2017

Annual Performance Highlights Report

Bonitas

We care about our members

> They found a tumour in my spine 6 weeks after the birth of my son. I had to have neurosurgery and was stressed out about everything except my cover. I walked out the hospital after my surgery and all I had to pay was R79 for pain meds! Bonitas Medical Fund is amazing!

> Bonitas is the best medical aid I have ever been on. No problem to help you and the staff is always friendly. Keep up the good work.

> Been shopping around but there's not ONE medical aid that can beat the plan I'm on from Bonitas. I get the same price but benefits here are so much more! Thank you!

> After struggling how long to get a reversal matter done, I finally found someone that listened and helped super fast. Thank you, Natasha for the help! Every company that works with people should have a few more Natashas so that stuff can actually be done.

We would like to thank all our members for their feedback and continued support.


One Bonitas baby born every 60 minutes
25
births a day
26 069
Hospital authorisations per month
88 159
Phone calls received per month
9 144 382
Total claims processed per year

Table of contents

2017 Highlights

Net healthcare results **R345.9 million**

Surplus of **R730.2 million**

Investment income of R394.3 million

Fraud, waste and abuse
35 criminal cases

Fraud, Waste and Abuse
recovered R31.2 million

Hospital negotiation strategy **yielded** savings of R242 million

Enhancements

call centre and website

New diabetes management programme

OUR MEMBERS

Total beneficiaries
728 943

Principal members
338 649

33
Average beneficiary age

Pensioner rate (%)
8.29

Number of dependants
1.15 per member

OUR FINANCES

R4.0 billion in reserves

9.5%
non-healthcare expenditure

24.5%
solvency ratio

OUR HIGHLIGHTS

95.9%
of claims paid within 5 days

36 287
claims processed per day

868
hospital admissions authorised per day

Board of Trustees

S. Claassen
Chairperson

Mr Claassen has more than 20 years of successful proven experience in the pharmaceutical and medical industry and extensive knowledge of the total healthcare industry (including medical aids). He has excellent skills in strategic growth and business development and is very competent in corporate governance and financial management.

O. Komane
Vice-Chairperson

Mr Komane holds a Master of Science degree in Engineering Business Management from the University of Warwick. He is the founder and chairman of Bambatha Engineers and Mining Services. Prior to this, he served as the Deputy General Secretary of the National Union of Mineworkers. He brings with him extensive experience in strategic corporate management and negotiations, has served on numerous boards in various capacities and acquired extensive knowledge as a non-executive director and trustee.

J. Bagg

Mr Bagg is a qualified Actuary with 40 years of actuarial, financial management and consulting experience. He currently serves as Statutory Actuary for a number of life insurance companies and is a trustee on various retirement funds. In addition, he holds directorships at life insurance and re-insurance companies.

Board of Trustees

R. Cowlin

Mr Cowlin has 23 years' experience in the medical aid industry and has been involved in several aspects of the industry including administration, marketing, product design and managed care. He has held various top management positions within Medscheme and was the Managing Director of Aid for AIDS for 10 years.

L. Koch

Trustee with effect from 1 October 2017

Advocate Lugene Koch holds BLC and LLB qualifications. She is an admitted Advocate of the High Court and is currently employed as a senior at the Specialised Commercial Crimes Unit where she has worked since 2001.

M. Lesunyane

Ms Lesunyane holds a BA degree from the University of South Africa. She is the founder of Lesunyane Enterprises. She worked at RAF until 2017.

Board of Trustees

H.E. Nematswerani

A medical practitioner, Dr Nematswerani has a wealth of experience in the healthcare industry. He holds a MBChB degree from the University of Natal, a Masters in Medical Science (Sports Medicine) and postgraduate diplomas in Occupational Health and Tropical Medicine and Hygiene.

M.G. Netshisaulu

Trustee with effect from 1 September 2017

Mr Netshisaulu is the holder of an M.Com in Taxation. He is a registered Tax Practitioner with the South African Institute of Taxation Professionals and a member of the Compliance Institute of South Africa. He is currently employed as a Financial Strategic Analyst at the University of South Africa and is studying towards an LLB degree.

J. Usher

Ms Usher is a qualified Chartered Accountant with 25 years' senior executive Board experience across a broad sector of industries including medical schemes, fast goods, industrial manufacturing, conservation tourism and emerging economic empowerment sectors. She possesses excellent skills in corporate governance, financial management, commercial and strategic growth and skills development. She is currently the Chief Financial Officer of Great Plans Conservation Ltd, an eco-tourism business operating in South Africa and abroad.

Executive Team

G. van Emmenis
Principal Officer

Gerhard has an MCom qualification from the University of Pretoria and a Diploma in Healthcare Management from the University of Luton. He has extensive experience in the healthcare industry, including HR management, client services, and as an administrator in Managed Care. He is no stranger to the management of medical schemes, and was Principal Officer of two others before joining Bonitas.

K. Marion
Chief Operations Officer

Kenneth joined Bonitas in July 2014 as the General Manager responsible for operations. Prior to this, he served as the Bonitas Senior Fund Manager responsible for administrative management. He has managed a number of closed schemes and has a total of 18 years of experience in medical scheme operational management.

C. Sanqela
Chief Financial Officer

Charlotte is a qualified Chartered Accountant, registered with the South African Institute of Chartered Accountants (SAICA) and she holds a Senior Management Development Programme certificate from Stellenbosch University. She is currently enrolled for an MCom (Accounting) and has vast experience in financial services and wealth management.

Report of the Principal Officer

Gerhard van Emmenis
Principal Officer

2017 was an exceptional year for Bonitas Medical Fund ("the Scheme"). We recovered from previous years to produce the best results in the Scheme's 35-year history. The R16.9 million deficit in 2016, was recouped as several strategies and initiatives showed pleasing results. We are proud to report a solid surplus of R730.2 million for 2017 after taking into account net healthcare results of R345.9 million and investment income of R394.3 million. The positive net healthcare results are mainly attributable to the hospital negotiations initiative which delivered savings of R242.0 million, and the fraud, waste and abuse initiatives which delivered recoveries of R31.2 million. This result proves the Scheme's ability to remain resilient during difficult financial periods and implement strategies that will yield positive results for its members.

Since the inception of the Scheme in 1982, our mission to make quality healthcare more affordable and more accessible has remained constant. This is a worldwide concern with many countries struggling to offer affordable healthcare and to make it accessible to all citizens. In fact, only countries with low growth in population and strong, steady economic progress have come close to achieving this.

Solid surplus of R730.2 million for the year

In the South African context there are many other factors which come into play over and above the challenges faced by other countries. This includes a lack of economic growth, increasing unemployment, a large gap between the rich and the poor and a stark contrast between first and third world elements. The reality is that many urbanised cities are faced with an over-supply of healthcare services while remote, rural areas have access to fewer healthcare facilities. Thus, limitation of utilisation is required to make contributions more affordable. In addition, the ability of the current public health system to provide the foundation for an NHI in the near future is questionable – especially in light of the recent failures in the public health sector. It, therefore, stands to reason that the public healthcare system cannot carry more of the burden.

To combat this, the Scheme participates in engagements with the Competition Commission on the cost of private healthcare and medicine, the Department of Health on the establishment of National Health Insurance (NHI) and proposed mergers in the private healthcare space. The Scheme also participates in engagements with the Department of Health regarding the opening of new private healthcare facilities to improve access.

During the 2016 financial year, the Scheme experienced an increase in the utilisation of healthcare services particularly hospital admissions and related benefits. Increased hospital admissions prompted the Scheme to embark on the hospital negotiations strategy at the end of 2016, with the aim of addressing the burden of hospital costs. The strategy was implemented without compromising members' access to quality healthcare and yielded a saving of R242 million in the 2017 financial year. We will continue to use our size to negotiate robustly with healthcare providers to contain costs as far as possible and negotiate the best possible rates for members. This is supported by preventative care initiatives to ensure that serious chronic conditions are identified and treated before they manifest and become more serious. In 2018, we will carry out a secondary initiative to identify hospitals on our networks that are not cost-effective and work towards improving their efficiency, while ensuring costs are lowered.

There is an increased prevalence of lifestyle diseases such as diabetes, hypertension, HIV/AIDS and mental illness. In support of our efforts to identify these conditions and help put members on the path to wellness, we offer a range of managed care programmes to help members manage these conditions in the most clinically appropriate way. This includes programmes for HIV/AIDS, cancer, chronic medicine management, back and neck, hip and knee replacements as well as diabetes management.

