Africans. This requires strategic, process and product innovation.

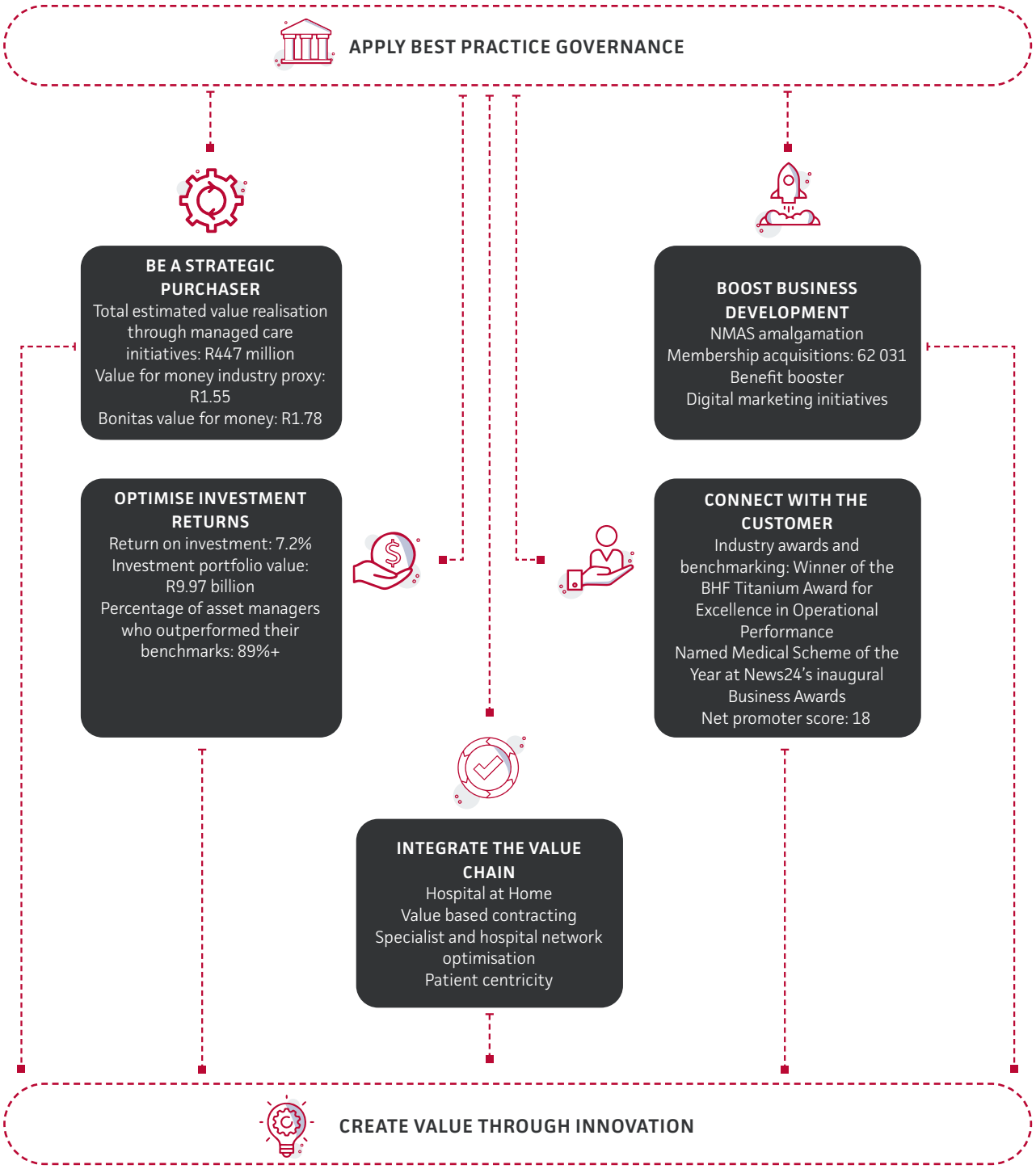
We execute our strategy through the plans we offer. These have been designed for simplicity, flexibility and affordability, while also meeting our members' varying needs at different stages in their lives. Plans were reviewed by the Board on 21 September 2022, submitted to the CMS on 23 September 2022, and announced to brokers and members on 28 September 2022. The CMS approved our benefit options on 29 November 2022.

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 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 of the MSA 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 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.

STRATEGY PERFORMANCE AT A GLANCE



PROGRESS WITH IMPLEMENTING OUR STRATEGIC PILLARS

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.

SHORT-TERM FOCUS AREAS	• Focus on reimbursement models with provider networks • Review existing risk transfer arrangements • Align network hospitals and contracted healthcare providers to reduce member co-payments • Contract with managed care service providers at an option level to reduce deficits
LONG-TERM FOCUS AREAS	• Define and optimise purchasing power with hospital groups • Build more efficient networks of service providers and enhance current networks • Ensure preventative and primary services are available when required • Ensure that secondary and tertiary healthcare only come into play after the first level of relevant care has been accessed
RELATED MATERIAL MATTER	• Leveraging our bargaining power, footprint and networks

2022 PROGRESS

A robust network of service providers ensures that members receive relevant and quality care, and reduces member co-payments. Significant progress was made in 2022 to both consolidate and increase Bonitas's network.

- Bonitas embarked on a GP Network Rationalisation Project to increase the efficiency of the network. 1 448 GPs were identified who have either been inactive for a significant period or are persistently recalcitrant. To limit the impact on members and the affected GPs, a phased approach will be taken to remove these GPs from the network, starting on 1 January 2023 and concluding on 1 January 2024. Once the identified GPs have been removed, the GP network size will have reduced by 21%. Read more about our engagement with GPs in the Principal Officer's report from page 52.
- Bonitas has identified 1 634 additional non-contracted specialists to increase alignment to network hospitals. These specialists will be contracted in two tranches, with the first tranche of 618 specialists being responsible for 50% of the claim volumes. This process commenced in December 2022 and will conclude in September 2023, and will result in an 80% congruency between Bonitas's hospital and specialist network.
- We are progressing well in terms of expanding our network of anaesthetists, and have identified 150 service providers to be targeted by June 2023.
- In 2023, 80% of our members will be within a 30 km radius of a network hospital – with a presence across all nine provinces in line with the footprint of our member base.

Bonitas has made strides in improving contracting with primary service providers through the introduction of outcomes-based measures and various other requirements, as well as reduced fees. Contract and pricing negotiations are ongoing with service providers whose contracts are due for renewal, and where relevant we embark on an RFP process to benchmark current services and pricing against other service providers in the market.

Some new service providers have been identified to expand Bonitas's offering to members. For example, a Memorandum of Understanding (MoU) has been signed with HearConnect for virtual audiology screening and referral for early treatment or intervention where relevant.

Hospital at Home

Bonitas's Hospital-at-Home service enables some patients who need acute-level care to receive care in their homes rather than in a hospital. This care delivery model improved outcomes, enhanced the patient experience and reduced costs. The need for home-based care is not only the result of the cost of hospital care, but also the shortage of beds, nursing staff and other healthcare professionals.

This technology-enabled service brings all the essential elements of in-hospital care to the patient's home, without moving away from evidence-based protocols and state-of-the-art vital sign monitoring. Patients are monitored wirelessly, automatically and continuously to enable early identification of significant clinical change or deterioration.

The Hospital-at-Home service is ideal for generalised illnesses, post-operative care and palliative care. It consists of two offerings:

1. Remote patient monitoring, which includes 24/7 virtual vital signs monitoring, virtual visits and clinical support from healthcare practitioners, and continuous care by a treating doctor.
2. Clinical intervention, which includes all the above, as well as daily visits by healthcare practitioners, blood tests, wound dressings, medication and/or fluid, and applied healthcare services such as physiotherapy.

The Hospital-at-Home service is a key innovation in reducing member contributions. Hospitalisation costs are the main cost driver for all medical schemes, and even 24-hour professional care at home is less expensive than hospital costs.

The number of members benefiting from the Hospital-at-Home service grew rapidly in 2022.

A number of initiatives have been introduced to improve preventative care and/or early intervention. For example, members who use dental services receive education cards after their consultation that include dental wellness recommendations. Optical/optometry services have been enhanced through diabetic retinopathy screening and relevant referral if needed.

Strategic purchasing yielded estimated savings of R447 million (2021: R407 million), mainly driven by hospital negotiation savings of R260 million.

KEY INDICATORS

TOTAL ESTIMATED VALUE REALISATION THROUGH MANAGED CARE INITIATIVES

R447 million

10% ↑

VALUE FOR MONEY SCORE (2021)

R1.78 (2020: R1.49)

19.5% ↑

ADDITIONAL INDICATORS

BENEFICIARIES REGISTERED FOR CHRONIC MEDICINE

202 611 (2021: 194 199)

4.3% ↑

BENEFICIARIES ON THE HIV/AIDS PROGRAMME

40 311 (2021: 41 977)

4.0% ↓

BENEFICIARIES ON THE CANCER PROGRAMME

12 724 (2021: 13 562)

6.2% ↓

BENEFICIARIES ON THE DIABETES PROGRAMME

67 641 (2021: 63 780)

6.1% ↑

BENEFICIARIES IDENTIFIED FOR THE BACK AND NECK PROGRAMME

7 144 (2021: 5 022)

42.3% ↑

BENEFICIARIES REFERRED TO THE BACK AND NECK PROGRAMME

5 430 (2021: 4 304)

26.2% ↑

Future priorities

Bonitas continues working with the humanitarian aid organisation Gift of the Givers, and in 2023 we aim to conduct auditory screening for almost 15 860 learners. If the screening fails, a full diagnostic test will be undertaken, and medical treatment and after-care will be provided where needed.

We are also planning a number of enhancements to the Hospital-at-Home service in 2023, including a programme for readmissions, screening and disease prevention, an alternative to step-down facilities, kidney dialysis at home, and an improved programme for chronic kidney disease.

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.

SHORT-TERM FOCUS AREAS	• 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
LONG-TERM FOCUS AREAS	• Enhancement of distribution channels • Improved retention (groups and direct paying members) • Corporate membership growth and the integration of value-add products • Continued pursuit of amalgamation opportunities
RELATED MATERIAL MATTER	• Successful and efficient healthcare reform

2022 PROGRESS

Despite the economic climate, Bonitas continues to grow its membership base through a two-pronged focus on corporate membership acquisitions and organic growth. The total number of new members for 2022 was 62 031 (2021: 51 396).

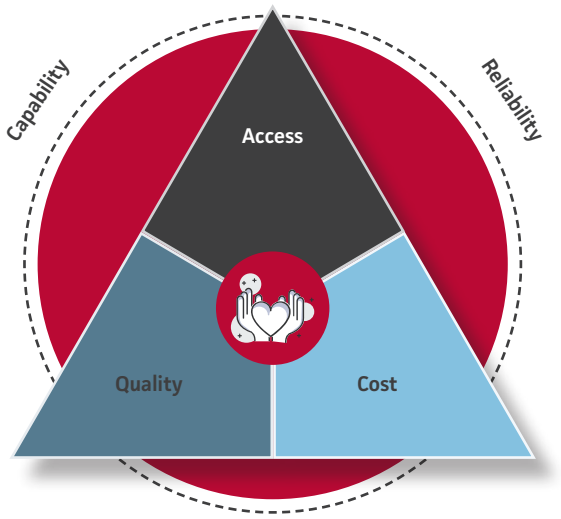
- 14 585 new members were due to the amalgamation with NMAS, which concluded on 1 January 2022. This amalgamation serves to maintain and enhance Bonitas's reputation in the industry as an attractive and capable amalgamation partner.
- 47 446 new members were the result of organic growth, which demonstrates the relevance of our value proposition.
- The average age of new members as of 1 January 2023 is only 0.4 years older than our previous membership base a year earlier. We are therefore attracting a healthier profile, which is coveted across the industry. Our Edge plans – BonStart and BonStart Plus – are specifically designed to appeal to new entrants to the workplace between the ages of 18 and 35. These plans are driven by technology and ease of access through virtual integration and digital intervention. They are proving popular, with approximately 8 135 lives covered on these options.
- The retention unit is well established and is investigating strategies to enhance corporate retention. A retention target of 30% of controllable terminations was effective for 2022, and the achieved retention rate for the year was 49%. For 2023, a new retention target of 25% of all terminations (not just controllable) was established to encourage a holistic approach towards retention.

We continue to make progress in terms of corporate membership. In 2022 we launched a new corporate portal with a dedicated corporate application form.

Value offering for corporates and amalgamations

Bonitas is an attractive choice for corporates and amalgamations due to our focus on ensuring sustainability while meeting the needs of our members.

Our approach is based on:



- We have access to all income segments in South Africa, and our members come from small and medium enterprises, corporates, government bodies, parastatals, and sectors including mining and manufacturing
- We have multi-layered distribution and engagement channels and adhere to a diverse platform engagement strategy
- We are a preferred split-risk partner for corporates
- We provide choice through a diversified product range
- We have proven new membership growth and an improved profile of new business
- We have a demonstrated ability to compete on price
- We drive innovation in product development and virtual care solutions

To enhance distribution channels, we solidified our relationship with brokers through questionnaires, power breakfasts, focus groups and a roadshow. We also identified and engaged separately with our Top 40 brokers to ensure their ongoing understanding of our value proposition and new initiatives. We continue to work with distribution channels including Hippo, Medquote and Sanlam Healthcare Distribution Services.

In March 2022 we introduced the innovative Benefit Booster, which equates to an increase in day-to-day benefits ranging from 15% to 47%, depending on the member's plan. The Booster provides members with R457.4 million worth of additional benefits that can be used to fund acute medication, specialist consultations or non-surgical procedures. By the end of December 2022, 32 885 members had accessed the benefit. In 2023 we will adjust the benefit limits in line with utilisation trends, and introduce enhancements to several plans.

BONITAS SOS
0860 555 505

europ assistance
you live we care

Launched in May 2022, Bonitas's **dedicated emergency medical service** offers members access to a range of support services in the case of medical emergencies.

What does this benefit cover?

- Emergency medical response by road or air from the scene of the medical emergency
- Instructions on how to manage the emergency while waiting for the ambulance (e.g. start CPR)
- Transfer to the closest appropriate medical facility by road or air
- Inter-hospital transfers (subject to authorisation) in accordance with Bonitas's Rules
- Virtual doctor consultations via the Bonitas member app (available 24/7)

What to do in the case of a medical emergency

1. Call 0860 555 505 and provide your name, telephone number and medical aid number
2. Give a brief description of the incident and its severity
3. Provide the address/location (road name, number and nearest crossroad) of the scene of the incident
4. Stay on the phone and ensure that Bonitas SOS has all the details of the incident

NATIONAL HEALTH INSURANCE

NHI remains an uncertainty that creates difficulties for private medical schemes in terms of strategic planning and can adversely impact their revenue streams and membership growth.

Regulatory process

Bonitas envisages the following actions in relation to the draft NHI Bill:

- The Parliamentary portfolio committee and the National Department of Health will deliberate and respond to the inputs received from medical schemes in January 2022, as well as the issues raised during public hearings. The committee will process the Bill clause by clause. Once processed, the committee will submit the Bill to the National Assembly and National Council of Provinces (NCOP) for adoption.
- The NCOP will call the Department of Health for a briefing on the Bill, and the provinces will then conduct public hearings. Feedback from the public hearings will be reported to the NCOP, which will deliberate on the inputs with the Department of Health. The report will be finalised for adoption by the NCOP.
- Once adopted by the NCOP, Parliament will submit the Bill to the president for assent.

Anticipated impacts

If the NHI goes live in its current format:

- Medical scheme products are unlikely to be eradicated but will need to be redesigned to provide complementary services – i.e. those services not covered by the NHI – which will significantly impact revenue streams.
- Insurance products (such as gap cover, hospital cash plans, travel insurance, etc.) will remain but will need to be redesigned to reflect the NHI – such as to reflect 'new' gaps resulting from NHI coverage.
- Low-cost benefit options (LCBOs) will either be absorbed into current products that offer complementary services, or become new products offering lower-cost complementary services. Low-cost health insurance products will likely fall away or be incorporated into LCBOs.

Our way forward

In response to the NHI, the industry and Bonitas Board have resolved that we will:

- Continue lobbying and engaging with relevant stakeholders for the importance of a well-governed Universal Healthcare system.
- Create cohesion within BHF on the importance of the NHI and the industry as part of strengthening health systems.
- Clearly define the role of medical schemes within the NHI, using COVID-19 as an example of an NHI partnership approach.
- Push for a multi-funder model and the use of existing medical schemes and/or administrators for NHI roll-out.

Bonitas intends to:

- Increase our voice through public relations and messaging to members, citizens and healthcare professionals.
- Ensure that we remain relevant in terms of service provision.
- Conduct a survey to assess members' current perception, knowledge and attitude towards the proposed NHI Bill. The results of this survey will inform our future actions.

KEY INDICATORS

MEMBERSHIP ACQUISITIONS

62 031 21% ↑

(2021: 51 396)

ADDITIONAL INDICATORS

ONLINE UNIQUE ENGAGEMENTS

797 222 (2021: 885 446) ↓

LEADS GENERATED

104 214 (2021: 95 867) ↑

BROKERS

1 POWER BREAKFAST STREAMED TO OVER

523

DELEGATES WITH 82 IN PERSON

(2021: 1 657)

1 BROKER ROADSHOW STREAMED TO OVER

1 179

DELEGATES

(2021: 1 898)

1 PRODUCT LAUNCH STREAMED TO

2 115

DELEGATES

(2021: 2 727)

2

CORPORATE LAUNCHES

(2021: 2)

27

UNION ENGAGEMENTS

(2021: 19)

Future priorities

We will maintain momentum in engaging with corporate clients and understanding their specific needs, as well as monitoring distribution channel performance to evaluate risks and opportunities for membership growth.

In addition to ensuring that our members' voices are heard in relation to the proposed NHI Bill, we will be investigating and planning for two possible NHI outcomes:

1. A loss of membership. In response, Bonitas will intensify our retention efforts, and increase our focus on new member growth through our wide variety of plans that are designed to appeal to the greater South African population.
2. Transform Bonitas from a fully-fledged medical scheme to a role player that complements the NHI.

OPTIMISE INVESTMENT RETURNS

Bonitas optimises the return on investments within its risk appetite. Our investment strategy considers regulations and the constraints imposed by the MSA.

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

Our liabilities are short-term in nature. As a result, a significant portion of the investment portfolio is invested in cash instruments. The MSA also requires medical schemes to hold a minimum of 20% of investable assets in cash.

SHORT-TERM FOCUS AREAS	• Achieve a targeted net (of fees and taxes) return in excess of CPI+3.5% per annum over a rolling 36-month period
LONG-TERM FOCUS AREAS	• Preserve capital over a rolling 12- to 18-month period • Be proactive and reposition Bonitas when there are opportunities to maximise returns while adhering to the set strategic asset allocation parameters • Manage investment risk to be within tolerable levels
RELATED MATERIAL MATTER	• Protecting our financial sustainability

2022 PROGRESS

We continued reinvesting operating surpluses and increased our allocation to equities in 2022. Due to a volatile and unpredictable market, we did not meet our investment return target but exceeded our rand value target. Local equity markets returned disappointingly small positive outcomes (less than 2%) on the back of rising inflation and the devastating impact of loadshedding on the economy.

The market value of Bonitas's investment portfolio, excluding cash and cash equivalents, was R9.97 billion at 31 December 2022 (2021: R8.32 billion), representing growth of 20%.

Read more about investment performance in the financial and operational review from page 55.

KEY INDICATORS

RETURN ON INVESTMENT:

7.2%

(TARGET OF 10.4%)
(2021: 16.2%)

INVESTMENT PORTFOLIO VALUE:

R9.97 billion

(2021: R8.3 BILLION)

PERCENTAGE OF ASSET MANAGERS WHO OUTPERFORMED THEIR BENCHMARKS NET OF FEES: **89%**

Future priorities

Bonitas will be using reserves more strategically to support members in the medium term, which will require a prudent and responsible investment strategy to ensure sustainability.

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.

SHORT-TERM FOCUS AREAS	• Implement a comprehensive customer relationship management capability, including a proper system • Align brokers' efforts with those of Bonitas in the engagement of members
LONG-TERM FOCUS AREAS	• Educate and engage patients to take responsibility for their health and conditions • Form partnerships with doctors, health practitioners and patients • Actively promote openness and approachability
RELATED MATERIAL MATTERS	• Trust and confidence in our ability to protect stakeholders' interests • Thought leadership in functional, clinical and specialist areas • Making it easy for members to look after their health

2022 PROGRESS

In 2022 we continued our focus on improving members' experience by enhancing digital communication platforms, and better understanding the needs of our members and other stakeholders.

- Up to the end of December 2022, 76 563 people had downloaded the Bonitas member app (2021: 55 174), and the app is now our core engagement platform with members. Among others, the app allows members to check their benefits, find a network provider, virtually consult a GP, see the balance in their medical savings account, talk to a call centre agent, and get their tax certificate.
- The AMP section in the Bonitas app promotes preventative care and early intervention through education, questionnaires and risk assessments. Biometric data, claims and wearable data are used to regularly update members' health scores, and an avatar reminds them of the best steps to boost their health.
- Our WhatsApp channel increased by 137 623 unique users between the end of December 2021 and end December 2022.
- Members can use the Live Chat function on our WhatsApp channel and member app to engage with a call centre support agent from Monday to Saturday.
- Through the Member Zone portal on our website, members can virtually engage with healthcare professionals 24/7. They can also upgrade or downgrade their plans on this platform.
- A new online member application form was introduced, allowing for easier applications to join Bonitas.

Through these digital communication platforms, we can engage with members on a real-time basis to answer questions and provide assistance. Furthermore, the use of the latest virtual technology and science allows scaled participation and early signs and symptoms detection to ultimately decrease health claims and improve risk to Bonitas. For example, the member app uses behavioural economics, a health score for each member, and a clever communications engine to deliver appropriate and subtle nudges to educate and change member behaviour.

However, since some members do not have ubiquitous internet access, we continue to use traditional communication channels as customer touchpoints, including our call centre, email, short messaging service (SMS), website, postage and various media communications.

2022 CUSTOMER EXPERIENCE

GREENFIELDS RESEARCH PTY LTD	askafrika Liberating truth for humanity	B·H·F Board of Healthcare Funders
Behaviours and Perceptions of Members The Bonitas call centre conducts monthly member surveys to assess member satisfaction. This year we sent out 198 331 surveys and had an average 18.89% response rate. • 83.21% of respondents indicated that the call centre agent satisfactorily resolved or facilitated a resolution to their query. • 63.66% said it was easy to get to the point where their query was resolved.	**Brand Health Tracker and Brand Positioning** Bonitas commissioned Ask Afrika to conduct research on our brand health and positioning. The resulting report, received in April 2022, included the following key findings: • 86% of surveyed members were delighted with how they had been treated. • Bonitas has a higher net promoter score than all its competitors and achieved more consistency with emotional satisfaction among members than its competitors. • The medical aid industry has seen a 1% drop in service levels year on year, but Bonitas has a higher service satisfaction level than its competitors. Bonitas was one of only two schemes that saw an increase in customer satisfaction.	**Excellence in Operational Performance** In May 2022 Bonitas was awarded the BHF Titanium Award for Excellence in Operational Performance. This award category requires nominees to demonstrate how they created, supported and sustained access to affordable and quality healthcare services for their members in terms of: • Growth over the past three years • Contribution increases • Health governance measures • Preventative healthcare benefits • Risk benefits The award recognises Bonitas's strategy to reshape the healthcare ecosystem by bringing affordable, quality care to more South Africans. This is the third Titanium Award for Bonitas, the previous two being for Service to Membership in the open medical schemes category.

KEY INDICATORS

INDUSTRY AWARDS AND BENCHMARKING:

Winner OF THE BHF TITANIUM AWARD FOR EXCELLENCE IN OPERATIONAL PERFORMANCE

NAMED **Medical Scheme of the Year** AT NEWS24'S INAUGURAL BUSINESS AWARDS

NET PROMOTER SCORE

18
(2021: 23)

ADDITIONAL INDICATORS

53 379 ↑
LIVE CHAT AND CHATBOT INTERACTIONS (2021: 16 532)

278 993 ↑
WHATSAPP AGENT CHATS (2021: 203 820)

183 795 ↓
WHATSAPP BOT AND SELF-SERVICE INTERACTIONS (2021: 207 821)

66 163 ↑
VIA WALK-IN CENTRES (FACE-TO-FACE) (2021: 59 859)

1 526 874 ↑
VIA CALL CENTRES (2021: 1 322 618)

- **678 961** ↑ main call centre (2021: 634 322)
- **230 115** ↑ BonCap call centre (2021: 225 077)
- **460 182** ↑ hospital benefit management (2021: 330 950)
- **157 616** ↑ chronic medicine management (2021: 132 269)

582 885 ↑
EMAILS (2021: 561 503)

- **484 715** ↑ main back office (2021: 477 157)
- **51 749** ↑ BonCap back office (2021: 38 990)
- **46 421** ↑ BonCap emails (2021: 45 356)
- **330 547** ↑ hospital benefit management authorisations created (2021: 281 719)
- **13 891** ↓ chronic medicine management authorisations created (2021: 19 447)

Future priorities

- Member education and awareness
- Enhanced digital servicing platforms
- Customer focused communication that is simplified and adds value

INTEGRATE THE VALUE CHAIN

Bonitas believes that 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.

SHORT-TERM FOCUS AREA	• 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
LONG-TERM FOCUS AREAS	• Define and achieve common future goals with these entities • Brand Bonitas as the future of healthcare in South Africa
RELATED MATERIAL MATTERS	• Making it easy for members to look after their health • Leveraging our bargaining power, footprint and networks

2022 PROGRESS

Bonitas operates an outsourced model and makes use of strategic service providers to execute some of our activities. These service providers and relationships are pivotal to creating value for our members and enabling us to deliver on our strategic pillars.

We have made steady progress in moving from a transactional to an outcomes-based model for disease management to help members manage their health, while we negotiate the best rates to provide them with additional value. We have also been moving to outcomes-based contracting in which service providers clearly understand their role, their expected deliverables, and how they contribute to achieving Bonitas's strategic objectives. SLAs are continually reviewed to ensure that outcomes-based measures are valid and up to date, and supplier performance is evaluated against the agreed-upon outcomes.

A significant focus in 2022 was to consolidate suppliers' digital offerings with the Bonitas Member Zone portal and member app so that members can access the information and services they need from a single point of contact. Key digital consolidation achievements in 2022 include the following:

- Documentation Based Care (DBC) offers an online programme of routine exercises aimed at members who struggle with back or neck issues and cannot attend a DBC clinic. This programme is offered through the eDBC app, which has been integrated into the Bonitas member app.
- The Bonitas member app allows members access to Nedbank's AVO store, which provides a range of value-added services such as discounts, rewards and special deals from merchants. This year, the number of merchants increased from 20 000 to 24 000.
- Bonitas has partnered with Europ Assistance to offer a dedicated emergency medical service called Bonitas SOS. We have been able to create our own identity for this offering.
- Our provider locator has been updated to include the ability to search for PPN-contracted optometrists and DENIS-contracted dentists.

KEY INDICATORS

VALUE FOR MONEY

R1.78* (2021) **19.5%** ↑

R1.49 (2020)

* *Data is based on the Deloitte Transactional and Relational Governance Review that was done in 2022 for 2021 indicators.*

Future priorities

- Preventative care
- Patient centricity
- Value based contracting

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 dependents. 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.

Innovation can be segmented into three types:

Product innovation to respond to the needs of our members.

Process innovation to improve the customer experience and ensure members are educated and empowered concerning their health and wellness needs.

Strategic innovation to ensure we remain 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.

SHORT-TERM FOCUS AREAS	• Issue communication that is focused on aligning providers in Bonitas's value chain as opposed to the supply and demand of the healthcare economy • Actively build a future for Bonitas to be part of the NHI in South Africa
LONG-TERM FOCUS AREAS	• 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
RELATED MATERIAL MATTERS	• Successful and efficient healthcare reform • Thought leadership in functional, clinical and specialist areas

2022 PROGRESS

The future of healthcare is anchored in primary and preventative care as well as sustaining wellbeing, as opposed to responding to illness. For example, the rise in non-communicable or lifestyle diseases such as cancer and diabetes is caused by lifestyle risk factors, which is why Bonitas offers a range of managed care programmes aimed at assisting members to understand and manage their conditions.

- Cancer prevalence is one of the key concerns facing South Africans and is increasing year on year. In 2021 we announced our partnership with the South African Oncology Consortium – the largest network of oncologists in the country – to enhance the offerings of our cancer programme, including screening for early detection, treatment and palliative care. Overall, 17 986 members used our oncology services in 2022, and for 2023 we have restructured benefits to be unlimited for PMB cancers on all options.
- The latest data from the South African Health Quality Assessment shows that Bonitas has an effective disease management programme and better outcomes than the industry standard for diabetic members, with improved metrics for Hb1Ac, statins and cholesterol. In our effort towards continual improvement, in 2023 we introduced a benefit of R51 000 per family per year for an insulin pump or continuous glucose monitor for Type 1 diabetics and under 18s on five of our options.
- In 2022 Bonitas launched Panda, a free-to-download mental health and wellness mobile app that provides scientifically validated assessment tools to enable users to objectively measure their mental wellbeing. A gamified tracking tool allows users to document and monitor progress on their personal mental health journey. The app allows for interactive, audio-only sessions with peers and mental health experts, assignments and videos, text-based chat support from an accredited wellness counsellor, and the ability to book one-on-one virtual consultations with counsellors, social workers, psychologists and other mental health professionals.

South Africans continue to face tough economic times, and cost-savings are front of mind for many members. In this regard, we have aligned our medicines formulary to the WHO's Essential Medicines List (EML) to promote affordability and accessibility to clinically approved medicines, in support of universal healthcare and the promotion of medicine adherence for our members.

Preventative care in 2023

Bonitas offers robust preventative care benefits covered by risk premiums since early detection can help improve clinical outcomes and increase longevity for our members.

Our current preventative care benefits include cover for HIV tests, lipograms, mammograms, pap smears, pneumococcal vaccines, prostate antigen screenings, flu vaccines, bone density screenings, stool tests for colon cancer, and cover for COVID-19 vaccines and boosters. We also offer a range of preventative care benefits for children, such as new-born hearing screenings and childhood vaccines.

- In 2023 we are extending our preventative care benefits to include cover for two doses of the Human Papillomavirus (HPV) vaccine for girls aged between 9 and 14 on five of our options. The WHO indicates that two doses of the vaccine in this age group may prevent 70% of cervical cancer, 80% of anal cancer, 60% of vaginal cancer and 40% of vulva cancer. The vaccine has also shown over 90% efficacy in preventing HPV-positive oropharyngeal cancers.
- Pertussis or whooping cough has been highlighted as a key concern across Africa – particularly as it is spread easily and can be fatal. We are therefore introducing one booster vaccine per beneficiary aged between 7 and 64 on five of our options.

APPLY BEST PRACTICE GOVERNANCE

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

CORE ELEMENTS (SEE IMAGE BELOW)	• Governance • Compliance • Risk management
RELATED MATERIAL MATTERS	• Trust and confidence in our ability to protect stakeholders' interests • Preventing fraud, waste and abuse • Cyber and information resilience

GOVERNANCE IS THE OVERALL SYSTEM OF RULES, PRACTICES AND STANDARDS THAT GUIDE BONITAS

- Strategy
- Organisational structure
- Integrity
- Fairness and transparency
- Accountability and responsibility
- Policies and standards

THE CORE ELEMENTS OF OUR GOVERNANCE SYSTEM

COMPLIANCE IS THE SET OF PROCESSES AND PROCEDURES THAT BONITAS HAS IN PLACE TO MAKE SURE THE ORGANISATION AND OUR EMPLOYEES CONDUCT BUSINESS IN A LEGAL AND ETHICAL MANNER

- Compliance risk identification and assessment
- Regulatory compliance
- Operational compliance
- Risk and compliance coverage plan
- Monitoring of compliance
- Reporting of non-compliance matters

RISK MANAGEMENT IS THE PROCESS OF IDENTIFYING POTENTIAL HAZARDS OR OPPORTUNITIES FOR BONITAS AND ACTING TO REDUCE OR ENHANCE THEIR FINANCIAL IMPACT

- Risk identification and assessments
- Risk scores
- Monitoring and analysis
- Risk mitigation

2022 PROGRESS

NMAS AMALGAMATION

Following Bonitas's amalgamation with NMAS, which concluded on 1 January 2022, the internal auditors were requested to conduct an audit. The audit consisted of three phases, with the final phase concluded in September 2022. The reports of all three phases rated the amalgamation as satisfactory, thus concluding the assurance activities on the amalgamation.

TRANSACTIONAL AND GOVERNANCE REVIEW

Medical schemes are not-for-profit and its reserves are for the benefit of their members. Therefore, good governance and ethical behaviour are critical to ensure that Bonitas operates in members' best interests. To this end, Bonitas commissioned Deloitte to conduct a Transactional and Relational Governance Review of the years 2020 and 2021, and the final results were received in November 2022.

Overall, Deloitte reported that Bonitas has improved from the fourth to the second-best open medical aid scheme in the medium to large category, and has achieved membership growth during a challenging economic period. The report also found that Bonitas obtains significant value for money from our primary contracted service providers – for every R1.00 spent on administration and managed care, Bonitas derived R1.49 value for 2020 and R1.78 for 2021, demonstrating substantial improvement year on year. For 2021 we also surpassed the industry proxy of R1.59 for the first time.

This indicates that, in 2021, Bonitas derived more value from our primary contracted service providers than other comparable schemes from their administrators.

