

A photograph of a smiling couple, a woman with dark curly hair and a man with a grey beard, standing on a sandy beach. In the background, there are mountains and a small town. The image is overlaid with several red circular graphic elements.

INTEGRATED REPORT

REGISTRATION NUMBER 1512

2024

Bonitas

Medical Aid for South Africa

TABLE OF CONTENTS

ABOUT THIS REPORT

2024 Performance at a glance

ABOUT BONITAS

Our healthcare model

Benchmarking Bonitas

Our footprint

Bonitas healthcare plans

Our key relationships

How we create and protect value

OUR MATERIAL MATTERS

Material matters

OUR STRATEGY

Performance against our strategy

Initiatives supporting our strategic pillars

Future priorities

Risks and opportunities

OUR PERFORMANCE

Message from the Chairperson

Report from the Principal Officer

Financial and operational results

Operational statistics

GOVERNANCE AND REMUNERATION

Board of Trustees: profiles

Executive management: profiles

Senior management: profiles

Governance structure and practices

Remuneration report

Introduction and background statement

Remuneration policies

Remuneration implementation report

ANNUAL FINANCIAL STATEMENTS

OTHER INFORMATION

Our contact details

Abbreviations and definitions

1

3

4

5

6

6

7

8

13

20

22

27

28

32

40

41

48

48

50

52

60

62

62

65

66

67

85

85

87

91

92

162

162

164

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.

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 498 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 THIS REPORT

This integrated report covers the period 1 January to 31 December 2024. It describes material aspects relating to Bonitas's performance, operations, governance, sustainability, and how we create and preserve consistent value for our stakeholders.

CONTENT SCOPE AND APPROACH

As a non-profit organisation, Bonitas exists to serve our members, and we are accountable to them for the effective and efficient use of resources at our disposal. We believe this report includes all material information our members and other stakeholders may require to determine whether we have succeeded in this endeavour. The process for determining what is material is described on page 22.

To ensure year-on-year consistency and comparability, the structure of this report, data and measurements are comparable to previous reports.

We use the following general classifications when making timeframe references in this report:

- Short term: Up to one year
- Medium term: One to three years
- Long term: Three to 10 years

This report was compiled with due consideration to the following reporting frameworks and standards:

International Integrated Reporting Framework, 2021 (<IR> Framework)

This report complies with the <IR> Framework and provides a holistic view of the factors that substantively affect our ability to create value over time.

King IV Report on Corporate Governance™ for South Africa, 2016 (King IV™)¹

We adhere to the King IV™ corporate governance principles and practices. On page 68 we describe how we promote the governance outcomes of an ethical culture, good performance, effective control and legitimacy.

International Financial Reporting Standards (IFRS)

Financial information in this report was compiled using IFRS and was extracted from and agrees with the annual financial statements audited by Deloitte. See page 95 for the unqualified audit opinion of fair presentation and representation.

United Nations Sustainable Development Goals (SDGs)

We have identified the following SDGs as part of our value creation model and highlight our contribution in this report on page 17.



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

¹ Copyright and trademarks are owned by the Institute of Directors in South Africa NPC and all of its rights are reserved.

APPROVAL AND SALIENT FEATURES

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

- 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
- Material risks and opportunities impacting our sustainability
- How the Board exercised and discharged its governance responsibility

Approved on 22 April 2025 by

Mr OJ Komane

Chairperson of the Board

Mr LR Callakoppen

Principal Officer

WE WELCOME FEEDBACK

We aim to continually improve the quality and relevance of our reporting. Please email suggestions for improvement to annualreportqueries@bonitas.org.za.

In addition to this document, we report to members and other stakeholders during annual and special general meetings. Please look out for member invitations to these meetings. Recordings and minutes of past meetings are available on our website.

See page 164 for a list of abbreviations and definitions of terms used in this report.