The Scheme bolstered its managed care initiatives in 2017, with the introduction of the Bonitas Diabetes Management Programme. The first phase of this entailed the introduction of the new diabetes programme in 2017 with the new mental health programme due for implementation in 2018. The success of the diabetes programme is underpinned by the Scheme's ability to identify potential diabetic patients and enrol these patients on the programme as well as actively manage these patients through support, testing and education. The Scheme and its partners have worked tirelessly to improve actively managed diabetes patients by 31% between May and December 2017. In 2018, we will look to improve our offerings with a managed care programme focussed on mental health and will explore other options to introduce alternative reimbursement models for procedures such as knee and hip surgery.

Report of the Principal Officer (continued)

The healthcare industry is plagued by fraudulent and wasteful activities that result in invalid claims. It is estimated that 15% of claims in the healthcare industry contain an element of fraud, waste and/or abuse. As we aim to protect members' funds, the Scheme implemented initiatives against fraud, waste and abuse including hospital and pharmacy claim analytics. Our initiatives resulted in the identification of fraud, waste and abuse of R129.8 million, with R31.2 million recovered in 2017. The Scheme further benefitted from R75 million in potential savings. Five imprisonment sentences have been handed down by the judiciary – clearly indicating a zero-tolerance approach to fraud, waste and abuse. We continue to institute criminal charges against those involved in these activities and expand our fraud, waste and abuse initiatives to include hospital groups and other healthcare services.

Attracting younger and healthier members is vital to ensuring the sustainability of the Scheme. To assist in this regard, we introduced BonFit in 2016 as well as several benefits to appeal to younger individuals and families in 2017. In 2018, we will seek identify other options to grow Bonitas and retain our existing membership base. This will include the possibility of amalgamations as well as developing new distribution models and channels.

Our members are at the forefront of our business and ensuring we deliver service and products of the highest quality to them is imperative. It was with this in mind that we enhanced our call centre and website in 2017 and introduced the Electronic Health Record and Personal Health Record to make it easier for members to proactively manage their health.

In 2018, connecting with our customers will be a key focus area as we seek to improve our digital capabilities to improve our members' experience and communicate effectively with them so that they informed and engaged. We will use the best technology available to make things simpler and more efficient for our members.

Such favourable results could not have been delivered without the continued support of the Scheme's partners and service providers. The Scheme continues to engage its service providers with the objective of enhancing the delivery of quality healthcare to its members at lower costs and ensuring the long-term sustainability of the Scheme.

I would like to take this opportunity to offer my gratitude my Executive Team and staff, the Board of Trustees and our partners for their support in ensuring we deliver a solid performance that contributes towards the long-term sustainability of the Scheme. Your continued support will ensure we continue to deliver to the benefit of the Scheme and its members, ensuring that our members have access to quality and affordable healthcare.

Gerhard van Emmenis
Principal Officer
19 April 2018

Report of the Board of Trustees

1. INTRODUCTION

The Board of Trustees ("Board") and executive management of Bonitas Medical Fund ("Bonitas" or "the Scheme") are pleased to share the Report of the Board for the financial year ended 31 December 2017 with its partners and valued members. This report details the Scheme's strategy to ensure the delivery of affordable and quality healthcare to members, its performance against this strategy, an overview of the Scheme's financial performance, challenges faced by the Scheme and how the Board has exercised and discharged its responsibility for governance.

2. REPORT OF THE BOARD OF TRUSTEES

2.1 Board of Trustees in office during the period under review to the date of this report

Chairperson:	Mr S Claassen	
Vice-chairperson:	Mr O Komane	Appointed as Vice-chairperson with effect from 1 October 2017
	Mr O Pretorius	Resigned with effect from 30 September 2017
Trustees:	Mr J Bagg	
	Mr R Cowlin	
	Adv L Koch[1]	Appointed with effect from 1 October 2017
	Ms M Lesunyane	
	Ms F Martin	Term as Trustee ended on 31 January 2018
	Ms Y Mbuli	Term as Trustee ended on 30 August 2017
	Dr H Nematswerani	
	Mr M Netshisaulu	Elected with effect from 1 September 2017
	Dr M Rampedi	Resigned with effect from 8 March 2017
	Ms J Usher	

[1] Adv L Koch was appointed to replace Mr O Pretorius who resigned with effect from 30 September 2017. The appointment of Adv L Koch is effective until the next Annual General Meeting in accordance with the Scheme Rules.

2.2 General overview of the Board of Trustees

The South African economy has been marred by political uncertainty and poor domestic conditions due to a widening budget deficit and sovereign credit downgrades. The local economy has been further impacted by governance failures at both State-owned and corporate entities as well as the implications of a widening gap between the rich and poor.

From a healthcare perspective, there are some key themes currently impacting the healthcare industry. These are outlined below.

Increased supply of healthcare service providers
The addition of new healthcare service providers, including new hospitals, has resulted in increased supply of hospital beds in urban areas. This has the potential to increase utilisation which drives costs up.

Regulatory impact
The establishment of NHI has been the major unknown variable in the healthcare industry for the past 5 years, as there has been little information regarding it. The first step that indicates substantive direction is the removal of the tax credit for private healthcare.

The recent demarcation between insurance products and medical aid products has also changed the landscape for medical schemes.

Technology
Advancements in technology continue to have an impact on the healthcare sector. This is especially true in respect of ideas, regulation of patent rights and intellectual property. The trend of technology in healthcare indicates that a disruptive strategy will play a major role in making new inventions available to the greater public. Technology in the healthcare industry is aimed, firstly, at improving quality of life and then, over time, affordability.

2.3 The Scheme's strategy

Over the past three years, Bonitas has developed a strategy which aligns with its core objective to provide quality healthcare at affordable prices.

2.3.1 Bonitas aims to...be a strategic purchaser

a. Hospital group negotiations

Escalating healthcare inflation and costs is one of the key concerns facing the medical scheme industry. Bonitas believes that the way forward is rigorous negotiations premised on strategic purchasing and the development of advanced managed care protocols. Over the past few decades, healthcare costs have consistently outpaced inflation - a trend which continues today. Given that some of these costs are not regulated, exploring ways and means of decreasing costs on the supplier side particularly with hospitals is pivotal.

As a result in 2016, the Scheme commenced negotiations with the three large hospital groups in South Africa, with a view of creating a hospital network. This network allows for the Scheme to negotiate preferential tariffs with participating hospitals, to help curtail the burden of escalating healthcare costs on members. The strategy followed the Scheme's core strategic pillar of strategic purchasing which uses Bonitas' market share to negotiate and influence prices.

Hospital groups were advised that the Scheme would restrict access at 14 hospitals, located in metropolitan areas where there is an oversupply of hospital beds. These hospitals were carefully selected to ensure that members would continue to have access to quality care at facilities in close proximity to them at the lowest possible tariffs.

By retaining this strategy a saving of more than R242.0 million was realised in 2017. It is projected that this saving will increase to approximately R550.0 million over the next two years in present value terms. This will directly impact future contribution increases and ensure that the Scheme can continue to meet the needs of its members.

b. Fraud, waste and abuse

Over the years the Scheme has observed an increasing trend in the abuse of the members' benefits by certain healthcare professionals as well as increased potential for fraudulent claims as a result of collusion between healthcare professionals and, in some instances, members of the Scheme. This behaviour undermines the financial sustainability of the Scheme and, therefore, has an impact on members.

To minimise the impact of the above and to address the risk, Bonitas adopted a zero-tolerance approach to fraud, waste and abuse. This resulted in a new risk management initiative being introduced in April 2016.

During 2017, the Scheme dealt with 35 criminal matters regarding healthcare professionals who were identified to have submitted fraudulent claims to the Scheme. These cases were reported to the South African Police Services after investigations revealed that false claims were submitted by the respective healthcare professionals. Five criminal cases were finalised and five healthcare professionals were found guilty of fraud.

Three of these professionals are currently serving sentences while one was handed a suspended sentence. Sentencing on the last case is currently pending. The remaining 30 criminal cases are at various stages in the criminal justice system. Where appropriate, the Scheme has instituted civil proceedings to recover money due to the Scheme.

Our identification and confirmation of fraud, waste and abuse has increased to over R129.8 million in 2017 compared to R79.0 million in 2016. It is pleasing to note that, the recovery of money related to fraud, waste and abuse increased to R31.2 million in 2017 compared to R19.0 million in 2016. The Scheme will continue to ensure that all outstanding money is successfully recovered and repaid to Bonitas. The Scheme has further noted changes in claiming behaviour, which has resulted in savings of R75.0 million being realised in 2017.

Based on the Scheme's zero tolerance approach various sanctions have been applied in instances where healthcare professionals and/or members have been identified as being involved in either fraudulent, wasteful or abusive activities.

The sanctions applied include:

- Laying criminal charges with the South African Police Services
- Reporting the healthcare professional to the relevant medical regulatory bodies
- Application of sections 59(2) and (3) of the Medical Schemes Act against the healthcare professional
- Implementing civil action against the perpetrator, and
- Termination of membership where relevant.