In terms of governance, Deloitte found that Bonitas complies with the MSA and has a strong governance structure in which the Board is supported by various committees and forums. The Board has the necessary skills, knowledge and experience to fulfil their mandate, and the elected/appointed trustees have the right mix of skills to enhance Bonitas's sustainability.

The transactional component of the review focused on five performance areas:

Financial strength

Bonitas is able to withstand adverse claims experiences and meet liabilities as they fall due.

Growth and sustainability

Bonitas ranks second in terms of growth and sustainability. We also navigated the negative impacts of COVID-19 better than most schemes.

Non-healthcare expenditure

Bonitas is better able to maintain the average age of beneficiaries than other schemes. The average age for all Bonitas plans was lower than the industry in 2020, and the pensioner ratio for all plans was lower in 2021 than in 2018.

Perceived value

We sustained our market-leading position in perceived value received from 2019 to the 2020/2021 period, with low beneficiary complaints relative to comparable schemes, and competitive and innovative offerings.

Compliance, governance and reputation

Bonitas improved on compliance, governance and reputation from 2019 to 2020/2021. Deloitte conducted a detailed SLA review and noted exceptions in only five of the 50 SLA criteria reviewed. The SLA penalties levied in the 2020/2021 period indicate our robust governance of third-party service providers.

FRAUD, WASTE AND ABUSE PREVENTION

The repercussions of fraud are widespread and directly impact every Bonitas member. When a scheme is defrauded, or money is wastefully spent, it impacts the funds available to pay claims, and also has a direct link to increased membership contributions. For these reasons, FWA is one of our primary risk management focus areas, and we maintain a zero-tolerance approach to FWA.

- Our approach to managing FWA includes fraud prevention, detection, investigation, risk management and reporting.
- Our Anti-Fraud, Waste and Abuse Policy ensures a consolidated approach in dealing with FWA, while also protecting our reputation and relationships with stakeholders. The policy provides guidelines for preventing, deterring, detecting, reporting and investigating incidences of FWA, as well as the appropriate actions and/or sanctions, in line with applicable legislation.
- All Bonitas service providers are expected to abide by the principles contained in the Anti-Fraud, Waste and Abuse Policy. Non-compliance may result in sanctions and/or penalties, as per agreed-upon SLAs.
- The Bonitas FWA Forum meets monthly with the Medscheme, PPN, DENIS, and Europ Assistance forensics teams to report and discuss operational FWA matters, and both parties engage with service providers to drive preventative and corrective measures.
- We use analytical software to identify anomalies or irregularities that could indicate potential instances of FWA, and document each step of the forensic process to provide an auditable trail and assurance to all stakeholders.
- FWA interventions are planned using a risk-based approach and incorporate the Medscheme Consortium of administered schemes. Bonitas has exposure to most of the providers paid in the Medscheme Consortium.

Investigating alleged cases of FWA has inherent benefits since the action itself has a deterrent effect on those engaging or considering engaging in FWA. The investigation may also reveal additional corrective or preventative measures to improve systems, processes and policies.

If evidence of FWA is obtained during an investigation, Bonitas may initiate alternative dispute resolution or legal proceedings (disciplinary, civil or criminal). In the case of legal proceedings, we continually engage with SAPS and the Specialised Commercial Crime Unit to provide the necessary assistance to make headway on FWA cases.

Anti-FWA success story

Bonitas received an anonymous tipoff that an educational psychologist was submitting fraudulent claims for services not rendered. Bonitas instituted an investigation which included interviewing members and obtaining affidavits. Based on the evidence gathered during the investigation, Bonitas lodged a criminal case with SAPS for fraud in 2018. The National Prosecuting Authority (NPA) decided to prosecute, and it took approximately four years for the matter to be concluded.

In the second quarter of 2022, the healthcare provider appeared in a Pretoria court and pleaded guilty to all the charges against her. She was found guilty of fraud and was sentenced to 12 months imprisonment, wholly suspended for five years on condition that she was not found guilty of a similar offence during the suspension period. A fine of R20 000 was also imposed, and she was further declared unfit to possess a gun.

FWA STATUS AS AT 31 DECEMBER 2022

Investigations and remedial action

560
practices under investigation

1 507
practices in recovery

184
practices with existing regulatory matters

74
active criminal cases

Risk mitigation

185
practices on withhold (>R0)

20
indirect payment

700
blocked

1 660
practices vetted

Recoveries

R55.5 million*
recovered in 2022, including reversals, recoveries and claim interventions (target of R52 million)

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

FRAUD, WASTE AND ABUSE PREVENTION (R'000)								
	2016	2017	2018	2019	2020	2021	2022	TOTAL
Quantified	79 559	111 612	106 208	85 881	64 920	75 869	**102 037**	626 086
Recoveries (Gross)	17 529	26 469	39 847	39 875	37 060	26 642	**44 141***	231 563
Change in behaviour	83 000	85 000	60 000	165 219	237 309	272 710	**200 225**	1 103 463
Prepayment intervention	729	6 521	10 942	11 338	14 216	16 989	**10 969***	71 704
Reversals	1 804	371	424	182	401	461	**393***	4 036

INDICATORS

2 CONVICTIONS OF A HEALTHCARE PRACTITIONER (2021: 1)	**R626 million** QUANTIFIED IN FWA SINCE 2016 (2021: R524 MILLION)	**90** OPEN AND ACTIVE HPCSA CASES (2021: 121)

Whistle-blowing

Bonitas is committed to providing confidential avenues for whistle-blowers to report any unethical behaviour.

PHONE **0800 112 811** WHATSAPP OR SMS **33490** (NATIONAL)

OR **+27 (0)71 868 4792** (INTERNATIONAL)

APP: WHISTLE BLOWERS APP THAT CAN BE DOWNLOADED FROM GOOGLE PLAY OR THE APPLE APP STORE

ONLINE PLATFORM: **www.whistleblowing.co.za**

INDICATORS

448 WHISTLE-BLOWER HOTLINE CASES REPORTED (2021: 450)	**53%** CLOSED WITH NO FINDINGS (2021: 57%)
38% CLOSED WITH FINDINGS AND THE RELEVANT CLAIMS REVERSED (2021: 21%)	**6%** CLOSED WITH FINDINGS, RELEVANT CLAIMS REVERSED AND PROMOTED FOR FURTHER INVESTIGATION (2021: 15%)
3% CLOSED WITH NO FINDINGS, NO REVERSAL BUT PROMOTED FOR FURTHER INVESTIGATION (2021: 7%)	**97%** OF ALL CASES ACKNOWLEDGED, CAPTURED AND REVIEWED WITHIN THREE WORKING DAYS FROM DATE OF RECEIPT (2021: 95%)

Whistle-blowing success story

Following a report to the whistle-blowing hotline, a healthcare practitioner was investigated for alleged fraud. The investigation confirmed that the practitioner had been submitting false claims.

The total loss assessment was over R444 000 and 95% of this amount had been recovered by the end of December 2022. Bonitas was entitled to almost R106 000, which has been recovered in full.

STRATEGIC FUTURE FOCUS AREAS

The strategic focus areas for 2023 were determined as part of the Bonitas strategy review process, and they are to:

- Maintain growth and financial stability
- Drive innovation, especially in terms of technology and managed care
- Address affordability and competitiveness per option and category
- Identify and capitalise on economies of scale in the growth options
- Continue working towards a below-market-related increase
- Increase access to alternative distribution channels, such as through Sanlam

STRATEGIC RISKS AND OPPORTUNITIES

Our approach to risk management helps ensure our sustainability while meeting the needs of our members.

APPROACH TO RISK MANAGEMENT

Bonitas has identified eight risk management principles that 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

Risk management 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 day-to-day processes, activities and decision-making.

CONTINUAL IMPROVEMENT

The risk management process is continually assessed and revised to remain relevant.

Risk management is driven by three key role players:

- The Board, through the Audit and Risk Committee, remains ultimately responsible for the oversight and approval of risk management within Bonitas, and for setting our risk appetite. The Board is supported by the Principal Officer and the Governance, Risk and Compliance (GRC) function.
- The Principal Officer is responsible for risk management across Bonitas. This includes the facilitation of risk identification, assessment, monitoring and reporting of risks.
- The GRC is an independent function and is considered a second line of defence from a governance and combined assurance perspective. The GRC works closely with Bonitas's management team to execute risk management activities.

RISK MANAGEMENT FRAMEWORK

Bonitas has a Board-approved Risk Management Framework that provides guidance on identifying, evaluating and responding to key risks and opportunities in a consistent, efficient and effective way. The Risk Management Framework includes the following:

The Risk Management Framework includes several important elements:

- The relationship between assurance providers 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's 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.

STRATEGIC RISKS AND OPPORTUNITIES

Bonitas's most significant opportunity over the long term is to pursue further amalgamations and growth in the corporate member base.

STRATEGIC RISK AND OPPORTUNITY	CONTEXT AND CAUSES
The proposed NHI can impact the sustainability of Bonitas from a regulatory and private healthcare model perspective.	NHI discussions picked up again post-COVID-19, and at the end of 2022, the Parliamentary portfolio committee and the National Department of Health were deliberating the issues raised during public hearings and the inputs received from medical schemes. See page 34 for a detailed description of the regulatory process, anticipated impacts of the NHI and Bonitas's response.
OUR STRATEGIC RESPONSE	

Boost business development

Apply best practice governance

STRATEGIC RISK AND OPPORTUNITY	CONTEXT AND CAUSES
Increasing regulation or regulatory changes and/or the lack thereof can impact Bonitas.	Bonitas continues to implement the requirements set out in new CMS Circulars. This year saw a continued focus on requirements flowing from the Protection of Personal Information Act (POPIA), and we are in the process of reviewing key contracts for adherence to this legislation. We await clarity from the CMS on Circular 24 of 2021 – pertaining to the selection process of Designated Service Providers (DSPs) and matters relating to the imposition of excessive co-payments – and will then define a strategy to approach this matter. The CMS had undertaken to provide this clarity by 30 September 2021, but no further updates have been provided. We also provided input on the LCBO Framework Draft Report and Framework Risk Assessment Draft, and await feedback.

OUR STRATEGIC RESPONSE

Boost business development | Integrate the value chain | Apply best practice governance

STRATEGIC RISK AND OPPORTUNITY	CONTEXT AND CAUSES
Cyber security threats and vulnerabilities, inadequate or insufficient I&T control, and system instability can have financial, operational, strategic and reputational impacts.	The I&T Steering Committee is responsible to provide oversight, governance, risk identification and monitoring for all Bonitas IT-related functions, inclusive of primary contracted service providers. Internal and external audits were conducted, as well as penetration testing. There is ongoing monitoring of execution against contracts, and in 2023 we will continue reviewing outcomes-based measures and SLAs. See page 84 for a detailed understanding of the Information and Technology structure and operating model.

OUR STRATEGIC RESPONSE

Boost business development | Be a strategic purchaser | Connect with the customer | Integrate the value chain | Apply best practice governance | Create value through innovation

STRATEGIC RISK AND OPPORTUNITY	CONTEXT AND CAUSES
Bonitas's sustainability and stability rely on optimal financial performance, and adequate business continuity and disaster recovery processes.	On 25 February 2022, the Investment Committee revised the strategic asset allocation, which was subsequently approved by the Board. An updated Investment Policy Statement now caters for derivatives to protect Bonitas against volatility in the short term. The Investment Committee continues to monitor and track the performance of the investment portfolio, with input and guidance from our investment consultant, RisCura Solutions. Business continuity forms part of our SLAs with primary contracted service providers, and they successfully conducted their mandatory business continuity tests in late 2022. Bonitas's Business Continuity and Disaster Recovery Management Policy and Plan were approved by the Board on 19 April 2022 and are being implemented.

OUR STRATEGIC RESPONSE

Boost business development | Be a strategic purchaser | Connect with the customer | Integrate the value chain | Apply best practice governance | Optimise investment returns

STRATEGIC RISK AND OPPORTUNITY	CONTEXT AND CAUSES
Bonitas relies on service provider partnerships, which can be at risk when third parties fail to deliver against contracts, SLAs or outcomes-based measures.	Service levels are monitored monthly and the relevant corrective measures are implemented. Where service providers fail to meet some SLA requirements, they are given the opportunity to rectify the identified issues. Responses and mitigation plans are overseen by the Managed Healthcare Committee and if appropriate, an independent review of the SLA is commissioned.

OUR STRATEGIC RESPONSE

Integrate the value chain

Connect with the customer

STRATEGIC RISK AND OPPORTUNITY	CONTEXT AND CAUSES
The Bonitas brand and reputation can be affected by negative publicity and industry issues such as the Section 59 and CMS inspection reports.	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.

OUR STRATEGIC RESPONSE

Connect with the customer

Apply best practice governance

STRATEGIC RISK AND OPPORTUNITY	CONTEXT AND CAUSES
Major competitors or new market entrants can disrupt and threaten Bonitas's sustainability.	Obtaining market intelligence on competitors and new entrants in the healthcare sector can be challenging, as there is often a lack of transparency in terms of value positioning, products, costs and pricing – particularly considering the increases in healthcare and medical costs. Bonitas requires such market intelligence to keep pace with competition and innovation, and to continue growing its member base. We therefore commission our own competitor, member and market research where relevant, and ensure that strategies are aligned to research results.

OUR STRATEGIC RESPONSE

Boost business development

Apply best practice governance

STRATEGIC RISK AND OPPORTUNITY	CONTEXT AND CAUSES
To be sustainable, Bonitas has to ensure membership growth, retention and ensure affordability for members.	Bonitas strives to increase value for members, for example by increases that are lower than the rest of the market. In benefit design and pricing, we evaluate affordability and competitiveness per option and per category to achieve economy of scale in growth options. We continuously enhance the new member experience, including the ease of joining. We implemented a segmented broker strategy to improve support and provide them with a range of value-added products to aid member retention and create new business opportunities. This year we revised the retention mandate to improve our member risk profile, resulting in a better recovery rate. The wellness strategy was reviewed and a wellness benefit included in our offering to attract young and healthy beneficiaries.

OUR STRATEGIC RESPONSE

Boost business development

Connect with the customer

MANAGEMENT OF INSURANCE RISK

Our priority is to manage the healthcare risk exposure of our members and their dependents. Since the extent of this risk relates directly to the health of our members and beneficiaries, we have to mitigate uncertainty around 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 that requires Bonitas to pay PMBs at total invoice price and not according to benefit limits and sub-limits. Refer to note 21 of the annual financial statements for more information.

RISK TRANSFER ARRANGEMENTS

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

Bonitas has risk transfer arrangements with the following service providers, who all have a national footprint across South Africa:

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

* *Following an RFP tender process, the contract for ambulance and emergency services with ER24 was terminated on 30 April 2022, and Europ Assistance was appointed with effect from 1 May 2022.*

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 continued 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.

In 2022 the Board approved a capitation agreement on the BonCap option which will see a risk transfer arrangement for non-hospital costs. Private Health Administrators (Pty) Ltd (PHA) was appointed as the service provider, and pricing and contracting negotiations were finalised in January 2023.

Administration and managed care services for the BonCap option will also be performed by PHA.

Although the BonCap option has grown gradually, it has presented challenges as a result of high claims ratios exceeding 100% caused by the high number of direct paying members, pensioner ratio and PMBs, among others. The appointment of PHA affords Bonitas an opportunity to pilot the impact of contracting with an alternative administrator and managed care service providers at an option level. This will potentially assist us to improve the market competitiveness and long-term sustainability of loss-making options.

In 2023 Bonitas is launching a capitation pilot programme with HearConnect for sourcing hearing aids and driving hearing education and awareness.

Many of the capitation providers proposed fee increases from 2022 to 2023 which are in line with inflation.

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

PERFORMANCE

Mr OJ Komane
Chairperson

MESSAGE FROM THE CHAIRPERSON

Mr OJ Komane, who has been on the Board of Bonitas in different roles since 2016, highlights the key topics and Board deliberations in 2022.

The Board ensured that the benefits and product design process delivered attractive options for current and potential members.	It is always a Board priority to ensure that the annual benefit and product design process is completed successfully with input from a range of committees, service providers and specialists. Bonitas saw more young people joining as members this year following changes to our plans implemented in the past year. This had a positive impact on our membership demographic profile. We also enhanced some options which resulted in good membership traction.
We ensured affordable average contribution increases given the economic and social pressures that emerged during the year.	We are mindful of members' circumstances and lived experiences, especially when the going gets tough. As a result, the Board decided to limit the 2023 increases below inflation, directly addressing the affordability challenge. We also took the unprecedented step of deferring the implementation of these increases to April 2023, to provide members with some relief at the height of the economic hardship.
We were able to transform loss-making options into surplus-making options.	The Board is often confronted with trade-offs where we have to balance our members' short-term needs with the long-term sustainability of the Scheme. Loss-making options are an example of this, as they often provide an affordable alternative for members, but can be a risk to the solvency of the Scheme. In 2021 Bonitas had seven loss-making options, which were effectively reduced to six in 2022. This followed guidance and oversight from the Board, ensuring that loss-making options were reviewed during the pricing process, and corrective measures were considered. 50% of our plans delivered a net healthcare surplus in 2022. On a net surplus level (after investment income), eight of our 12 registered benefit options reported surpluses.
The managed healthcare programmes featured significant improvements to secure maximum satisfaction for Bonitas members.	The Board is responsible for ensuring that Bonitas delivers affordable, sustainable and quality healthcare. We want our members to join managed healthcare programmes and be satisfied with the outcomes achieved. This year we developed a managed healthcare strategy and will track our success in delivering quality service to members. This includes improved preventative healthcare initiatives.
The responsible use of reserves remains critical to Bonitas's long-term sustainability.	The Board provides oversight and ensures that Bonitas's approved strategy is implemented. We monitor progress and make sure that the strategy remains relevant and responsive to stakeholder needs. Our strategy includes specific financial objectives that consider adequate provision for possible long-term adverse claims experiences and requires that we maintain a financially sound position by managing reserves responsibly. One of the areas where Bonitas made good progress again this year was in negotiating low increase fees with service providers, resulting in cost savings on non-healthcare expenses and increasing reserves. The Board regularly reviews the investment strategy to ensure a good return on investment in pursuit of increasing reserves. We also monitor claims closely and assess the IBNR provision to mitigate possible high claims that can put Bonitas's reserves at risk. Read more about our future position on reserves in the Principal Officers' report from page 52 and the financial and operational results from page 55.
Continued stakeholder engagement and feedback keep the Board in tune with new risks and opportunities.	The Board receives regular feedback from all committees and management who engage with stakeholders. Bonitas's outsourced model relies on quality partnerships that serve our members and the Scheme according to defined standards and desired outcomes. We continued building and refining Bonitas's networks. This year, the Board paid specific attention to our GP and specialist doctor networks where we addressed member issues related to cost and co-payments. We also saw an improvement in broker communication via roadshows.
Board priorities for 2023.	• An effective review process for benefits and product design will remain a priority. • The Board will monitor the implementation of the managed healthcare strategy to ensure improved quality of healthcare programmes. • We plan to further optimise GP, specialist and hospital networks. • The Board will focus on maintaining a good membership profile for Bonitas through our outsourced administration model. • BBBEE remains a key focus area for the BOT as part of its fiduciary duties in promoting its corporate stewardship.

REPORT OF THE PRINCIPAL OFFICER

Mr LR Callakoppen
Principal Officer

OVERVIEW

The daily lives of South Africans have become a series of difficulties and distresses. Global events reach us on the streets, where rising food and fuel costs, combined with loadshedding, relentlessly test our resilience and belief in a better future.

In this environment, Bonitas can make a difference for our members. We are committed to ensuring affordability and access to quality healthcare for our members, and growing our membership to be there for more South Africans and their dependents.

To demonstrate our commitment, we were able to keep the average contribution increase across our plans to well below CPI in 2023, and introduced our first-ever contribution deferral. Increases will only be applied from 1 April 2023.

The affordability pressures facing South Africans necessitate that we find the right balance between Bonitas's short- and long-term sustainability. We recognise that the economic situation is likely to stifle membership growth and increase retention risk, but simultaneously we must manage cost increases across the value chain, and expand access to quality healthcare for more South Africans.

While it is difficult to succeed in an uncertain economic and regulatory environment, we remain committed to acting in the best interests of our members through a well-considered investment strategy, and an increasingly agile approach to the execution of our strategy.

HEALTHCARE INFLATION

One of the key cost drivers in medical aid contributions is healthcare inflation, which is typically around 4% higher than CPI. The reasons for this include both global and local factors. Globally, the cost of raw materials, consumables and medical technology is on the rise, and these costs are exacerbated locally by exchange rate impacts and a shortage of skilled medical professionals.

Bonitas addresses healthcare inflation through two of the pillars in our strategy – strategic purchasing and integration of the value chain.

STRATEGIC PURCHASING AND NETWORK ALIGNMENT

We continue to optimise the Bonitas network of hospitals and other service providers. We negotiated reasonable tariff increases with hospital groups in 2022 and identified key specialists and non-specialists to be added to the Bonitas network to increase alignment with our hospital network. These medical professionals will be onboarded during 2023.

Using networks and network alignment is a key way in which Bonitas manages costs. Since we evaluate the quality of all service providers on our network, there is a reduction in healthcare risk for Bonitas (and for our members). Since Bonitas manages the care pathway, we are able to mitigate passing substantial increases to members.

VALUE CHAIN INTEGRATION AND OUTCOMES-BASED MEASURES

Integrating the value chain is another key optimisation tool, and in this regard, our outcomes-based measures are yielding positive results. Over the past few years, Bonitas has been moving from a transactional to an outcomes-based model for measuring the quality of healthcare provision.

Traditionally, healthcare service providers are paid based on the service they provide, such as appointments, treatments, tests ordered and prescriptions given. This 'fee-for-service' model is simple to track and bill but does not consider whether or not the care provided is effective.

In contrast, in an outcomes-based model (also called value-based healthcare) the service provider is compensated based on the quality of care delivered to patients and their healthcare outcomes, using metrics such as hospital readmissions, patient engagements and patient-reported outcomes.

Although it is likely to take many years for Bonitas (and the industry globally and locally) to shift completely to value-based healthcare, our outcome-based measures with service providers stipulate the key standards and/or expectations we require them to meet to ensure that members enjoy quality and affordable healthcare.

For example, before being contracted to our network, GPs must agree the quality of healthcare we expect of them, as well as what is allowed in terms of pricing. We also produce a 'report card' for each GP in which we compare their markers and indicators to those of their peers – for example, the types of diseases diagnosed and the percentage of the GP's population being admitted to hospitals. Using this data, GPs can evaluate and improve their treatment options, and Bonitas is able to ensure the quality of healthcare provided on our GP network.

TRANSITION TO HEALTHCARE PARTNER

Bonitas's shift from a transactional to an outcomes-based healthcare model reflects a larger transition from being a risk partner to taking up a critical role as healthcare partner.

The role of a medical scheme can no longer be one of a fund that collects member contributions and pays claims. This is partly because South African regulations prohibit us from risk profiling and anti-selection – unlike insurers, medical schemes are required to accept any person who wishes to join, regardless of their risk profile.

Over and above the regulatory requirements, Bonitas is a medical aid for all South Africans – not just certain segments or income groups. We have a responsibility to be proactive in terms of guiding existing and potential members on the road towards better health and wellbeing, and to do this we need to take cognisance of all socioeconomic factors impacting South Africans. Issues such as poverty, unemployment, mental health and gender-based violence impact and are impacted by healthcare, and must therefore be considered within the broader value chain.

STRATEGY AND AGILITY

South Africa's socioeconomic challenges – as well as global economic uncertainty – make it more difficult than ever to accurately predict the future and execute the appropriate strategy. In this volatile environment, success is dependent on the strength of our leadership, and our ability to be resilient, responsive and agile.

Bonitas is fortunate to have a skilled, experienced Board. Our trustees critically evaluate our investment strategy, the performance of all service providers, and the recommendations made by Board Committees and Executive Management. They guide us in striking the right balance between business sustainability and ensuring affordability for our members.

The success of our Board was evidenced in the successful amalgamation with NMAS, which required us to demonstrate the quality of our governance and compliance. Looking to the future, amalgamations remain central to our strategy for growth, and we are engaging those schemes that we believe would benefit from amalgamation.

We are in a position of strength. Bonitas's reputation and brand continued to gain recognition through awards such as the BHF Titanium Award for excellence in operational performance and by being named as the Medical Scheme of the Year by News24 at their inaugural Business Awards in March 2023.

REGULATORY UNCERTAINTIES

The Bonitas Board also provided significant oversight in terms of navigating regulatory uncertainties. We await the final inspection report from the CMS and the final report on the Section 59 Investigation into the alleged racial profiling of medical practitioners by medical schemes.

In terms of the NHI draft Bill, we have done extensive scenario planning over the past years to consider both best- and worst-case scenarios for Bonitas. A significant focus for us is creating understanding and awareness on the part of our members, and driving influence on the proposed Bill.

We remain unequivocally in favour of the principle of universal healthcare but believe that a collaborative and cohesive approach is required to draft a Bill that is fit for purpose for our country and citizens.

Serving approximately nine million South Africans, the private healthcare sector plays a significant role in alleviating pressure on the public sector. We remain firm in our conviction that an approach to universal healthcare that exists in harmony with the private sector is most likely to result in access to quality healthcare for all South Africans.

OUTLOOK FOR 2023

Our agile approach to the execution of our strategy is likely to stand us in good stead in 2023 as we expect further volatility in local and international markets. For our members, affordability is likely to remain front of mind. Medical aid contributions have shifted from being a grudge purchase to a necessary monthly budget item during COVID-19, but Bonitas still needs to deliver benefit enrichment for our members – which we can do through our value-added offerings, healthy reserves and solvency level.

We anticipate continued challenges in growing our membership numbers considering the low level of expected economic growth. Our approach to membership growth and retention is founded on the quality of service we provide. We will continue implementing, refining and evaluating the outcomes-based measures of our service providers to ensure quality healthcare at affordable rates.

We are also placing a significant focus on member and stakeholder experiences in 2023. Although the Deloitte Transactional and Relational Governance Review demonstrated that we have unlocked significant value in terms of managed healthcare, we scored below expectation in some customer service indicators – specifically our net promoter score and Customer Service Aptitude Profile (CSAP) score. Our focus going forward is therefore to critically review our existing business models to ensure process, system and people improvement, to enable Bonitas to outperform its competitors in terms of service excellence.

I&T governance and management will continue to receive attention. The gathering and analysis of healthcare data is a powerful tool for managing healthcare risk, and informing and educating our members. However, these activities must be undertaken with due consideration to data protection and cyber security, especially considering the sensitive nature of much of the data in our care. We will therefore continue identifying innovative but responsible ways of leveraging data to improve healthcare outcomes for our members.

Given the unpredictability of our operating environment, we will continue to prioritise sound corporate governance and risk management. Our risk universe is ever-changing, and the regular scenario and sensitivity analyses Bonitas performs help us set the direction for the road ahead, knowing that we can pivot as needed to ensure that we continue delivering on our value proposition.

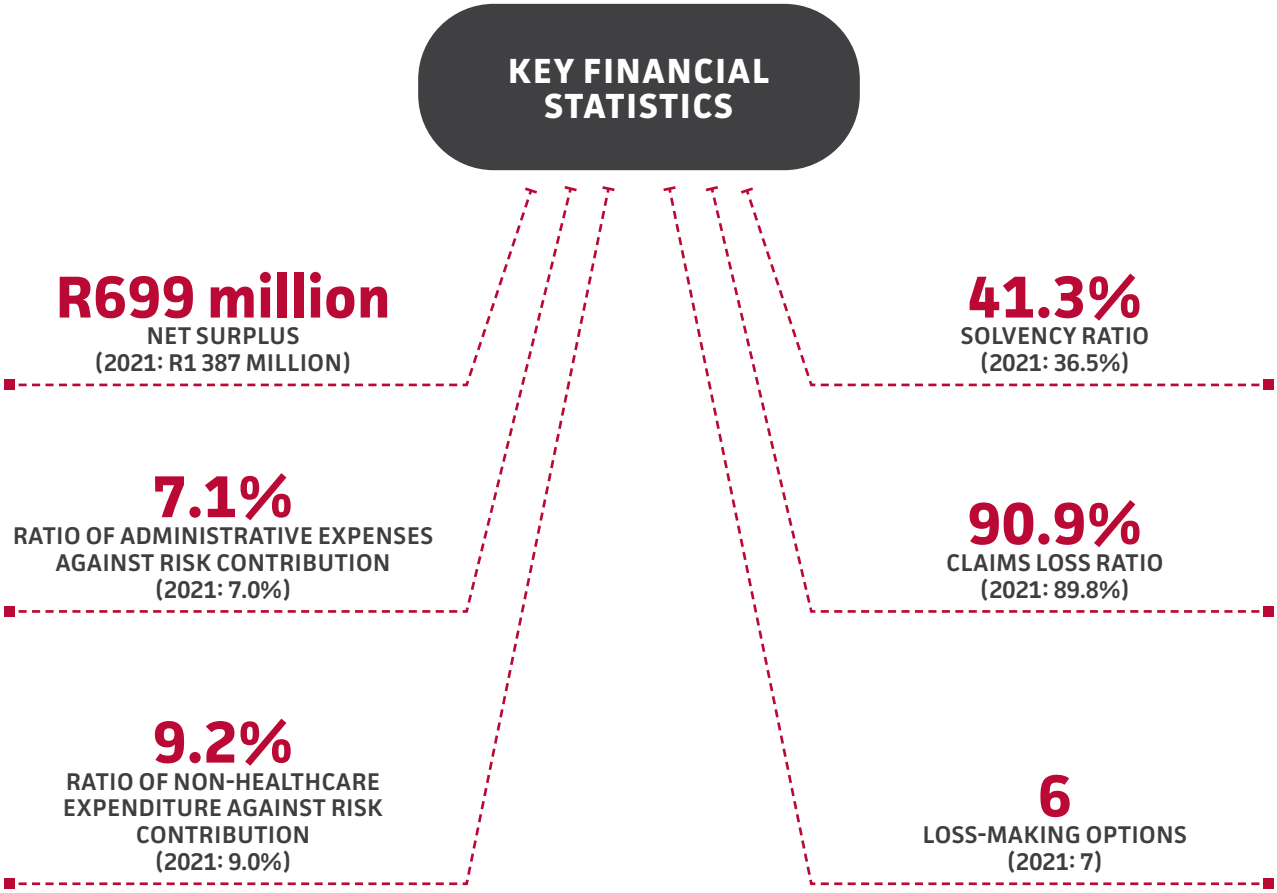
Mr LR Callakoppen
Principal Officer

21 April 2023

FINANCIAL AND OPERATIONAL RESULTS

DRIVERS FOR FINANCIAL HEALTH

Membership growth and contributions	Healthy gross acquisitions of 62 031 (including the NMAS amalgamation), but organic growth of 47 446 was lower than our internal target of 48 000
Investment performance	Although we did not meet our investment target of CPI+3.5% across our portfolio, the budget was exceeded in terms of rand value – a total investment income of R781 million compared to R1.2 billion in 2021
Claims trends	Lower than expected claims utilisation and limited new COVID-19 cases were a significant contributor to positive financial results
Cost-saving initiatives	Significant savings impact following successful collective bargaining and negotiation with hospital groups, targeted initiatives on loss-making options and successful disease management
Fraud, waste and abuse	First year in which the amount spent on our FWA programme yielded a positive cash return, with banked recoveries of R55.5 million
Reserves and contributions	Reserves remain healthy, leading to an average contribution increase for 2023 of 4.7% (inflation rate of 7.2% as at December 2022) which includes a three-month deferral in contribution increases



OVERVIEW

Following two exceptionally strong years for Bonitas, our financial results for 2022 reflect a difficult economic environment where our members and networks were grappling with increased costs on all fronts. Recognising these challenges, Bonitas is in the fortunate position – due to the prudent long-term management of reserves – to use our financial strength to cushion members against hardship while still delivering quality healthcare and peace of mind.

In 2022, risk contribution income increased by 5.8% to R19.2 billion whereas healthcare expenditure increased by 7% following the peak of COVID-19. At R14 million, the net healthcare deficit for 2022 is R225 million lower than in 2021 given a normalisation of claims trends.

Although investment performance was lower than that achieved in 2021, we still ended 2022 with a total investment portfolio value (excluding cash and cash equivalents) of R9.97 billion and a solvency level of 41.3%, well above the minimum required level of 25%.

STATEMENT OF COMPREHENSIVE INCOME

for the year ended 31 December 2022

	Notes	**2022 R'000**	2021 R'000
Risk contribution income	13	**19 183 315**	18 138 159
Relevant healthcare expenditure	14	**(17 439 033)**	(16 289 636)
Net claims incurred	14.1	**(17 032 156)**	(15 851 053)
Risk claims incurred		**(17 107 121)**	(15 913 500)
Third party claim recoveries		**74 965**	62 447
Accredited managed healthcare services	14.2	**(591 335)**	(549 251)
Net income on risk transfer arrangements	14.3	**184 458**	110 668
Risk transfer arrangement fees/premiums paid		**(1 547 984)**	(1 531 348)
Recoveries from risk transfer arrangements		**1 732 442**	1 642 016
Gross healthcare result		**1 744 282**	1 848 523
Broker service fees		**(381 799)**	(360 620)
Administrative expenditure	15	**(1 370 660)**	(1 276 920)
Net impairment losses on healthcare receivables	16	**(5 977)**	(63)
Net healthcare result		**(14 154)**	210 920
Other income		**813 422**	1 243 833
Investment income – Scheme	17	**780 862**	1 221 652
Change in fair value of investment property	17	**1 500**	(700)
Sundry income	18	**31 060**	22 881
Other expenditure		**(100 250)**	(67 262)
Asset management fees		**(54 846)**	(38 675)
Interest expense	11/4.2	**(40 644)**	(24 010)
Operating expenses on rental of investment property		**(4 760)**	(4 577)
Surplus for the year		**699 018**	1 387 491
Total comprehensive income for the year		**699 018**	1 387 491

MEMBERSHIP AND RISK CONTRIBUTION INCOME

Membership growth and retention are the cornerstones of Bonitas's long-term sustainability and short-term performance. We had 47 446 new members joining Bonitas, and retained 49% of controllable terminations against a target of 30%. 48 387 members terminated their membership in 2022, compared to 44 418 in 2021.