NAVIGATING THIS REPORT

Interactive PDF



Stakeholders



Board and employees



Government and regulatory bodies



Members, brokers and agents



Service providers

Five core strategic pillars supported by governance and innovation



Be a strategic purchaser



Boost business development



Optimise investment returns



Connect with the customer



Integrate the value chain



Create value through innovation



Apply best practice governance

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

2024 PERFORMANCE AT A GLANCE

MEMBERSHIP TRENDS

Principal members
358 717 ↑
(2023: 350 505)

Total beneficiaries
731 576 ↑
(2023: 715 856)

Average beneficiary age
35.9 →
(2023: 35.9)

Dependants per principal member
1.04 →
(2023: 1.04)

Pensioner ratio
11.5% ↑
(2023: 11.4%)

Chronic profile
18.8% ↓
(2023: 19.1%)

ENSURING BONITAS REMAINS SUSTAINABLE

Insurance liability for future members (reserves) **R9.0 billion ↑**
(2023: R8.9 billion)

Solvency ratio
(Minimum legislative requirement is 25%)
38.6% ↓
(2023: 41.5%)

Amounts attributable to future members (surplus)
R133.9 million ↓
(2023: R265.3 million)

Investment income
R1.4 billion ↑
(2023: R830 million)

Total investment portfolio value excluding cash **R10.69 billion ↑**
(2023: R10.21 billion)

Insurance service result
R966 million deficit ↑
(2023: R451 million deficit)

Return on investment
13.4% ↑
(2023: 7.7%)

AA+ credit rating →
(2023: AA+)

Gross recoveries from fraud, waste and abuse (FWA) **R46.2 million ↓**
(2023: R52.3 million)

VALUE CREATED FOR MEMBERS

Percentage of hospital claims paid within 10 days
89.89% ↓
(2023: 95.31%)

Hospital claims processed per day
1 472 ↑
(2023: 1 163)

Hospital authorisations per day
1 491 ↑
(2023: 1 347)

Non-healthcare expenditure as a percentage of risk contributions
9.4% ↑
(2023: 9.3%)

Hospital tariff savings
R532 million ↑
(2023: R475 million)

ABOUT BONITAS

Bonitas is a medical aid for all South Africans. Our doors opened in 1982 and we are currently the second-largest open medical scheme in the country by membership numbers.

We aim to provide access to quality healthcare for every South African through our range of healthcare plans. Contributions and benefits are determined based on member needs and market trends, and we negotiate favourable rates with healthcare and other service providers to keep contributions affordable.

OUR PURPOSE

Our purpose is to align our strategic intent to a new South Africa while achieving balance between growth and financial sustainability, thus securing the future of Bonitas Medical Fund.

OUR VALUE PROPOSITION

- We care about our members so we always act in their best interest.
- We offer a wide range of plans that are easy to use and understand to suit a broad variety of our members' healthcare needs.
- We partner with the best service providers so our members have access to quality care at affordable rates.
- We are financially stable so we can afford to pay out members' claims.
- We 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.
- We find innovative ways to connect with our members, including our helplines, walk-in centres, website, app, WhatsApp and social media.

Member contributions are invested prudently and resulting returns are used to reduce costs to members and ensure Bonitas's long-term sustainability. We provide health and wellness screenings and managed care programmes that improve member wellbeing while also reducing risk.