The identification and further investigation of such cases has provided the Scheme with an opportunity to enhance the Scheme's Rules and structure benefits to minimise the impact of these activities.

2.3.2 Bonitas aims to... boost business development

The main focus of the strategy on business development is to:

1. Actively build more distribution channels
2. Identify complementary products to be sold
3. Build the Bonitas brand
4. Re-align the options of the Scheme to address the specific needs of different target groups.

The Scheme continues to bolster its business development efforts through the building and re-positioning of the Bonitas brand. To this end, the Scheme has continued with its advertising campaigns which commenced in 2016, with the focus being on digital marketing campaigns. The focus on digital marketing has proved to be more successful in attracting younger members to the Scheme. Bonitas will continue to engage in digital strategies with the aim of consolidating its market position and attracting new members to the Scheme.

Although the Scheme considered proposals relating to the introduction of complementary products for members during 2017, these were deemed to be a poor fit for the current membership base. The Scheme continues to engage with its partners in the introduction of complementary products with the proviso that these products will add value to its members, in accordance with its duty to act in the best interests of members at all times.

Over the past few years the Scheme has focussed on repositioning the Bonitas brand, with particular emphasis on using above the line marketing to attract more members and grow the Scheme. A larger scheme aids sustainability and allows the Scheme to use its size to negotiate the best rates possible for members.

At the end of 2017, several changes were made to allow the BonFit option to be more competitive in the market during 2018. This included the addition of dental benefits paid from risk, which significantly strengthened the option's benefits. The Scheme also introduced a benefit for contraceptives, benefits for congenital hypothyroidism screenings for newborns and infant hearing screenings and enhanced the wellness extender benefit to appeal to younger families and individuals. During 2018, we will continue to evaluate the current options to improve their benefits and competitiveness in the market.

2.3.3 Bonitas aims to... enhance customer experience

a. Diabetes Managed Care Programme

Chronic conditions are the leading causes of death and disability globally, putting an enormous and increasing burden on most healthcare systems. Prevention and early intervention are critical steps towards the goal of making people healthier through better lifestyles and increased compliance with suggested care regimens.

The Council for Medical Schemes recently cited an increased prevalence of chronic conditions, and diabetes in particular, as one of the key contributors to a rising disease burden and escalating healthcare costs. As a means to offset this growing disease burden and proactively empower diabetic patients to take control of their health, the Scheme launched an integrated, holistic programme which is based on the specific needs of these members.

Diabetic patients often have other chronic conditions (co-morbidities), such as high blood pressure, high cholesterol, heart disease and depression. It was noted that over 80% of the Scheme's diabetic patients have associated chronic conditions. This increases the risk of diabetic patients developing complications. To manage diabetes effectively, all the other conditions and complications must be managed as well. A key feature of the diabetic programme is that it manages each diabetic patient's unique mix of disease and lifestyle factors rather than taking a standard approach. Members on the programme have access to a dedicated health coach, diabetes nurse educators and personalised care plans to help them proactively manage their condition and take control of their health.

Since the introduction of the programme on 1 May 2017, the Scheme has increased the number of actively managed diabetic patients by 31%. Thus far 58.6% of the actively managed diabetic patients have undergone an HBA1c test. The Scheme has seen a marked improvement in the health of actively managed diabetic patients with 6% of these showing a controlled HBA1c score and hospital admissions related to diabetic patients having reduced by 11.6% year on year.

The Scheme will continue with its efforts of registering more members on this programme to enable these members to benefit from the dedicated care offered through the programme.

Our managed care programmes

- **135 757 beneficiaries registered to receive chronic medicine**
- **35 730 beneficiaries on the HIV/AIDS programme**
- **5 783 beneficiaries on the cancer programme**
- **10 727 beneficiaries on the new diabetes programme**
- **1 234 beneficiaries completed the back and neck programme in 2017**

3. DESCRIPTION OF THE SCHEME

3.1 Terms of registration

The Scheme is an open medical scheme registered in terms of the Medical Schemes Act of South Africa, No 131 of 1998, as amended ("the Act"), under registration number 1512. The Scheme is incorporated and domiciled in the Republic of South Africa. Bonitas Medical Fund is one of the top three medical schemes registered in South Africa and one of the top two open medical schemes in South Africa. The Scheme is administered by Medscheme Holdings Proprietary Limited.

3.2 Benefit options

The Scheme offered the following benefit options to employers and members of the public during the year:

- **BonComprehensive:** This first-class savings plan offers ample savings, an above threshold benefit and extensive hospital cover.
- **BonClassic:** This generous savings option offers a wide range of medical benefits, in and out of hospital. BonComplete: This savings option offers generous savings, an above threshold benefit and rich hospital cover.
- **BonSave:** This savings option offers savings to use as you choose for medical expenses and extensive hospital cover.
- **BonFit:** This savings plan offers basic cover for day-to-day medical needs and essential hospital cover.
- **Standard:** This traditional option offers rich day-to-day benefits and comprehensive hospital cover.
- **Standard Select:** This traditional option uses a quality provider network to offer rich day-to-day benefits and hospital cover.
- **Primary:** This traditional option offers simple day-to-day benefits and hospital cover.
- **Hospital Plus:** This hospital plan offers comprehensive hospital benefits with some value-added out-of-hospital benefits.
- **Hospital Standard:** This hospital plan offers extensive hospital benefits with some value-added benefits.
- **BonEssential:** This hospital plan offers rich hospital benefits with some value-added benefits.
- **BonCap:** This income-based entry-level plan offers basic day-to-day benefits and hospital cover using a network of doctors, providers and hospitals.

3.3 Personal Medical Savings Options

In order to provide a facility for members to set aside funds to meet healthcare costs not covered in the benefit options, the Board has made the personal medical savings plan options available.

The BonComprehensive, BonClassic, BonComplete, BonSave and BonFit options provide members with the facility to pay an agreed sum into a personal medical savings account to help pay the members' portion of healthcare costs up to a prescribed threshold.

Unused savings amounts are accumulated for the long-term benefit of the member and interest is allocated monthly on the balances at the rate specified in the rules of the Scheme which is not less than the average rate applicable to cash and cash equivalents. The liability to the members in respect of the personal medical savings plan is reflected as a financial liability in the annual financial statements, repayable in terms of Regulation 10 of the Act. These funds are invested separately and managed by an independent asset manager, Taquanta. The average interest earned on these funds in 2017 was 8.1%

Members are refunded any credit balance of savings contributions where a member enrols in another benefit option or another medical scheme without a personal medical savings account, or does not enrol in another medical scheme. The credit balances are refunded in accordance with the Scheme Rules.

In June 2017, the Constitutional Court handed down a judgment outlining how medical schemes should account for the funds in members' medical savings accounts. The Court ruled that all funds paid by members of a medical scheme should be considered as assets of that medical scheme. The ruling means that medical schemes can now retain the interest, and if a medical scheme is liquidated, the money in a members' medical savings accounts will not be protected from creditors. The Scheme Rules were subsequently amended and we are pleased to note that Bonitas members will continue to earn interest on positive savings balances, although the magnitude of interest may vary.

4. INVESTMENT STRATEGY

The investment strategy of the Scheme is to optimise the return on investments within the Scheme's risk appetite. The investment strategy takes into consideration constraints imposed by regulations as well as the Board of Trustees.

The investment portfolio of the Scheme is suitably diversified in accordance with the Scheme's Investment Policy Statement. Asset allocation is managed by taking into account asset liability matching of the Scheme. This to ensure that the Scheme has sufficient liquid funds to meet claims and other liabilities as they fall due. Due to the short-term nature of the Scheme's liabilities, a significant portion of the investment portfolio is invested in cash instruments.

In 2017 the local market was plagued by the downgrades of the sovereign credit rating, the majority of asset classes delivered above-inflation returns. The FTSE/JSE All Share Index returned 21% (2016:2.6%); JSE All Bond Composite Index returned 10.2% (2016:15.5%) and the Cash STeFi Composite Index returned 6.9% (2016:7.4%). The Scheme delivered an overall investment return of 8.9% for 2017.

5. MANAGEMENT OF INSURANCE RISKS

5.1 Insurance risk

The business of the Scheme is to manage the healthcare risk exposure of its members and their dependants. This risk is directly correlated to the health of the Scheme's beneficiaries. As such, uncertainty exists on the timing and severity of claims members may submit to the Scheme.

5.2 Assessing insurance risk exposure

The Scheme uses several methods to assess and monitor insurance risk exposure, both for individual types of risks insured and overall risks. These methods include internal risk measurement models, sensitivity analysis, scenario analysis 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 are greater than expected.

5.3 Managing insurance risk

The Scheme manages its insurance risk through various methods including 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 and the centralised management of risk transfer arrangements.