The amalgamation with NMAS was concluded on 1 January 2022 and Bonitas welcomed new members to the fold. Due to NMAS deciding on a split-risk option for medical schemes only 58% of the total members chose to join Bonitas, with the rest electing alternative medical scheme options. Despite the fact that the NMAS members who chose to join Bonitas had a higher age profile, these members demonstrated a profitable claims ratio at the end of 2022, which is testament to our success in terms of designing appropriate benefit plans and applying effective managed care. The bulk of NMAS members joined the BonSave, Standard and BonFit Select options.

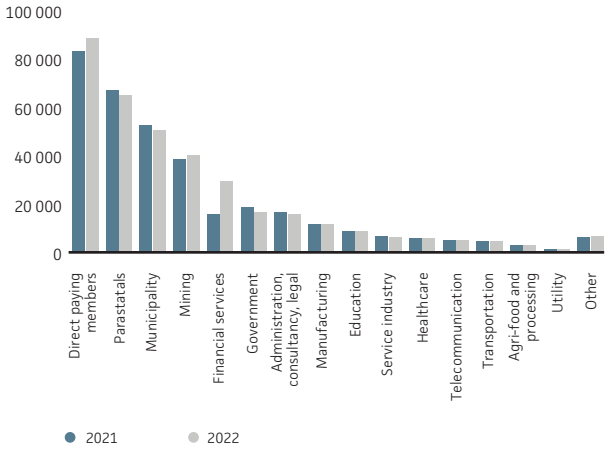
New organic member acquisitions were lower than expected, but we reported impressive growth on our new Edge plans. BonCap growth did not materialise as expected, and the option increased by only 353 principal members in 2022. New membership from corporate groups did not meet expectations as a result of economic hardships in both the private and public sector, but these sectors will remain a focus area in 2023.

The plateau in terms of new member growth reflects South Africa's challenging economic climate. In 2022 the South African economy grew by only 2.5% and the unemployment rate hovered between 32% and 34%. Bonitas acknowledges the plight of our members and will continue to use our bolstered reserves to ensure affordability and accessibility to quality healthcare.

Risk contribution income increased by 5.8% to R19.2 billion (2021: R18.1 billion). Of the total lives covered by Bonitas, 11% (2021: 10.3%) were 65 years and older. The total number of beneficiaries increased by 14 282 (2021: 276). Our principal membership grew by 4%, and our total beneficiaries (lives covered) increased by 2.4%. This is largely due to declining family sizes and a reduction in dependant ratios, which is driven by affordability.

The buying-down trend improved dramatically compared to 2021 with 5 242 (2021: 6 629) members moving to lower-cost options and 5 617 (2021: 4 459) moving to higher-cost options during the period December 2022 to January 2023. This reversed the trend of reporting net buy-downs, as Bonitas experienced a net buy-up of 375 members.

MEMBERSHIP DISTRIBUTION BY INDUSTRY



PLAN PRICING AND AFFORDABILITY

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

- Conducting market value analyses
- Investigating how customers responded to our benefits, pricing, rules and restrictions
- Obtaining broker feedback
- Comparing projected claims and benefit utilisation to actuals
- Identifying the needs of corporate clients
- Eliciting the views of the CMS

Any potential benefit changes are assessed against the following themes, which support the Bonitas strategic pillars:

Strategic positioning/ Unique value proposition

Retention and growth by target market

Improving efficiency and quality

Strategic industry disruptors

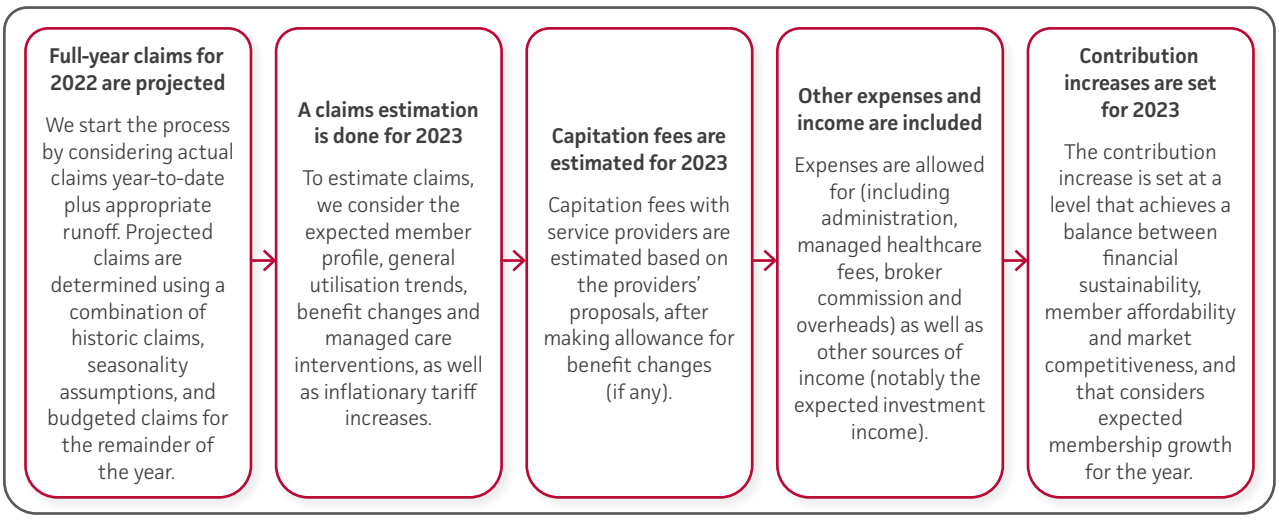
Maintain affordability

Limited changes to plans and benefits were implemented for 2023, but focus was applied to network optimisation. Bonitas will aim to maintain member affordability through minimising contribution increases and increasing value to members. The two new Edge options, BonStart and BonStart Plus, showed strong growth in 2022.

We continuously review the performance of our plans, focusing on making options more attractive relative to other options available in the market, and simplifying benefits where members find these complicated. This year, for example, we restructured the day-to-day benefits for some plans so members can use these for a wider range of services and increased savings allocations on BonSave.

CMS Circular 44 of 2022 requested medical schemes to keep contribution increases for 2023 below CPI, and in October 2022 we announced an average increase of only 5.9% (4.7% weighted average after deferral) across all plans compared to an inflation rate of 7.2% as at December 2022. A contribution deferral for the first three months of 2023 applied, and increases would only be effective on 1 April 2023.

This is the first time Bonitas instituted a contribution deferral. In 2022 the Board decided to purposefully reduce reserves in an effort to increase affordability for new and potential members. The deferral will reduce our reserves by an estimated R300 million.



Even a robust process like ours is still subject to assumptions, uncertainties and risk, including higher levels of inflation, higher negotiated tariffs for hospital groups or unexpected fluctuations in the exchange rate. Our pricing process considers the next five years while determining the most optimal price increases for the next 12 months.

HEALTHCARE EXPENDITURE

CLAIMS TRENDS

South Africa entered its fourth COVID-19 wave towards the end of 2021 and early 2022. Since the less-severe Omicron variant dominated this wave, COVID-related claims remained lower than anticipated. Bonitas expected a significant increase in claims for non-elective surgeries in 2022 since many such surgeries had been postponed during the pandemic. However, there was a lower uptake in elective procedures than expected.

Overall, net claims were 3.0% higher per member per month than in 2021. Claims included COVID-19 costs of R425.9 million (2021: R2.6 billion).

Net claims increased by 7.5% to R17 billion (2021: R15.9 billion) and were impacted by factors such as an increase in elective procedures, infectious disease admissions, and injury and trauma admissions to similar levels as before the pandemic. Hospital costs were R6.8 billion, up 4.4% against 2021.

The net claims ratio for the year ended on 90.9% (2021: 89.8%), and excluding COVID-19 costs the ratio was 88.7% (2021: 75.7%).

COST MANAGEMENT INTERVENTIONS

Costs incurred by accredited managed healthcare services increased by 7.7% (2021: 0.4%), and managed care initiatives realised an estimated reduction in healthcare costs of R447 million (2021: R407 million). This includes R260 million (2021: R198 million) in hospital costs following another successful collective bargaining process with hospitals.

The gross healthcare result at R1.7 billion showed a 5.6% decrease compared to 2021, mainly due to increased hospitalisation rates.

Of particular significance in 2022 was the value-for-money rating achieved by Bonitas in Deloitte's Transactional and Relational Governance Review. Every second year, Bonitas commissioned an independent review of (among others) its administration and managed care contracts. The 2022 report found that for every R1.00 Bonitas spends on these contracts, we get R1.78 in value. This represents an increase of 38% over the previous review, which stood at R1.29 (2018). Bonitas is now reporting a value-for-money score that exceeds the industry proxy of R1.59.

We believe that our success in this regard is due in large part to significant strides in managed care protocols, as well as the outcomes-based measures that have been incorporated into our contracts. Read more about outcomes-based measures in the Principal Officer's report from page 52.

Another optimisation initiative in 2022 was the establishment of a Bonitas loss-making option forum to investigate options that have higher-than-usual claims ratios and identify strategies to mitigate losses. Three options were investigated by the forum, and the resulting strategies included:

- Identifying the root causes of hospital admissions to improve preventative and managed care initiatives
- Investigating to ensure that members are on the correct plans, and educating them where necessary on the best plan to meet their needs
- Cost optimisation across the value chain and with all service providers

Following an investigation by the loss-making option forum, it was determined that some members on the BonCap option (where the contribution is based on the member's income) may not be paying the correct contribution amount. Following an income verification process during which members were required to submit proof of their income, member contributions were realigned where required, resulting in a significant improvement to losses in the BonCap option.

The total number of loss-making options was six out of 12 registered benefit options in 2022, compared to seven out of 11 registered benefit options in 2021.

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. We aim to maintain the non-healthcare expenditure as a percentage of risk contribution income at 9% or below, with 9.16% reported for 2022.

Administrator fees increased by 10.7% to R1.01 billion (2021: R910 million) as a result of net membership growth of 4% and CPI-related fee increases. Broker fees increased by 6% to R382 million. Bonitas's overhead expenses increased by only 2%.

In 2022 Bonitas spent R49 million on its FWA programme with Medscheme, and for the first year ever we saw banked recoveries in excess of that amount at R55 million. It is important to note that banked recoveries represent a small portion of the actual savings emanating from successful FWA detection and prevention, as service providers who engage in FWA are likely to continue doing so if they are not held to account.

Bonitas has estimated a saving of R1.1 billion from change in behaviour since the commencement of our FWA programme in 2016. Read more about FWA on pages 42 and 43.

STATEMENT OF FINANCIAL POSITION

at 31 December 2022

	Notes	**2022 R'000**	2021 R'000
ASSETS			
Property and equipment	4	**7 390**	4 231
Investment properties	5	**78 500**	77 000
Financial assets held at fair value through profit or loss	6	**4 892 220**	4 784 072
Non-current assets		**4 978 110**	4 865 303
Financial assets held at fair value through profit or loss	6	**5 004 190**	3 461 898
Insurance, trade and other receivables	7	**705 285**	706 417
Cash and cash equivalents	8	**646 015**	766 465
Current assets		**6 355 490**	4 934 780
Total assets		**11 333 600**	9 800 083
MEMBERS' FUNDS AND LIABILITIES			
Accumulated funds		**8 759 140**	7 447 331
Members' funds		**8 759 140**	7 447 331
Lease liability	4.2	**4 342**	–
Long-term employee benefit obligation	9	**3 449**	–
Non-current liabilities		**7 791**	–
Outstanding risk claims provision	10	**960 490**	904 350
Personal medical savings accounts liability	11.1	**1 016 135**	894 037
Insurance, trade and other payables	12	**588 064**	551 318
Lease liability	4.2	**1 980**	3 047
Current liabilities		**2 566 669**	2 352 752
Total Members' funds and liabilities		**11 333 600**	9 800 083

SURPLUS

Bonitas reported another healthy surplus of R699 million (2021: R1.39 billion).

As per our intent to support members, solvency levels will reduce in the next three years. Over the 2023 financial year, we plan to start allocating reserves built up during the pandemic to offer members lower annual contribution increases and improved benefits.

INVESTMENT PERFORMANCE

Investment results in 2022 were satisfactory in a volatile and unpredictable market, with a composite return of 7.2% (2021: 16.2%) on our investment portfolio. This was on the back of strong reserves, and Bonitas increasing our investment risk appetite. We slightly increased our allocation in equities in 2022, which will be reconsidered in early 2023.

Despite the impact of rising inflation, low investor confidence and unprecedented loadshedding, the Scheme was able to deliver a return exceeding inflation in 2022. Although we did not achieve our investment target of CPI+3.5% across our portfolio, we exceeded the target in terms of rand value, reporting an investment income of R781 million. This is due primarily to strong operational surpluses that were ploughed back into our investment portfolio during the course of the year, and impressive returns generated from Bonitas's asset managers.

The market value of Bonitas's investment portfolio, excluding cash and cash equivalents, was R9.97 billion at 31 December 2022 (2021: R8.32 billion), representing growth of 20%.

SOLVENCY RATIO

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 provides consulting on 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.

	2022 R'000	2021 R'000
Members' funds per the statement of financial position	**8 759 140**	7 447 331
Adjusted for:		
Regulation 29 exclusion of unrealised gains on remeasurement of investments and investment property to fair value*	**(490 628)**	(558 986)
Accumulated funds per Regulation 29	**8 268 512**	6 888 345
Gross contributions (note 13)	**20 027 822**	18 887 490
Solvency ratio (%)	**41.29%**	36.47%
Cumulative net (losses)/gains on remeasurement to fair value of investments are calculated as follows:		
At beginning of year	**539 212**	(15 548)
Net (losses)/gains on remeasurement to fair value of financial instruments included in accumulated funds	**(69 858)**	554 760
At end of year	**469 354**	539 212
Cumulative net gains on remeasurement to fair value of investment properties are calculated as follows:		
At beginning of year	**19 774**	20 474
Movement in unrealised gains on remeasurement to fair value of investment properties included in accumulated funds	**1 500**	(700)
At end of year	**21 274**	19 774
* ***Cumulative net gains on remeasurement of investments and investment property at the end of the year***	**490 628**	558 986

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 41.3% (2021: 36.5%). Our reserves remain healthy and significantly higher than the regulatory requirement of 25%.

Given the current and forecasted economic climate, we expect that our members will be under continued financial strain during 2023. Since our solvency position is comfortably higher than the statutory minimum, Bonitas is in a position to target a lower level of surplus in 2023 and still remain above the statutory minimum solvency level, while remaining cognisant of the longer-term impacts of a reduced surplus.

OUTSTANDING CLAIMS PROVISION

The outstanding claims reserve for 2022 was R960 million (2021: R904.3 million), which represents 5.5% of relevant healthcare expenditure. Provisions have mainly been in the hospital and specialist categories.

Included in incurred but not reported (IBNR) is a provision of R28 million for outstanding COVID-19 vaccine claims expected from the public sector.

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 with recommendations from our actuary.

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES

for the year ended 31 December 2022

R'000	Notes	Accumulated funds R'000	Total R'000
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
Total comprehensive income		**1 311 809**	**1 311 809**
Surplus for the year		**699 018**	**699 018**
Reserves acquired through amalgamation with Nedgroup Medical Aid Scheme	28	**612 791**	**612 791**
Balance as at 31 December 2022		**8 759 140**	**8 759 140**

STATEMENT OF CASH FLOWS

for the year ended 31 December 2022

	Notes	**2022 R'000**	2021 R'000
Cash flows from operating activities			
Cash receipts from members and providers		**20 168 419**	18 911 597
Cash receipts from members – contribution		**20 117 745**	18 800 873
Cash receipts from members and provider – Other		**50 674**	110 724
Cash paid to providers, employees and members		**(20 062 577)**	(18 773 017)
Cash paid to providers and employees – claims		**(18 236 397)**	(17 075 960)
Cash paid to providers and employees – non healthcare expenditure		**(1 732 749)**	(1 641 144)
Cash paid to members – savings plan refunds	11	**(93 431)**	(55 913)
Cash generated by operating activities		**105 842**	138 580
Interest paid	11	**(40 380)**	(23 606)
Interest received	17	**7 075**	4 661
Net cash inflow from operating activities		**72 537**	119 635
Cash flows from investing activities			
Acquisition of property and equipment	4	**(327)**	(103)
Proceeds on disposal of property and equipment	18	**14**	4
Settlement of derivative financial instruments		**–**	(86 373)
Acquisition of financial assets held at fair value through profit or loss	6	**(1 798 938)**	(1 009 999)
Disposal of financial assets held at fair value through profit or loss	6	**1 215 958**	842 104
Interest received	20.1.1	**181 218**	192 641
Dividends received	20.1.2	**180 694**	128 546
Asset management fees	20.1.3	**(53 964)**	(36 766)
Rentals received	20.1.4	**9 400**	9 695
Net cash (outflow)/inflow from investing activities		**(265 945)**	39 749
Cash flows from financing activities			
Lease payments	4.2	**(3 768)**	(4 009)
Net cash outflow from financing activities		**(3 768)**	(4 009)
Net (decrease)/increase in cash and cash equivalents		**(197 176)**	155 375
Net cash acquired on amalgamation	28	**76 726**	–
Cash and cash equivalents at beginning of the year		**766 465**	611 090
Cash and cash equivalents at end of the year		**646 015**	766 465
Analysed as follows:			
Cash and cash equivalents	8	**646 015**	766 465
		646 015	766 465

FUTURE PERFORMANCE EXPECTATIONS

As a result of our strong reserves and solvency ratio, **2023 will be a year of giving back to our members through low contribution increases and enhanced benefits**. To ensure Bonitas's sustainability, this will be balanced with a focus on outcomes-based measures with service providers, value realisation and expanding on our managed care strategy.

To manage the rising cost of healthcare, Bonitas will continue analysing its network of service providers to ensure that members get access to high-quality care at an affordable price. By optimising networks, we are able to limit premium increases, but both service providers and members need to understand the benefits and constraints of this healthcare model. We will therefore be driving awareness among our members, and ensuring that our network continues to meet members' needs.

I&T remains a focus for 2023, and our primary contracted service providers are investing significantly in maintaining and upgrading their systems to ensure stability. These upgrades will decrease the time required to process claims and improve members' experience.

Finally, IFRS 17 (Insurance Contracts) became effective on 1 January 2023 and Bonitas is on track towards full compliance with these requirements in our next report. IFRS 17 will have an impact on some aspects of our reporting – especially the statement of comprehensive income and statement of financial position – but the standard will have no impact on members or their experience with Bonitas.

Mr L Woodhouse
Chief Financial Officer

21 April 2023

OPERATIONAL STATISTICS

Bonitas Medical Fund 2022	**Consolidated total**	**Standard**	**BonSave**	**Primary**
Average number of members during the year (n)	**353 905**	**106 479**	**40 794**	**95 580**
Number of members at 31 December (n)	**353 763**	**104 874**	**40 607**	**95 566**
Average number of beneficiaries during the year (n)	**729 904**	**228 091**	**93 355**	**222 035**
Number of beneficiaries at 31 December (n)	**727 041**	**224 085**	**93 017**	**221 413**
Proportion of dependants at the end of the year (n)	**1.06**	**1.14**	**1.29**	**1.32**
Risk contributions per average member per month (Rands)	**4 517**	**6 548**	**3 783**	**4 099**
Risk contributions per average beneficiary per month (Rands)	**2 190**	**3 057**	**1 653**	**1 764**
Healthcare expenditure per average beneficiary per month (Rands)	**1 991**	**2 741**	**1 410**	**1 560**
Non-healthcare expenditure per average beneficiary per month (Rands)	**201**	**208**	**199**	**190**
Relevant healthcare expenditure as a percentage of gross contributions (%)	**87.1**	**89.7**	**68.9**	**88.4**
Relevant healthcare expenditure as a percentage of risk contributions (%)	**90.9**	**89.7**	**85.3**	**88.4**
Non-healthcare expenditure as a percentage of gross contributions (%)	**8.8**	**6.8**	**9.7**	**10.8**
Average beneficiary age (n)	**35.5**	**39.0**	**32.0**	**30.8**
Pensioner ratio at 31 December (%)	**11.0**	**15.4**	**7.2**	**5.2**
Chronic profile at 31 December (%)	**18.7**	**28.0**	**13.8**	**12.0**

Bonitas Medical Fund 2021	Consolidated total	Standard	BonSave	Primary
Average number of members during the year (n)	340 138	109 448	35 748	93 177
Number of members at 31 December (n)	340 119	107 173	35 618	94 128
Average number of beneficiaries during the year (n)	712 759	238 038	83 516	218 671
Number of beneficiaries at 31 December (n)	709 881	232 592	83 362	220 045
Proportion of dependants at end of the year (n)	1.09	1.17	1.34	1.34
Risk contributions per average member per month (R)	4 444	6 303	3 718	3 940
Risk contributions per average beneficiary per month (R)	2 121	2 898	1 591	1 679
Healthcare expenditure per average beneficiary per month (R)	1 905	2 537	1 359	1 492
Non-healthcare expenditure per average beneficiary per month (R)	191	209	191	186
Relevant healthcare expenditure as a percentage of gross contributions (%)	86.2	87.5	68.9	88.8
Relevant healthcare expenditure as a percentage of risk contributions (%)	89.8	87.5	85.4	88.8
Non-healthcare expenditure as a percentage of gross contributions (%)	8.7	7.2	9.7	11.1
Average beneficiary age (n)	35	38	31	30
Pensioner ratio at 31 December (%)	10.3	13.7	6.8	4.8
Chronic profile at 31 December (%)	18.7	27.2	13.6	11.9

BonCap	BonClassic	BonComp	BonEssential	BonFit	Hospital Std	BonComplete	BonStart	BonStart Plus
56 555	**8 632**	**4 343**	**13 528**	**9 870**	**4 525**	**8 674**	**3 674**	**1 251**
56 823	**8 423**	**4 256**	**13 612**	**10 260**	**4 398**	**8 456**	**4 570**	**1 918**
81 760	**14 941**	**7 342**	**29 856**	**21 287**	**8 333**	**16 826**	**4 066**	**2 012**
81 978	**14 538**	**7 160**	**30 022**	**22 333**	**8 084**	**16 276**	**5 057**	**3 078**
0.44	**0.73**	**0.68**	**1.21**	**1.18**	**0.84**	**0.92**	**0.11**	**0.60**
1 845	**6 996**	**9 645**	**3 173**	**2 808**	**4 297**	**5 839**	**1 450**	**4 260**
1 276	**4 042**	**5 705**	**1 438**	**1 302**	**2 333**	**3 010**	**1 311**	**2 649**
1 319	**4 074**	**6 786**	**1 250**	**1 049**	**2 152**	**2 886**	**812**	**1 010**
182	**266**	**264**	**193**	**206**	**244**	**237**	**220**	**162**
103.4	**86.6**	**96.7**	**87.0**	**67.8**	**92.2**	**81.7**	**62.0**	**75.0**
103.4	**100.8**	**119.0**	**87.0**	**80.5**	**92.2**	**95.9**	**62.0**	**75.0**
14.2	**5.7**	**3.8**	**13.4**	**13.3**	**10.5**	**6.7**	**16.8**	**12.0**
35.7	**53.9**	**55.7**	**36.2**	**29.2**	**49.1**	**45.6**	**33.8**	**27.9**
8.6	**39.0**	**44.3**	**12.0**	**4.6**	**28.9**	**23.4**	**2.8**	**1.9**
11.3	**49.0**	**51.4**	**11.6**	**9.0**	**20.4**	**31.3**	**4.1**	**3.8**

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

GOVERNANCE REPORT

BOARD OF TRUSTEES: PROFILES

MR OJ KOMANE (57) CHAIRPERSON (ELECTED TRUSTEE)

Mr Komane is a non-executive director of Mineworkers Investment Company. 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.

Appointed: 1 June 2021

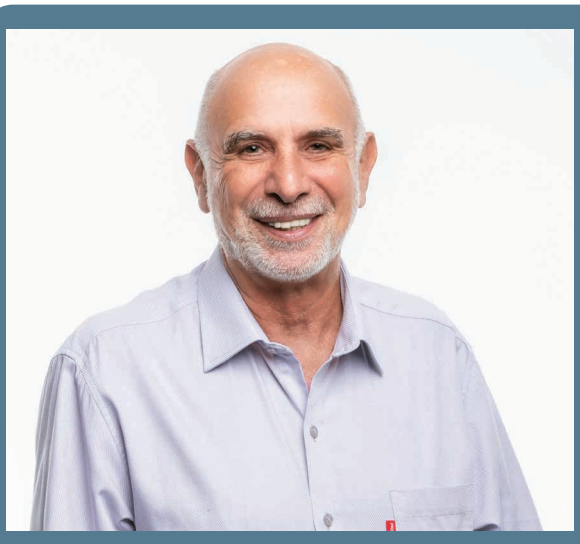
First appointed as Trustee 2 January 2016; appointed Vice-Chairperson with effect from 1 October 2017; appointed Chairperson with effect from 13 March 2019 to 3 December 2020; Trustee term ended with effect 4 January 2021; re-elected as Trustee with effect 1 June 2021 and appointed as Chairperson with effect 28 September 2021; re-appointed as Chairperson with effect 12 August 2022.

MR R COWLIN (68) VICE-CHAIRPERSON (APPOINTED TRUSTEE)

Mr R Cowlin has over thirty years' experience in the medical aid industry and was 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.

Appointed: 5 January 2021

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; appointed as Vice-Chairperson with effect 12 August 2022.



MR J BAGG (70) (APPOINTED 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.

Appointed: 5 October 2022

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 and stepped down as Vice-Chairperson on 12 August 2022; Trustee term ended 31 August 2022 and appointed by the Board with effect 5 October 2022.

DR PW HILL (76) (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.

Appointed: 1 June 2021

MR MG NETSHISAULU (46) (ELECTED TRUSTEE)

Mr MG Netshisaulu holds an LLB and MCom in Taxation. He is a chartered tax adviser and a member of the Compliance Institute of South Africa. He has extensive experience in the tax industry from SARS, as well as corporate and non-profit organisations. He completed a CMS trustee development and inhouse BHF programme. He is currently employed as a Financial Strategic Analyst at the University of South Africa (UNISA). He also serves as UNISA member of the Professional Research Committee. He also previously served as Nehawu Branch Chairperson and Deputy Chairperson.

Appointed: 1 September 2017 and re-elected 9 September 2022

MR PJ RIBBENS (51) (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.

Appointed: 1 July 2019

MR JD NGWANE (66) (ELECTED TRUSTEE)

Mr JD Ngwane was employed by the National Union of Mineworkers as Unit Head: Social Benefits. He assisted union negotiated retirement funds with a process involving harmonising of benefits, resulting in consolidation of funds. His self-insurance experience on retirement funds helped in reducing repudiated permanent disability claims, thus resulting in savings in premiums paid to the insurer and these reverting to the members fund credit. He assisted with medical aid comparisons across the mining industry resulting in the chosen option, benefits and costs being favourable to the members and their families during hard financial times.

Appointed: 1 July 2019

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

MR JR VENTER (41) (ELECTED TRUSTEE)

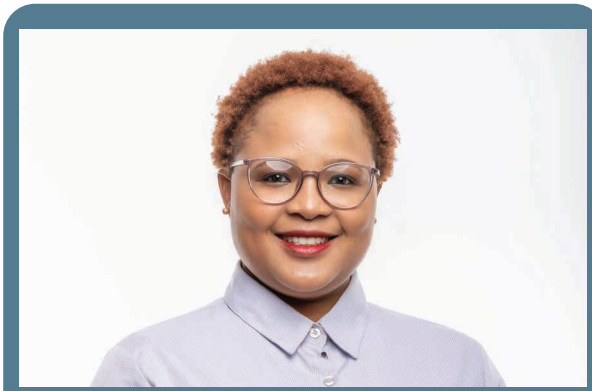
Mr JR Venter holds a BCom from the University of Pretoria. He has extensive experience in business development, corporate governance, strategic member relationship, retention management and financial management. He is employed by the largest technology service provider in Africa with more than 15 years'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

Appointed: 1 July 2019

MS V RIKHOTSO (37) CA(SA) (ELECTED TRUSTEE)

Ms Rikhotso is a chartered accountant registered with the South African Institute of Chartered Accountants. She has 14 years' experience in public and private sector auditing, specialising in financial services, tourism and transport sectors. She is currently a Senior Specialist: Governance, Risk and Compliance at Transnet SOC Ltd. She is responsible for establishing and maintaining sustainably effective internal controls across the Transnet Corporate Centre operating division, identifying areas that require financial and operational improvements in the internal control processes and driving the development of appropriate models/ solutions to sustainably address risks and compliance with applicable legislation.

Appointed: 9 September 2022

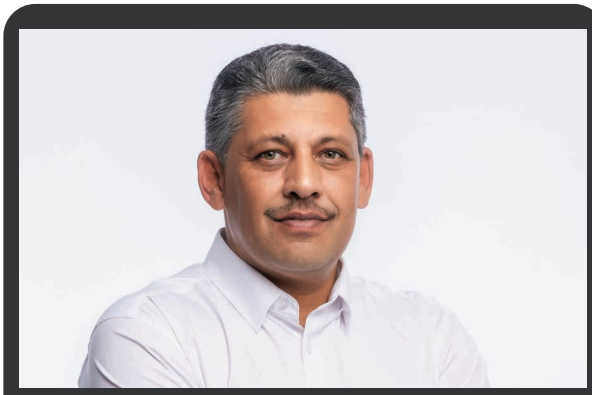


ADV RT MONENE (30) (ELECTED TRUSTEE)

Adv Monene completed her diploma in Law, LLB, and additional module Public International Law at UNISA. She joined the Johannesburg Bar in December 2018 after her studies at UNISA and serving on student representative bodies. In 2017, she Chaired the Student Representative Council at UNISA. In 2022, Adv Monene was appointed as a member of the Board of Trustees of Bonitas Medical Fund. Adv Monene is a general litigator with experience and interest in administrative and public law, medical negligence, constitutional law, human rights law, family law, labour law and regulatory law.

Appointed: 9 September 2022

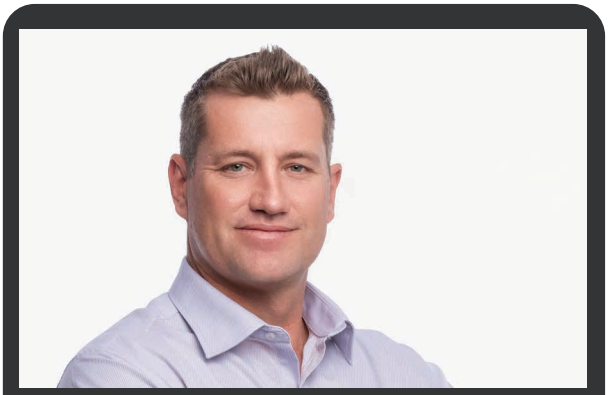
EXECUTIVE MANAGEMENT: PROFILES



MR LR CALLAKOPPEN (46) PRINCIPAL OFFICER

Mr LR Callakoppen holds a Master HR Professional (SA Board for People Practices), MPhil (Human Resource) and Industrial Sociology and Information Science Honours Degree from the University of Johannesburg. He also holds a Global Executive Development Qualification (GEDP) from GIBS and Completed the Professional Trustee Development Programme at Wits Business School. 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 BHF Board and is Chair of the BHF Finance and Audit Committee.

Appointed: 1 May 2019



MR L WOODHOUSE (42) 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: 1 October 2019

DR M MKHATSHWA (64) CLINICAL EXECUTIVE

Dr BM Mkhatshwa is a qualified medical practitioner and holds MBChB, DOH and MBA qualifications. He has over 20 years' work experience in the healthcare industry, both public and private, as a clinician and held various managerial roles. He recently joined the medical scheme's environment.