OUR PRIORITIES

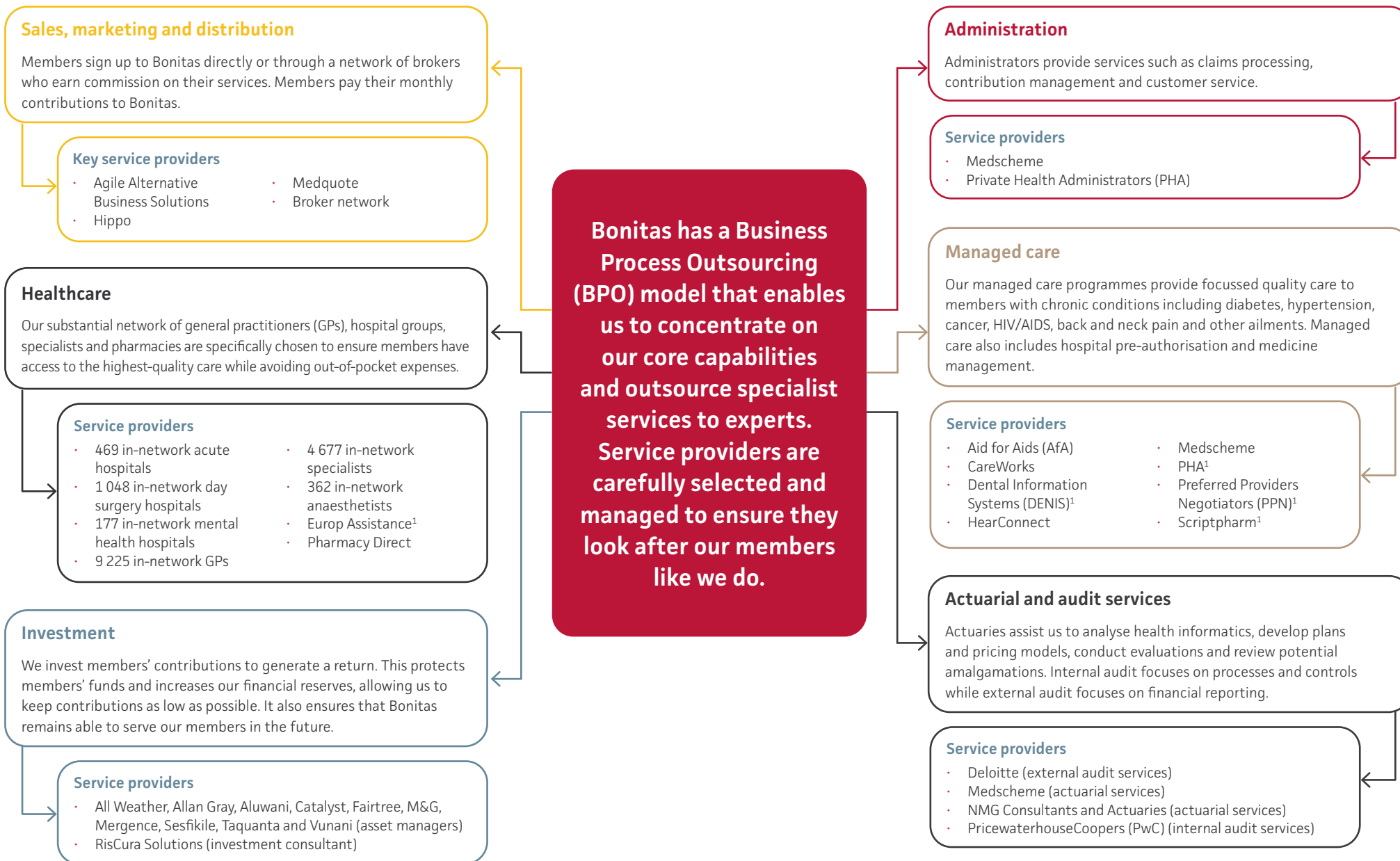
Our two interdependent priorities are to:

- 1** Ensure financial sustainability while meeting the needs of our members
- 2** Make quality healthcare more affordable and accessible

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 provide broader access to preventative care benefits paid from risk to proactively support members at all life stages.
- We perform data analytics proactively to identify key trends for decision-making.
- We ensure quality care in and out of hospital through extended benefits and innovations.
- We extend emergency medical services to a greater pool of service providers, with a dedicated line through Bonitas SOS.

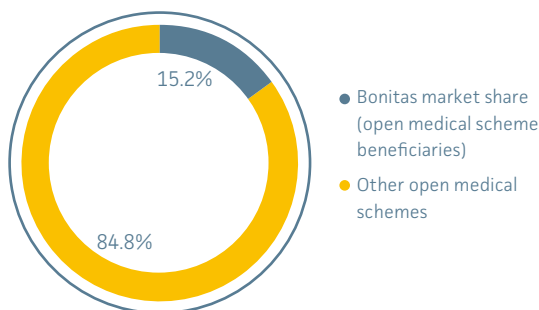
OUR HEALTHCARE MODEL



¹ Risk transfer agreement in place. See page 47 for more information.

BENCHMARKING BONITAS

For over four decades, we have honed our understanding of South African healthcare dynamics. This, coupled with our knowledge of the healthcare needs of people from all walks of life, is the foundation for Bonitas's success and ensures our relevance in an ever-changing industry.