5.4 Risk transfer arrangements

The Scheme has entered into risk transfer arrangements with the following service providers:

Service provider	Risk transfer arrangements and options affected
Dental Information Systems Proprietary Limited - ("DENIS")	Dental benefits, including dental induced hospitalisation **Standard, BonSave, Primary, BonClassic, BonComplete and Standard Select**
ER24 EMS Proprietary Limited - ("ER24")	Emergency and evacuation services as well as emergency medical and international travel services **All Options**
Iso Leso Optics Limited - ("ISO LESO")	Optical benefits **Standard, Primary, BonCap and BonClassic**
CDE Holdings Proprietary Limited - ("CDE") Service provider terminated with effect from 30 April 2017	Diabetic insulin and non-insulin benefits **Standard and BonComprehensive**

6. REVIEW OF SCHEME'S ACTIVITIES DURING THE PERIOD

6.1 Operational statistics per benefit option

THE BONITAS FAMILY													
Bonitas Medical Fund 2017	**Consolidated total**	**Standard**	**BonSave**	**Primary**	**BonCap**	**Bon-Classic**	**Bon-Comp**	**Bon-Essential**	**Standard Select**	**BonFit**	**Hospital Standard**	**Hospital Plus**	**Bon-Complete**
Average number of members during the year (n)	339 003	128 299	35 661	72 687	42 942	11 704	6 928	8 229	4 045	3 440	7 718	4 049	13 301
Number of members at 31 December (n)	338 649	127 332	35 364	72 529	45 233	11 522	7 123	8 269	4 038	3 550	7 216	3 836	12 637
Average number of beneficiaries during the year (n)	731 494	292 199	82 144	172 948	64 707	22 118	13 097	17 890	8 846	6 812	14 780	7 744	28 210
Number of beneficiaries at 31 December (n)	728 943	289 391	81 908	172 796	68 496	21 649	13 239	17 944	8 782	7 040	13 825	7 279	26 594
Proportion of dependants at the end of the year (n)	1.15	1.27	1.32	1.38	0.51	0.88	0.86	1.17	1.17	0.98	0.92	0.90	1.10
Risk contributions per average member per month (Rands)	3 664	4 835	2 894	3 117	1 321	4 697	6 586	2 401	4 122	2 156	2 788	4 455	3 866
Risk contributions per average beneficiary per month (Rands)	1 698	2 123	1 256	1 310	877	2 485	3 484	1 104	1 885	1 088	1 456	2 330	1 823
Healthcare expenditure per average beneficiary per month (Rands)	1 500	1 846	1 040	1 082	887	2 463	3 912	838	2 005	737	1 326	2 287	1 670
Non-healthcare expenditure per average beneficiary per month (Rands)	159	165	161	156	103	183	192	163	173	180	187	194	176
Relevant healthcare expenditure as a percentage of gross contributions (%)	84.95	86.95	69.67	82.58	101.13	85.13	91.26	75.88	106.38	57.58	91.06	98.19	78.07
Non-healthcare expenditure as a percentage of gross contributions (%)	9.00	7.78	10.81	11.89	11.78	6.32	4.48	14.73	9.16	14.06	12.85	8.31	8.23
Average beneficiary age (n)	33	35	29	28	32	48	50	34	37	29	43	52	39
Pensioner ratio at 31 December (%)	8.29	8.52	4.84	3.49	6.62	25.22	31.32	8.88	11.73	5.00	18.92	34.08	13.38
Chronic profile at 31 December (%)	16.70	21.74	10.45	8.78	8.36	40.33	43.19	8.74	27.19	6.25	15.04	24.76	22.15

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

6.1 Operational statistics per benefit option (continued)

THE BONITAS FAMILY											
Bonitas Medical Fund 2016	**Consolidated Total**	**BMF Total**	**Standard**	**BonSave**	**Primary**	**BonCap**	**BonClassic**	**BonComp**	**BonEssential**	**Standard Select**	**BonFit**
Average number of members during the year	348 025	294 999	134 461	30 448	67 875	38 984	12 104	3 601	5 307	1 538	681
Number of members at 31 December	348 088	295 278	131 913	30 425	68 200	41 127	11 782	3 555	5 675	1 651	948
Average number of beneficiaries during the year	755 758	650 471	309 826	71 836	162 928	58 350	23 290	7 177	12 161	3 550	1 354
Number of beneficiaries at 31 December	753 514	648 933	303 637	71 964	163 426	61 703	22 519	7 054	12 969	3 806	1 855
Proportion of dependants at the end of the year	1.16	1.20	1.30	1.37	1.40	0.50	0.91	0.98	1.29	1.31	0.96
Risk contributions per average member per month (Rands)	3 271	3 287	4 179	2 618	2 797	1 188	4 221	5 914	2 263	3 826	2 141
Risk contributions per average beneficiary per month (Rands)	1 506	1 491	1 814	1 110	1 165	794	2 194	2 968	988	1 658	1 076
Healthcare expenditure per average beneficiary per month (Rands)	1 384	1 369	1 672	893	1 011	833	2 240	3 558	845	1 654	563
Non-healthcare expenditure per average beneficiary per month (Rands)	148	151	159	154	150	94	175	180	150	157	173
Relevant healthcare expenditure as a percentage of gross contributions (%)	87.30	87.25	88.73	67.75	86.76	104.96	87.74	97.40	85.58	96.14	45.09
Non-healthcare expenditure as a percentage of gross contributions (%)	9.53	9.62	8.42	11.67	12.89	11.82	6.85	4.92	15.19	8.9	13.85
Average beneficiary age	33	31	33	27	27	32	46	44	31	33	26
Pensioner ratio at 31 December (%)	8.32	6.94	8.22	3.35	3.13	6.50	24.47	23.29	7.25	10.12	2.16
Chronic profile at 31 December (%)	16.40	15.94	21.11	8.72	7.99	8.23	38.90	43.27	7.71	27.64	5.44

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

6.1 Operational statistics per benefit option (continued)

THE BONITAS FAMILY										
Bonitas Medical Fund 2016 (LMS options managed 1 October 2016 - 31 December 2016)	**LMS Total**	**Complete Plus**	**Saver Plus**	**Hospital Plus**	**Saver Standard/ Select**	**Hospital Standard/ Select**	**Complete Standard/ Select**	**Traditional Standard**	**Traditional Ultimate**	**Traditional Basic**
Average number of members during the year	53 026	3 908	894	4 946	7 250	11 253	16 788	4 504	122	3 360
Number of members at 31 December	52 812	3 888	888	4 918	7 206	11 176	16 681	4 439	122	3 494
Average number of beneficiaries during the year	105 287	7 474	1 604	9 640	14 600	21 299	36 550	9 316	245	4 560
Number of beneficiaries at 31 December	104 581	7 428	1 589	9 565	14 504	21 149	36 230	9 185	245	4 686
Proportion of dependants at the end of the year	0.98	0.91	0.79	0.94	1.01	0.89	1.17	1.07	1.01	0.34
Risk contributions per average member per month (Rands)	3 184	6 436	4 111	4 018	2 539	2 428	3 472	2 453	10 506	1 128
Risk contributions per average beneficiary per month (Rands)	1 604	3 365	2 292	2 062	1 261	1 283	1 595	1 186	5 231	831
Healthcare expenditure per average beneficiary per month (Rands)	1 448	3 279	1 918	1 893	1 055	1 177	1 392	1 040	3 846	1 019
Non-healthcare expenditure per average beneficiary per month (Rands)	134	139	147	138	130	136	136	125	138	113
Relevant healthcare expenditure as a percentage of gross contributions (%)	81.45	83.00	75.61	91.79	70.82	91.70	74.29	87.68	73.52	122.51
Non-healthcare expenditure as a percentage of gross contributions (%)	7.51	3.51	5.80	6.68	8.69	10.59	7.25	10.52	2.63	13.54
Average beneficiary age	39	50	46	49	35	41	37	35	44	29
Pensioner ratio at 31 December (%)	16.90	35.40	29.20	32.90	10.80	17.10	12.60	13.90	30.20	6.20
Chronic profile at 31 December (%)	18.90	39.10	28.60	23.90	19.10	15.80	24.30	21.80	27.30	3.50

7. RESULTS OF OPERATIONS

7.1 Financial results

Bonitas Medical Fund delivered a surplus of R730.2 million for the year ended 31 December 2017 (2016: loss of R16.9 million). This financial turnaround is attributable to robust healthcare risk management measures, tight cost management measures and solid investment income generated by the Scheme.

Risk contribution income rose by 22.8% to R14.9 billion (2016: R12.1 billion) due to an average contribution increase of 11.9% and the full year impact of the LMS amalgamation. Of this risk contribution income, 88.5% was used to fund members' claims. The Scheme experienced a net membership decline of 2.7% (2016: increased by 17.8%) from 348 088 to 338 649. The decline in membership had the effect of reducing the number of lives covered by the Scheme by 3.3% (2016: increased by 15.1%) from 753 514 to 728 943. Although the Scheme experienced a decline in membership, an increase in membership on BonSave, Primary, BonEssential and BonFit was experienced.