Appointment: 1 October 2022

GOVERNANCE PRACTICES AND STRUCTURES

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

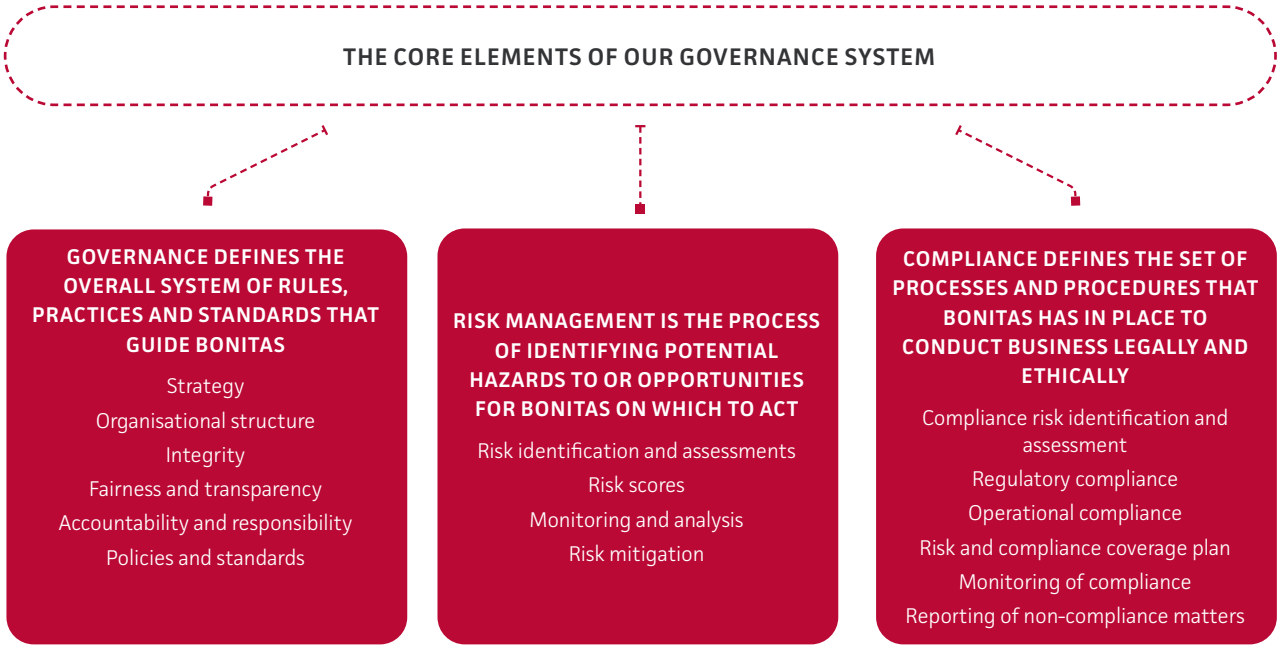
EXECUTIVE SUMMARY OF KEY GOVERNANCE DECISIONS AND DELIBERATIONS FOR 2022

Deloitte Transactional and Relational Governance Review	The Board commissioned Deloitte to do a Transactional and Relational Governance review which indicated that Bonitas improved its overall industry ranking. This was driven by an improvement in growth and compliance, governance and reputation. Bonitas improved from fourth to second-best open medical aid scheme in South Africa. The report included value for money (VFM) scores, which indicated that Bonitas had been creating value for the past two years. The report acknowledged that Bonitas had made great strides in improving contracting with Medscheme through the introduction of outcome-based measures and reduced fees. The Board will continue to evaluate the service provider's performance.
NHI Bill and actions	The Board continuously assesses the potential impact of proposed universal healthcare legislation on the sustainability and structure of the Scheme, particularly regarding uncertainty around the role of medical schemes as well as constitutional and legal implications. The Board continued to track, engage and provide oversight in terms of the NHI Bill. The Board guided Bonitas in ongoing lobbying to ensure a well-governed system with clearly defined roles.
Regulatory engagements, inspections and reports	The main Scheme Rules have been amended and approved and registered with the CMS dated 11 July 2022. The Board continues to await feedback and responses related to the CMS's Section 44 final inspection report and the Section 59 Panel's final report on allegations of unfair treatment based on racial profiling. No further progress has been made by the CMS on both the Section 44 inspection and the Section 59 investigation since the detail reported on these two matters as part of the 2021 Annual Report.
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.
Loss-making options	The Board is cognisant of the challenge to reduce loss-making options while ensuring Bonitas remains competitive and that members have an optimum range of plans to choose from. The dedicated forum that was established in 2021 made good progress to address loss-making options by understanding the sources of any increase in costs and considering interventions to limit losses and ensure the continued sustainability of low-income options. This work informed the pricing plans for 2023.
Member meetings and Board appointments	Bonitas successfully conducted a virtual AGM on 27 July 2022 in line with Circular 17 of 2022 and the Scheme Rules. BDO was appointed as the Independent Oversight Body (IOB). An in-person Special General Meeting (SGM) was held on 24 August 2022 with PwC appointed as Independent Electoral Body (IEB) to ensure compliance and oversee the election processes. An independent consultant was also appointed to do final vetting and oversight of the IEB processes and to provide specialist guidance where necessary. 40 candidates stood for election. Based on the votes, the following members were elected to the Board: Adv Ramadimetja Tokologo Monene Mr Mbengeni Gilbert Netshisaulu Ms Vurhonga Rikhotso

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, cooperate 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.

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 44.

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 and retention
- Healthcare affordability, 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 coordinated 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 2022.

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 pages 13 and 14.

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

- Forging a partnership with humanitarian aid organisation, Gift of the Givers, to provide relief to the most vulnerable and marginalised communities, specifically for healthcare interventions.
- Contributing R500 000 to the Gift of the Givers' relief efforts during the devastating floods in Durban and surrounding areas.
- Partnering with Gift of the Givers on an audiology project that will initially screen around 15 860 South African school children to detect and treat hearing impediments at an early stage.
- Continuing with the distribution of hand sanitisers and multivitamins to all high-risk members.
- Virtual and in-person upskilling sessions to GPs on our network to equip them with the skills needed to improve the service they provide to our members.
- Adding COVID-19 vaccinations to our preventative care benefits for members across all our plans.
- Maintaining the COVID-19 hub on our website to keep South Africans updated with the latest information on reported cases as well as preventative care measures before and after scrapping of regulations by Government.
- Annual wellness screenings in various sectors including mining, parastatals, healthcare and corporates to detect serious chronic conditions such as hypertension, heart disease and diabetes.

We do not sponsor political parties or entities involved in extreme sports that are controversial or disruptive.

Following the success of the two learnership positions created in 2021, two new learners were appointed in 2022. The South Africa Business School assisted Bonitas with the recruitment of the two learners, who were funded by Bonitas until the completion of their NQF Level 4 Business Administration learnerships. One learner was assigned to Bonitas and the other was based at the South Africa Business School's facilities.

FUTURE FOCUS AREAS

- Ongoing focus to promote corporate responsibility, and to position Bonitas effectively as a good corporate citizen. This is achieved through our partnership with Gift of the Givers.
- Increased focus on Bonitas's journey to effectively incorporating ESG from an ESG investing perspective and 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.

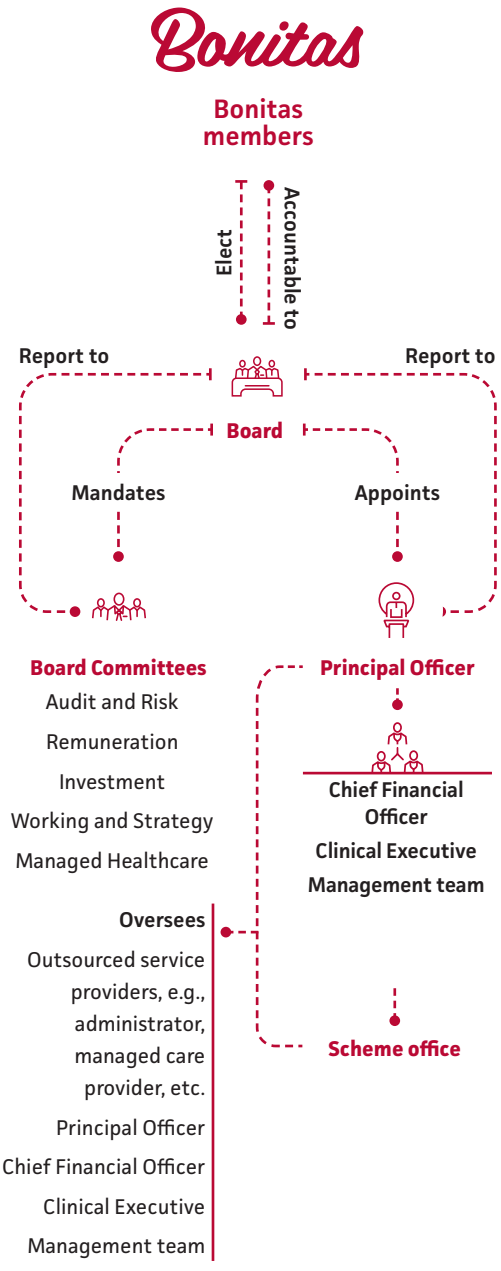
Governing legislation and regulation

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 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 Executive and Management team

BOARD COMPOSITION

As at 31 December 2022, the Board consisted of ten Trustees: eight Trustees elected by members and two Trustees appointed by the Board. The Board composition changed during September/October 2022.

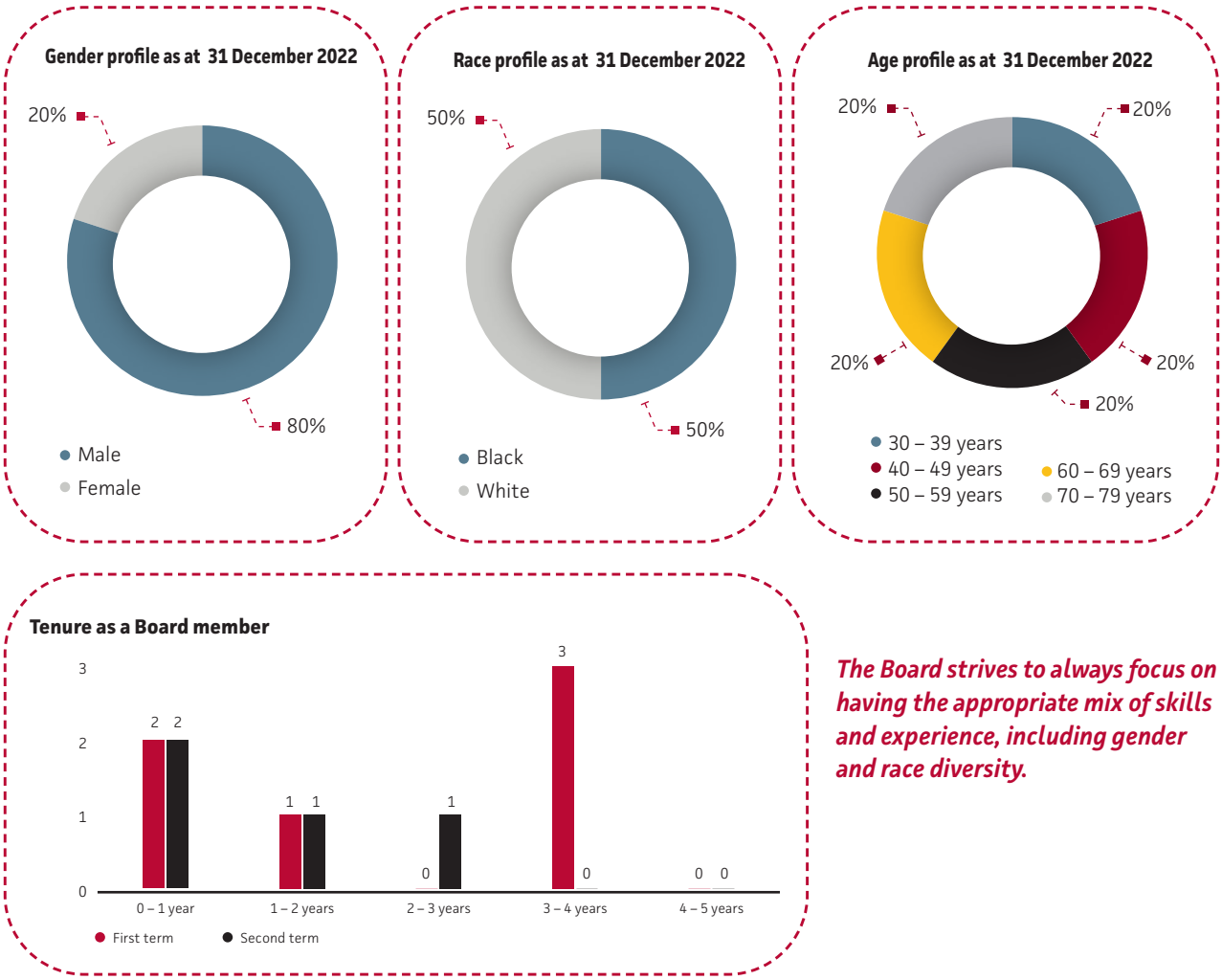
According to the Scheme Rules, the Board can appoint a maximum of three Trustees who bring specific skills and diversity to the Board without undergoing elections. Such an appointed Trustee must be a member of the Scheme and must possess qualifications or belong to professions such as attorney/advocate, 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	Mkhatshwa	Monene	Netshisaulu	Ngwane	Ribbens	Rikhotso	Venter	Woodhouse
Corporate governance	✓	✓	✓	✓	✓	✓		✓			✓	✓	✓
Medical and retirement funds	✓	✓	✓	✓		✓			✓				✓
Strategy		✓	✓	✓	✓	✓		✓		✓	✓		✓
Financial management	✓	✓	✓					✓		✓	✓	✓	✓
Business development		✓	✓							✓		✓	
Law							✓	✓					
Marketing			✓							✓			
Taxation								✓			✓		✓
Skills development	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓
Clinical			✓	✓		✓							
Actuarial science	✓												
Leadership	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Information technology												✓	



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

TRAINING AND EVALUATION

In addition to the Trustees who attended the Investment Committee and Managed Healthcare Committee workshops in February 2022, the Board also received specialist input from Dr Sooliman, the CEO of Gift of the Givers, on his experience of the South African healthcare system and disaster relief projects.

The Trustees, Executives and Senior Management attended a continuous development training session on 2 March 2023 which was facilitated through the Institute of Directors in South Africa (IoDSA). The training session will mainly focus on corporate governance and Board effectiveness. 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 beginning 2023, 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 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 various Board Committees' membership 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, including the Arm's Length Assertion.
- Approved the 2023 budget.
- Appointed the external auditor and approved the audit fee.
- Tracked performance and determined remuneration increases and incentives against the Organisational Performance Matrix.
- Participated in the Investment Committee workshop in February 2022.

OPERATIONAL

- Considered and approved the pricing and benefit option design for 2023.
- Tracked claims history and projections.
- Concluded the NMAS amalgamation with a satisfactory audit report issued for the investment take-on.
- Provided oversight for the appointment of Private Healthcare Administrators as a new administration and managed care service provider at an option level for BonCap.
- Approved the potential disposal of the Bonitas Park property subject to the sale price.
- Approved a range of service provider contracts.

STAKEHOLDERS

- Made arrangements for the virtual AGM including online voting at the AGM.
- Made arrangements for the in-person SGM.
- Supervised the process of Board elections, Trustee nominations and appointments.
- Considered updates on legal proceedings and, where required, provided official responses to matters such as the CMS investigation.

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.
- Considered the appointment of an independent service provider to conduct the performance evaluations of the Board and Board Committees during 2023.

STRATEGY, PEOPLE AND PERFORMANCE

- Approved the strategic objectives for 2022 – 2025 as relevant and fit for purpose.
- Considered strategy and risk alignment.
- Approved the Organisational Performance Matrix 2022.

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.

MEETING ATTENDANCE

The schedule below summarises mandatory Board and Board Committee meetings held during 2022[1]. This includes special meetings and attendance by invitation.

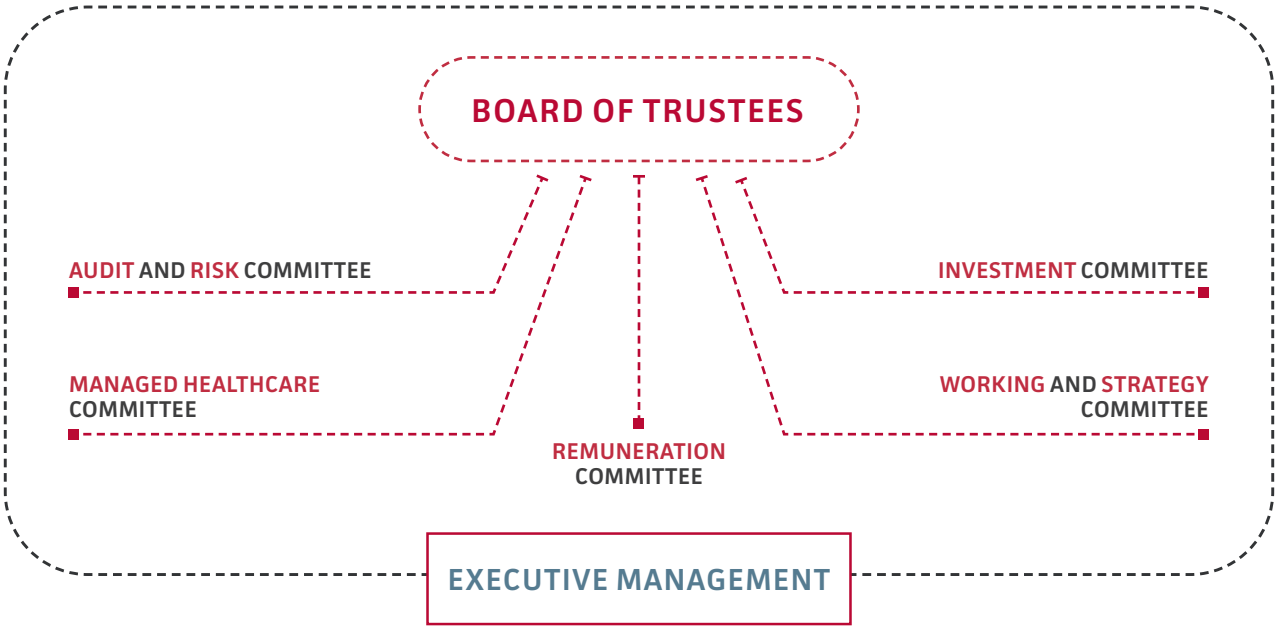
Trustee and/ or Independent Member	Board	Audit and Risk Committee	Remuneration Committee	Investment Committee	Working and Strategy Committee	Managed Healthcare Committee
Number of meetings	11 (including 3 special meetings)	7 (including 1 special meeting)	5 (including 2 special meetings)	5 (including 1 workshop)	11 (including 1 special meeting)	6 (including 1 workshop)
J Bagg*^	9/9	2/2**		5/5	9/9	
R Cowlin	11/11			5/5	11/11	7/7
PW Hill	11/11					7/7
R T Monene^	5/5		1/1			
O Komane#^	11/11	7/7	5/5	5/5	11/11	7/7
M Lesunyane^^	6/6		4/4			
M Netshisaulu**^	11/11		5/5		11/11	
D Ngwane	11/11					
P Ribbens	11/11			5/5		7/7
J Usher^^	6/6	5/5			8/8	1/1#
J Venter	11/11	7/7				1/1#
V Rikhotso^	5/5	2/2				
P Kekana	1/1*		5/5			
W Kirima				5/5		
C van Zyl			5/5	5/5		
P van der Nest	1/1*	7/7				
Y Carrim+		7/7				2/2
T Poho		7/7				

Notes

* *Independent Members attended the Board meeting by invitation.*
^ *Elected to the Board effective 9 September 2022.*
^^ *Term ended 31 August 2022.*
*^ *Term ended 31 August 2022 and appointed as Trustees effective 5 October 2022.*
**^ *Term ended 31 August 2022 and re-elected as Trustees effective 9 September 2022.*
** *Attended the Audit and Risk Committee by invitation.*
#^ *Re-elected Chairperson effective 12 August 2022.*
Attended the Managed Healthcare Committee by invitation.
+ *Appointed as Independent Member of the Managed Healthcare Committee effective 5 October 2022.*

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

BOARD COMMITTEES AND ACTIVITIES FOR 2022



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.

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 2022

- 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 inspection and Section 59 investigation (racial profiling), including pending legal and criminal matters.
- Considered all matters relating to non-compliance to the MSA including other relevant regulations.
- Monitored the implementation of the Information and Technology Governance Framework and Strategy.
- Provided oversight of the Combined Assurance Forum feedback and the Forum's Terms of Reference.
- 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. Risk Management Policy, Credit Control Policy, Impairment Policy, Governance, Risk and Compliance Framework, Combined Assurance Framework and Compliance Management Policy
  - Audited annual financial statements and related disclosures (including the report of the Board)
  - Going concern status

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 2022 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.

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. A new external audit partner was appointed for Bonitas in 2022.

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 on the outsourced internal auditors 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 2022	CAPACITY	MEMBER SINCE
D van der Nest***	Independent Member (Chairperson)	1 August 2019
J Usher*	Trustee Member	1 January 2012 – 31 August 2022
YO Carrim**	Independent Member	1 August 2019 – 4 October 2022
T Poho	Independent Member	1 August 2019
J Venter	Trustee Member	1 August 2019
V Rikhotso*^	Trustee Member	5 October 2022

* *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 Usher's Trustee term ended 31 August 2022 and therefore also as a member of the Audit and Risk Committee.*

** *YO Carrim - term as member of the Committee ended with effect 4 October 2022. YO Carrim was appointed as an Independent Member of the Managed Healthcare Committee.*

*** *D van der Nest - appointed as Chairperson of the Committee with effect 1 February 2021. Appointment as Chairperson was extended from 1 August 2022 to 31 July 2023.*

*^ *V Rikhotso - appointed as member of the Audit and Risk Committee in her capacity as a Trustee with effect 5 October 2022.*

Note: *S Padayachy - appointed as a new Independent Member effective 6 February 2023.*

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 2022

- Conducted an Investment Committee workshop to revisit strategic asset allocation.
- Monitored the performance of asset managers.
- Evaluated the delivery of services and extended the contract of the appointed investment consultant.
- Interrogated investment reports.
- Considered and approved annual report disclosure on investment performance.
- Provided oversight of process for cash flow management and strategic asset balancing.
- Recommended to the Board for approval:
  - Updated Committee Charter
  - Updated Investment Policy Statement to include derivatives.

MEMBERS AS AT 31 DECEMBER 2022	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 was 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.*
*^ *J Bagg – Trustee term ended on 31 August 2022 and appointed as Trustee by the Board with effect from 5 October 2022. Re-appointed by the Board to the Investment Committee effective 27 October 2022.*

REMUNERATION COMMITTEE

MANDATE

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

KEY ACTIVITIES FOR 2022

- Considered and approved the proposed annual employee salary increases based on oversight of employee performance management reviews.
- Discussed succession planning.
- Reviewed the employment equity plan and encouraged diversity through the appointment of employment equity candidates.
- Considered training updates, which included progress with learnerships.
- Endorsed a new operational structure for the Scheme.
- Recommended new and updated policies to the Board for approval: Remuneration Strategy and Philosophy, Travel and Reimbursement Policy, the Trustee Remuneration Policy and the Talent and Succession Management Policy and Plan.
- Noted the approval of the Board Committees Independent Member Remuneration Policy by the Principal Officer.
- Recommended annual increases and STI proposal.
- Recommended the updated Committee Charter to the Board for approval.

MEMBERS AS AT 31 DECEMBER 2022	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 – 31 August 2022
Adv R T Monene*^	Trustee Member	5 October 2022

* *P Kekana – Re-appointed as an Independent Member and the Chairperson for another term effective 2 January 2021.*
*^ *Adv R T Monene - appointed as member of the Remuneration Committee in her capacity as a Trustee with effect 5 October 2022.*
**^ *M Netshisaulu - Term as Trustee ended 31 August 2022 and re-elected as Trustee effective 9 September 2022. Continued as member of the Remuneration Committee.*
^^ *M Lesunyane - Term as Trustee ended 31 August 2022.*

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 2022

- Performed ongoing oversight and reviewed the following new or renewed contracts:
  - Emergency Management Services: Ambulance Services
  - Aid for Aids
  - ADS sales and marketing contract
  - NMG actuarial contract
  - Optometry and Dental contracts
  - International travel contract
- Ratified the implementation of the Sponsorship Strategy and the strategic partnership with Gift of the Givers.
- Reviewed the Scheme performance against the Organisational Performance Matrix scorecard, including the year-end remuneration process and timelines.
- Arranged for Trustee election at the SGM.
- Monitored operational reports regarding any non-adherence to SLAs by service providers.
- Recommended the appointment of PHA as the preferred service provider to administer the BonCap option.
- Reviewed the professional indemnity insurance based on Bonitas's latest credit rating.
- Considered I&T Governance reports.
- Considered FWA reports.
- Recommended for approval by the Board:
  - 2023 plan options, pricing and benefits
  - Board and the Working and Strategy Committee Charter
  - Reviewed and updated the Anti-Fraud, Waste and Abuse Policy, Procurement and Contract Management Policy, I&T Governance Charter and Framework, Delegation of Authority, Business Continuity and Disaster Recovery Management Policy and Plan, Conflict of Interest Policy, Stakeholder Engagement and Communication Framework and Membership Policy.
  - The 2023 budget

MEMBERS AS AT 31 DECEMBER 2022	CAPACITY	MEMBER SINCE
O Komane*	Trustee member (Board Chairperson and Chairperson of this Committee)	1 June 2021
R Cowlin**	Trustee Member (Board Vice-Chairperson)	1 October 2017
J Bagg***	Trustee Member	4 December 2020
M Netshisaulu**^	Trustee Member	16 November 2019
J Usher *^	Trustee Member	28 November 2015 – 31 August 2022
V Rikhotso***^	Trustee Member	24 November 2022
LR Callakoppen	Principal Officer	1 May 2019
L Woodhouse	Chief Financial Officer	1 October 2019
Dr M Mkhatshwa^	Clinical Executive	1 October 2022

* *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. Re-elected as Chairperson of the Board effective 12 August 2022.*

** *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. Re-elected as Vice-Chairperson of the Board effective 12 August 2022.*

*** *J Bagg – Trustee term ended on 31 August 2022 and appointed as Trustee by the Board with effect from 5 October 2022. Re-appointed by the Board to the Working and Strategy Committee effective 5 October 2022.*

*^ *J Usher - Trustee term ended 31 August 2022.*

**^ *M Netshisaulu - Term as Trustee ended 31 August 2022 and re-elected as Trustee effective 9 September 2022. Continued as member of the Working and Strategy Committee.*

***^ *V Rikhotso - Appointed as member of the Working and Strategy Committee effective 24 November 2022.*

^ *Dr M Mkhatshwa – appointed as Clinical Executive of the Scheme effective 1 October 2022.*

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 2022

- Ongoing monitoring of the changing healthcare environment and providing advice to the Board on the implications for Bonitas.
- Conducted a workshop during February 2022 to consider the managed care objectives and strategy, deliverables, and timelines.
- Provided oversight of managed care initiatives' performance, gaps and targets while tracking progress with savings interventions.
- Considered claims trends, the health risk management feedback report and health quality assessment results to benchmark the effectiveness of Bonitas's Managed Care strategy and outcomes-based progress.
- Briefed and provided oversight of an independent ad hoc review of the Aid for Aids contract and SLA compliance.

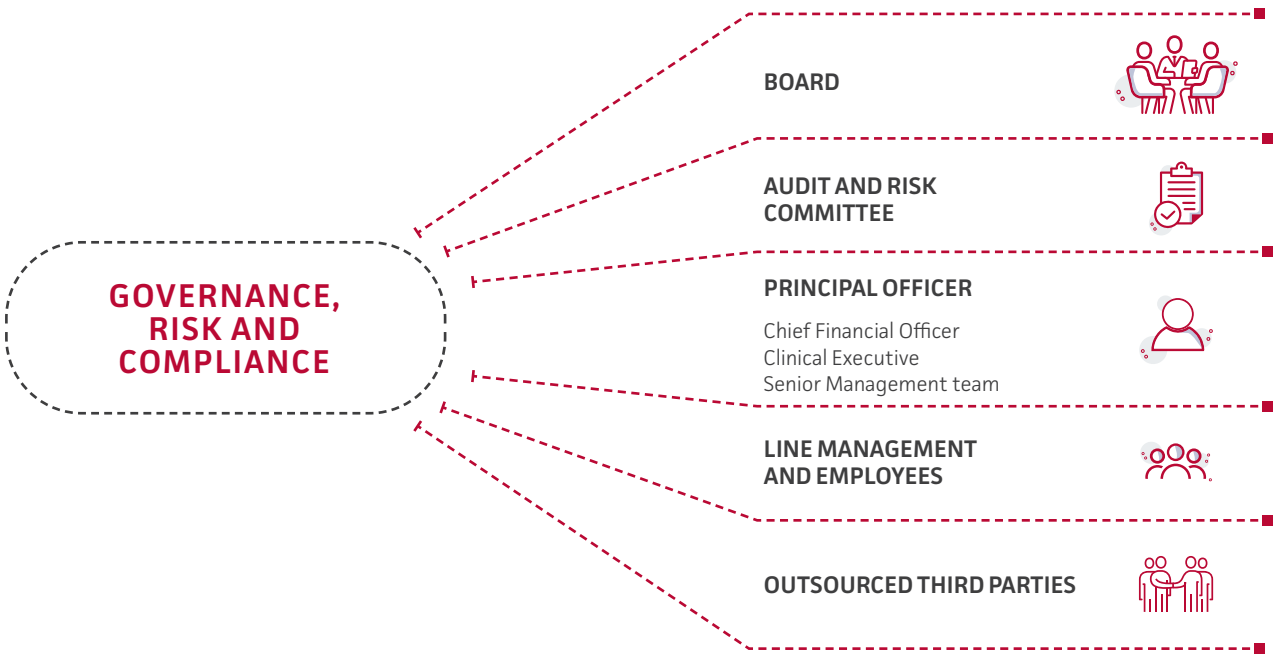
MEMBERS AS AT 31 DECEMBER 2022	CAPACITY	MEMBER SINCE
R Cowlin*	Trustee Member (Chairperson)	16 July 2020
P Ribbens	Trustee Member	16 July 2020
P Hill	Trustee Member	7 October 2021
YO Carrim**	Independent Member	5 October 2022

* *R Cowlin – Trustee term ended 4 January 2021 and appointed by the Board with effect from 5 January 2021.*
** *YO Carrim was appointed as an Independent Member of the Managed Healthcare Committee.*

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. The Risk Management Framework comprises the following:

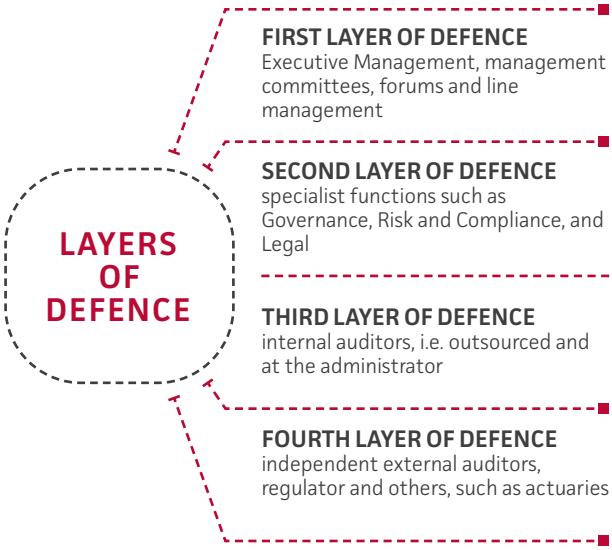
- Risk Management Policy and Manual
- Risk Register (only "high" and "unacceptable" residual risks)
- Risk Universe (complete list of risks)
- Risk Dashboard(s)
- Risk Reporting

Read more about the strategic risks and opportunities that Bonitas is facing, as well as mitigation through our strategic pillars, from page 45.

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 Management 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 2022:

- Ongoing regulatory compliance monitoring with regards to the MSA and MSA Regulations including the Scheme Rules
- Ongoing regulatory compliance monitoring with regard to other legislation such as the POPI Act.
- Ongoing operational compliance monitoring with regard to Scheme Policies.

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 regard to non-compliance matters as reported in the next section.

NON-COMPLIANCE WITH THE MSA

The areas of non-compliance with the MSA which were identified during the financial year are included in note 26 of the annual financial statements for more details.

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 reports to the Principal Officer, who is accountable to the Board.

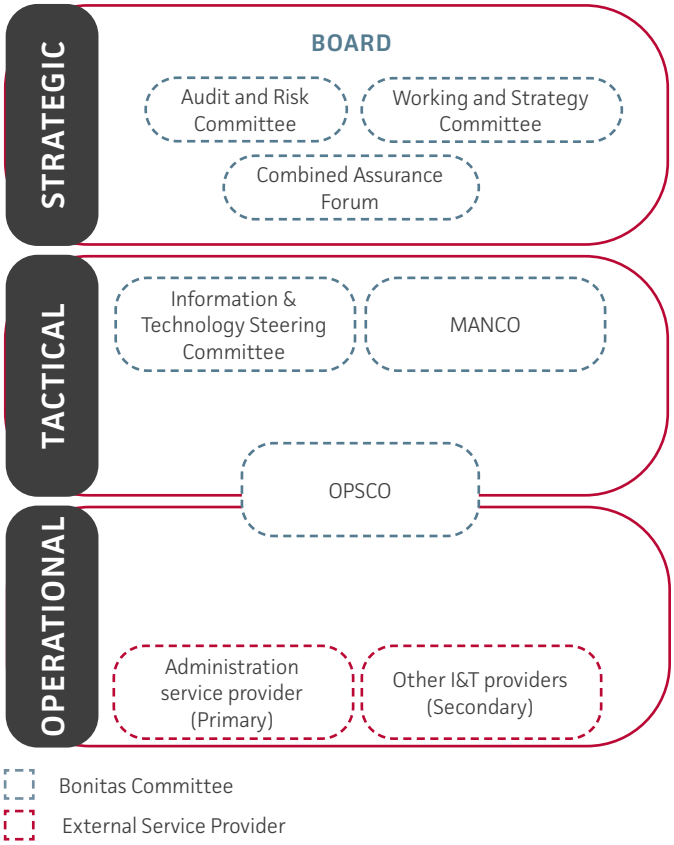
As the custodian of the I&T Governance Charter and Framework, the I&T Steering Committee provides oversight, governance, risk identification and monitoring for all Bonitas IT-related functions, inclusive of primary contracted service providers. It also ensures compliance with the Framework, adherence 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 of the 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 2022

The I&T Steering Committee 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 during 2022:

- I&T Governance Charter and Framework
- I&T Steering Committee Terms of Reference
- Business Continuity and Disaster Recovery Management Policy and Plan
- Data Management and Data Governance Policy
- Project Management Policy
- Information Security and Acceptable Use Policy
- General Access Management Policy
- Security Incident Management Policy
- Security Incident Management Process – Data Breach Response

The I&T Governance Charter and Framework including relevant IT policies were rolled out to all contracted service providers.