Source: CMS Industry Report 2023

Average beneficiary age

35.9 (2023: 35.9)
(Average for registered open schemes: 2023: 36.1)

Pensioner ratio

11.5% (2023: 11.4%)
(Average for registered open schemes: 2023: 11.7%)

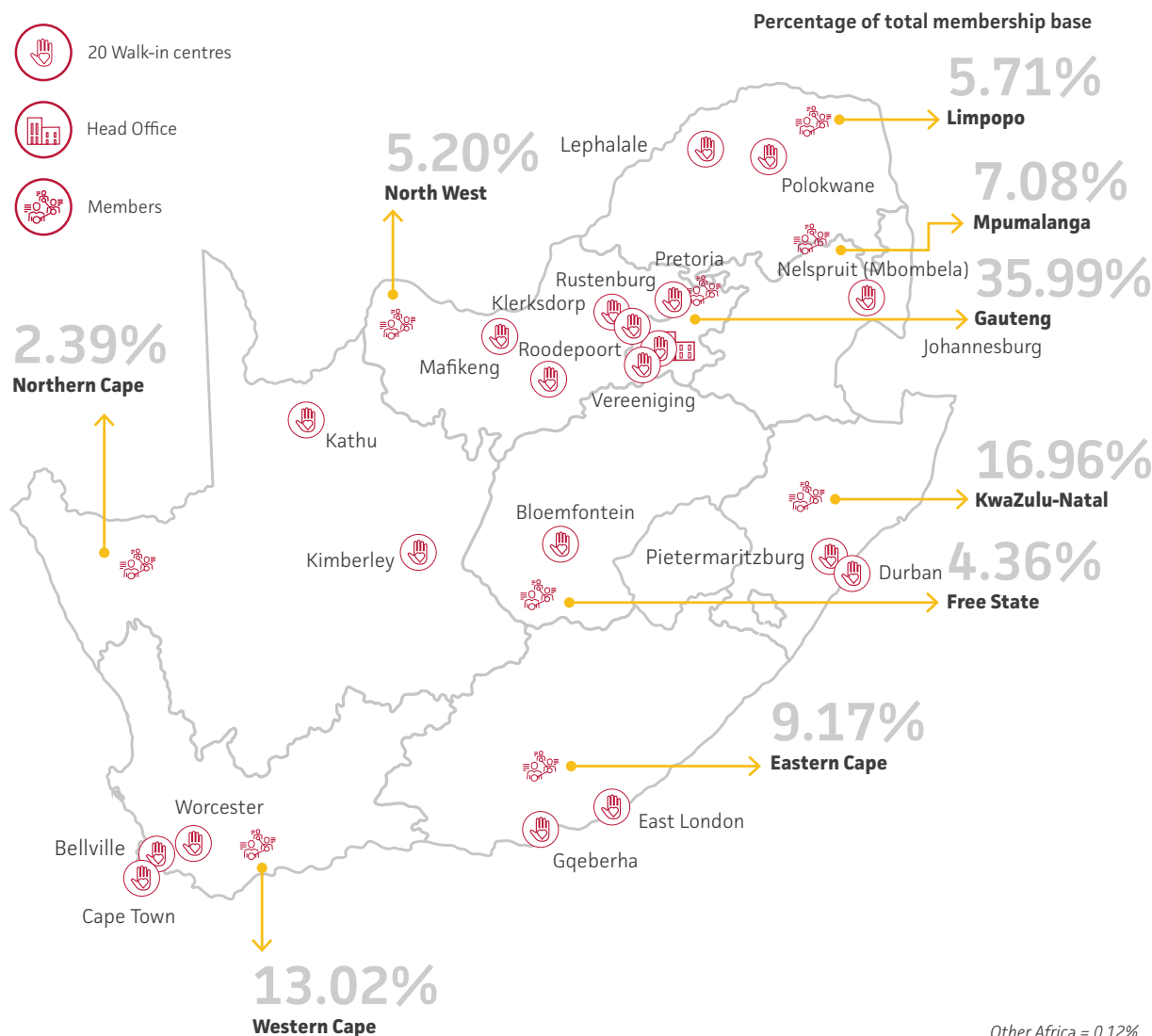
Solvency ratio

38.6% (2023: 41.5%)
(Average for registered open schemes: 2022: 38%)*

* 2023 number not yet available.
Source: CMS Industry Report 2023

OUR FOOTPRINT

We engage with members through an extensive physical network, supported by a range of digital channels. We have a national presence, and the highest concentration of our membership base is in Gauteng.



BONITAS HEALTHCARE PLANS

Our healthcare plans are developed to suit the needs of all South Africans. Efficiency-discounted options provide additional cost savings to members who use healthcare providers in the Bonitas network. Our Edge plans are technology focused and include virtual care benefits.