Net claims incurred increased by 17.8% to R12.6 billion (2016: R10.7 billion). The pressure on healthcare costs is a critical concern to the Scheme, as healthcare inflation was again reported above CPI. The rise in healthcare costs is largely driven by tariff increases and higher utilisation of healthcare services. Despite these pressures, the Scheme continues to implement risk management measures aimed at curbing the impact of the rise in healthcare costs. As a consequence of these measures, the Scheme contained the claims loss ratio to 88.5% for the year.

The Scheme's investment portfolio delivered investment income of R394.3 million (2016:R 248.6 million) which translates to an investment return of 8.9% for 2017 (2016:8.0%).

7.2 Administration expenses

Administration expenses are made up of operational expenses and administration fees paid to the Scheme's administrator. The administration fees increased by 14% to R778.9 million (2016: R682.5 million). The increase is attributable to the administration fee per member rate increase and accounting for the LMS membership for a full year in 2017 in comparison to a three-month period in 2016. Administration fees make up 5.1% of gross contributions.

7.3 Accredited managed care services

The Scheme has the following managed care services in place through its managed care services providers:

- Active risk disease management
- Aids/HIV management
- Chronic benefits management
- Diabetes management (since 1 May 2017)
- Hospital benefits management

The accredited managed care services costs increase of 27.9% to R447.8 million (2016: R350.2 million) is attributable to the accredited managed care cost costs per member per month rate increase due to inflation, the new diabetes management programme and accounting for the LMS membership for the full year in 2017 in comparison to a three-month period in 2016.

7.4 Investments

Although in 2017, the local market was plagued by the downgrades of the sovereign credit rating, the majority of asset classes experienced above-inflation returns. The FTSE/JSE All Share Index returned 21% (2016: 2.6%); JSE All Bond Composite Index returned 10.2% (2016: 15.5%) and the Cash STeFi Composite Index returned 6.9% (2016: 7.4%). The Scheme's investment portfolio delivered investment income of R394.3 million (2016: R248.6 million) which translates to an investment return of 8.9% for 2017.

These results contributed to the net surplus of R730.2 million (2016: deficit of R16.9 million) achieved by the Scheme. This solid financial performance has bolstered members' funds by 23% from R3.2 billion to R4.0 billion. This is a strong financial base to meet members' healthcare needs in the foreseeable future.

The liquidity position of the Scheme remains strong. The Scheme held R3.9 billion (2016: R3.3 billion) in investments and R714.8 million (2016: R492.0 million) in cash and cash equivalents at the end of the year. Liquidity is a key measure of our ability to settle claims and meet our operational activity requirements.

Overall we maintain a positive outlook on the Scheme's future and sustainability in the years to come.

8. SOLVENCY RATIO

R '000	2017	2016
Members' funds per the statements of financial position	**3 969 191**	3 235 000
Adjusted for:		
Regulation 29 exclusion of unrealised gains on investments	**(156 341)**	(95 858)
Cumulative net gains on re-measurement to fair value of investment properties included in the accumulated funds*	**(21 774)**	(20 374)
Accumulated funds per Regulation 29	**3 791 076**	3 118 768
Gross contributions	**15 497 049**	12 805 108
Solvency ratio (%)	**24.5%**	**24.4%**

**Cumulative net gains on re-measurement to fair value of investment properties included in the accumulated funds are calculated as follows:*

At beginning of year	**20 374**	19 174
Movement in unrealised gains/(losses) on re-measurement to fair value of investment properties included in accumulated funds*	**1 400**	1 200
At end of year	**21 774**	**20 374**

Our solvency ratio improved by 0.1% points from 24.4% in 2016 to 24.5% in 2017, albeit below the statutory requirement of 25%. The initiatives undertaken by the Board to address and improve benefit options; healthcare costs and non-healthcare costs are yielding the intended results and impacting favourably on the Scheme's solvency ratio.

9. RESERVE ACCOUNTS

Movements in the reserve accounts are set out in the annual financial statements in the statement of changes in members' funds and reserves.

10. OUTSTANDING CLAIMS

The basis of calculation and movements of the outstanding claims provision is consistent with 2016. There have been no unusual movements that should be brought to the attention of the members of the Scheme.

11. ACTUARIAL VALUATION

An actuarial valuation of the Scheme is performed annually and contributions and benefit levels are re-designed taking into consideration recommendations from the actuary. Reports are received on a monthly basis from the actuary on the status of the Scheme.

12. OTHER MATTERS FOR REPORTING TO MEMBERS

12.1 Claim for recovery of ceded policies

The matter of the Scheme's claim against Louis Pasteur Hospital Holdings ("Louis Pasteur") still remains a matter before the Court. In previous reports, the Board has indicated it had instituted a claim to recover R44 million arising from certain policies ceded to Louis Pasteur pursuant to shareholder funding requirements. Judgment was granted in favour of the Scheme in June 2016 for the full amount plus interest. However, Louis Pasteur applied to Court for leave to appeal, which was denied by the High Court. It then petitioned the Supreme Court of Appeal (SCA) for leave to appeal, which was granted in March 2017. The matter will now be ventilated in the SCA, and is only anticipated to be heard early in 2018.

12.2 Inspection notice

During the course of December 2014, the Registrar issued an inspection notice in terms of which it sought to inspect certain issues which primarily arose during the time when the Scheme was under curatorship.

The Scheme tendered its co-operation provided that the parameters of the inspection were lawful. The Scheme was of the view that the inspection was unlawful, and lodged an appeal in terms of section 49 of the Act. The Regulator contended that the challenge was not appealable under the Act. The Regulator, therefore, brought an application to Court (known as a declaratory order) for the Court to determine whether the matter was appealable under section 49 of the Act or whether the Scheme should challenge the decision to inspect directly in Court. The SCA ruled that the decision was not appealable under section 49 of the Act, and therefore, should the Scheme wish to challenge the Registrar's right to order the inspection, it would have to approach the Court. In the intervening period the Regulator and the Scheme have by agreement concluded that for the present time, the inspection would continue. However, due to circumstances beyond both parties' control, the then inspector resigned from the position, and a new inspector has recently been appointed. The Scheme continues to co-operate with the Regulator and new inspector, and hopes that the inspection will be concluded as soon as possible.

12.3 Change in VAT

In the 2018/2019 budget speech, the Minister of Finance announced an increase of 1% to the VAT rate to 15% with effect from 1 April 2018. As already communicated to our members, the consequence of this rate increase will be a corresponding increase in the tariffs and fees levied by service providers. For the 2018 financial period, the rate increase may result in the accelerated use of members' benefits. The Scheme may bring this rate increase into consideration during the 2019 pricing.

13. BOARD OF TRUSTEES AND SUB-COMMITTEE MEETING ATTENDANCE

The schedule below summarises the attendance by the Board, Audit and Risk Committee members, Remuneration Committee members, Investment Committee members and Working and Strategy Committee members, at the various Board and committee meetings held during 2017.

	Board		Audit & Risk Committee		Remuneration Committee		Investment Committee		Working & Strategy Committee	
Trustee and/or Independent member	A	B	A	B	A	B	A	B	A	B
Dr M Rampedi[1]	2	1	-	-	-		-	-	-	-
Mr S Claassen	9	8	7	7	5	4	7	6	6	6
Mr J Bagg	9	9	-	-	-	-	7	7	-	-
Mr R Cowlin	9	9	-	-	-	-	7	7	2	2
Ms L Koch[2]	1	1	-	-	-	-	-	-	-	-
Mr O Komane	9	8	-	-	5	5	-	-	2	2
Ms M Lesunyane	9	9	-	-	1	1	6	3	-	-
Ms F Martin	9	9	-	1	5	5	-	-	-	-
Ms Y Mbuli[3]	7	7	-	-	4	4	-	-	-	-
Dr H Nematswerani	9	9	-	-	-	-	-	-	-	-
Mr M Netshisaulu[4]	2	2	1	1	-	-	-	-	-	-
Mr O Pretorius[5]	8	7	-	-	-	-	-	-	4	4
Ms J Usher	9	9	7	7	-	-	-	-	6	6
Ms KG Mbonambi	-	-	7	6	-	-	-	-	-	-
Mr J Prinsloo	-	1	7	7	-	-	-	-	-	-
Mr J Ferreira	-	-	7	7	-	-	-	-	-	-
Ms P Kekana	-	-	-	-	5	4	-	-	-	-
Ms W Kirima	-	-	-	-	-	-	7	7	-	-
Mr C Van Zyl	-	-	-	-	-	-	7	7	-	-

1 Dr M Rampedi resigned as Trustee on 8 March 2017
2 Adv L Koch was appointed as Trustee on 1 October 2017
3 Ms Y Mbuli term as Trustee ended on 30 August 2017
4 Ms M Netshisaulu was elected as Trustee with effect from 1 September 2017
5 O Pretorius resigned as Trustee on 30 September 2017

In total there were thirty four (34) meetings held during the year.
A - Total possible number of meetings member could have attended during the period the member was in office
B - Actual number of meetings attended

Trustees have the option of attending any sub-committee meeting. Where a trustee is not a member of that sub-committee, the trustee attends the meetings of that sub-committee as an observer and this is reflected in column B above.