The Scheme appointed an IT Manager with an effective date of 2 November 2022 as part of the operations functional area.

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.
- Effective cyber threat management by penetration testing and vulnerability assessments.
- Enforcement of IT policies.

REMUNERATION REPORT

INTRODUCTION AND BACKGROUND STATEMENT

This is our first Bonitas remuneration report, which marks a step towards greater disclosure in terms of the King IV™ requirements. The Board provides leadership and sets the direction in terms of Bonitas's holistic remuneration approach and implementation.

With the guidance and input of the Remuneration Committee, the Board approved a new Remuneration Strategy and Philosophy this year. This framework sets out the remuneration strategy, financial reward model and detail on the components of remuneration relevant to all employee levels.

The Remuneration Strategy and Philosophy provides guidance on:

- The strategic intent of remuneration decision-making, thereby enhancing Bonitas's profile as an employer of choice
- The need for consistency in remuneration decision-making, thereby enhancing internal and external equity
- Corporate governance principles to inform remuneration decisions

The philosophy is based on the following principles:

- Ensure alignment with the business strategy and Bonitas vision
- Attract and retain key talent
- Manage risk and liability and be financially responsible
- Be externally competitive
- Be internally equitable, fair and supportive of diverse and individual needs
- Offer pay for performance
- Comply with relevant legislation
- Stand up to scrutiny by key stakeholders

The Remuneration Strategy and Philosophy is an important guide to the Remuneration Committee and the Board as we evolve our remuneration practices. For example, the philosophy recognises the concept of equal pay for work of equal value and requires adherence. It establishes Executive Management accountability and ownership of the reward process by linking the total reward process to business objectives and managing it in a fair and equitable way that balances affordability and quality of life for employees.

The Board has mandated the Remuneration Committee to provide oversight in terms of remuneration. The Committee's membership, meeting attendance, mandate and key activities for the past year are set out on page 79.

REMUNERATION CONTEXT AND BENCHMARKING

Unlike restricted medical schemes, Bonitas finds itself in a very small but competitive industry that is shrinking every year. Given changes in legislation and regulatory controls, our employees, as well as the Board and Committee members, have to be well acquainted with compliance requirements and corporate governance principles while ensuring Bonitas's sustainability.

To attract people with the required skills, Bonitas compares its remuneration with other medical schemes and considers research done on the remuneration of non-executives. We gave due consideration to the Guidelines on Trustee Remuneration issued by the CMS, which acknowledge that medical schemes are not-for-profit organisations.

Bonitas has an Employee Remuneration Policy and Scheme Strategy and Philosophy in place to ensure remuneration governance and best practices. The Employee Remuneration Policy is reviewed every two years for good governance. However, we ensure we apply industry salary benchmarking best practices to the annual employee increment process.

We continue to work with industry remuneration experts on further updates to the remuneration elements and for salary benchmarking data.

In May 2022, Willis Towers Watson released the results of research done on medical scheme remuneration guidelines focusing on the fees for the roles of chairperson, vice chairperson and trustees. Bonitas was one of five schemes that participated.

The research indicated that fee structures included a combination of retainer payments vs fees per meeting. There was also variation in the number of board meetings (between four and eight meetings per year) whereas the number of committee meetings was more aligned at an average of four per year.

Fee increases between 2021 and 2022 were between zero and 7.26%. Two schemes did not have increases due to the pandemic. The average increase excluding the two zero participants was 4.98%. Bonitas increased trustee and independent member fees by 4.6% between 2021 and 2022.

REMUNERATION IN PRACTICE

ANNUAL INCREASES FOR EMPLOYEES

Employees are eligible for annual increases in April every year. These are based on performance reviews of which guidelines, rating scales and definitions are included in the Performance Management Policy, Employee Remuneration Policy and Remuneration Strategy and Philosophy.

Executive and Senior Management performance is measured against an organisational performance scorecard that includes key performance indicators with weightings and targets.

INCENTIVE SCHEME ALLOCATIONS

Annual incentive awards to employees are based on biannual performance reviews and are directly linked to Bonitas's overall performance. Minimum performance criteria and the calculation of the incentive pool are defined in the Incentive Scheme Policy.

INDEPENDENT MEMBER REMUNERATION

The Independent Member Remuneration Policy and fees are reviewed annually by the Executive Management and recommended for approval to the Board if/when an increase above CPI is considered. As the Remuneration Committee chair and some members are independent members, the Committee follows good governance principles and does not participate in this process. Fee changes apply from 1 June every year, following approval and/or adoption at the Board meeting in April depending on the proposed fee increase amount.

TRUSTEE REMUNERATION

The Trustee Remuneration Policy is reviewed by the Executive Management and the Remuneration Committee annually.

Bonitas members are only required to vote on trustee remuneration at the AGM if there is a material change to the Trustee Remuneration Policy or if an increase above CPI is recommended.

2019 AGM	Members approved the Trustee Remuneration Policy and fees
2020 AGM	Members were not required to vote on the Trustee Remuneration Policy and fees as there were no material changes to the Policy and fees reflected a CPI increase
2021 AGM	Members were not required to vote on the Trustee Remuneration Policy and fees as there were no material changes to the Policy and fees reflected a CPI increase

Fee changes apply from 1 September each year to provide for member approval, if necessary, as the Scheme Rules require that the AGM be held before 31 August every year.

FUTURE FOCUS AREAS

The new Bonitas Remuneration Strategy and Philosophy will direct future remuneration, reward and employee value proposition decisions based on best practice.

REMUNERATION POLICIES

Bonitas has a holistic rewards approach based on the following:

	ELEMENTS	PURPOSE	RELATED POLICIES AND FRAMEWORKS
Financial rewards			
Guaranteed remuneration	Basic salary | Retirement benefits | Medical benefits | Death and disability benefits | Statutory payments	We aim to be a competitive employer that offers market-related remuneration while managing costs and promotion fairness and pay equity. We want to enable long-term financial security for employees including support for their individual healthcare needs. While complying with legislation our intent is to also give employees benefits that will ensure their peace of mind.	• Employee Remuneration Policy • Scheme Pension rules • Scheme Medical Aid rules • Scheme risk-benefit rules • Relevant legislative framework
Variable remuneration	Short term incentives | Long term incentives	Bonitas wants to retain talent by rewarding individual performance through short and long term incentives. This will support succession and Scheme performance.	• Employee Remuneration Policy • Incentive Scheme Policy • Performance Management Policy • Talent & Succession Management Policy & Framework
Non-financial reward			
Learning and development	Performance management | Training | Workplace learning | Career development	We support employee development, performance and productivity through formal and informal learning, including professional development where relevant. We want to create a pipeline of skills for future talent needs while providing employees with opportunities to manage life, career choice, learning and career prospects.	• EE & Transformation Policy • Diversity, inclusion, engagement and satisfaction initiatives
Work environment	Leadership, climate and culture | Core values | Job/ work design | Work-life balance | Wellness	We promote a culture of empowerment and leadership that values diversity. We strive to create and maintain a positive working environment, conducive to productivity, performance, strong relationships, health, and commitment to organisational culture and values.	• Scheme values • Code of Conduct and Ethics • Leave Policy • Flexible work arrangements • Employee Wellness programme
Other			
Additional benefits and reimbursement	Travel expenses | Cellular & data | Overtime | Acting	We provide employees with tools to perform and reward them for assuming duties that exceed current role requirements.	• Overtime Policy included in Travel and Reimbursement Policy • Acting Allowance Policy

EMPLOYEE REMUNERATION POLICY

Reviewed and approved by the Board on 27 February 2023.

This Policy aims to ensure a remuneration system that supports Bonitas's strategy and is linked to business and employee performance.

This Policy aims to ensure a remuneration system that:

- Is an integral part of an overall human resources strategy supporting Bonitas's strategy.
- Reflects the competitiveness of the market and alignment with Bonitas's strategic direction.
- Is designed to attract and retain high-quality employees with the optimum mix of competencies.
- Is aimed at securing employee commitment to the Scheme's purpose and goals.
- Is aligned with the anti-discriminatory clause in the Bill of Rights.

It seeks to:

- Attract, engage and retain the best talent available, and recognise and reward individual performance against accountabilities set out by Bonitas.
- Drive high levels of performance through the provision of fair and competitive remuneration.
- Encourage the development of competencies required to meet future business needs.
- Motivate and reinforce superior performance amongst employees.

Applicable to all Bonitas employees, the Policy aligns with the following regulatory and internal policy:

- Basic Conditions of Employment Act, 2002 (as amended)
- Labour Relations Act, 1998 (as amended)
- Amendments of the Employment Equity Act
- Equal Pay for Equal Work Act 2014
- Leave Policy
- Performance Management Policy
- Recruitment, Selection and Appointment Policy
- Incentive Scheme Policy
- Disciplinary Policy

INCENTIVE SCHEME POLICY

Reviewed and approved by the Board on 27 February 2023.

This Policy aims to ensure that incentives attract, reward and retain high-performing individuals and create a clear link between performance and strategic objectives.

SHORT-TERM INCENTIVES

Payment of short-term incentives is directly linked to the performance of Bonitas and the employee's performance review outcome. Performance below the set threshold level results in no performance incentive payment.

The Policy sets out the performance cycles, assessment arrangements and short-term incentive pool calculation. Bonitas must also achieve a minimum score per the approved Organisational Performance Scorecard to provide for an incentive pool. The short-term incentive pool is capped at a maximum of 30% of Bonitas's annual salary CTC total for the financial year.

The calculation of the incentive pool and final incentive awards is subject to approval by the Remuneration Committee and the Board.

The incentive pool is the maximum total short-term incentive that can be paid in a financial period by the Scheme.

The Policy sets out all conditions for awards, including for new hires, after promotions and during disciplinary proceedings.

LONG-TERM INCENTIVES (LTI)

The aim of the LTI is to attract, retain, motivate, and reward executives and identified employees who can influence Bonitas's performance.

It supports Bonitas's vision by attracting and retaining the right talent and correlating with the long-term growth plans and financial performance of the Scheme.

The LTI Scheme has a three-year fixed cycle. LTI targets are agreed and approved by the Board. These targets focus on Bonitas's medium to long-term sustainability.

The value of the incentive is determined by the performance of Bonitas over a three-year period.

The final calculation of the LTI vested amount shall occur at the end of the three-year performance period (2023) and shall be subject to sign-off by the Remuneration Committee and approval by the Board following the sign-off of the Scheme's 2023 annual financial statements.

BOARD COMMITTEES' INDEPENDENT MEMBER REMUNERATION POLICY

Approved by the Principal Officer on 1 June 2022. This Policy will only require approval by the Board for subsequent years if there are material changes or if remuneration increases are above the South Africa Consumer Price Index (CPI). No material changes have been made to this Policy since the Board approval on 16 November 2019 and signed by the Chairperson of the Board on 20 February 2020.

This Policy is designed to facilitate a fair and responsible remuneration model for Independent Members by ensuring that the level and composition of remuneration is sufficient and reasonable. This includes considering their fiduciary duties and responsibilities towards Bonitas and its members, and the inherent risks and responsibilities associated with such positions of trust.

The Policy aims to remunerate Independent Members appropriately and in line with sound corporate governance principles and based on market-leading practices. The Policy is further based on and relates to:

- Regulations applicable to medical schemes established in terms of the MSA
- Scheme Rules
- King IV™
- Board and Committee Charters
- Delegation of Authority Policy
- Travel and Reimbursement Policy

OUR APPROACH AND MODEL

In setting fees related to Independent Member remuneration, Bonitas ascribes to the process set out by the South African Institute of Directors in their Position Paper of 3 October 2014. This ensures conflicts of interest are appropriately managed.

Independent Members are appointed by the Board to serve on the various Board Committees, and they do so based on the roles and duties set out in the charters of the relevant Committee to which they are appointed. This includes attending and participating in meetings, preparing for such meetings, conducting research to execute their duties and keeping in touch with industry developments. In accepting their appointment, they also attract possible personal liability as provided for in various legislation. Their remuneration is therefore not different to that of other Bonitas non-executive directors.

However, as Bonitas is a not-for-profit organisation, Independent Member remuneration is not comparable to that of JSE listed or private companies. Based on the different remuneration models applied in the healthcare industry, Bonitas elected a Per Meeting Fee model.

The Per Meeting Fee relates to scheduled and special Committee meetings on which an Independent Member is a permanent member. This includes any SGM attendance. Independent Members may also be required to attend specific Board meetings and/or ad-hoc meetings, for example, interviews or tender evaluations, for which an Independent Member will be entitled to a Per Hourly Meeting Fee, which includes preparation time.

Independent Members are not remunerated for attending training and development activities, seminars, functions or meetings with stakeholders or the regulator. No retirement benefits or other forms of bonus or incentive payments are paid to Independent Members.

INDEPENDENT MEMBERS' FEES

Fees are reviewed annually. Increases are equivalent to CPI unless extraordinary circumstances justify a higher increase. Fees applicable for the past and next year are:

Committee meetings	Meeting fee from 1 June 2021	Meeting fee from 1 June 2022
Audit and Risk Committee: Chairperson	R36 155	R37 818
Audit and Risk Committee: Member	R30 990	R32 415
Investment Committee: Member	R26 858	R28 093
Remuneration Committee: Chairperson	R30 990	R32 415
Remuneration Committee: Member	R26 858	R28 093
Managed Healthcare Committee: Member	R26 858	R28 093

Ad hoc meetings*	Hourly meeting fee from 1 June 2021	Hourly meeting fee from 1 June 2022
Ad hoc meeting: Chairperson	R4 855	R5 078
Ad hoc meeting: Invitee	R4 132	R4 322

* *Ad hoc meetings are those scheduled in addition to the formal meeting calendar due to specific business requirements and dictated by the Board.*

TRUSTEE REMUNERATION POLICY

The Policy has been recommended by the Remuneration Committee on 8 April 2022 and adopted by the Board on 26 July 2022. This Policy was approved by the members at the AGM held on 11 February 2019. No material changes have been made to this Policy since this date and given that the 2022 increase reflects a CPI increase for the preceding financial period, approval from the members at the last AGM was not required.

This Policy aims to facilitate a fair and responsible remuneration model for Trustees. We want to ensure that the level and composition of remuneration is sufficient and reasonable given the fiduciary duties and responsibilities of Trustees towards Bonitas and our members. It considers the inherent risks and responsibilities associated with such positions of trust.

The Board and Committees focus on Bonitas's long-term strategic direction, overall performance and sustainability. Trustee remuneration is not directly related to short-term results but considers longer-term sustainability and performance.

The Policy aims to remunerate Trustees appropriately and in line with sound corporate governance principles and based on market-leading practices. The Policy is further based on and relates to:

- Regulations applicable to medical schemes established in terms of the MSA
- Scheme Rules
- King IV™
- Board and Committee Charters
- Delegation of Authority Policy
- Travel and Reimbursement Policy

Trustees are elected from among our Bonitas members or appointed by the Board and have to be fit and proper to manage Bonitas's business. As such, Trustees carry substantial accountabilities and risks and assume substantial fiduciary duties and responsibilities. Therefore, it is of crucial importance to attract and retain suitable and qualified individuals to serve as Trustees and to dedicate the appropriate time to serve Bonitas and our members. Therefore, trustees are remunerated according to sound corporate governance principles and based on market-leading practices.

In recommending fees for Trustees, Bonitas and the Remuneration Committee acknowledge the process suggested by the South African Institute of Directors in determining the fees of Non-executive Directors as set out in their Position Paper 3 of October 2014. The Remuneration Committee ascribes to this process to ensure conflicts of interest are appropriately managed when determining fees.

Bonitas applies a combination of a Retainer Fee model and Per Meeting Fee model. The rationale is that the Retainer Fee model will enable Bonitas to attract and retain suitable and qualified individuals to serve as Trustees to assume the fiduciary duties and responsibilities associated with such positions, while the Per Meeting Fee will ensure attendance. In other words, the combined model will ensure that Trustees dedicate enough time to Bonitas while avoiding unnecessary meetings that could increase costs.

TRUSTEES' FEES

Fees are reviewed annually. The fees below demonstrate a comparative analysis for FY 2021 and FY 2022 aligned to the Scheme's Trustee Remuneration policy.

Fees applicable for the past year are reflected in FY 2022.

Committee meetings	Retainer fee from 1 September 2021 (monthly)	Meeting fee from 1 September 2021 (monthly)	Retainer fee from 1 September 2022 (monthly)	Meeting fee from 1 September 2022 (monthly)
Board of Trustees: Chairperson	R26 884	R20 324	R28 121	R21 259
Board of Trustees: Trustee	R19 356	R13 550	R20 246	R14 173
Audit and Risk Committee: Member		R13 550		R14 173
Investment Committee: Chairperson		R16 743		R17 513
Investment Committee: Member		R9 033		R9 449
Remuneration Committee: Member		R6 774		R7 086
Working and Strategy Committee: Chairperson		R16 743		R17 513
Working and Strategy Committee: Member		R9 033		R9 449
Managed Healthcare Committee: Chairperson		R16 743		R17 513
Managed Healthcare Committee: Member		R9 033		R9 449
Sales and Marketing Committee: Member		R6 774		R7 086

REMUNERATION IMPLEMENTATION REPORT

EXECUTIVE REMUNERATION

EXECUTIVE REMUNERATION SUMMARY (INCLUDING THE PRINCIPAL OFFICER)

	2021	2022
Executive remuneration	R7 704 128	R8 484 297
Performance bonus	R2 221 702	R2 451 388
Defined contribution benefits	R753 317	R893 616

2021 had two Executives and 2022 ended with three.
Dr Mkhatshwa was appointed to the Executive management from 1 October 2022.

The Principal Officer's salary increase of 5.3% was approved by the Board.

There were no deviations from the Employee Remuneration Policy.

SHORT TERM INCENTIVES

Short-term incentives are determined by performance against an agreed organisational scorecard and targets. Bonitas exceeded the minimum required organisation score for purposes of a short-term incentive. The total bonus pool was calculated as R6.1 million and the final short-term incentive value totalled R5 million before tax. Surpluses in the bonus pool are not carried over to the next financial period.

INDEPENDENT MEMBER FEES

Independent members' fees included attendance at the committee meetings, the AGM and workshops.

Independent Member	Audit and Risk Committee meetings	Investment Committee meetings	Remuneration Committee meetings	Managed Healthcare Committee	Other	Total
Prof van der Nest	R258 074	–	–		R17 551	R275 626
Dr Carrim	R221 207	–	–	R56 187		R277 394
T Poho	R221 207	–	–			R221 207
C van Zyl	–	R136 761	R109 903		–	R246 664
M Kirima	–	R136 761	–		–	R136 761
P Kekana	–	–	R126 811		R4 855	R131 666

A fee increase of 4.6% was implemented as from 1 June 2022.

There were no deviations from the Independent Member Remuneration Policy.

TRUSTEE FEES

The Remuneration Committee confirmed that the effective date of new Trustee fees is 1 September of each financial year. This aligns with the AGM which means that Trustees would have completed a 12-month cycle since the date of the previous AGM.

A fee increase of 4.6% was implemented as from 1 September 2022. The fees for the 2022 financial year are set out in note 15.3 of the annual financial statements.

There were no deviations from the Trustee Remuneration Policy.

The meeting attendances by Trustees and Independent members are set out in the Governance section on page 76.

ANNUAL FINANCIAL STATEMENTS

STATEMENT OF RESPONSIBILITY OF THE BOARD OF TRUSTEES

for the year ended 31 December 2022

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 2022, 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 97 to 160 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 claims sensitivities to determine the financial impact of adverse and abnormal claiming trends 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 93. 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 21 April 2023.

Mr OJ Komane
Chairperson of the Board
21 April 2023

Mr LR Callakoppen
Principal Officer
21 April 2023

Mr R Cowlin
Vice-Chairperson of the Board
21 April 2023

STATEMENT OF CORPORATE GOVERNANCE

for the year ended 31 December 2022

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 or appointed by the Board 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 16 February 2023) for the year ended 31 December 2022 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 2022, 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

21 April 2023

Mr LR Callakoppen
Principal Officer

21 April 2023

Mr R Cowlin
Vice-Chairperson of the Board

21 April 2023

Private Bag X6
Gallo Manor 2052
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 97 to 160, which comprise the statement of financial position as at 31 December 2022, and the statement of comprehensive income, the statement of changes in members' funds and reserves and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, these financial statements present fairly, in all material respects, the financial position of Bonitas Medical Fund (the Scheme) as at 31 December 2022 , and its financial performance and cash flows for the year then ended, in accordance with International Financial Reporting Standards (IFRS) and the requirements of the Medical Schemes Act of South Africa 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' International Code of Ethics for Professional Accountants (including International Independence Standards)*. 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, 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 R960.5 million (2021: R904.4 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 several 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 considered 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, • Assessing the presentation and disclosure in respect of the IBNR and considered the adequacy of these disclosures, and • 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, 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 of South Africa, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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 Scheme's 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 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 based on 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 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 Scheme's trustees.
- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists in relation 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 Scheme's 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 Scheme's 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

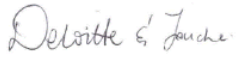
Non-compliance with the Medical Schemes Act of Act No 131 of 1998 South Africa

As required by the Council for Medical Schemes, we report the following material instances of non-compliance with the requirements of the Medical Schemes Act of 131 of 1998 South Africa 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 & Touché has been the auditor of Bonitas Medical Fund for 6 years.

The engagement partner, Rachel Nkgodi, has been responsible for Bonitas Medical Fund audit for 1 year.



Deloitte & Touché
Registered Auditor
Per: Rachel Nkgodi
Partner

6 June 2023

Deloitte
Magwa Crescent
Waterfall
Waterfall City

STATEMENT OF FINANCIAL POSITION

at 31 December 2022

	Notes	**2022 R'000**	2021 R'000
ASSETS			
Property and equipment	4	**7 390**	4 231
Investment properties	5	**78 500**	77 000
Financial assets held at fair value through profit or loss	6	**4 892 220**	4 784 072
Non-current assets		**4 978 110**	4 865 303
Financial assets held at fair value through profit or loss	6	**5 004 190**	3 461 898
Insurance, trade and other receivables	7	**705 285**	706 417
Cash and cash equivalents	8	**646 015**	766 465
Current assets		**6 355 490**	4 934 780
Total assets		**11 333 600**	9 800 083
MEMBERS' FUNDS AND LIABILITIES			
Accumulated funds		**8 759 140**	7 447 331
Members' funds		**8 759 140**	7 447 331
Lease liability	4.2	**4 342**	–
Long-term employee benefit obligation	9	**3 449**	–
Non-current liabilities		**7 791**	–
Outstanding risk claims provision	10	**960 490**	904 350
Personal medical savings accounts liability	11.1	**1 016 135**	894 037
Insurance, trade and other payables	12	**588 064**	551 318
Lease liability	4.2	**1 980**	3 047
Current liabilities		**2 566 669**	2 352 752
Total Members' funds and liabilities		**11 333 600**	9 800 083

STATEMENT OF COMPREHENSIVE INCOME

for the year ended 31 December 2022

	Notes	**2022 R'000**	2021 R'000
Risk contribution income	13	**19 183 315**	18 138 159
Relevant healthcare expenditure	14	**(17 439 033)**	(16 289 636)
Net claims incurred	14.1	**(17 032 156)**	(15 851 053)
Risk claims incurred		**(17 107 121)**	(15 913 500)
Third party claim recoveries		**74 965**	62 447
Accredited managed healthcare services	14.2	**(591 335)**	(549 251)
Net income on risk transfer arrangements	14.3	**184 458**	110 668
Risk transfer arrangement fees/premiums paid		**(1 547 984)**	(1 531 348)
Recoveries from risk transfer arrangements		**1 732 442**	1 642 016
Gross healthcare result		**1 744 282**	1 848 523
Broker service fees		**(381 799)**	(360 620)
Administrative expenditure	15	**(1 370 660)**	(1 276 920)
Net impairment losses on healthcare receivables	16	**(5 977)**	(63)
Net healthcare result		**(14 154)**	210 920
Other income		**813 422**	1 243 833
Investment income – Scheme	17	**780 862**	1 221 652
Change in fair value of investment property	17	**1 500**	(700)
Sundry income	18	**31 060**	22 881
Other expenditure		**(100 250)**	(67 262)
Asset management fees		**(54 846)**	(38 675)
Interest expense	11/4.2	**(40 644)**	(24 010)
Operating expenses on rental of investment property		**(4 760)**	(4 577)
Surplus for the year		**699 018**	1 387 491
Total comprehensive income for the year		**699 018**	1 387 491

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES

for the year ended 31 December 2022

	Notes	Accumulated funds R'000	Total R'000
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
Total comprehensive income		**1 311 809**	**1 311 809**
Surplus for the year		**699 018**	**699 018**
Reserves acquired through amalgamation with Nedgroup Medical Aid Scheme	28	**612 791**	**612 791**
Balance as at 31 December 2022		**8 759 140**	**8 759 140**

STATEMENT OF CASH FLOWS

for the year ended 31 December 2022

	Notes	**2022 R'000**	2021 R'000
Cash flows from operating activities			
Cash receipts from members and providers		**20 168 419**	18 911 597
Cash receipts from members – contribution		**20 117 745**	18 800 873
Cash receipts from members and provider – Other		**50 674**	110 724
Cash paid to providers, employees and members		**(20 062 577)**	(18 773 017)
Cash paid to providers and employees – claims		**(18 236 397)**	(17 075 960)
Cash paid to providers and employees – non healthcare expenditure		**(1 732 749)**	(1 641 144)
Cash paid to members – savings plan refunds	11	**(93 431)**	(55 913)
Cash generated by operating activities		**105 842**	138 580
Interest paid	11	**(40 380)**	(23 606)
Interest received	17	**7 075**	4 661
Net cash inflow from operating activities		**72 537**	119 635
Cash flows from investing activities			
Acquisition of property and equipment	4	**(327)**	(103)
Proceeds on disposal of property and equipment	18	**14**	4
Settlement of derivative financial instruments		**–**	(86 373)
Acquisition of financial assets held at fair value through profit or loss	6	**(1 798 938)**	(1 009 999)
Disposal of financial assets held at fair value through profit or loss	6	**1 215 958**	842 104
Interest received	20.1.1	**181 218**	192 641
Dividends received	20.1.2	**180 694**	128 546
Asset management fees	20.1.3	**(53 964)**	(36 766)
Rentals received	20.1.4	**9 400**	9 695
Net cash (outflow)/inflow from investing activities		**(265 945)**	39 749
Cash flows from financing activities			
Lease payments	4.2	**(3 768)**	(4 009)
Net cash outflow from financing activities		**(3 768)**	(4 009)
Net (decrease)/increase in cash and cash equivalents		**(197 176)**	155 375
Net cash acquired on amalgamation	28	**76 726**	–
Cash and cash equivalents at beginning of the year		**766 465**	611 090
Cash and cash equivalents at end of the year		**646 015**	766 465
Analysed as follows:			
Cash and cash equivalents	8	**646 015**	766 465
		646 015	766 465

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

for the year ended 31 December 2022

1. GENERAL INFORMATION

The Scheme is a registered non-profit, open medical scheme in terms of the Medical Schemes Act of South Africa, No 131 of 1998, as amended ("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 BASIS OF CONSOLIDATION

Business combinations

The acquisition of accounting is used when a business is acquired.

The cost of acquisition is the consideration given in exchange for control over the identifiable assets, liabilities and contingent liabilities of the acquired entity. This consideration includes the cash paid plus the fair value at the date of exchange of assets given, liabilities incurred or assumed and equity instruments issued by the Scheme.

Contingent consideration arrangements are included in the cost of acquisition at fair value. If the contingent consideration is classified as equity, then it is not remeasured and settlement is accounted for within equity. Otherwise, subsequent changes in the fair value of the contingent consideration are recognised in profit and loss. Directly attributable transaction costs are expensed in the current period and reported within administrative expenses. The acquired net assets being the identifiable assets, liabilities and contingent liabilities, are initially recorded at fair value on the acquisition date. Where the Scheme does not obtain 100% ownership over the acquired entity, non-controlling interests are recorded as the portion of the fair value of the acquired net assets.

When an acquired entity is a mutual entity amalgamated into the Scheme, all identifiable assets, liabilities and members funds are accounted for at fair values. The acquiree's net assets are recognised as a direct addition to accumulated funds. No consideration is paid for these transactions and they are recognised as from the transaction date.

2.1.4 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. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS

(a) New standards, amendments and interpretations issued and not yet effective in 2022 and relevant to the Scheme

STANDARD	DETAILS OF AMENDMENT	EFFECTIVE DATE PERIODS BEGINNING ON OR AFTER
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

IFRS 17: Insurance Contracts will replace IFRS 4: Insurance Contracts for reporting periods beginning on or after 1 January 2023, with comparative restatement for 2022. Early adoption is permissible, however the Scheme has chosen not to early adopt.

IFRS 17 aims to standardise the accounting treatment of insurance contracts, by providing the basis for recognising, measuring and disclosing insurance contracts as defined in the Standard, including those contracts that meet the definition of a reinsurance contract. The main principle introduced by IFRS 17 is to recognise revenue arising from insurance contracts to best reflect the transfer of services provided in any given reporting period. IFRS 17 does not allow for profits to be earned at inception of insurance contracts i.e. initial recognition, but rather deferred to reflect to the delivery of contracted obligations. In line with the Standard's requirements, losses on onerous contracts are required to be recognised upfront on initial recognition.

IFRS 17 introduces a default measurement model for insurance contract liabilities referred to as the General Measurement Model or "GMM".

An optional simplified approach referred to as the Premium Allocation Approach or "PAA" is available to entities where their contracts have a coverage period of 12 months or less, or where the entity reasonably expects that applying the PAA would not produce a measurement of the liability for remaining coverage (component of the insurance contract liabilities) that would differ materially from that under the GMM. When a Scheme is eligible to apply the PAA, simplifications can be made with respect to discounting insurance contract liabilities, expensing acquisition cashflows and the identification of onerous contracts, where certain criteria are met.

Due to the short duration nature of the Scheme's contracts, the Scheme expects to apply the PAA.

Unless impracticable to do so, the Standard requires full retrospective application prior to the transition date of 1 January 2023. The Scheme will be applying the Standard fully retrospectively.

The Scheme has assessed both its gross contracts and risk transfer arrangements and assessed these to meet the definition of insurance/reinsurance contracts in accordance with IFRS 17. This remains unchanged from IFRS 4.