TWO TRADITIONAL PLANS WITH TWO EFFICIENCY DISCOUNTED OPTIONS (EDOs)

Standard and Standard Select (EDO)

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 (EDO)

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 (EDO)

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

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

FIVE SAVINGS PLANS

Personal medical savings accounts (PMSA's) are managed in terms of the Scheme Rules and are repayable in terms of Regulation 10 of the MSA.

For further information on the Scheme Rules adopted for PMSA's, refer to note 12.4 in the annual financial statements.

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

OUR KEY RELATIONSHIPS

Bonitas operates in a complex and highly regulated environment and our operations directly impact members' health and wellbeing. Our aim is to provide quality and affordable healthcare through a robust network of agents and service providers while adhering to regulatory requirements and good governance principles.



Our engagement with stakeholders aims to be purposeful, relevant, open and honest, inclusive and responsive, and aligned to Bonitas's strategic objectives.



STAKEHOLDER ENGAGEMENT AND COMMUNICATION FRAMEWORK

The Bonitas Stakeholder Engagement and Communication Framework provides guidance on building and maintaining trust-based relationships that advance shared value creation and a sustainable future for all stakeholders.

APPROACH

Leverage existing experience

Share knowledge and develop joint expertise

Build partnerships based on mutual values and trust

Adapt and respond to one another's needs

Be purposeful in our work with stakeholders

Engage timeously with stakeholders

OUTCOMES

- Communicate our value proposition to 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

PRINCIPLES

- Bring about consistency across the value chain on issues relating to stakeholder interests and engagement
- Raise mutual awareness of Bonitas, our strategy, and our position on strategic issues, industry concerns and stakeholder interests
- Build trust-based relationships through effective engagements with all key stakeholders while ensuring transparent and honest communication, to understand and address stakeholder issues and concerns
- Proactively analyse stakeholder needs, interests in relation to Bonitas's interests, and potential impacts on decision-making, and reduce expectation gaps and misunderstandings
- Create a caring, empowering and consensus-building environment that promotes coexistence and partnership, and contributes to South Africa's overall healthcare ecosystem
- Be agile and proactive in all media, business and communication strategies

STAKEHOLDER ENGAGEMENTS AND RESPONSES

BOARD AND EMPLOYEES

5

Bonitas is managed by an Executive Management team, supported by employees, and with oversight from a Board of Trustees and Board Committees.

These internal stakeholders are fundamental to the achievement of our value proposition and are the cornerstone of our service to members.

Stakeholders in this group include: Board of Trustees | Board Committees | Employees

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

- The Trustees on our Board are skilled and experienced, and are either elected by members or appointed by the Board (a maximum of three Trustees may be appointed by the Board).
- Trustees and employees must adhere to our Code of Ethics and Professional Conduct.
- We conduct biennial independent performance assessments of the Board and its Committees.
- We design our strategy to ensure that we deliver on our purpose.
- We continually monitor progress against strategic objectives.
- We benchmark remuneration against industry practice and view rewards holistically.

KEY FOCUS AREAS FOR 2024

- Oversaw appointments to the Board and Board Committees (see page 73).
- Conducted the annual formal strategy review and approved a new corporate service delivery model (see page 73).
- Expanded the mandate of the Working and Strategy Committee in line with the recommendation of King IV™ (see page 73).
- Approved the short- and long-term incentive calculations for 2024 as well as the performance targets for the next long-term incentive cycle (see page 88).

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



MEMBERS, BROKERS AND AGENTS

4

Bonitas exists to create and protect value for our members. By understanding members' needs, we are better able to deliver relevant products and services, identify growth opportunities, retain existing members and attract new members.

Members can be either direct-paying members (DPMs) who pay contributions directly to Bonitas, or corporate members who obtain membership of Bonitas through their employer.

Our members are advised, assisted and signed up through our distribution network, which includes brokers and direct sales.

Stakeholders in this group include: Members | Brokers | Trade unions | Employer groups and paypoints

HOW WE ENGAGE

- Integrated report and annual financial statements
- Publications, websites and other material
- Meetings and forums
- Annual General Meetings
- Surveys, focus groups, workshops and roadshows
- Contracts and service level agreements (SLAs)
- Formal correspondence
- Physical and digital touchpoints

THEIR KEY CONCERNS

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

BONITAS RESPONSE

- We follow a rigorous and data-driven approach to our annual review and adjustment of healthcare plans, benefits and pricing.
- We look for innovative ways to increase member value on our plans, such as through additional benefits, reduced co-payments and innovative managed care programmes.
- We continually evaluate our healthcare provider and hospital networks and negotiate favourable fees so we can pass cost-savings on to our members.
- We address queries through touchpoints including our walk-in centres, call centre, Bonitas member app and Member Zone portal, WhatsApp channel, corporate portal, brokers' portal and Business Hub.
- We measure customer satisfaction on an annual basis by calculating our net promoter score (NPS), customer satisfaction score and consumer experience score.