14. SCHEME GOVERNANCE

14.1 Governance Structure and Framework

All medical schemes in South Africa are governed by the Medical Schemes Act 131 of 1998, as amended ("the Act"). The Scheme Rules are developed and maintained in accordance with the Act and are approved by the Council for Medical Schemes ("CMS"). Furthermore, the Scheme refers to the King Code of Governance Principles for additional guidance and best practice on corporate governance.

Bonitas Medical Fund ("the Scheme") is governed by an independent Board of Trustees ("the Board") which is duly elected by members of the Scheme for a five-year term, as stipulated in the Scheme Rules. The Board is accountable for the governance and oversight of the business of the Scheme. The Board is ultimately responsible for the decision-making and management of the Scheme as well as overseeing the implementation of the Scheme's strategy. In executing its accountabilities, the Board has developed and implemented a governance framework and governance structures that are in line with the requirements of the Act, Scheme Rules and good corporate governance practices. The Board is driven by the objective of ensuring that the Scheme acts in the best interests of the members while ensuring long-term sustainability of the Scheme.

The Board is supported by four sub-committees to enable it to effectively fulfil its duties and responsibilities. Members of these sub-committees consist of both trustees and independent members. The Board mandates the sub-committees through defined charters which outline the duties and responsibilities of each of the sub-committees. The sub-committees make recommendations to the Board for consideration and approval of any proposal made.

Furthermore, the Board appoints a Principal Officer who is accountable for implementing the Scheme's strategy and any other decision made by the Board; and the day-to-day management of the Scheme. The Principal Officer is supported by an executive management team in executing his responsibilities.

14.2 Board Sub-Committees

The Board continues to strengthen the governance of the Scheme through four sub-committees, namely the Audit and Risk Committee; Remuneration Committee; the Investment Committee; and the Working and Strategy Committee.

14.2.1 Audit and Risk Committee

In terms of the Act, the Scheme is obliged to have an Audit and Risk Committee, which it has, and which is duly constituted and functional. The Audit and Risk Committee comprises of a majority of independent members whose function is to assist the Board in discharging its duties relating to the safeguarding of assets; the operation of adequate and effective systems, internal controls and processes; and the preparation of financial statements that fairly represent the financial position of the Scheme. This independent committee is mandated by the Board through a formal terms of reference which stipulates the membership, duties, responsibilities and authority of the committee.

Ms K Mbonambi	Chairperson and independent member (appointed chairperson with effect from 1 May 2017
Mr S Claassen	Trustee (stepped down with effect from 30 September 2017)
Mr J Ferreira	Independent member
Mr M Netshisaulu	Trustee (appointed with effect from 1 October 2017)
Mr J Prinsloo	Independent member (stepped down as chairperson with effect from 30 April 2017)
Ms J Usher	Trustee

14.2.2 Remuneration Committee

The purpose of the Remuneration Committee is to assist the Board to oversee the Scheme's remuneration strategy and related policies whilst ensuring compliance with these policies. The Remuneration Committee oversees the remuneration of Trustees, independent members and employees of the Scheme.

Ms P Kekana	Chairperson and independent member (appointed as Chairperson with effect from 1 October 2017)
Mr O Komane	Trustee (stepped down as Chairperson with effect from 30 September 2017)
Ms M Lesunyane	Trustee (appointed with effect from 1 October 2017)
Ms Y Mbuli	Trustee (Term as Trustee came to an end on 30 August 2017)
Ms F Martin	Trustee (Term as Trustee came to an end on 31 January 2018)

14.2.3 Investment Committee

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. The sub-commiteee advises the Board on strategic matters relating to the investment of the Scheme's reserves ensuring that the investments are made in the best interest of the members. Refer to point 4 of this report for further details on the Scheme's investment strategy.

Mr R Cowlin	Chairperson
Mr J Bagg	Trustee
Ms W Kirima	Independent member
Ms M Lesunyane	Trustee (stepped down with effect from 30 September 2017)
Mr C van Zyl	Independent member

14.2.4 Working and Strategy Committee

The Working and Strategy Committee assists the Board in directing and monitoring the implementation of the strategy of the Scheme, and has the responsibility of managing the Scheme's procurement process and recommending the non-healthcare expenses budget to the Board for its consideration.

Mr S Claassen	Chairperson
Mr O Komane	Trustee (appointed with effect from 1 October 2017)
Mr O Pretorius	Trustee (resigned with effect from 30 September 2017)
Ms J Usher	Trustee
Mr R Cowlin	Trustee (appointed with effect from 1 October 2017)

15. NON-COMPLIANCE WITH THE ACT

The following areas of non-compliance with the Act were identified during the course of the financial year:

15.1 Contravention of Section 33(2) of the Act

15.1.1 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 2017 the Scheme reported a net healthcare deficit on seven (2016: nine) of its benefit options:

R '000	2017	2016
Standard	-	79 136
Standard Select	**31 048**	5 308
BonCap	**87 216**	97 165
BonClassic	**42 484**	66 116
BonComp	**97 405**	66 171
BonEssential	-	3 851
BonComplete	**7 764**	-
Hospital Standard	**10 030**	-
Hospital Plus	**14 031**	-
Complete Plus[1]	-	1 181
Hospital Select	-	1 885
Traditional Basic[1]	-	4 100

[1] Benefit options added as part of the amalgamation with LMS on 1 October 2016 and cancelled with effect from 31 December 2016.

15.1.2 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.

15.1.3 Corrective course of action

The Scheme has seen a turnaround in the performance of its largest options. In 2017 Standard and Primary have reported a net healthcare surplus of R394.0 million and R151.3 million respectively. Much of the turnaround can be attributed to successful hospital negotiations, benefit design and the realignment of membership into the correct options. The Scheme continues to monitor the performance of the seven benefit options listed above on a monthly basis. There are also quarterly operational meetings held with the regulator advising on the performance of these options. The Scheme has adopted a long term strategy to correct the loss making options in the future, in particular on the BonCap and BonComp options. The Scheme has also appointed a task team to drive initiatives which will reduce both healthcare and non-healthcare costs over the next 12 months. These cost-saving measures should have a positive impact across all options.

15.2 Contravention of Section 26(7) of the Act

15.2.1 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.

15.2.2 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 2017 financial period the Scheme incurred bad debt write offs of R20.9 million (2016: R15.6 million) which equals 0.14% (2016: 0.13%) of risk contribution income.

15.2.3 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.

15.3 Exemption of Section 26(11)

15.3.1 Nature and cause

As a result of the amalgamation between the Scheme and Protector Health on 1 January 2006 a post retirement health obligation arose with reference to the provisions stipulated in Protector Health's prior amalgamation agreement with Vaalmed. This resulted in an unavoidable contravention of section 26(11) of the Act as retirement funding of any sort is not considered to be the business of a medical scheme.

15.3.2 Possible impact

There is little negative impact to any members of the Scheme as the Scheme is currently honouring its obligation to the three members affected by these amalgamations.

15.3.3 Corrective course of action

The Scheme obtained an exemption notice on 1 June 2010 in terms of Section 8(h) of the Act from the Council for Medical Schemes, in respect of the non-compliance raised.

15.4 Exemption of Section 35(8) of the Act

15.4.1 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.

15.4.2 Possible impact

The Scheme has invested with various entities associated with its administrator and the Scheme's employer groups during the financial year.

15.4.3 Corrective course of action

The Scheme obtained an exemption in terms of Section 35(8) of the Act from Council for Medical Schemes in respect of the non-compliance noted.

15.5 Contravention of Section 59(2) of the Act

15.5.1 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 found at the beginning of the financial year when claims are put on hold, to ensure that the approved tariff and benefit limits were loaded correctly on the administration platform. This process resulted in a delay in the processing of payments due to the backlog in claims, but this only lasted a few days.

The administrator implemented the FICO Blaze Advisor™ decision management system ("Blaze") on 16 November 2017 under their claims assessing project to enhance the existing claims and reimbursement management capabilities. The system has the ability to evaluate the validity and eligibility of a claim, whilst the current administration system, Nexus, continues to apply the benefit and limit checks as well as the pricing and payment of the claim.