The Scheme has assessed the requirements of the standard and agreed a project plan to implement the standard. The main outcomes of the assessment are summarised below.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS (CONTINUED)

(a) New standards, amendments and interpretations issued and not yet effective in 2022 and relevant to the Scheme (continued)

STANDARD	AMENDMENT	DETAILS OF AMENDMENT	IMPLEMENTATION PROGRESS	TRANSITIONAL IMPACT
IFRS 17 Insurance Contracts	**Separation of components**	An investment component is the amount that an insurance contact requires the entity to repay to a policyholder in all circumstances regardless of whether an insured event occurs. IFRS 17 requires an entity to separate a distinct investment component from the host insurance contract if both the following conditions are met: 1. An investment component and an insurance component are highly interrelated if, and only if: a) the entity is unable to measure one component without considering the other. Thus, if the value of one component varies according to the value of the other, an entity shall apply IFRS 17 to account for the combined investment and insurance component; or b) the policyholder is unable to benefit from one component unless the other is also present. Thus, if the lapse or maturity of one component in a contract causes the lapse or maturity of the other, the entity shall apply IFRS 17 to account for the combined investment component and insurance component. 2. A contract with equivalent terms is sold, or could be sold, separately in the same market of the same jurisdiction, either by entities that issue insurance contracts or by other parties.	In some benefit options, the Scheme provides for personal medical savings account facilities to members. Savings contributions are recognised when at least one of the parties has performed and that is generally deemed to be when the contribution has been received and withdrawals (i.e. claims) when paid. Unexpended savings at the end of the accounting period are carried forward to meet future expenses for which the members are responsible. Unexpended savings are classified as current liabilities in the statement of financial position and are derecognised as and when utilisation by the members occurs or when the funds are refunded to the member. Medical savings are allocated on an annual basis. In instances where the member has utilised the saving prior to making a contribution towards that saving, this effectively results in a "loan" to the member and will therefore be recognised as a receivable until such time it has been settled by the member. There is no distinction between Scheme and PMSA assets and all assets are invested in accordance with the Medical Schemes Act and Regulations. Furthermore, there is no statutory requirement for assets arising from any unspent PMSA allocation to be invested separately. Personal medical savings accounts will be accounted for as part of the membership contracts, in line with the requirements of IFRS 17, as these accounts are non-distinct investment components.	Contracts issued by medical schemes are insurance contracts as defined in IFRS 17 Insurance Contracts (IFRS 17) and fall within the scope of this standard. As a result, medical schemes are required to apply IFRS 17 retrospectively for their financial periods commencing on 1 January 2023. Before this date, medical schemes are applying IFRS 4 Insurance Contracts (IFRS 4) when preparing annual financial statements. In line with the above, the financial statements for the year ended 31 December 2022 have been prepared in accordance with IFRS 4 Insurance Contracts. The Scheme will apply IFRS 17 for the year commencing on 1 January 2023. The standard will be applied retrospectively by adopting the full retrospective approach.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS (CONTINUED)

(a) New standards, amendments and interpretations issued and not yet effective in 2022 and relevant to the Scheme (continued)

STANDARD	AMENDMENT	DETAILS OF AMENDMENT	IMPLEMENTATION PROGRESS	TRANSITIONAL IMPACT
IFRS 17 Insurance Contracts	**Level of aggregation of insurance contracts**	The standard requires an entity to identify portfolios of insurance contracts. A portfolio comprises contracts subject to similar risks and managed together. Contracts within a product line would be expected to have similar risks and hence would be expected to be in the same portfolio if they are managed together. Contracts in different product lines would not be expected to have similar risks and hence would be expected to be in different portfolios. Portfolios of insurance contracts issued are required to be divided into minimum of: • A group of contracts that are onerous at initial recognition. • A group of contracts that at initial recognition have no significant possibility of becoming onerous subsequently; and • A group of remaining contracts in the portfolio. If, applying the above requirements, contracts within a portfolio would fall into different groups only because law or regulation specifically constraints the entity's practical to set a different price or level of benefits for policyholders with different characteristics, the Scheme will include those contracts in the same group. The Scheme shall not include contracts issued more than one year apart in the same group.	This Scheme has performed as assessment with reference to the IFRS 17 requirements and deems it appropriate that all 12 of its benefit options are managed together as a single portfolio of contracts that display similar risks. Therefore contracts held by the Scheme across all the members are considered to constitute a single portfolio in their entirety. The Scheme will further apply the exemption to include all contracts within the same group given that the Medical Schemes Act prevents the Scheme from setting different prices for its members. The Scheme will not apply this requirement by analogy to other items.	Contracts issued by medical schemes are insurance contracts as defined in IFRS 17 Insurance Contracts (IFRS 17) and fall within the scope of this standard. As a result, medical schemes are required to apply IFRS 17 retrospectively for their financial periods commencing on 1 January 2023. Before this date, medical schemes are applying IFRS 4 Insurance Contracts (IFRS 4) when preparing annual financial statements. In line with the above, the financial statements for the year ended 31 December 2022 have been prepared in accordance with IFRS 4 Insurance Contracts. The Scheme will apply IFRS 17 for the year commencing on 1 January 2023. The standard will be applied retrospectively by adopting the full retrospective approach.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS (CONTINUED)

(a) New standards, amendments and interpretations issued and not yet effective in 2022 and relevant to the Scheme (continued)

STANDARD	AMENDMENT	DETAILS OF AMENDMENT	IMPLEMENTATION PROGRESS	TRANSITIONAL IMPACT
IFRS 17 Insurance Contracts	**Initial recognition**	An entity shall recognise a group of insurance contracts it issues from the earliest of the following: (a) the beginning of the coverage period of the group of contracts; (b) the date when the first payment from a policyholder in the group becomes due; and (c) for a group of onerous contracts, when the group becomes onerous. **Onerous Contracts** For contracts issued to which an entity applies the premium allocation approach, the entity shall assume no contracts in the portfolio are onerous at initial recognition, unless facts and circumstances indicate otherwise. An entity shall assess whether contracts that are not onerous at initial recognition have no significant possibility of becoming onerous subsequently by assessing the likelihood of changes in applicable facts and circumstances.	The Bonitas coverage period aligns to the financial reporting year as both begin on 1 January each year and conclude on 31 December of the same year. The contracts with members will be recognised from 1 January, or from inception of cover should the member join Bonitas after 1 January. The Scheme will recognise contracts at the earliest of the three events, either the beginning of the coverage period of the group of contracts, the date when the first payment from the policyholder in the group becomes due or for a group of onerous contracts, when the group becomes onerous. The onerous loss assessment will be performed annually around December once the Council for Medical Schemes has approved the pricing and benefit changes and the Scheme's budget has been approved by the Board of Trustees for the following year. The Scheme monitors the performance of insurance contracts consistently, as such, should at any time during the coverage period, facts and circumstances indicate that a group of insurance contracts is onerous, an onerous provision will be determined and recognised immediately.	Contracts issued by medical schemes are insurance contracts as defined in IFRS 17 Insurance Contracts (IFRS 17) and fall within the scope of this standard. As a result, medical schemes are required to apply IFRS 17 retrospectively for their financial periods commencing on 1 January 2023. Before this date, medical schemes are applying IFRS 4 Insurance Contracts (IFRS 4) when preparing annual financial statements. In line with the above, the financial statements for the year ended 31 December 2022 have been prepared in accordance with IFRS 4 Insurance Contracts. The Scheme will apply IFRS 17 for the year commencing on 1 January 2023. The standard will be applied retrospectively by adopting the full retrospective approach.
	Contract boundary	Cash flows are within the boundary of an insurance contract if they arise from subsequent rights and obligations that exist during the reporting period in which the entity: • Can compel the policyholder to pay the premiums; or • Has a substantive obligation to provide the policyholder with insurance contract services. This substantive obligation ends when both of the following criteria are satisfied: • The entity has a practical ability to reassess the risk of the portfolio of insurance contracts and as a result can set the price or level of benefits that fully reflects the risks of that portfolio; and • The pricing of the premiums up to the date when the risks are reassessed does not take into account the risks that relate to the periods after the reassessment date.	The contract boundary has been assessment as being one year from 1 January to 31 December each year.	

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS (CONTINUED)

(a) New standards, amendments and interpretations issued and not yet effective in 2022 and relevant to the Scheme (continued)

STANDARD	AMENDMENT	DETAILS OF AMENDMENT	IMPLEMENTATION PROGRESS	TRANSITIONAL IMPACT
IFRS 17 Insurance Contracts	**Measurement model**	IFRS 17 introduces a default measurement model for insurance contract liabilities referred to as the General Measurement Model (GMM). An optional simplified approach referred to as the Premium Allocation Approach (PAA) is available to entities where their contracts have a coverage period of 12 months or less, or where the entity reasonably expects that applying the PAA would not produce a measurement of the liability for remaining coverage (component of the insurance contract liabilities) that would differ materially from that under the GMM. When a Scheme is eligible to apply the PAA, simplifications can be made with respect to discounting insurance contract liabilities, expensing acquisition cashflows and the identification of onerous contracts, where certain criteria are met.	***Member contracts*** The Scheme has taken the accounting policy choice to apply the PAA model to all contracts since the coverage period for all contracts issued is one year or less. ***Reinsurance contracts held*** Re-insurance contracts held will be accounted for per the PAA since the coverage period of each contract in the group of reinsurance contracts held is one year or less.	Contracts issued by medical schemes are insurance contracts as defined in IFRS 17 Insurance Contracts (IFRS 17) and fall within the scope of this standard. As a result, medical schemes are required to apply IFRS 17 retrospectively for their financial periods commencing on 1 January 2023. Before this date, medical schemes are applying IFRS 4 Insurance Contracts (IFRS 4) when preparing annual financial statements. In line with the above, the financial statements for the year ended 31 December 2022 have been prepared in accordance with IFRS 4 Insurance Contracts. The Scheme will apply IFRS 17 for the year commencing on 1 January 2023. The standard will be applied retrospectively by adopting the full retrospective approach.
	Liability for remaining coverage (LRC)	The LRC is defined as an entity's obligation to investigate and pay claims under existing insurance contracts for insured events that relates to the unexpired portion of the coverage period. Using the premium allocation approach, the Scheme will measure the liability for remaining coverage as follows: (a) on initial recognition, the carrying amount of the liability is: (i) the premiums, if any, received at initial recognition; (b) at the end of each subsequent reporting period, the carrying amount of the liability is the carrying amount at the start of the reporting period: (i) plus the premiums received in the period; (ii) plus any adjustment to a financing component, (iii) minus the amount recognised as insurance revenue for coverage provided in that period; and (iv) minus any investment component paid or transferred to the liability for incurred claims. If insurance contracts in the group have a significant financing component, an entity shall adjust the carrying amount of the LRC to reflect the time value of money and the effect of financial risk using the discount rates as determined on initial recognition. The entity is not required to adjust the carrying amount of the liability for remaining coverage to reflect the time value of money and the effect of financial risk if, at initial recognition, the entity expects that the time between providing each part of the coverage and the related premium due date is no more than a year. In applying the PAA, the Scheme may choose to recognise any insurance acquisition cash flows as expenses when it incurs those costs, provided that the coverage period of each contract in the group at initial recognition is no more than one year.	***Measurement of Liability for remaining coverage : Initial and subsequent*** Bonitas has opted to adopt the PAA (as discussed above). Therefore, a simplified approach to the measurement of the LRC will be applied. ***Significant financing component: LRC*** Bonitas will not discount the LRC since the remaining coverage period for which the liability is raised is one month (therefore less than a year) since members pay contribution on a monthly basis ***Insurance acquisition cash flows*** In applying the premium allocation approach, the Scheme has elected to recognise any insurance acquisition cash flows as expenses when it incurs those costs, provided that the coverage period of each contract in the group at initial recognition is no more than one year.	

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS (CONTINUED)

(a) New standards, amendments and interpretations issued and not yet effective in 2022 and relevant to the Scheme (continued)

STANDARD	AMENDMENT	DETAILS OF AMENDMENT	IMPLEMENTATION PROGRESS	TRANSITIONAL IMPACT
IFRS 17 Insurance Contracts	**Liability for incurred claims (LIC)**	The LIC is defined as an entity's obligation to (a) investigate and pay valid claims for insured events that have already occurred, including events that have occurred but for which claims have not been reported (IBNR), and other incurred insurance expenses; and (b) pay amounts that are not included in (a) that relate to insurance contract services that have already been provided or any investment components or other amounts that are not related to the provision of insurance contract services and that are not in the LRC. In applying the PAA, an entity shall measure the LIC for the group of insurance contracts at fulfilment cash flows relating to incurred claims, within the boundary of each contract in the group, applying the GMM. The entity is not required to adjust future cash flows for the time value of money and the effect of financial risk if those cash flows are expected to be paid or received in one year or less from the date the claims are incurred.	***Measurement of Liability for incurred claims*** As the scheme is applying the PAA, it has to measure the LIC for the group of insurance contracts at the fulfilment cash flows relating to incurred claims, applying the general measurement model. For insurance contracts issued at each of the subsequent reporting dates the LIC will consist of: a. Best estimate of fulfilment cash and b. Risk adjustment The Scheme will estimate which cash flows are expected and the probability that they will occur as at the measurement date. In making these expectations, the Scheme will use information about past events, current conditions and forecasts of future conditions. The uncertainty in the insurance contracts lies in the number, severity and timing of claims. Assumptions used to develop estimates about future cash flows will be reassessed at each reporting date and adjusted where required. Judgement is involved in assessing the most appropriate technique to estimate insurance liabilities. The generally accepted actuarial methodology used in assessing the estimated claims outcome of insurance liabilities is the chain ladder method. The chain ladder method involves an analysis of historical claims development factors and the selection of estimated development factors based on historical patterns. Run-off triangles will be used in situations where it takes time after the treatment date for the full extent of the claims to become known. It is assumed that payments will emerge in a similar way in each service month. The proportional increase in known cumulative payments from one development month to the next can then be used to calculate payments for future development months. The following will be taken into account when estimating the LIC: • The level of homogeneity of the data; • Changes in patterns of claims and claims processing; • Changes in the composition of the Scheme ie. distribution of members and their beneficiaries across various options; • Changes in benefit limits; and • Changes in prescribed minimum benefits. Risk adjustment - the risk adjustment for non-financial risk will be applied to the present value of the estimated future cash flows and will reflect the compensation the Scheme requires for bearing the uncertainty about the amount and timing of cash flows from non-financial risk as the Scheme fulfils contracts. The risk adjustment will be calculated at portfolio level as the Scheme does not have groups due to regulations that constrain the Scheme's ability to set a price for different members. The confidence level method will be used to derive the overall risk adjustment for non-financial risk. In the confidence level method, the risk adjustment will be determined by applying a confidence level to the run-off triangles used to calculate the LIC. ***Significant financing component: LIC*** Discounting of LIC is not required as claims are typically received and paid within a year from the date the claims were incurred.	Contracts issued by medical schemes are insurance contracts as defined in IFRS 17 Insurance Contracts (IFRS 17) and fall within the scope of this standard. As a result, medical schemes are required to apply IFRS 17 retrospectively for their financial periods commencing on 01 January 2023. Before this date, medical schemes are applying IFRS 4 Insurance Contracts (IFRS 4) when preparing annual financial statements. In line with the above, the financial statements for the year ended 31 December 2022 have been prepared in accordance with IFRS 4 Insurance Contracts. The Scheme will apply IFRS 17 for the year commencing on 01 January 2023. The standard will be applied retrospectively by adopting the full retrospective approach.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS (CONTINUED)

(a) New standards, amendments and interpretations issued and not yet effective in 2022 and relevant to the Scheme (continued)

STANDARD	AMENDMENT	DETAILS OF AMENDMENT	IMPLEMENTATION PROGRESS	TRANSITIONAL IMPACT
	Onerous contracts	In addition to identifying and recognising onerous contracts at initial recognition, if at any time during the coverage period, facts and circumstances indicate that a group of insurance contracts is onerous, an entity shall calculate the difference between: • the carrying amount of the LRC determined applying the PAA; and • the fulfilment cash flows that relate to the remaining coverage of the group, applying the GMM. To the extent that the fulfilment cash flows exceed the carrying amount of the LRC (determined applying the PAA), the entity shall recognise a loss in profit or loss and increase the liability for remaining coverage.	***Measurement of onerous contracts*** The Scheme will assess the onerous contracts and where the Scheme is priced as a whole for a deficit result, based on fulfilment cash flows the group of contracts will be considered onerous and will increase the liability for remaining coverage and the related loss that will be recognised in the profit or loss immediately. This will be reversed in the subsequent periods.	Contracts issued by medical schemes are insurance contracts as defined in IFRS 17 Insurance Contracts (IFRS 17) and fall within the scope of this standard. As a result, medical schemes are required to apply IFRS 17 retrospectively for their financial periods commencing on 01 January 2023. Before this date, medical schemes are applying IFRS 4 Insurance Contracts (IFRS 4) when preparing annual financial statements. In line with the above, the financial statements for the year ended 31 December 2022 have been prepared in accordance with IFRS 4 Insurance Contracts. The Scheme will apply IFRS 17 for the year commencing on 01 January 2023. The standard will be applied retrospectively by adopting the full retrospective approach.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS (CONTINUED)

(a) New standards, amendments and interpretations issued and not yet effective in 2022 and relevant to the Scheme (continued)

STANDARD	AMENDMENT	DETAILS OF AMENDMENT	IMPLEMENTATION PROGRESS	TRANSITIONAL IMPACT
IFRS 17 Insurance Contracts	**Insurance Service result**	A Scheme will present in profit or loss insurance revenue arising from the groups of insurance contracts issued which shall depict the provision of coverage and other services arising from the group of insurance contracts at an amount that reflects the consideration to which the entity expects to be entitled in exchange for those services. A Scheme will present profit or loss insurance service expenses arising from a group of insurance contracts issued, comprising incurred claims (excluding repayments of investment components), and other incurred insurance services. A Scheme will separately disclose a reconciliation in insurance expenses, showing separately, if applicable: (i) incurred claims (excluding investment components) and other incurred insurance service expenses; (ii) amortisation of insurance acquisition cash flows; (iii) changes that relate to past service, i.e. changes in fulfilment cash flows relating to the liability for incurred claims; and (iv) changes that relate to future service, i.e. losses on onerous groups of contracts and reversals of such losses. Reinsurance contracts - income and expenses A Scheme may present the income or expenses from a group of reinsurance contracts held, other than finance income or expenses, as a single amount; or the Scheme may present separately the amounts recovered from the reinsurer and an allocation of the premiums paid that together give a net amount equal to that single amount.	***Insurance revenue*** As the Scheme will apply premium allocation approach, insurance revenue for the period is the amount of expected premium receipts (excluding any investment component and adjusted to reflect effect of financial risk, if applicable) allocated to the period. The Scheme will allocate the expected premium receipts to each period of coverage on the basis of the passage of time. ***Insurance service expenses*** The Scheme will present in profit or loss insurance service expenses arising from a group of insurance contracts issued, comprising incurred claims (excluding repayments of investment components), other incurred insurance service expenses, for example attributable fixed and variable overheads, changes that relate to past service i.e. changes in fulfilment cash flows relating to the liability for incurred claims and changes that relate to future services, i.e. losses on onerous groups of contracts and reversals of such losses. ***Reinsurance contracts held*** The Scheme will present the income or expenses from a group of reinsurance contracts held, other than insurance finance income or expenses, as a single amount	Contracts issued by medical schemes are insurance contracts as defined in IFRS 17 Insurance Contracts (IFRS 17) and fall within the scope of this standard. As a result, medical schemes are required to apply IFRS 17 retrospectively for their financial periods commencing on 01 January 2023. Before this date, medical schemes are applying IFRS 4 Insurance Contracts (IFRS 4) when preparing annual financial statements. In line with the above, the financial statements for the year ended 31 December 2022 have been prepared in accordance with IFRS 4 Insurance Contracts. The Scheme will apply IFRS 17 for the year commencing on 01 January 2023. The standard will be applied retrospectively by adopting the full retrospective approach.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.5 NEW STANDARDS, AMENDMENTS TO PUBLISHED STANDARDS AND INTERPRETATIONS (CONTINUED)

(a) New standards, amendments and interpretations issued and not yet effective in 2022 and relevant to the Scheme (continued)

Implications of adopting IFRS 17

Key Performance Indicators

Solvency is a Medical Schemes Act metric and is defined by Regulation 29 whereby a medical scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may not be less than 25%.

The existing method applied to calculate the accumulated funds ratio will remain unchanged. Bonitas has under consideration to present both solvency calculations (including and excluding the onerous provision loss) when reporting the solvency result until official guidance is provided by the Council of Medical Schemes.

IFRS 17 Insurance Contracts: Expected impact of implementation assessment

The onerous contract loss assessment will be performed annually in December once the Council for Medical Schemes has approved the Scheme's pricing and benefit changes and the Scheme's budget has been approved by the Board of Trustees for the following financial period. Where the Scheme is priced as a whole for a deficit position at a net healthcare result level, the group of contracts will be considered onerous and the total onerous loss will be recognised immediately in the current financial period prior to the losses being incurred. While cash flows are not recorded in the Statement of Comprehensive Income they are considered in assessing onerous contracts. No discounting will be applied as no contracts exceed the 12-month period. The insurance contracts will be recognised from 1 January or from inception of cover should a member join the Scheme after 1 January. A risk adjustment will also be computed at portfolio level by applying a confidence level to run-off triangles used to calculate the LIC.

The onerous loss and risk adjustment recognised in the previous year would be reversed in the following financial year and offset with the actual year's financial results reported in the Statement of Comprehensive Income.

Recognition of onerous loss:

- Decrease in accumulated funds (SOFP) in the current year and increase in accumulated funds with the reversal in the following year
- Increase in current liabilities (SOFP) – Liabilities for remaining coverage - in the current year and decrease in funds with reversal in the following year
- Decrease in comprehensive income (SOCI) in the current year and increase in comprehensive income with the reversal in the following year

Recognition of risk adjustment

- Decrease in accumulated funds (SOFP) in the current year and increase in accumulated funds with the reversal in the following year
- Increase in current liabilities (SOFP) – Liabilities for incurred claims - in the current year and decrease in funds with reversal in the following year
- Decrease in comprehensive income (SOCI) in the current year and increase in comprehensive income with the reversal in the following year

2.2 EVENTS AFTER REPORTING DATE

Recognised amounts in the annual financial statements are adjusted to reflect events arising after the 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.

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;
- 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.

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.

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 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; and 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.

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 prepayments.

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.

2.13.3 OTHER LONG-TERM BENEFITS

There is currently a long term deferred remuneration scheme/long-term employee benefit obligation (LTI) in place whereby key employees who qualify are entitled to a deferred portion of each year's incentive determined based on tenure and certain performance conditions agreed to by the Board of Trustees. The amounts are payable at the end of the applicable three-year vesting period if the employees are still in the employment of the Scheme and the performance conditions have been met. The Board of Trustees will approve the final amount of the LTI to be settled in line with the terms and conditions of the Scheme's incentive policy and each participant will be allocated their amounts payable accordingly.

The liability due to eligible participants is recognised over the required service/vesting period and reflects the present value of amounts due to the participants at the end of that period. The liability is measured on the mostly likely outcome basis, with the corresponding expense recognised over the service period.

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. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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.

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 average 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. USE OF ESTIMATES AND JUDGEMENTS (CONTINUED)

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.

3.3 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.

4. PROPERTY AND EQUIPMENT

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

R'000	Note	2022	2021
Property and equipment	4.1	**1 176**	2 269
Right of use asset	4.2	**6 214**	1 962
		7 390	4 231

4. PROPERTY AND EQUIPMENT (CONTINUED)

R'000	Motor Vehicles	Leasehold improvements	Computer Equipment	Office Equipment	Furniture and Fittings	Total
4.1 COST						
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
Additions	**–**	**26**	**236**	**–**	**65**	**327**
Disposals/scrappings	**–**	**–**	**(117)**	**–**	**(132)**	**(249)**
Balance at 31 December 2022	**359**	**4 365**	**5 659**	**1 161**	**5 199**	**16 743**
ACCUMULATED DEPRECIATION						
Balance at 31 December 2020	287	2 771	5 243	349	4 108	12 758
Disposals/scrappings	–	–	(77)	–	–	(77)
Depreciation for the period	72	890	225	218	310	1 715
Balance at 31 December 2021	359	3 661	5 391	567	4 418	14 396
Disposals/scrappings	**–**	**–**	**(12)**	**–**	**(132)**	**(144)**
Depreciation for the period	**–**	**704**	**111**	**210**	**290**	**1 315**
Balance at 31 December 2022	**359**	**4 365**	**5 490**	**777**	**4 576**	**15 567**
CARRYING AMOUNT						
Balance at 31 December 2021	–	678	150	593	848	2 269
Balance at 31 December 2022	**0**	**(0)**	**169**	**384**	**623**	**1 176**

4.2 LEASE

The Scheme leases the building from which it operates its head office. The remaining lease term on 31 December 2022 was determined to be two years and 9 months. Depreciation charge is determined on a straight line basis over the remaining lease term. There are no impairments in the current period. Information about the lease for which the Scheme is the lessee is presented below:

RIGHT OF USE ASSET

R'000	Building
Balance at 1 January 2021	**5244**
Depreciation charge for the year	**(3 282)**
Balance at 31 December 2021	**1 962**
Additions	**6 779**
Depreciation charge for the year	**(2 527)**
Balance at 31 December 2022	**6 214**

LEASE LIABILITIES

R'000	Building	Total
Maturity Analysis – contractual undiscounted cashflows:		
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**
Not later than one year	**2 511**	**2 511**
Later than one year and not later than five years	**4 746**	**4 746**
Total undiscounted lease liabilities as at 31 December 2022	**7 257**	**7 257**

4. PROPERTY AND EQUIPMENT (CONTINUED)

4.2 LEASE (CONTINUED)

LEASE LIABILITIES (CONTINUED)

The Scheme terminated its head office lease as of 30 September 2022 and entered into a new lease agreement effective 1 October 2022 for a 3 year period ending 30 September 2025. Included in the Statement of Financial Position is the lease liability for the remaining lease term of 2 years and 9 months as at 31 December 2022:

	2022 R'000	2021 R'000
Current lease liability	**1 980**	3 047
Non-current lease liability	**4 342**	–
	6 322	3 047

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 35% 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 2022:

	2022 R'000	2021 R'000
Interest on lease liability	**(264)**	(404)
Rental costs – variable in nature	**(1 997)**	(1 858)
	(2 261)	(2 262)

Total cash outflow with respect to the head office lease for 31 December 2022 is as follows:

	2022 R'000	2021 R'000
Lease liability cashflows	**(3 768)**	(4 009)
Rental costs – variable in nature	**(1 997)**	(1 858)
	(5 765)	(5 867)

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.

5. INVESTMENT PROPERTIES

	2022 R'000	2021 R'000
Balance at the beginning of the year	**77 000**	77 700
Fair value increase/(decrease) in investment property	**1 500**	(700)
Balance at the end of the year	**78 500**	77 000
Direct operating expenses incurred in the generation of rental income applicable to investment properties	**4 760**	4 577

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 R10.0 million (2021: R9.8 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, on 11 January 2023, using an Income capitalisation approach. The capitalisation rate used in determining the open market value was 9.50% (2021: 9.25%).

		2022 R'000	2021 R'000
6.	**FINANCIAL ASSETS HELD AT FAIR VALUE THROUGH PROFIT OR LOSS**		
	Balance at the beginning of the year	**8 245 970**	7 139 473
	Acquisition through amalgamation (Note 28)	**666 487**	–
	Additions/reinvestments	**1 798 938**	1 009 999
	Withdrawals	**(1 215 958)**	(842 104)
	Interest income reinvested	**186 469**	102 801
	Dividend income reinvested	**22 161**	1 203
	Asset management fees capitalised to investments	**(882)**	(1 909)
	Net fair value gains on fair value assets through profit or loss (note 17)	**193 225**	836 507
	Balance at the end of the year	**9 896 410**	8 245 970
	Non-current	**4 892 220**	4 784 072
	Current	**5 004 190**	3 461 898
		9 896 410	8 245 970
	Comprises:		
	Listed equities	**4 449 465**	3 154 282
	Bonds	**3 581 279**	3 684 494
	Money market instruments	**1 865 666**	1 407 194
		9 896 410	8 245 970

		2022 R'000	2021 R'000
7.	**INSURANCE, TRADE AND OTHER RECEIVABLES**		
7.1	**INSURANCE RECEIVABLES**		
	Contributions outstanding	**587 008**	646 822
	Recoveries due from members for co-payments	**5 404**	6 545
	Service provider receivables	**5 370**	5 745
	Amounts owing from Managed care organisation	**–**	3 631
	Amounts owing from related entities	**3 663**	9 492
	Receivables under risk transfer arrangements	**107 848**	39 194
	Savings plan account advances (note 11)	**1 300**	1 333
	Allowance for impairment losses	**(15 081)**	(15 523)
	Balance at 1 January	**(15 523)**	(24 566)
	Acquisition through amalgamation (Note 28)	**(1 430)**	–
	Decrease in provision charged to profit or loss (note 16)	**1 872**	9 033
	Total insurance receivables	**695 512**	697 239
7.2	**TRADE AND OTHER RECEIVABLES**		
	Prepaid expenses	**5 887**	5 714
	Other receivables	**3 886**	3 464
	Interest receivables	**42**	12
	Rent receivables	**838**	564
	Rent deposit	**1 210**	1 533
	Sundry receivables	**1 796**	1 355
	Total trade and other receivables	**9 773**	9 178
	Total insurance, trade and other receivables	**705 285**	706 417

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

	2022 R'000	2021 R'000
8. CASH AND CASH EQUIVALENTS		
Cash with investment managers	**240 963**	128 472
Call accounts with investment managers	**85 421**	90 739
Current accounts with banks	**319 631**	547 254
Total cash and cash equivalents	**646 015**	766 465

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 6.4% (prior year: 4.6%) on call account balances.

9. LONG-TERM EMPLOYEE BENEFIT OBLIGATION

Eligible executives and employees qualify for a long-term incentive that runs over a fixed three year cycle. The vesting criteria are dependent upon both service and performance elements. The three year cycle/vesting period runs from January 2021 to December 2023.

	2022 R'000	2021 R'000
Uninvested long-term employee benefit obligation	**3 449**	–
	3 449	–

The liability is recognised over the required service/vesting period and reflects the present value of amounts due to the participants on a most likely outcome basis at the end of the three year cycle. A discount factor of 7% was utilised to present value the liability.

Of the total liability reported of R3.4 million, an amount of R1.4 million related to the previous financial period (2021). No restatement has taken place given that the amount is immaterial in nature

	2022 R'000	2021 R'000
10. OUTSTANDING RISK CLAIMS PROVISION		
Covered by risk transfer arrangements	**50 043**	39 194
Not covered by risk transfer arrangements	**910 447**	865 156
Outstanding risk claims provision – incurred but not yet reported (IBNR)	**960 490**	904 350

	Covered by risk transfer arrangements R'000	Not covered by risk transfer arrangements R'000
2022		
Analysis of movements in outstanding risk claims		
Balance at 1 January	**39 194**	**865 156**
Acquisition through amalgamation (note 28)	**53**	**56 293**
Payments in respect of prior year claims	**(39 247)**	**(804 954)**
Over provision in prior year*	**–**	**116 495**
Adjustment for current period	**50 043**	**793 952**
Balance at 31 December	**50 043**	**910 447**
Net exposure in respect of outstanding risk claims		
Gross outstanding risk claims		**960 490**
Less: Estimated risk transfer arrangements recoveries		**(50 043)**
Net outstanding risk claims		**910 447**

* *The over provision of R116 million in the prior year was as a result of faster run-off speeds observed for 2021 treatments when compared to earlier years' trends, on which these assumptions were based, amounting to R86 million. This was mainly as a result of faster run-off speeds associated with specialists costs as illustrated below. In addition R30 million related to vaccine claims from the public sector that were not forthcoming.*

10. OUTSTANDING RISK CLAIMS PROVISION (CONTINUED)

	Specialists	
Month	Actual run-off observed	Assumed run-off
0	**58%**	**51%**
1	**90%**	**86%**
2	**95%**	**91%**
3	**98%**	**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%**

	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

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 2023.

Data was compared to the Scheme's December 2022 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 2022. 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.

10. OUTSTANDING RISK CLAIMS PROVISION (CONTINUED)

DATA, METHODOLOGY AND ASSUMPTIONS (CONTINUED)

10.2 PROCESS USED TO DETERMINE THE ASSUMPTIONS (CONTINUED)

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.

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 2020, 2021 and 2022 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 Fund'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

R' million	Total claims	Outstanding risk claims provision[#]	Change in outstanding risk claims provision
2022			
As at 31 December	**15 500**	**910**	**–**
Run-off factors 20% faster than assumed	**15 464**	**874**	**(36)**
Run-off factors 20% slower than assumed	**15 537**	**947**	**37**
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

[#] *Not covered by risk transfer arrangements.*

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

11.1 PERSONAL MEDICAL SAVINGS ACCOUNT LIABILITY

	2022 R'000	2021 R'000
Balance of Personal medical savings account liability at 1 January	**894 037**	812 078
Less: Personal medical savings plan advances	**(1 333)**	(1 448)
Add: Acquisition through amalgamation (note 28)	**67 920**	–
Balance of Personal medical savings account liability at 1 January	**960 624**	810 630
Add: Savings account contributions received	**844 507**	749 331
Savings plan liabilities transferred to the Scheme from other schemes in terms of Regulation 10 (4)	**2 854**	1 914
Net interest paid on savings plan account	**40 380**	23 606
Interest paid	**54 625**	35 761
Investment fees	**(1 251)**	(732)
Recovery of personal medical savings account investment and administrative expense (note 18)	**(12 994)**	(11 423)
Less: Claims paid on behalf of members	**(735 899)**	(627 388)
Refunds on death or resignation in terms of Regulation 10 (5)	**(93 431)**	(55 913)
Personal medical savings plan advances (note 7)	**1 300**	1 333
Advances on savings accounts written off	**–**	68
Unclaimed Personal medical savings account liability written off to Scheme funds	**(4 200)**	(9 544)
Balances due to members on Personal medical savings accounts held at 31 December	**1 016 135**	894 037

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 2022 but not reported will amount to R8.8 million (2021: R9.2 million). Advances paid on personal medical savings accounts are funded by the Scheme and are included in trade and other receivables (refer to note 7).

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 6.0% (2021: 4.7%) and 4.5% was allocated to the PMSA balances.

	2022 R'000	2021 R'000
12. INSURANCE, TRADE AND OTHER PAYABLES		
12.1 INSURANCE PAYABLES		
Contributions received in advance	**399 982**	420 116
Reported claims not yet paid (note 12.3)	**108 265**	74 874
Credit balances due to members – overpayments	**5 898**	7 037
Total insurance payables	**514 145**	502 027
12.2 TRADE AND OTHER PAYABLES		
Accrual of external audit fees	**2 216**	2 277
Accrual of internal audit fees	**321**	581
Amounts owing to administrator	**4 376**	7 322
Amounts owing to related entities (including marketing costs)	**23 149**	15 414
South African Revenue Service	**257**	225
Broker fees payable	**–**	10 000
Accrual for advertising and marketing expenses (excluding related entity)	**6 847**	1 377
Sundry payables	**36 753**	12 095
Total trade and other payables	**73 919**	49 291
Total insurance, trade and other payables	**588 064**	551 318

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

	2022 R'000	2021 R'000
12.3 REPORTED CLAIMS NOT YET PAID		
Balance at 1 January	**74 874**	104 787
Net movement – members and providers	**33 391**	(29 913)
Claims received	**14 419 414**	14 036 589
Claims paid	**(14 386 023)**	(14 066 502)
Reported claims not yet paid	**108 265**	74 874

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.