KEY FOCUS AREAS FOR 2024

- Scrutinised and analysed financial and operational performance (see page 52).
- Managed the performance of service providers against SLAs and outcome-based measures (see page 36).
- Introduced new managed care programmes (see page 32).
- Reviewed and approved the 2025 pricing and benefits (see page 55).

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

3 We meet members' needs by contracting with a range of service providers. Quality partnerships with these providers are crucial to our ability to offer affordable and high-quality products and services to members.

Stakeholders in this group include: Sales, marketing and distribution partners | Administrators | Healthcare providers | Managed care organisations and service providers | Investment and asset managers | Actuaries and auditors

See page 5 for a full list of our service providers.

HOW WE ENGAGE

- Integrated report and annual financial statements
- Meetings and forums
- Contracts and SLAs
- Formal correspondence
- Circulars

THEIR KEY CONCERNS

- Contractual roles and responsibilities
- Fees and reimbursements
- Financial and operational performance

KEY FOCUS AREAS FOR 2024

- Managed the performance of service providers against SLAs and outcomes-based measures where applicable (see page 36).
- Procured and onboarded new service providers to meet identified needs (see page 72).
- Monitored service provider information and technology (I&T) risks and mitigating actions (see page 44).
- Commissioned Deloitte to conduct a Transactional and Relational Governance Review (see page 36).

BONITAS RESPONSE

- We implement outcomes-based contracting by ensuring that service providers clearly understand their role, expected deliverables and how they contribute to achieving our strategic objectives.
- We provide detail on contractual roles and responsibilities in service provider contracts and SLAs.
- We monitor the operational performance of our service providers monthly and engage with them as required.
- We review service provider fees as stipulated in the applicable SLA, considering performance and industry benchmarks.
- We aim to create a caring, empowering and consensus-building environment with service providers that promotes coexistence and partnership, and contributes to South Africa's overall healthcare ecosystem.



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 |
|----------------------------------|--|--|--|---|



GOVERNMENT AND REGULATORY BODIES

3

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

Stakeholders in this group include: Council for Medical Schemes (CMS), the regulator that controls and coordinates medical schemes, administrators, managed care organisations and brokers | Board of Healthcare Funders (BHF), 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
- Anti-competitive behaviour
- National Health Insurance (NHI)

BONITAS RESPONSE

- We monitor and implement all relevant legislative and regulatory updates and remain abreast of progress regarding applicable CMS and Competition Commission investigations.
- Our approach to managing FWA includes fraud prevention, detection, investigation, risk management and reporting, and the Bonitas FWA Forum meets monthly.
- We aim to make quality healthcare more affordable and accessible and believe that universal healthcare is a right, not a privilege.
- We lobby and engage with relevant stakeholders regarding the importance of an effective, efficient and well-governed NHI and the critical role of the private sector in ensuring universal healthcare.

KEY FOCUS AREAS FOR 2024

- Monitored and responded to NHI developments (see page 37).
- Monitored FWA as a primary risk management focus area (see page 39).
- Promoted universal healthcare through our strategic partnership with Gift of the Givers (see page 37).
- Introduced enhanced preventative care solutions for improved member health and wellbeing, paid from risk (see page 33).