Despite the testing performed on the Blaze system and a "parallel run" of the old and new rules engines, various issues were unfortunately experienced since the implementation which resulted in certain claims being incorrectly rejected or short paid.

15.5.2 Possible impact

The delay only occurs at the beginning of the financial year when new tariffs and benefit limits are loaded; claims are paid within the first week of tariff and benefit limit approval. Bonitas is not compliant with the Act and/or its rules. Valid claims could be rejected or amounts due on valid claims could be short paid.

15.5.3 Corrective course of action

This is not considered to be significant due to the members and providers conforming to the annual practice. The practice above ensures accurate claims processing for the new benefit year and is in the interest of risk management for the Scheme.

The system faults have been corrected and the claims incorrectly rejected or short paid since the implementation of the claims decision management system have been reassessed and paid in/ by February 2018.

15.6 Contravention of Regulation 29 of the Act

15.6.1 Nature and cause

Regulation 29 of the Act requires the Scheme to maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review of 25%. The Scheme's solvency ratio was 24.5% at 31 December 2017.

15.6.2 Possible impact

Non-compliance with Regulation 29 of the Act.

15.6.3 Corrective course of action

The Scheme has submitted a business plan to the Council for Medical Schemes in terms of Regulation 29(4) of the Act. The business plan provides that the Scheme will increase the statutory reserves to the required level of 25%. The Scheme's solvency recovery initiatives included in the business plan have already proven to have a positive impact on the Scheme's solvency.

16. APPRECIATION

The Scheme would like to express its sincere gratitude to its service providers and the members for their loyalty and continued support, its staff and all other stakeholders.

G Van Emmenis

Mr G van Emmenis
Principal Officer
19 April 2018

SE Claassen

Mr SE Claassen
Chairman of the Board of Trustees
19 April 2018

Presentation of financial information

The financial information presented in this Annual Performance Highlights Report for the year ended 31 December 2017 has been extracted from Bonitas' signed statutory annual financial statements for the year ended 31 December 2017, which have been filed with the Council for Medical Schemes.

The following extracts from the audited financial statement have been presented:

- Statements of financial position as at 31 December 2017
- Statement of profit or loss and other comprehensive income for the year ended 31 December 2017
- Statement of changes in members' funds and reserves for the year ended 31 December 2017
- Statement of cash flow for the year ended 31 December 2017

Statement of financial position

as at 31 December 2017

R '000	2017	2016
ASSETS		
Property and equipment	**6 019**	2 297
Investment properties	**70 000**	87 600
Available-for-sale investments	**-**	1 579 612
Financial assets held at fair value through profit or loss	**2 192 102**	267 869
Non-current assets	**2 268 121**	1 937 378
Investment property held-for-sale	**18 000**	-
Available-for-sale investments	**-**	1 368 517
Financial assets held at fair value through profit or loss	**1 662 616**	37 048
Insurance, trade and other receivables	**761 665**	622 575
Cash and cash equivalents	**1 306 002**	1 010 819
Scheme cash and cash equivalents	**714 712**	492 020
Personal medical savings account trust investment	**591 290**	518 799
Current assets	**3 748 283**	3 038 959
Total assets	**6 016 404**	4 976 337
MEMBERS' FUNDS AND LIABILITIES		
Accumulated funds	**3 969 191**	3 137 771
Available-for-sale fair value reserve	**-**	97 229
Members' funds	**3 969 191**	3 235 000
Outstanding risk claims provision	**690 319**	534 762
Personal medical savings accounts trust liability	**603 812**	537 640
Insurance, trade and other payables	**753 082**	668 935
Current liabilities	**2 047 213**	1 741 337
Total members funds and liabilities	**6 016 404**	4 976 337

Statement of profit or loss and other comprehensive income for the year ended 31 December 2017

R '000	2017	2016
Risk contribution income	**14 906 405**	12 141 191
Relevant healthcare expenditure	**(13 165 501)**	(11 179 255)
Net claims incurred	**(12 563 696)**	(10 668 600)
Risk claims incurred	**(12 614 708)**	(10 709 988)
Third party claim recoveries	**51 012**	41 388
Accredited managed healthcare services	**(447 771)**	(350 204)
Net expense on risk transfer arrangements	**(154 034)**	(160 451)
Risk transfer arrangement fees/premiums paid	**(821 156)**	(774 585)
Recoveries from risk transfer arrangements	**667 122**	614 134
Gross healthcare result	**1 740 904**	961 936
Broker service fees	**(281 235)**	(232 974)
Administrative expenditure	**(1 098 321)**	(984 637)
Net impairment losses on healthcare receivables	**(15 493)**	(2 322)
Net healthcare result	**345 855**	(257 997)
Other Income	**443 650**	279 219
Investment income - Scheme	**394 323**	248 608
Investment income - Personal medical savings account	**42 365**	24 889
Change in fair value of investment property	**1 400**	1 200
Sundry income	**5 562**	4 522
Other expenditure	**(59 345)**	(38 130)
Asset management fees	**(11 326)**	(7 930)
Interest expense	**(42 365)**	(24 889)
Operating expenses on rental of investment property	**(5 654)**	(5 311)
Surplus/(deficit) for the year	**730 160**	(16 908)
Other comprehensive loss		
Items that are or may be reclassified to profit or loss:	**-**	(9 784)
Fair value adjustments on available-for-sale investments	-	6 855
Reclassification of gains on disposal of available-for-sale investments	-	(16 639)
Total comprehensive income/(loss) for the year	**730 160**	(26 692)

Statement of changes in members' funds and reserves

for the year ended 31 December 2017

R '000	Accumulated funds	Available-for-sale fair value reserve	Total
Balance as at 31 December 2015	2 935 237	107 013	3 042 250
Total comprehensive loss	202 534	(9 784)	192 750
Deficit for the year	(16 908)	-	(16 908)
Other comprehensive loss	-	(9 784)	(9 784)
Reserves acquired through amalgamation with LMS	219 442	-	219 442
Balance as at 31 December 2016	3 137 771	97 229	3 235 000
Total comprehensive income	**831 420**	**(97 229)**	**734 191**
Surplus for the year	**730 160**	**-**	**730 160**
IFRS 9 expected credit loss model - opening balance adjustment	**4 031**	**-**	**4 031**
Transfer of Available-for-sale reserve to Accumulated funds	**97 229**	**(97 229)**	**-**
Balance as at 31 December 2017	**3 969 191**	**-**	**3 969 191**

Statement of cash flow

for the year ended 31 December 2017

R '000	2017	2016
Cash flows from operating activities		
Cash utilised by operations before working capital changes	**518 714**	(216 560)
Working capital changes		
Increase in insurance, trade and other receivables	**(150 520)**	(134 352)
Increase in insurance, trade and other payables	**84 030**	130 329
Increase in Personal medical savings account liability	**66 172**	61 135
Cash utilised by operating activities	**518 396**	(159 448)
Interest paid	**(42 365)**	(24 889)
Interest received	**49 641**	30 228
Net cash inflow/(outflow) from operating activities	**525 672**	(154 109)
Cash flows from investing activities		
Acquisition of property and equipment	**(5 162)**	(293)
Proceeds on disposal of property and equipment	**16**	229
Acquisition of financial assets held at fair value through profit or loss	**(9 623 750)**	-
Disposal of financial assets held at fair value through profit or loss	**9 221 532**	7 955
Acquisition of available-for-sale investments	**-**	(7 099 949)
Proceeds on disposal of available-for-sale investments	**-**	6 933 787
Interest received	**153 814**	184 628
Dividends received	**25 563**	19 346
Asset managers fees	**(11 095)**	(6 884)
Rentals received	**8 593**	7 626
Net cash (outflow)/inflow from investing activities	**(230 489)**	46 445
Net increase/(decrease) in cash and cash equivalents	**295 183**	(107 664)
Net cash acquired on amalgamation	**-**	263 716
Cash and cash equivalents at beginning of the year	**1 010 819**	854 767
Cash and cash equivalents at end of the year	**1 306 002**	1 010 819
Analysed as follows:		
Scheme cash and cash equivalents	**714 712**	492 020
Personal medical savings account trust investment	**591 290**	518 799
	1 306 002	1 010 819

Investment portfolio

At 31 December 2017, the Scheme's investment portfolio was valued at R4.7 billion. The table and investment chart show the nature of the investments. The Scheme continues to seek the most favourable return on investment at minimal cost without exposing the Scheme to undue investment risk.

R '000	2017	2016
Preference Shares	-	701
Listed equities	1 131 816	733 609
Unit Trusts	0	129 124
Bonds	1 380 822	1 747 981
Money market instruments	1 327 704	623 024
Unlisted equities	12 065	12 065
Unlisted property holding	2 311	2 100
Unlisted insurance policy	-	4 442
Cash and cash equivalents	714 712	492 020
Investment properties	70 000	87 600
Investment property held for sale	18 000	-
	4 657 530	**3 745 066**

Our plans

BONCOMPREHENSIVE

This first-class savings plan offers ample savings, an above threshold benefit and extensive hospital cover.