	2022 R'000	2021 R'000
13. RISK CONTRIBUTION INCOME		
Gross contributions per registered rules	**20 027 822**	18 887 490
Less: Personal medical savings account contributions received*	**(844 507)**	(749 331)
Risk contribution income	**19 183 315**	18 138 159

* *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.*

		2022 R'000	2021 R'000
14.	**RELEVANT HEALTHCARE EXPENDITURE**		
	Net claims incurred (14.1)	**17 032 156**	15 851 053
	Accredited managed healthcare services (14.2)	**591 335**	549 251
	Net income on risk transfer arrangements (14.3)	**(184 458)**	(110 668)
	Total relevant healthcare expenditure	**17 439 033**	16 289 636
14.1	**NET CLAIMS INCURRED**		
	Claims incurred excluding claims incurred in respect of risk transfer arrangements	**15 374 679**	14 271 484
	Current year claims per registered rules	**16 065 287**	14 966 204
	Movement in outstanding claims provision	**45 291**	(67 332)
	Provision in prior year	**(865 156)**	(932 488)
	Provision for the current year	**910 447**	865 156
	Claims paid from Personal Medical Savings Account**	**(735 899)**	(627 388)
	Claims incurred in respect of risk transfer arrangements	**1 732 442**	1 642 016
	Current year claims incurred in respect of risk transfer arrangements	**1 721 593**	1 646 609
	Movement in outstanding claims provision (note 10)	**10 849**	(4 593)
	Third party claims recoveries (note 14.4)	**(74 965)**	(62 447)
	Net claims incurred	**17 032 156**	15 851 053

** *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

	2022 R'000	2021 R'000
Hospital benefit management	**196 571**	191 595
Medicine benefit management	**96 590**	88 732
Disease management	**137 554**	123 051
HIV/AIDS management	**57 849**	54 601
Provider network management	**81 568**	74 020
Dental risk management	**21 203**	17 252
	591 335	549 251

	2022 R'000	2021 R'000
14. RELEVANT HEALTHCARE EXPENDITURE (CONTINUED)		
14.3 RISK TRANSFER ARRANGEMENTS		
Premiums/fees paid	**1 547 984**	1 531 348
Dental Information Systems Proprietary Limited	**378 198**	360 163
Scriptpharm Risk Management Proprietary Limited*	**785 099**	771 362
Preferred Provider Negotiators Proprietary Limited*	**225 720**	258 672
ER24 EMS Proprietary Limited#	**58 072**	128 842
Europ Assistance Worldwide Services (South Africa) Proprietary Limited – EMS#	**85 472**	–
Europ Assistance Worldwide Services (South Africa) Proprietary Limited – Travel	**15 423**	12 309
Recoveries received	**(1 732 442)**	(1 642 016)
Claims recoveries	**(1 732 442)**	(1 642 016)
Net income on risk transfer arrangements	**(184 458)**	(110 668)

* *FY2022 includes a refund of risk capitation fees totalling R65 million due by Preferred Provider Negotiators Proprietary Limited for R57 million and Scriptpharm Risk Management Proprietary Limited for R8 million. FY2021 includes a reduction of capitation fees of R9 million refunded by Scriptpharm Risk Management Proprietary Limited due to reduction of utilisation as a result of the COVID-19 pandemic.*

\# *Following a request for proposal tender process, the emergency medical services contract terminated with ER24 EMS Proprietary Limited on 30 April 2022 and a new contract was entered into with Europ Assistance from 1 May 2022. 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:

	2022 R'000	2021 R'000
Dental Information Systems Proprietary Limited	**(62 609)**	(25 615)
Scriptpharm Risk Management Proprietary Limited*	**(64 586)**	(37 864)
Preferred Provider Negotiators Proprietary Limited	**(54 532)**	(22 856)
ER24 EMS Proprietary Limited – EMS	**3 945**	(34 910)
Europ Assistance Worldwide Services (South Africa) Proprietary Limited – EMS	**(16 965)**	–
Europ Assistance Worldwide Services (South Africa) Proprietary Limited – International Travel	**10 289**	10 577
Net income on risk transfer arrangements	**(184 458)**	(110 668)

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 up until 30 April 2022 and Europ Assistance Worldwide Services (South Africa) Proprietary Limited from 1 May 2022; 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. The Scheme pays Scriptpharm a monthly fixed fee per beneficiary on all of the options.

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 optometrical services and pays a monthly fee per member per month on the Standard, Primary, BonClassic and BonCap. 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 6% of the total of the premiums paid, is due to PPN and the remainder to the Scheme.

ER24 EMS PROPRIETARY LIMITED (ER24) AND EUROP ASSISTANCE WORLD WIDE SERVICES (SOUTH AFRICA) PROPRIETARY LIMITED (EASA)

The Scheme appointed ER24 up until 30 April 2022 and EASA effective from 1 May 2022 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. This contract applies to all members of the Scheme except for those on the BonCap option.

14.4 THIRD PARTY CLAIM RECOVERIES

Third party claim recoveries of R75.0 million (2021: R62.4 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 R30.6 million (2021: R32 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 claims recoveries in the current year includes R41.4 million (2021: R25.3 million), net of recovery fees, in relation to forensic recoveries pertaining to the fraud waste and abuse services provided by the Administrator, R0.8 million (2021: R0.4 million) in relation to diabetes clawbacks and R2.2 million (2021: R4.7 million) in recoveries from Mediclinic and Life Healthcare related to settlement discounts.

15. ADMINISTRATIVE EXPENDITURE

	2022 R'000	2021 R'000
Accredited Administrator service fees (15.1)	**914 638**	818 006
Other administration services provided by Accredited Administrator (15.2)	**101 806**	92 122
Actuarial services	**3 910**	3 833
Annual general meeting costs	**1 236**	2 079
Audit remuneration – external	**4 953**	3 032
Audit fees	**4 953**	3 027
Prior year under provision	**–**	5
Audit remuneration – internal	**3 958**	4 403
Audit fees	**3 911**	4 380
Prior year under provision	**47**	23
Bank charges	**3 769**	3 434
Benefit management services	**18 409**	19 839
Communication expenses	**135**	126
Consulting fees	**5 477**	2 977
Council for Medical Schemes levies	**15 595**	14 426
Committee fees – Independent members	**1 588**	1 198
Audit and Risk Committee fees	**994**	701
Investment Committee fees	**259**	250
Remuneration Committee fees	**335**	247
Computer maintenance	**3 814**	3 402
Depreciation	**3 843**	4 997
Fidelity, professional indemnity and other insurance premiums	**1 709**	1 523
Forensic fees	**50**	3 129
Hire of equipment	**156**	176
Human resourcing and payroll management fees	**562**	111
Legal fees and inspection costs	**3 165**	4 209
Marketing and advertising expenses	**204 762**	200 656
Meeting venue and catering costs	**213**	63
Office expenses	**338**	309
Postage and courier service	**361**	148
Principal Officer short-term employee benefits	**8 806**	6 826
Principal Officer remuneration	**4 776**	5 021
Performance incentive	**1 610**	1 439
Uninvested long term employee benefit	**1 980**	–
Defined contribution benefits	**252**	239
Other disbursements	**188**	127
Printing and stationery	**1 557**	1 111
Professional services	**1 373**	2 047
RAF administration expense	**9 146**	11 676
Rental costs	**1 997**	1 858
Repairs and maintenance	**24**	18
Staff short-term employee benefits	**27 162**	25 229
Staff remuneration	**19 214**	19 679
Performance incentive	**3 846**	3 432
Uninvested long term employee benefit	**1 469**	–
Termination benefit	**293**	–
Defined contribution benefits	**1 036**	1 056
Other disbursements	**1 304**	1 062
Subscription fees	**3 380**	2 803
Sundry expenses	**434**	569
Travel, accommodation and conferences	**546**	68
Trustee elections	**7 330**	7 106
Trustees' remuneration and other disbursements (15.3)	**6 590**	6 067
Trustees' remuneration	**6 033**	5 868
Other disbursements	**557**	199
Wellness expenses	**7 869**	27 344
	1 370 660	1 276 920

		2022 R'000	2021 R'000
15.	**ADMINISTRATIVE EXPENDITURE (CONTINUED)**		
15.1	**ACCREDITED ADMINISTRATOR SERVICE FEES**		
	Member record management	**127 480**	114 107
	Contribution management	**49 028**	43 893
	Claims management	**218 484**	195 594
	Financial management	**39 212**	35 124
	Information management and data control	**137 227**	122 869
	Broker remuneration management	**98 060**	87 779
	Customer services	**245 147**	218 640
	Total Accredited Administrator service fees	**914 638**	818 006
15.2	**OTHER ADMINISTRATION SERVICES PROVIDED BY ACCREDITED ADMINISTRATOR**		
	Internal audit services	**31 586**	28 262
	Forensic investigations and recoveries	**35 942**	33 134
	Governance and compliance services rendered	**34 278**	30 726
	Total other administration services provided by Accredited Administrator	**101 806**	92 122

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							
2022							
Mr O Komane	**544 659**	**327 556**	**293 251**	**1 165 466**	**157 829**	**13 829**	**1 337 124**
Mr J Bagg	**169 400**	**212 974**	**192 574**	**574 948**	**5 524**	**13 329**	**593 801**
Mr MG Netshisaulu	**295 991**	**229 758**	**38 390**	**564 139**	**5 978**	**2 330**	**572 447**
Mr R Cowlin	**278 552**	**235 832**	**248 254**	**762 638**	**67 049**	**13 329**	**843 016**
Ms J Usher	**153 565**	**154 848**	**108 398**	**416 811**	**8 575**	**1 748**	**427 134**
Ms MP Lesunyane	**108 396**	**154 848**	**19 873**	**283 117**	**3 818**	**1 748**	**288 683**
Mr JD Ngwane	**138 615**	**235 832**	**56 765**	**431 212**	**19 098**	**13 329**	**463 639**
Mr JR Venter	**248 261**	**235 832**	**27 099**	**511 192**	**83 320**	**13 329**	**607 841**
Mr P Ribbens	**188 713**	**235 832**	**91 578**	**516 123**	**38 274**	**13 329**	**567 726**
Dr PW Hill	**152 165**	**235 832**	**92 078**	**480 075**	**62 870**	**13 329**	**556 274**
Ms V Rikhotso	**70 865**	**74 910**	**28 346**	**174 121**	**2 675**	**582**	**177 378**
Ms RT Monene	**70 865**	**74 910**	**7 086**	**152 861**	**1 606**	**582**	**155 049**
	2 420 047	**2 408 964**	**1 203 692**	**6 032 703**	**456 616**	**100 793**	**6 590 112**
2021							
Mr O 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

* *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

	2022 R'000	2021 R'000
(Decrease)/increase in provision for healthcare receivables (note 7)	**(1 872)**	(9 033)
Bad debts written off	**10 491**	12 549
Contributions	**2 917**	3 614
Members portion	**7 261**	8 493
Other receivables	**313**	442
Previous impairment losses recovered	**(2 642)**	(3 453)
	5 977	63

		2022 R'000	2021 R'000
17.	**INVESTMENT INCOME**		
	Cash and cash equivalents interest income	**7 075**	4 661
	Financial assets held at fair value through profit or loss	**570 542**	425 191
	Interest income	**367 687**	295 442
	Dividend income	**202 855**	129 749
	Net fair value gains on financial assets held at fair value through profit or loss	**193 225**	836 507
	Net fair value losses on derivative instruments	**–**	(54 495)
	Rentals received	**10 020**	9 788
	Contractual rental	**9 673**	9 644
	Straight-lining of lease accrual	**347**	144
	Investment income – Scheme	**780 862**	1 221 652
	Change in fair value of investment properties	**1 500**	(700)
		782 362	1 220 952
18.	**SUNDRY INCOME**		
	Profit on sale of property and equipment	**14**	4
	Forensic recoveries	**96**	1 020
	Sundry income	**30 950**	21 857
	Unclaimed personal medical savings account write backs (note 11.1)	**4 200**	9 544
	Recovery of personal medical savings account investment and administration expense (note 11.1)	**12 994**	11 423
	Service Level Agreement penalty recoveries from Administrator	**12 166**	–
	Other income	**1 590**	890
		31 060	22 881

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 14.4 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 twelve benefit options: Standard, BonSave, Primary, BonCap, BonFit, BonClassic, BonComprehensive, BonEssential, BonComplete, Hospital Standard, BonStart and BonStart Plus. 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	BonStart Plus	Scheme Total
2022													
Gross contribution income	8 366 094	2 294 149	4 700 859	1 252 090	395 035	843 386	618 310	515 043	713 065	233 342	63 947	32 502	20 027 822
Less : Savings contributions	–	(442 363)	–	–	(62 446)	(118 728)	(115 691)	–	(105 279)	–	–	–	(844 507)
Risk contribution income	8 366 094	1 851 786	4 700 859	1 252 090	332 589	724 658	502 619	515 043	607 786	233 342	63 947	32 502	19 183 315
Relevant healthcare expenditure	(7 501 371)	(1 579 530)	(4 157 763)	(1 294 245)	(267 873)	(730 494)	(597 876)	(447 835)	(582 817)	(215 228)	(39 618)	(24 384)	(17 439 033)
Net claims incurred	(7 434 229)	(1 515 393)	(4 009 938)	(1 231 464)	(250 291)	(729 290)	(589 316)	(429 441)	(578 107)	(209 308)	(34 327)	(21 053)	(17 032 156)
Claims incurred	(7 456 165)	(1 524 307)	(4 030 188)	(1 243 481)	(252 507)	(731 155)	(590 234)	(432 388)	(579 981)	(210 264)	(35 124)	(21 328)	(17 107 121)
Third party recoveries	21 936	8 914	20 250	12 017	2 216	1 865	918	2 947	1 874	956	797	275	74 965
Managed healthcare services	(215 768)	(60 882)	(166 956)	(69 622)	(14 383)	(13 335)	(6 716)	(17 948)	(13 719)	(6 356)	(4 277)	(1 373)	(591 335)
Net income on risk transfer arrangements	148 626	(3 255)	19 131	6 841	(3 199)	12 131	(1 844)	(446)	9 009	436	(1 014)	(1 958)	184 458
Risk transfer arrangement fees / premiums paid	(837 754)	(142 452)	(243 826)	(82 578)	(18 390)	(79 981)	(51 777)	(23 040)	(52 365)	(11 166)	(2 310)	(2 345)	(1 547 984)
Recoveries from risk transfer arrangements	986 380	139 197	262 957	89 419	15 191	92 112	49 933	22 594	61 374	11 602	1 296	387	1 732 442
Gross healthcare result	864 723	272 256	543 096	(42 155)	64 716	(5 836)	(95 257)	67 208	24 969	18 114	24 329	8 118	1 744 282
Broker service fees	(125 341)	(49 723)	(112 420)	(38 577)	(10 596)	(7 073)	(4 843)	(13 736)	(11 097)	(5 415)	(2 017)	(961)	(381 799)
Administrative expenditure	(441 127)	(174 391)	(393 107)	(140 763)	(42 436)	(36 854)	(18 313)	(55 690)	(37 013)	(19 106)	(8 851)	(3 009)	(1 370 660)
Net impairment losses on healthcare receivables	(3 621)	877	(1 590)	1 162	297	(3 818)	(94)	370	156	109	118	57	(5 977)
Net healthcare result	294 634	49 019	35 979	(220 333)	11 981	(53 581)	(118 507)	(1 848)	(22 985)	(6 298)	13 579	4 205	(14 154)
Other income	229 966	105 154	208 448	124 512	23 427	29 162	15 382	29 861	25 804	9 770	8 706	3 230	813 422
Investment income – Scheme	220 175	101 400	199 733	119 319	22 515	28 368	14 983	28 532	25 006	9 354	8 363	3 114	780 862
Sundry income	9 346	3 582	8 310	4 952	868	758	381	1 271	762	397	324	109	31 060
Change in fair value of investment property	445	172	405	241	44	36	18	58	36	19	19	7	1 500
Other expenditure	(17 735)	(22 631)	(16 171)	(9 600)	(3 125)	(11 834)	(6 687)	(2 316)	(8 438)	(756)	(690)	(266)	(100 250)
Interest on savings plan liability – PMSA	–	(15 670)	–	–	(1 395)	(10 379)	(5 959)	–	(6 977)	–	–	–	(40 380)
Interest expense	(79)	(30)	(71)	(42)	(7)	(6)	(3)	(10)	(6)	(3)	(3)	(4)	(264)
Asset management fees	(16 226)	(6 383)	(14 814)	(8 797)	(1 590)	(1 333)	(667)	(2 124)	(1 339)	(692)	(636)	(244)	(54 846)
Operating expenses on investment property	(1 430)	(548)	(1 286)	(761)	(133)	(116)	(58)	(182)	(116)	(61)	(51)	(18)	(4 760)
Net surplus/(deficit) for the year	506 865	131 542	228 256	(105 421)	32 283	(36 253)	(109 812)	25 697	(5 619)	2 716	21 595	7 169	699 018
Average number of members (n)	106 479	40 794	95 580	56 555	9 870	8 632	4 343	13 528	8 674	4 525	3 674	1 251	353 905

19. SURPLUS/(DEFICIT) PER BENEFIT OPTION (CONTINUED)

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	Hospital Plus	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)	(9 253)	(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

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.

	2022 R'000	2021 R'000
20.1.1 INTEREST RECEIVED		
Finance income (note 17)	**367 687**	295 442
Interest capitalised in investments	**(186 468)**	(102 801)
	181 218	192 641
20.1.2 DIVIDENDS RECEIVED		
Dividend income (note 17)	**202 855**	129 749
Dividends capitalised in investments	**(22 161)**	(1 203)
	180 694	128 546
20.1.3 ASSET MANAGEMENT FEES		
Asset management fees per statement of comprehensive income	**(54 846)**	(38 675)
Fees capitalised in investments	**882**	1 909
	(53 964)	(36 766)
20.1.4 RENTALS RECEIVED		
Rentals received (note 17)	**10 020**	9 788
Straight-lining of lease receivables	**(347)**	(144)
Decrease/(increase) in rent receivables	**(273)**	51
	9 400	9 695

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.

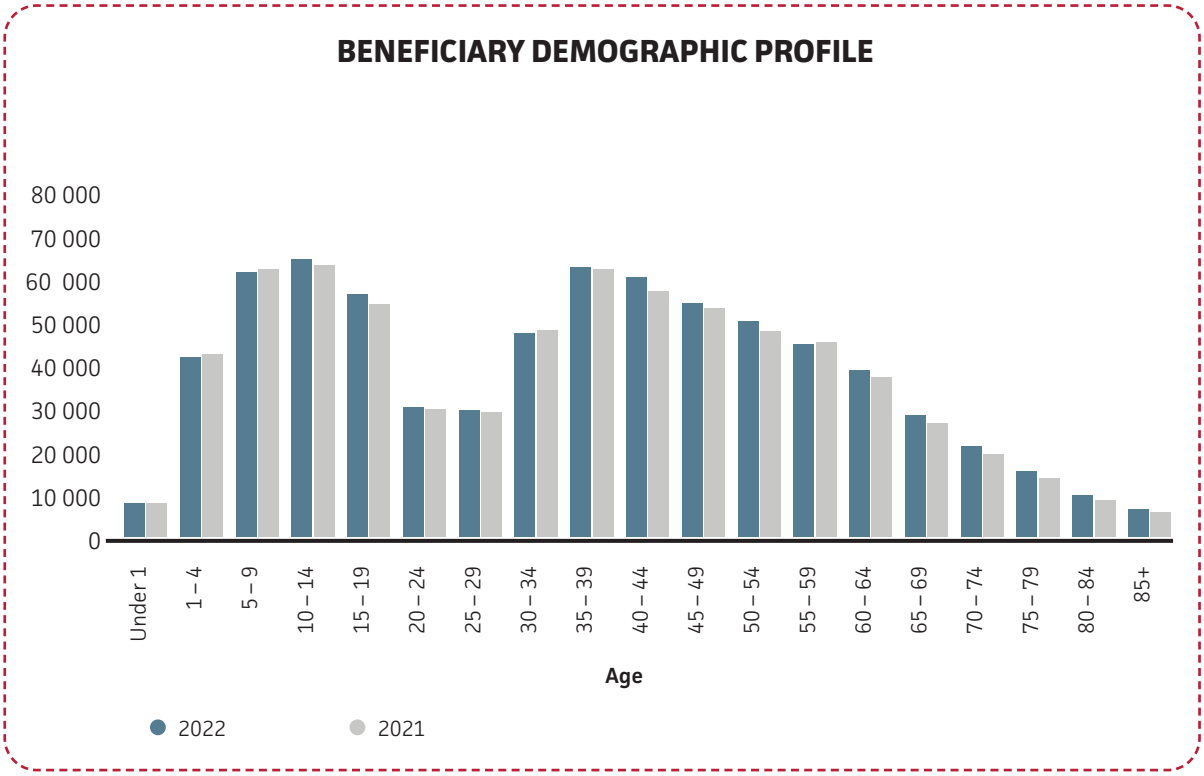
If a scheme charges higher contribution rates than the market, it is at risk of losing members and not replacing them. It is typically easier for younger, healthier members to move to another scheme. Should this happen, the member risk profile would deteriorate, resulting in even higher contribution 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.

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:



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 pricing and benefit 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 non-systematic 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 non-systematic 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.

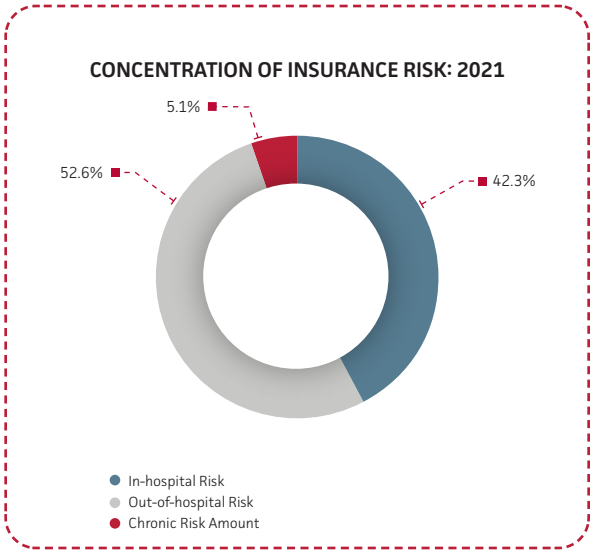
- **IN-HOSPITAL BENEFITS**

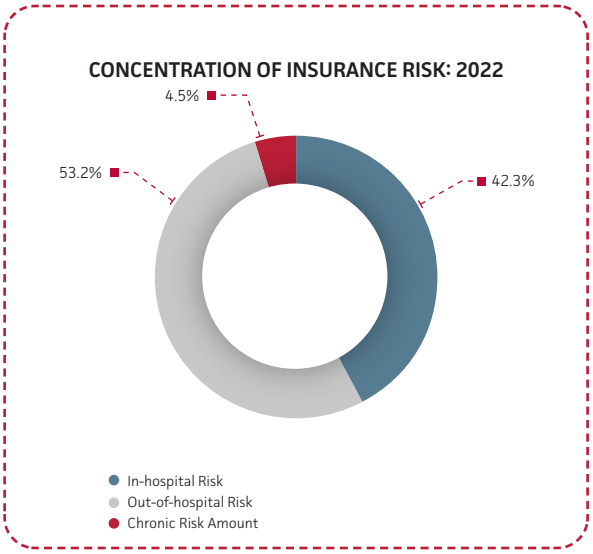
The hospital benefit covers medical expenses incurred due to admission to hospital.

- **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:





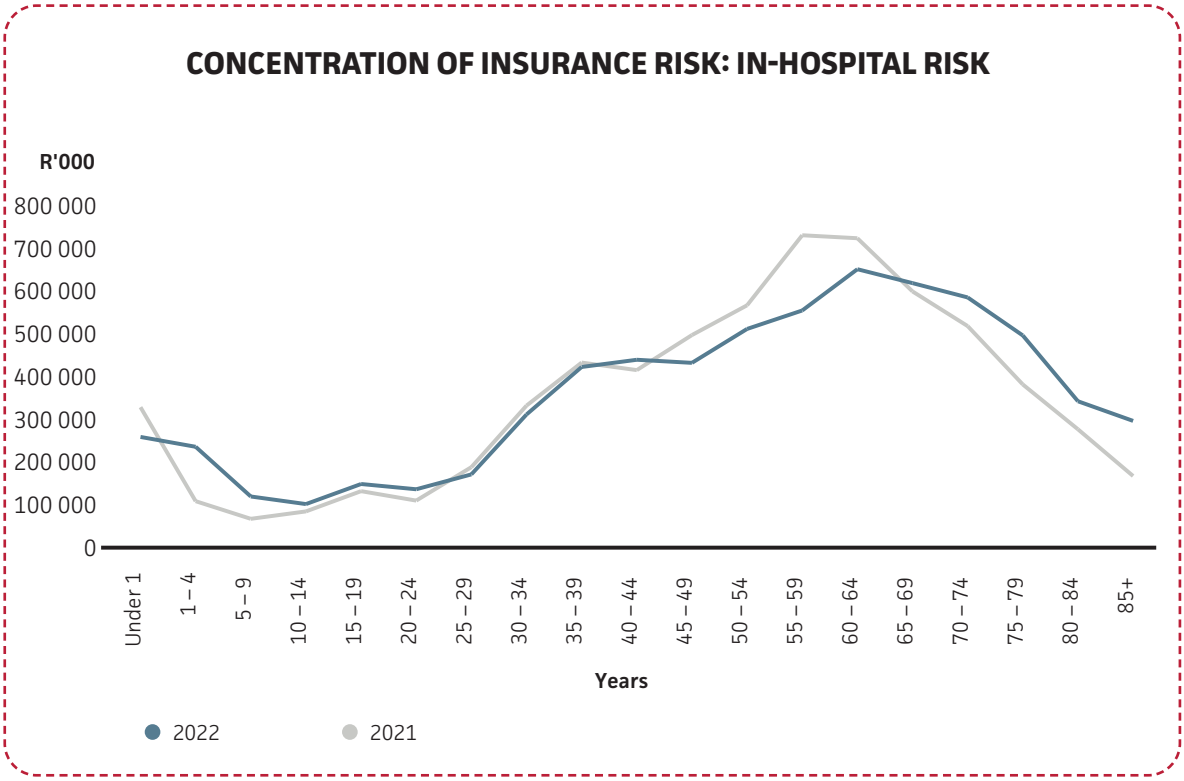
21. INSURANCE RISK MANAGEMENT (CONTINUED)

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



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.

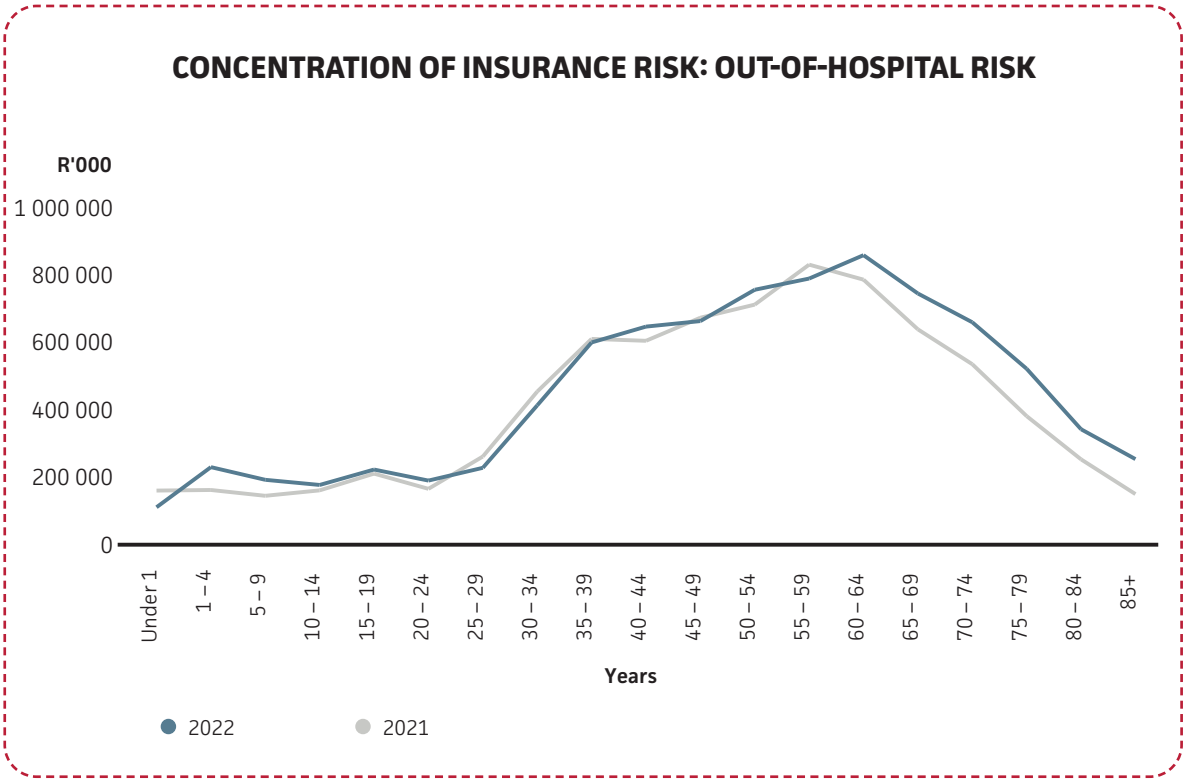
Initiatives used by the Scheme include:

- 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 Adviser 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 repricing of claims to ensure that claims are paid against the contracted hospital rates and the pre-authorised level of care.
- Promoting alternatives to hospitalisation such as step-down facilities, Hospital-at-home and Home-Based Nursing to ensure that the right patient receives the right care at the right time.

21. INSURANCE RISK MANAGEMENT (CONTINUED)

21.2 CONCENTRATIONS OF INSURANCE RISK (CONTINUED)

21.2.2 OUT-OF-HOSPITAL RISK



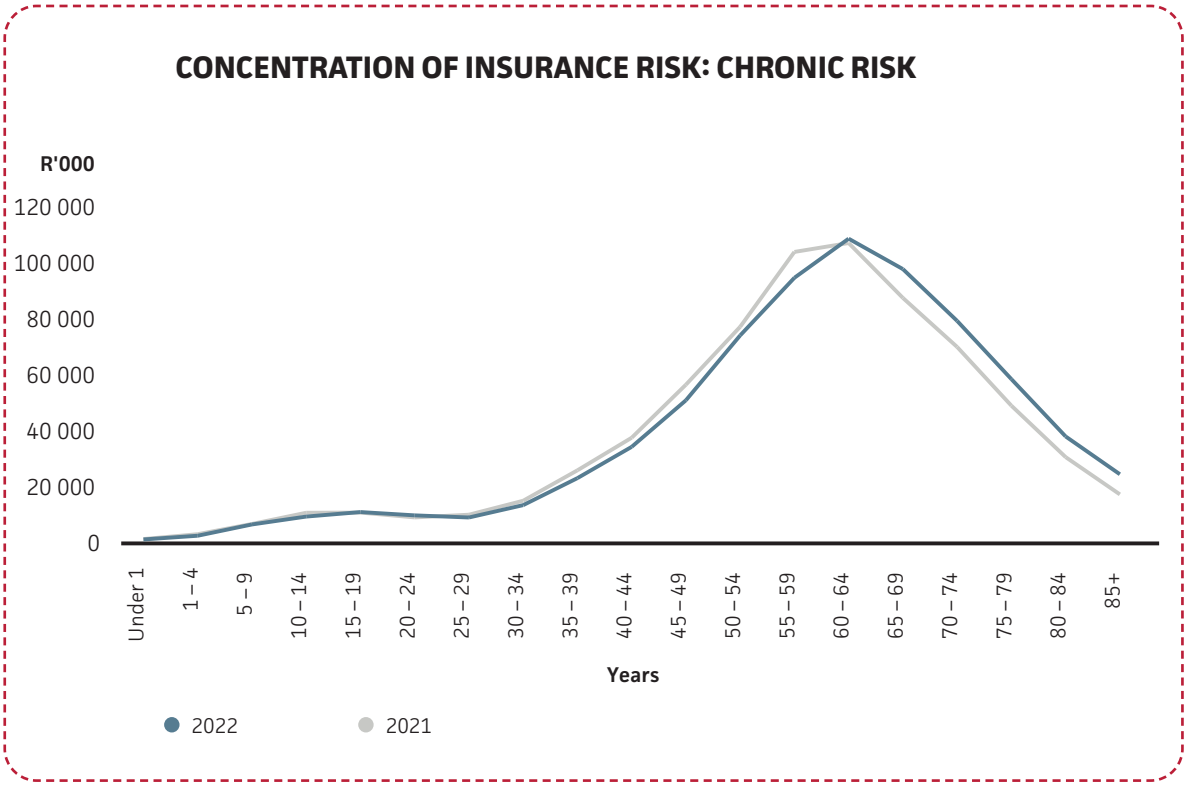
Managing claims expenditure is not only about negotiating lower rates but also about curtailing preventable hospital utilisation and cost. Initiatives focused on co-ordinating care for segments of the population who are likely to present for medical care, with associated high claim costs, have been implemented. Such initiatives include:

- Active Disease Risk Management Programme – An integrated care co-ordination 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.
- Palliative care for oncology – Most terminally ill patients indicate a wish to spend their remaining days at home, but in South African private healthcare sector they are much more likely to remain in an intensive care or high care unit, frequently receiving aggressive, invasive and non-beneficial care. Under the palliative care programme, oncology patients are supported by a multi-disciplinary team to ensure that they receive the most appropriate care in the most appropriate setting.
- 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.

21. INSURANCE RISK MANAGEMENT (CONTINUED)

21.2 CONCENTRATIONS OF INSURANCE RISK (CONTINUED)

21.2.3 CHRONIC ILLNESS RISK



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 8.9% of the Scheme's Relevant Healthcare Expenditure.