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

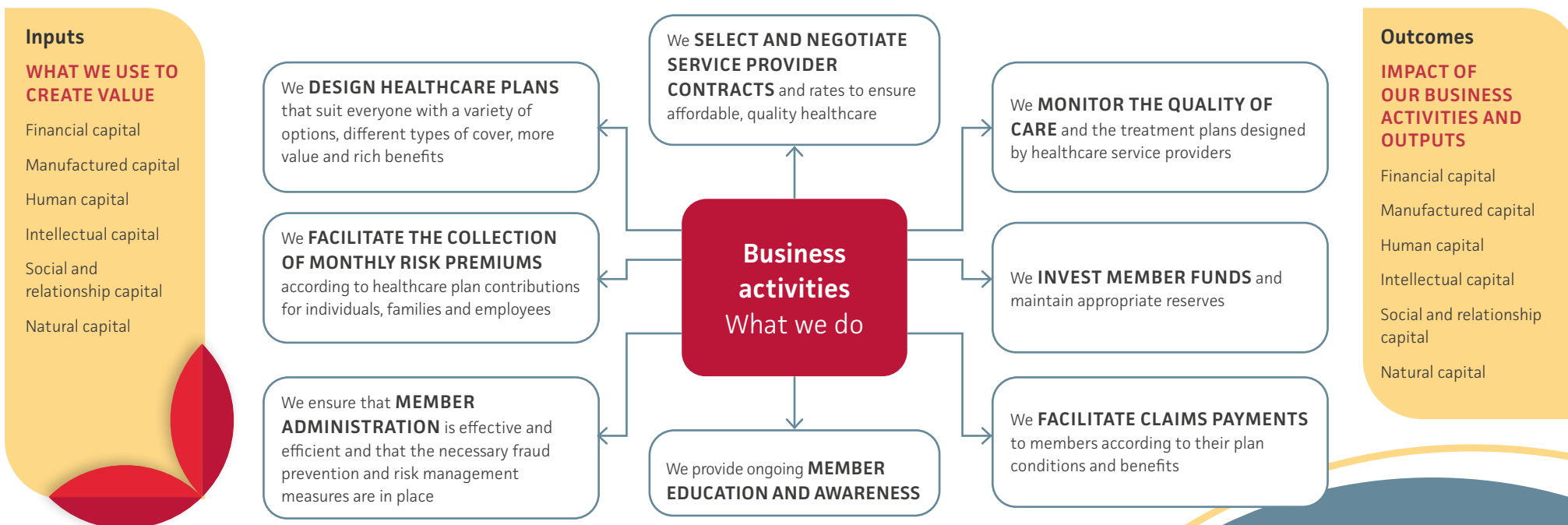
5 Strong relationship of trust, collaboration and mutual understanding

HOW WE CREATE AND PROTECT VALUE

To remain sustainable, Bonitas must create and protect value in the short, medium and long term. This requires us to carefully monitor the impact of our business activities and amend our strategy as needed to effectively respond to stakeholder needs and our operating environment.

OUR VALUE CREATION MODEL

We depend on key inputs to provide products and services to members. Bonitas controls some of these inputs while others are controlled by the service providers in our healthcare model (see page 5). This allows us access to more extensive inputs but also requires us to maintain effective relationships with service providers and continually monitor the quality of supplied inputs.



Outputs

OUR KEY PRODUCTS AND SERVICES

For 2024 we offered 15 (12 registered benefit options and three efficiency discounted options) healthcare plans to suit a range of member 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. Detail is available on www.bonitas.co.za.

Through our business activities and outputs, Bonitas improves access to and the affordability of healthcare

Financial capital

Bonitas is a non-profit organisation that exists and spends funds purely for the benefit of our members. Members' contributions are our primary source of income and are invested to generate further returns.

Claims are paid according to members' plans and benefits. We have no shareholders or investors who receive dividends.

Future availability and risk

The sustainability of financial capital relies on membership growth, investment returns, strategic purchasing and effective FWA measures.

Inputs	Outcomes	Value created, preserved or eroded
358 717 principal members (2023: 350 505)	R22.29 billion insurance expenditure (2023: R20.23 billion)	 Board and employees →
731 576 total beneficiaries (2023: 715 856)	13.4% return on investment (2023: 7.7%)	 Members, brokers and agents ↓
6.9% total weighted contribution increase for 2024 (2023: 4.7% after deferral)	8 loss-making options (2023: 5)	 Service providers →
R22.0 million gross contributions (2023: R20.4 million)	38.6% solvency ratio (2023: 41.5%)	 Government and regulatory bodies →
R20.1 billion claims (2023: R18.1 billion)	R9.0 billion insurance liability for future members (reserves) (2023: R8.9 billion)	
	R133.9 million attributable to future members (surplus) (2023: R265.3 million)	

Manufactured capital

We use a range of material goods and infrastructure to meet stakeholder needs and provide affordable and quality healthcare.

Our healthcare model provides access to the assets owned, leased or controlled by our service providers. See page 5 for more on our healthcare model.