BONFIT

This savings plan offers basic cover for day-to-day medical needs and essential hospital cover.

STANDARD

This traditional option offers rich day-to-day benefits and comprehensive hospital cover.

HOSPITAL PLUS

This hospital plan offers comprehensive hospital benefits with some value-added benefits.

BONCLASSIC

This generous savings option offers a wide range of medical benefits, in and out of hospital.

BONCAP

This traditional entry-level plan offers basic day-to-day benefits and hospital cover using a network of doctors, providers and hospitals.

STANDARD SELECT

This traditional option uses a quality provider network to offer rich day-to-day benefits and hospital cover.

HOSPITAL STANDARD

This hospital plan offers extensive hospital benefits with some value-added benefits.

BONCOMPLETE

This savings option offers generous savings, an above threshold benefit and rich hospital cover.

PRIMARY

This traditional option offers simple day-to-day benefits and hospital cover.

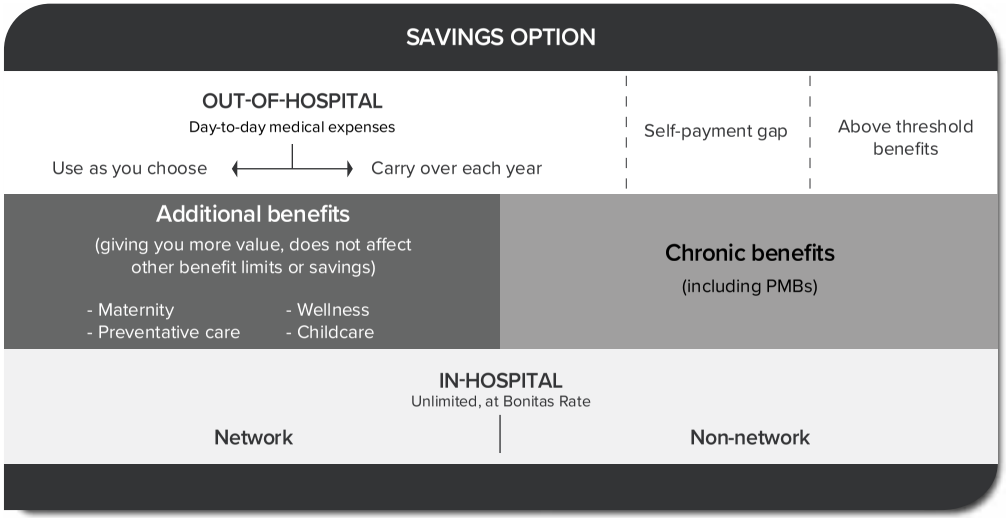
BONESSENTIAL

This hospital plan offers rich hospital benefits with some value-added benefits.

BONSAVE

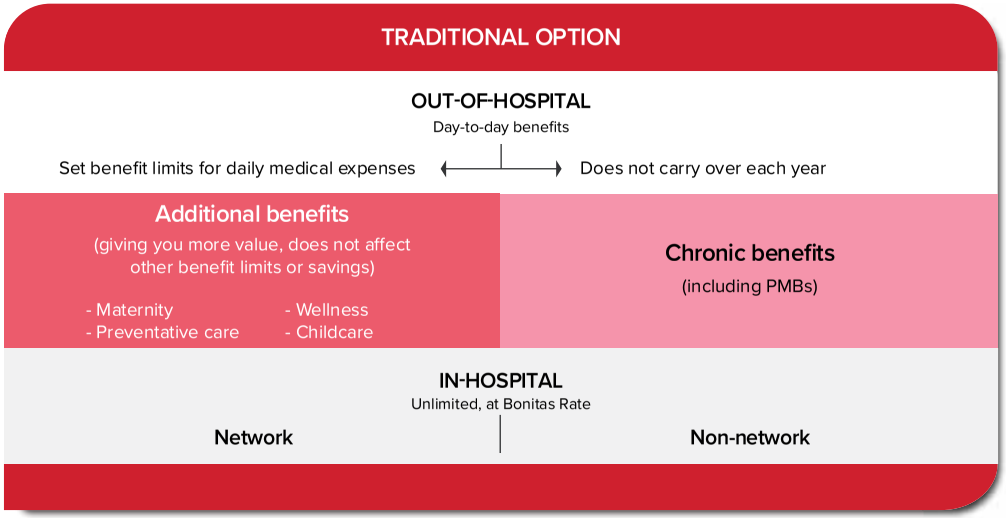
This savings option offers sufficient savings to use as you choose for medical expenses and extensive hospital cover.

How our plans work



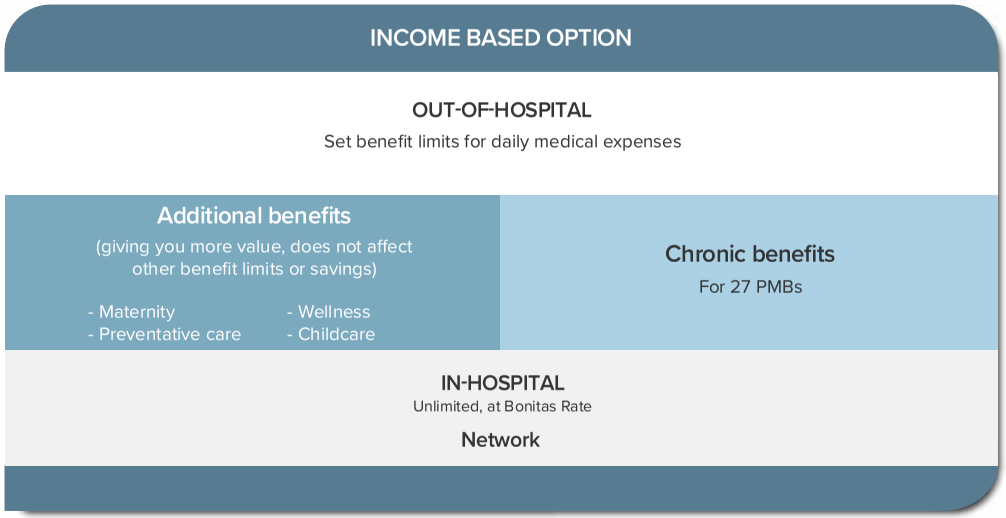
BONITAS SAVINGS OPTION

- **BonComprehensive**, **BonClassic**, **BonComplete** and **BonSave** - No hospital network
- **BonFit** - Hospital network
- Above threshold benefit available on **BonComprehensive** and **BonComplete**



BONITAS TRADITIONAL OPTION

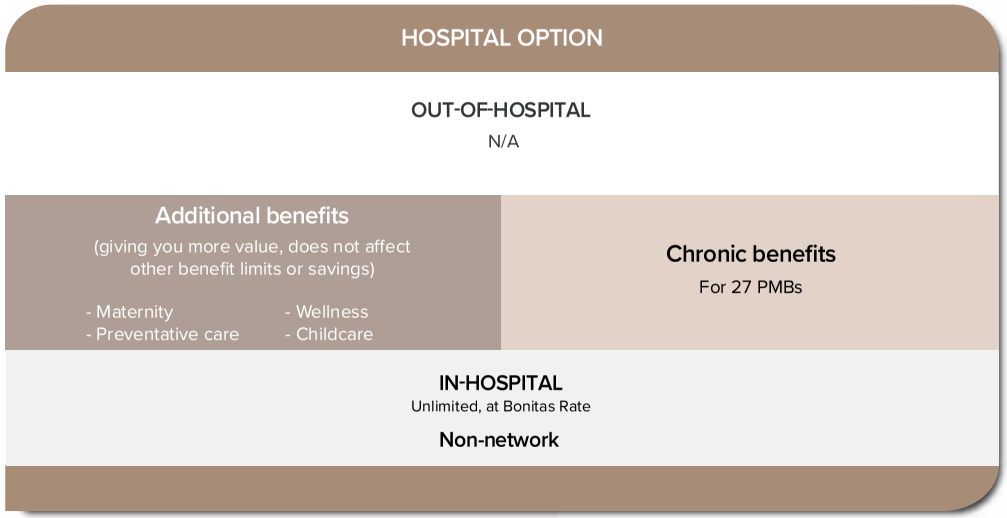
- **Standard** and **Primary** - No hospital network
- **Standard Select** - Hospital network



BONITAS INCOME BASED OPTION

- **BonCap** - Hospital network

Please note: Contributions for BonCap are income-based. Income will be verified once a year.



BONITAS HOSPITAL OPTION

- **Hospital Plus**, **Hospital Standard** and **BonEssesntial** - No hospital network

Bonitas

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Bonitas Medical Fund

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