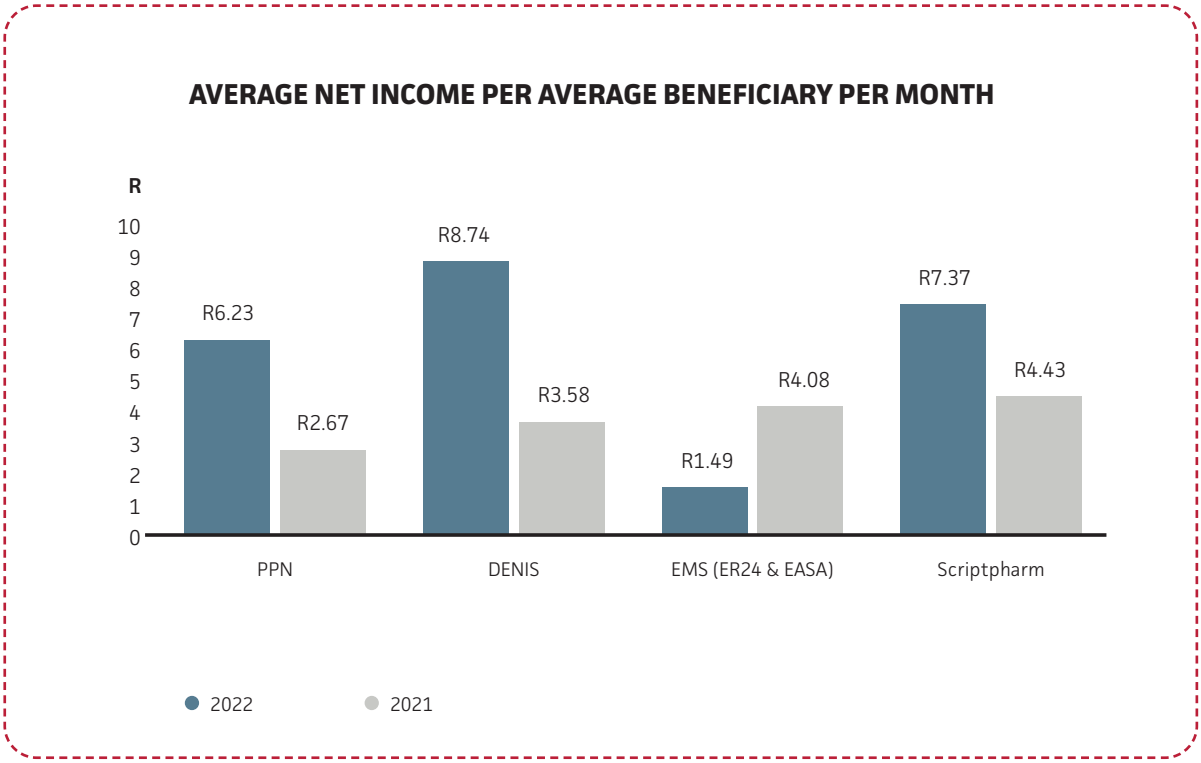
The Scheme entered into capitation agreements directly with DENIS, Scriptpharm, PPN, ER24, and Europ Assistance. The capitation agreements involve a transfer of risk however the Scheme remains ultimately liable to its members with respect to ceded risks if any supplier fails to meet the obligations it 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.



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 Schemes 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 for beneficiaries on Standard, BonSave, BonClassic, BonComplete and BonFit options. The fees range from R20.29 to R97.53 per beneficiary.

The current contract took effect from 1 January 2017 for a period of 5 years. After a request for proposal exercise (RFP), the contract was renewed on 1 January 2023 for a period of 3 years. Fees and benefits have been agreed for the 2023 benefit year.

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 on BonComprehensive, BonClassic, Standard, Standard Select, BonComplete, BonSave, Primary, Primary Select, BonFit, Hospital Standard BonEssential, BonEssential Select, BonCap, BonStart and BonStart Plus options. The fees range from R41.16 to R572.72 per beneficiary.

The contract commenced on 1 February 2020 and was renewed on 1 January 2022 and extended to 31 December 2023. Fees for the 2023 financial year have been agreed.

21.3.3 PREFERRED PROVIDERS NEGOTIATORS PROPRIETARY LIMITED (PPN)

The Scheme has contracted PPN for optometrical services and pays a monthly fixed fee per member per month on the Standard, Standard Select, Primary, Primary Select, BonClassic and BonCap options. The fees range from R22.36 to R58.50 per member. 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 6% of the total of the premiums paid, is due to the PPN and the remainder to the Scheme.

The contract of 1 January 2019 to 31 December 2022 was renewed, following an RFP process, on 1 January 2023 and will remain in force until 31 December 2024. Fees and benefits have been agreed for the 2023 financial year.

21.3.4 ER24 EMS PROPRIETARY LIMITED (ER24)

The Scheme contracted ER24 for the provision of emergency medical services for the period up until 30 April 2022. The provision of emergency medical was then awarded to Europ Assistance Worldwide Services. ER24 conducted its business as an emergency response, assistance and transportation company. ER24 ensured that all telephonic requests for medical assistance received from members are dealt with in accordance with the contract. ER24 maintained and updated its database to continuously reflect the most recently available data and information relating to the provision of services.

The Scheme paid ER24 a standard fee of R33.43 (2021: R31.72) per member per month for all members up until the contract terminated on 30 April 2022.

21.3.5 EUROP ASSISTANCE WORLDWIDE SERVICES (SOUTH AFRICA) PROPRIETARY LIMITED (EASA)

Travel benefit

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 R3.90 (2021: 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 and was extended to 30 June 2022. The service was renegotiated as part of the contract when EASA was appointed as the service provider for EMS, effective 1 May 2022. Fees and benefits were agreed upon for 2023.

Emergency medical services

From 1 May 2022 the Scheme entered into a risk transfer arrangement with EASA for the provision of emergency medical services to provide emergency response, assistance and transportation to the members of the Scheme.

The Scheme pays EASA a standard fee of R30.44 (R29.35 from May to September 2022) per member per month for all members on the Scheme except Boncap.

The contract commenced on the effective date of 1 May 2022 and will remain in force for a period of 32 months up until 31 December 2023. Fees and benefits were agreed upon for 2023.

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 2023 Budget.

Claims category	Change in variable	Estimated impact on expected 2023 claims R'000	Estimated impact on expected 2023 solvency %
Inflation assumptions			
Represents the increase in the price of service units rendered			
In-hospital claims (ward/theatre/consumables)	Tariff inflation 1% higher	70 367	(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	95 037	(0.45%)
Acute Medicine claims	Average member age 0.5 years higher	5 315	(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	73 587	(0.35%)
Specialist costs	Utilisation rate 1% higher	25 357	(0.12%)

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 36 of the Annual Report for further details on the Scheme's investment strategy.

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:

	2022 R'000	2021 R'000
Investments (current and non-current)	**9 896 410**	8 245 970
Insurance, trade and other receivables (excluding prepayments)	**699 398**	700 703
Cash and cash equivalents	**646 015**	766 465
	11 241 823	9 713 138

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 7.5% of the Investment Portfolio of the Scheme may be invested in the share instrument of any one company with market capitalisation of more than R50 billion.
- Not more than 5% of the Investment Portfolio of the Scheme may be invested in the share instrument of any one company with market capitalisation of between R5 billion and R50 billion.
- 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 Fund 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.

21. INSURANCE 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

	2022 R'000	2021 R'000
Not past due	**674 611**	689 004
Past due 1 – 30 days	**14 753**	8 428
Past due 31 – 60 days	**8 600**	1 165
Past due 61 – 90 days	**664**	126
Past due more than 90 days	**770**	1 980
Trade and other receivables (excluding prepayments)	**699 398**	700 703

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:

	2022 R'000	2021 R'000
Balance at the beginning of the year	**15 523**	24 556
Impairment loss recognised reversed	**(442)**	(9 033)
Acquisition through amalgamation (Note 28)	**1 430**	–
Decrease in provision charged to profit or loss	**(1 872)**	(9 033)
Balance at the end of the year	**15 081**	15 523

The provision for impairment at 31 December 2022 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.

21. INSURANCE 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

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 constitute 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
2022			
Financial liabilities			
Personal medical savings account liability	**(26 233)**	**(989 902)**	**(1 016 135)**
Insurance, trade and other payables (excluding VAT)	**(587 807)**	**–**	**(587 807)**
Outstanding risk claims provision	**(912 465)**	**(48 025)**	**(960 490)**
	(1 526 505)	**(1 037 927)**	**(2 564 432)**
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)

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.

	2022 R'000	2021 R'000
Interest-bearing instruments		
Financial assets	**6 092 960**	5 858 153
Investments – interest-bearing assets (note 6)	**5 446 945**	5 091 688
Cash and cash equivalents	**646 015**	766 465
Financial liabilities		
Personal medical savings account liability	**(1 016 135)**	(894 037)
	5 076 825	4 964 116

Interest rate sensitivity analysis

At the end of December 2022, the Scheme earned interest income of R375m (2021: R300m) 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. The sensitivity analysis is based on the modified duration of each of the Scheme's fixed income portfolios. The modified duration of each portfolio was obtained from the applicable Investment Manager. Modified duration is a measure of the sensitivity of the value of an investment to a change in interest rates. As an example, the value of a portfolio with a modified duration of 5 will increase by 5% when interest rates decrease by 5% and vice versa:

Decrease in interest rate	**(2.5%)**	**(2.0%)**	**(1.5%)**	**(1.0%)**	**(0.5%)**	**(0.25%)**	**0.0%**
2022							
Scheme impact (surplus) (R'000)	**559 823**	**447 858**	**335 894**	**223 929**	**111 965**	**55 982**	**–**
Solvency impact	**2.80%**	**2.24%**	**1.68%**	**1.12%**	**0.56%**	**0.28%**	**–**
2021							
Scheme impact (surplus) (R'000)	613 235	490 588	367 941	245 294	122 647	61 324	–
Solvency impact	3.25%	2.60%	1.95%	1.30%	0.65%	0.32%	–

Increase in interest rate	**0.0%**	**0.25%**	**0.5%**	**1.0%**	**1.5%**	**2.0%**	**2.5%**
2022							
Scheme impact (surplus) (R'000)	**–**	**(55 982)**	**(111 965)**	**(223 929)**	**(335 894)**	**(447 858)**	**(559 823)**
Solvency impact	**–**	**(0.28%)**	**(0.56%)**	**(1.12%)**	**(1.68%)**	**(2.24%)**	**(2.80%)**
2021							
Scheme impact (surplus) (R'000)	–	(61 324)	(122 647)	(245 294)	(367 941)	(490 588)	(613 235)
Solvency impact	–	(0.32%)	(0.65%)	(1.30%)	(1.95%)	(2.60%)	(3.25%)

Solvency figures are calculated on the assumption that all cumulative unrealised fair value reserves have been realised.

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.4 MARKET RISK (CONTINUED)

22.4.2 INTEREST RATE RISK (CONTINUED)

The impact of interest rate changes on the Scheme's money market deposits is as follows:

Increase in interest rate	**2.5%**	**2.0%**	**1.5%**	**1.0%**	**0.5%**	**0.25%**	**0.0%**
2022							
Scheme impact (surplus) (R'000)	**63 266**	**50 613**	**37 960**	**25 306**	**12 653**	**6 327**	**–**
Solvency impact	**0.32%**	**0.25%**	**0.19%**	**0.13%**	**0.06%**	**0.03%**	**–**
2021							
Scheme impact (surplus) (R'000)	50 196	40 157	30 118	20 078	10 039	5 020	–
Solvency impact	0.27%	0.21%	0.16%	0.11%	0.05%	0.03%	–

Decrease in interest rate	**0.0%**	**(0.25%)**	**(0.5%)**	**(1.0%)**	**(1.5%)**	**(2.0%)**	**(2.5%)**
2022							
Scheme impact (surplus) (R'000)	**–**	**(6 327)**	**(12 653)**	**(25 306)**	**(37 960)**	**(50 613)**	**(63 266)**
Solvency impact	**–**	**(0.03%)**	**(0.06%)**	**(0.13%)**	**(0.19%)**	**(0.25%)**	**(0.32%)**
2021							
Scheme impact (surplus) (R'000)	–	(5 020)	(10 039)	(20 078)	(30 118)	(40 157)	(50 196)
Solvency impact	–	(0.03%)	(0.05%)	(0.11%)	(0.16%)	(0.21%)	(0.27%)

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 7.5% of the Investment Portfolio of the Scheme may be invested in the share instrument of any one company with market capitalisation of more than R50 billion.
- Not more than 5% of the Investment Portfolio of the Scheme may be invested in the share instrument of any one company with market capitalisation of between R5 billion and R50 billion.
- 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 Fund 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.

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.4 MARKET RISK (CONTINUED)

22.4.3 MARKET PRICE RISK (CONTINUED)

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, domestic listed and fixed property and domestic cash to achieve a balanced investment portfolio.
- 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.

Sensitivity analysis

The analysis presented below assumes all other factors remain constant and is performed on the same basis for 2022 and 2021.

Listed equities

At the end of December 2022, the Scheme had 45.0% (2021: 37.9%) of its investment portfolio (excluding cash) invested in equity listed 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:

Decrease	**(35.0%)**	**(25.0%)**	**(15.0%)**	**(10.0%)**	**(5.0%)**	**(2.0%)**	**0.0%**
2022							
Scheme impact (surplus) (R'000)	**(1 557 313)**	**(1 112 366)**	**(667 420)**	**(444 946)**	**(222 473)**	**(88 989)**	**–**
Solvency impact	**(7.78%)**	**(5.55%)**	**(3.33%)**	**(2.22%)**	**(1.11%)**	**(0.44%)**	**–**
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%)	–

Increase	**0.0%**	**2.0%**	**5.0%**	**10.0%**	**15.0%**	**25.0%**	**35.0%**
2022							
Scheme impact (surplus) (R'000)	**–**	**88 989**	**222 473**	**444 946**	**667 420**	**1 112 366**	**1 557 313**
Solvency impact	**–**	**0.44%**	**1.11%**	**2.22%**	**3.33%**	**5.55%**	**7.78%**
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%

Solvency figures are calculated on the assumption that all cumulative unrealised fair value reserves have been realised.

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:

R'000	Level 1	Level 2	Level 3	Total
at 31 December 2022				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	**4 449 465**	**–**	**–**	**4 449 465**
Bonds	**3 581 279**	**–**	**–**	**3 581 279**
Money market instruments*	**–**	**1 865 666**	**–**	**1 865 666**
Investment properties*	**–**	**–**	**78 500**	**78 500**
Total assets	**8 030 744**	**1 865 666**	**78 500**	**9 974 910**
at 31 December 2021				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	3 154 282	–	–	3 154 282
Bonds	3 684 494	–	–	3 684 494
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

* *Movements and valuation techniques relating to Level 2 and Level 3 category items are disclosed in notes 5 and 6.*

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:

- 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.

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.5 FAIR VALUE (CONTINUED)

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 2022:

R'000	Investment property	Total
Opening balance	**77 000**	**77 000**
Fair value adjustment	**1 500**	**1 500**
Closing balance	**78 500**	**78 500**

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 2022 include:

Investment property

Refer to note 5 for the details regarding key inputs and assumptions used in the valuation at 31 December 2022.

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.

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 2022		at 31 December 2021	
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	**438 301**	**4%**	405 377	5%
Nedgroup Investments Money Market Fund Class C4	**486 006**	**5%**	100 551	1%
Nedgroup Investments Core Income Fund Class C4	**694 139**	**7%**	890 852	0%
27four Life: QML8 SRI Low Liquidity Funding Portfolio	**–**	**0%**	1 952	0%
	1 618 446	**16%**	1 398 733	6%

22. FINANCIAL RISK MANAGEMENT (CONTINUED)

22.6 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 provides consulting on 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.

	2022 R'000	2021 R'000
Members' funds per the statement of financial position	**8 759 140**	7 447 331
Adjusted for:		
Regulation 29 exclusion of unrealised gains on remeasurement of investments and investment property to fair value*	**(490 628)**	(558 986)
Accumulated funds per Regulation 29	**8 268 512**	6 888 345
Gross contributions (note 13)	**20 027 822**	18 887 490
Solvency ratio (%)	**41.29%**	36.47%
Cumulative net (losses)/gains on remeasurement to fair value of investments are calculated as follows:		
At beginning of year	**539 212**	(15 548)
Net (losses)/gains on remeasurement to fair value of financial instruments included in accumulated funds	**(69 858)**	554 760
At end of year	**469 354**	539 212
Cumulative net gains on remeasurement to fair value of investment properties are calculated as follows:		
At beginning of year	**19 774**	20 474
Movement in unrealised gains on remeasurement to fair value of investment properties included in accumulated funds	**1 500**	(700)
At end of year	**21 274**	19 774
* ***Cumulative net gains on remeasurement of investments and investment property at the end of the year***	**490 628**	558 986

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

	2022 R'000	2021 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	**1 980**	3 149
Later than one year and not later than five years	**4 342**	–
	6 322	3 149
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	**6 733**	5 358
Later than one year and not later than five years	**6 335**	3 382
	13 068	8 740

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, the Chief Financial Officer and the Clinical Executive.

Close family members include direct family members of the Chairman of the Board, the Board of Trustees, the Principal Officer, the Chief Financial Officer and the Clinical Executive.

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, was a key service provider as it handled the IT support services up until 30 June 2021. 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, was a key service provider as it handled the Scheme's wellness programmes for the period up until 30 June 2021 after which this was incorporated in the managed care contract with Medscheme Holdings Proprietary Limited. 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.

All transactions with related parties are at arms-length.

24. RELATED PARTY TRANSACTIONS (CONTINUED)

24.2 TRANSACTIONS WITH RELATED PARTIES

	2022 R'000	2021 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.	**1 016 444**	910 128
Service Level Agreement penalty recoveries from Administrator		
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.	**(12 416)**	(7 512)
Third party recoveries		
As part of the administration agreement, the Administrator was entitled to a 30% recovery fee until 31 May 2021 and 25% from June 2021 on fraud, waste and abuse recoveries.	**13 825**	9 021
Statement of financial position		
Balances payable to related party		
The balances payable bear no interest, are unsecured and are due within 30 days.	**(4 376)**	(7 322)
Medscheme Holdings Proprietary Limited – Managed care provider		
Statement of comprehensive income		
Managed care fees (including wellness)		
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.	**520 270**	481 513
Statement of financial position		
Balances (payable to)/owed by related party		
The balances (payable)/owed bear no interest, are unsecured and are owed upon presentation of an approved invoice (managed care).	**(5 285)**	3 631
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.	**2 745**	2 639
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.	**(229)**	(440)
Afrocentric Distribution Services Proprietary Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
Sales and marketing fees	**122 302**	112 086
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.	**(10 065)**	(9 340)

24. RELATED PARTY TRANSACTIONS (CONTINUED)

24.2 TRANSACTIONS WITH RELATED PARTIES (CONTINUED)

24.2.1 PARTIES WITH SIGNIFICANT INFLUENCE OVER THE SCHEME (CONTINUED)

	2022 R'000	2021 R'000
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.	**57 849**	54 601
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.	**(4 830)**	(4 584)
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
Statement of financial position		
Balances payable from related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**–**	–
* *IT Support services was only provided by Afrocentric Technologies Proprietary Limited up until 30 June 2021 and nothing was paid in the current year.*		
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	**324 726**	333 312
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.	**(2 740)**	(755)
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.	**791 982**	780 854
Refund of capitation fees	**(6 883)**	(9 492)
Statement of financial position		
Balances owing by related party		
The balance owing by bears no interest, is unsecured and is due within 30 days.	**3 663**	9 492

24. RELATED PARTY TRANSACTIONS (CONTINUED)

24.2 TRANSACTIONS WITH RELATED PARTIES (CONTINUED)

24.2.1 PARTIES WITH SIGNIFICANT INFLUENCE OVER THE SCHEME (CONTINUED)

	2022 R'000	2021 R'000
Dental Information Systems Proprietary Limited		
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)	**389 501**	377 932
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	**21 204**	17 252
Statement of financial position		
Balances payable to related party		
The balance payable 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)
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
Statement of financial position		
Balances payable to related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**–**	(118)
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	**19 736**	14 984
Statement of financial position		
Balances payable to related party		
The balance payable bears no interest, is unsecured and is due within 30 days.	**–**	–

* *No Wellness costs paid in the current year as these are now included in the Managed care contract payable to Medscheme Holdings Proprietary Limited (Managed Care Provider), effective 1 June 2021.*

24.2.2 KEY MANAGEMENT PERSONNEL AND THEIR CLOSE FAMILY MEMBERS

	2022 R'000	2021 R'000
Key management compensation		
Trustee's remuneration and other disbursements (note 15)	**6 590**	6 067
Principal Officer's remuneration and other disbursements (note 15)	**8 806**	6 826
Executive remuneration and other disbursements	**5 611**	3 222
	21 007	16 115
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.	**894**	925
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.	**276**	301
Trustee savings balances		
This constitutes savings balances held by the Scheme on behalf of the trustees.	**7**	2

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 R477 million (2021: R453 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 2022 the Scheme reported a net healthcare deficit on six (2021: seven) of its benefit options:

	2022 R'000	2021 R'000
BonCap	**220 333**	151 006
BonFit	**–**	6 277
BonClassic	**58 581**	15 038
BonComprehensive	**118 507**	65 951
BonEssential	**1 848**	36 303
BonComplete	**22 985**	937
Hospital Standard	**6 298**	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 2022 Standard has reported a net healthcare surplus of R294.6 million. Much of the positive performance can be attributed to successful hospital negotiations and managed care protocols. The Scheme continues to monitor the performance of the six 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 2022 financial period the Scheme incurred bad debt write offs of R10.5 million (2021: R12.5 million) which equals 0.05% (2021:0.07%) 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.

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 were identified by the internal auditors where claim payments were delayed due to system related issues experienced.

26.4.2 POSSIBLE IMPACT

Providers and/ or members not settled timely should be communicated with appropriately to avoid non-compliance.

26.4.3 CORRECTIVE COURSE OF ACTION

Provider limits are lifted before the next weekly payment run provided no fraud risk was identified and are communicated with within the 30-day period, where necessary.

Ongoing monitoring of exception reporting is in place to identify any issues proactively and ensure corrective measures are taken. Furthermore, a communication strategy is in place to inform the providers and members of any delays in claim payments outside the 30 days period to reduce the risk of non-compliance.

27. FINANCIAL IMPACT OF CORONAVIRUS (COVID-19) DURING THE 2022 YEAR

During 2022, the Scheme saw various categories of hospital authorisations follow broadly similar patterns in line with 2019 (pre-COVID) levels, with some above and below 2019 levels respectively. COVID-19 costs decreased throughout the year and remained low from August 2022, with low levels of COVID-19 testing, vaccination and hospitalisation.

The table below represents the financial impact experienced by the Scheme during the 2022 financial period.

27.1 COVID-19 AND NON-COVID-19 CLAIMS

27.1.1 COVID-19 CLAIMS IMPACT

The following table represents the COVID-19 claims financial impact using data as at January 2023:

	2022	2021
Total lives infected by COVID-19	**17 091**	62 146
% of total lives infected by COVID-19	**2.3%**	8.7%
Total lives recovered from COVID-19	**16 871**	59 740
Total deaths from COVID-19	**193**	2 401
Total lives vaccinated	**128 652**	137 811
Total vaccine costs in Rands	**51 563 574**	139 229 672
Total COVID-19 related claims (including outstanding risk claims provision) in Rands	**425 860 974**	2 563 383 093

- Due to the combination of vaccination, natural immunity and milder variants 2022 had no significant COVID-19 wave, which reduced the overall COVID-19 costs significantly from 2021 and 2020. This also led to significantly fewer COVID-19-related deaths in 2022 compared to previous years.
- The lifting of COVID-19 restrictions and a decreased concern about COVID-19 led to a lower COVID-19 testing rate, further reducing COVID-19 pathology costs from 2021.
- COVID-19 vaccination costs reduced from 2021 due to a much lower proportion of beneficiaries going for follow-up vaccinations. Many of the vaccinations in 2022 were second doses (after the first dose was administered in 2021).

27. FINANCIAL IMPACT OF CORONAVIRUS (COVID-19) DURING THE 2022 YEAR (CONTINUED)

27.1 COVID-19 AND NON-COVID-19 CLAIMS (CONTINUED)

27.1.2 NON-COVID-19 CLAIMS

Due to the reduced impact the COVID-19 pandemic had on South Africa in 2022, the following trends were observed:

- Various discretionary ("elective") procedures were not postponed anymore as was seen in 2020 and 2021. However, there was no evidence of "catch-up" procedures being done in 2022 for those that were postponed from 2020 and 2021.
- Infectious disease admissions increased to similar levels seen before the pandemic due to higher mobility of beneficiaries and the removal of the requirement to wear masks.
- Towards the end of 2022 injury and trauma admissions also increased to similar levels as before the pandemic.

28. AMALGAMATION WITH NEDGROUP MEDICAL AID SCHEME

On 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. The amalgamation was 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 Medical Scheme or Discovery Medical Scheme. 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.

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 Medical Scheme or Bestmed Medical Scheme or resigned from NMAS Scheme.

As this is deemed an amalgamation in terms of the Medical Schemes Act, 100% of the Assets and Liabilities of NMAS Scheme were transferred 1 January 2022 to Bonitas Medical Fund.

The acquisition date fair value of the total consideration transferred and the acquisition date fair value of each major class of asset and liabilities of NMAS 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 at fair value	
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 3.1% in January 2022.

29. EVENTS AFTER STATEMENT OF FINANCIAL POSITION DATE

29.1 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.

29.2 SANLAM ACQUISITION OF MAJORITY SHAREHOLDING IN THE ADMINISTRATOR, AFROCENTRIC INVESTMENT CORPORATION LIMITED

On 11 October 2022, Sanlam Limited (Sanlam) submitted an offer letter to the board of Afrocentric Investment Corporation Limited (Afrocentric), expressing Sanlam's firm intention to acquire AfroCentric shares that would result in Sanlam holding a controlling shareholding in Afrocentric.

The partial offer was declared unconditional on 16 February 2023 after 46.4% voting by AfroCentric shareholders. The last date for trading on the partial offer is 28 March 2023, with the closing date of the transaction aimed at 3 April 2023. Merger Filing submissions have been submitted to Botswana, South African and Namibian Competition Authorities.

New related party relationships will emerge with the following entities as a result of the transaction:

- Sanlam Limited
  The ultimate controlling shareholder of the Scheme's administrator and a key service provider that develops value-added products that are offered to the Scheme's members.
- AfroCentric Financial Services
  A key service provider that distributes value-added products offered by the ultimate controlling shareholder of the Scheme's administrator.
- Catalyst Fund Managers
  A key service provider that manages a portion of the Scheme's listed property investments as an asset manager.

29.3 DISPOSAL OF INVESTMENT PROPERTY.

Subsequent to year end the Board of Trustees resolved to commence with a process to dispose of the Scheme's Investment Property - Bonitas Park. Given current market conditions relating to office buildings and the increase in the cost of borrowing, it is unlikely the property will be sold within 12 months after the statement of financial position date and thus the Scheme has not applied IFRS 5: Non-current Assets Held for Sale. The investment property currently has a fair value of R78.5 million. Refer to note 5.

OTHER INFORMATION

OUR CONTACT DETAILS

BONITAS OFFICERS

Principal Officer	Chief Financial Officer	Clinical Executive
LR Callakoppen	**L Woodhouse**	**Dr M Mkhatshwa**
PHYSICAL ADDRESS 2nd Floor 34 Melrose Boulevard Melrose Arch Johannesburg 2076	**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	**POSTAL ADDRESS** PO Box 3496 Cramerview 2060

BONITAS REGISTERED OFFICE AND POSTAL ADDRESS

Bonitas Medical Fund	**Administrator** **Medscheme Holdings Proprietary Limited** Accreditation nr MCO53	**Managed care provider** **Medscheme Holdings Proprietary Limited** Accreditation nr 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 FSP nr 618	**Allan Gray Investment Managers** FSP nr 40592	**M&G Investments (Prudential Portfolio Managers)** FSP nr 615	**Fairtree Investment Manager** FSP nr 25917
PHYSICAL ADDRESS 5th Floor Draper on Main 47 Main Road Claremont Cape Town 7708	**PHYSICAL ADDRESS** 1 Silo Square V&A Waterfront Cape Town 8001	**PHYSICAL ADDRESS** 30 Dreyer Street Claremont Cape Town 7700	**PHYSICAL ADDRESS** 3rd Floor Willowbridge Place Corners of Carl Cronje Drive and Old Oak Bellville 7530
POSTAL ADDRESS PO Box 23450 Claremont 7700	**POSTAL ADDRESS** PO Box 51318 V&A Waterfront Cape Town 8002	**POSTAL ADDRESS** PO Box 44813 Claremont Cape Town 7735	**POSTAL ADDRESS** PO Box 4124 Tygervalley Cape Town 7536

ASSET/INVESTMENT MANAGERS

Sesfikile Capital FSP nr 39946	All Weather Capital (Pty) Limited FSP nr 36722	Catalyst Fund Managers FSP nr 36009	Vunani Fund Managers FSP nr 49846	Aluwani Capital Managers FSP nr 46196
PHYSICAL ADDRESS 2nd Floor 18 The High Street Melrose Arch Johannesburg 2076 **POSTAL ADDRESS** Suite 334, Private Bag X1 Melrose Arch 2076	**PHYSICAL ADDRESS** 9th Floor Katherine Towers 1 Park Lane Wierda Valley Sandton 2196	**PHYSICAL ADDRESS** 4th Floor Protea Place Protea Road Claremont 7708 **POSTAL ADDRESS** PO Box 44845 Claremont Cape Town 7735	**PHYSICAL ADDRESS** 1st Floor Cavendish Links 1 Cavendish Street, Claremont 7708	**PHYSICAL ADDRESS** EPPF Office Park 24 Georgian Crescent East Bryanston East 2152

ACTUARIES

Medscheme Holdings Proprietary Limited Accreditation nr MC053	NMG Consultants and Actuaries Proprietary Limited FSP nr 12968
PHYSICAL ADDRESS The Boulevard Building F Searle Street Woodstock 7925 **POSTAL ADDRESS** PO Box 38632 Pinelands 7430	**PHYSICAL ADDRESS** Nicolway West Office Block Cnr William Nicol Drive & Wedgewood Link Bryanston 2001

EXTERNAL AUDITOR

Deloitte

PHYSICAL ADDRESS
5 Magma Crescent
Waterfall City
2090

POSTAL ADDRESS
Private Bag x6
Gallo Manor
2052

INTERNAL AUDITOR

PwC

PHYSICAL ADDRESS
4 Lisbon Lane
Waterfall City
Jukskei View
2090

POSTAL ADDRESS
Private Bag x36
Sunninghill
2157

NOTES

ABBREVIATIONS AND DEFINITIONS

the administrator or Medscheme	Medscheme Holdings Proprietary Limited
ADS	AfroCentric Distribution Services Proprietary Limited
AfA	Aid for Aids
AGM	Annual general meeting
AI	Artificial intelligence
AIDS	Acquired immunodeficiency syndrome
BDO	BDO South Africa
BHF	Board of Healthcare Funders
Board	Board of Trustees
Bonitas	Bonitas Medical Fund
BPO	Business Process Outsourcing
CMS	Council for Medical Schemes
COVID-19	Coronavirus disease
CPI	Consumer Price Index
CPR	Cardiopulmonary resuscitation
CSAP	Customer Service Aptitude Profile
CTC	Cost to Company
DBC	Documentation Based Care
Deloitte	Deloitte & Touche
DENIS	Dental Information Systems Proprietary Limited
DSP	Designated Service Provider
DTP	Diagnosis and treatment pair
EDO	Efficiency discounted option
EML	Essential Medicines List
ER24	ER24 EMS Proprietary Limited
ESG	Environmental, social and governance
Europ Assistance	Europ Assistance Worldwide (South Africa) Services Proprietary Limited
FWA	Fraud, waste and abuse
GP	General practitioner
GRC	Governance, Risk and Compliance
HASA	Hospital Association of South Africa
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HPV	Human Papillomavirus
I&T	Information and technology
IBNR	Incurred but not reported
ICPS	Improved Clinical Pathway Services
IFRS	International Financial Reporting Standards
IR	Integrated Reporting
King IV™	King IV Report on Corporate Governance™ for South Africa, 2016*
LCBO	Low-cost benefit option
LTI	Long-term incentive
MoU	Memorandum of Understanding
MRI	Magnetic resonance imaging
MSA	Medical Schemes Act, No 131 of 1998, as amended
NCOP	National Council of Provinces
NHI	National Health Insurance
NMAS	NedGroup Medical Aid Scheme
NPA	National Prosecuting Authority
PMB	Prescribed minimum benefit
POPIA	Protection of Personal Information Act, No 24 of 2013
PPN	Preferred Providers Negotiators Proprietary Limited
PwC	PricewaterhouseCoopers
the report	2022 Integrated Report
RFP	Request for Proposal
RisCura Solutions	RisCura Solutions Proprietary Limited
SAMA	South African Medical Association
SAPS	South African Police Service
SASB	Sustainability Accounting Standards Board
Scriptpharm	Scriptpharm Risk Management Proprietary Limited
SDG	Sustainable Development Goal
SDL	Skills Development Levy
SGM	Special general meeting
SLA	Service level agreement
SMS	Short messaging service
STI	Short-term incentive
UIF	Unemployment Insurance Fund
WHO	World Health Organization
the year	Financial year ended 31 December 2022

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