Future availability and risk

Manufactured capital relies on national infrastructure and services, such as electricity and water, to function optimally.

Inputs	Outcomes	Value created, preserved or eroded
- Head office in Johannesburg 20 walk-in centres (2023: 20) - Call centre 24/7 helpline (for medical advice) - Bonitas member app - Bonitas Member Zone portal - WhatsApp channel - Corporate portal - Brokers' portal - Business Hub - Whistle Blowers hotline - Bonitas I&T infrastructure	62 959 visits to our walk-in centres (2023: 77 179) 1 482 441 calls to our call centre (2023: 1 519 996) 1 533 171 logins to the Bonitas member app (2023: 817 499) 397 485 logins to the Bonitas Member Zone portal (2023: 324 335) 1 758 017 Live Chat and chatbot interactions (2023: 68 688) 153 238 WhatsApp agent chats (2023: 475 637) 3 841 911 total digital interactions (2023: 5 964 650)	 Board and employees →  Members, brokers and agents →  Service providers ↓  Government and regulatory bodies →

Value created ↑

Value preserved →

Value eroded ↓

Human capital

Our healthcare model enables us to focus on our core capabilities while outsourcing other functions to carefully selected service providers with specialist skills and expertise.

Our management and operational team is small but highly skilled, and oversight is provided by an independent Board of Trustees.

Future availability and risk

Human capital relies on our ability to attract and retain talent as well as ensure high performance.

8 Trustees on our Board as at year-end (2023: 10)

Skilled Board with extensive experience in governance and the effective management of a medical scheme and healthcare model

22 employees (2023: 20)

Management team with **141** years' combined management experience in the healthcare/medical schemes industry

Our broader service provider network offers us access to experienced agents, brokers, customer service professionals and healthcare professionals such as GPs and medical specialists.

Outcomes

R7.4 million total Trustee remuneration excluding accommodation, travel and training costs (2023: R6.1 million)

R41.0 million total employee remuneration (2023: R37.5 million)

38% black and **13%** female Trustees (2023: 56%, 22%)

64% black and **64%** female employees (2023: 68%, 63%)

1 (5%) employee turnover (2023: 3, 14%)

1 new employee appointment (2023: 1)

Value created, preserved or eroded



Board and employees →



Members, brokers and agents →



Service providers →



Government and regulatory bodies →

Intellectual capital

Bonitas has been operating for more than 40 years. Our core competency is designing and pricing healthcare benefits and managed care plans.

Future availability and risk

Cyber risk can affect the availability, quality and integrity of data and impact our ability to ensure member privacy.

Data, information and insights on our members and their healthcare needs

Strategic imperative to create value through innovation

Appetite to improve service delivery and product quality through new technologies

Robust governance and risk management structures, policies and processes

Outcomes

2.3% increase in membership (2023: -0.9%)

Unique and comprehensive healthcare plans covering **334** conditions (2023: 334)

Protocols and formularies that ensure safe, effective and high-quality treatment

Digital channels that help members understand and manage health and wellbeing

Internal risk measurement models and tools that enable us to manage risk effectively

Value created, preserved or eroded



Board and employees →



Members, brokers and agents →



Service providers →



Government and regulatory bodies →

Value created ↑

Value preserved →

Value eroded ↓

Social and relationship capital

Our relationship with stakeholders has a direct impact on our sustainability and ability to provide quality and affordable healthcare.

We are committed to engaging and collaborating with stakeholders to ensure the transformation and longevity of the South African healthcare ecosystem and combat FWA.

Future availability and risk

Our partnership with service providers can be at risk when not transacted at arm's length or where fees are not market-related or value-adding.

Recognised brand and strong reputation associated with specific attributes and member benefits

Commitment to transformation, diversity and inclusion

Healthcare model enables us to partner with service providers who are best able to meet members' needs

Status as the second-largest open medical scheme (by membership numbers) strengthens our negotiating position

Active engagement with industry stakeholders such as the CMS, BHF, hospital groups and healthcare practitioners

Outcomes

Level 7 Broad-based Black Economic Empowerment (B-BBEE) contributor (2023: Level 8)

R532 million estimated savings yielded through strategic purchasing (collective bargaining) (2023: R475 million)

R901.1 million estimated savings due to managed care and strategic purchasing initiatives (2023: R745.2 million)

R1.2 billion quantified as a drop in billing behaviour as a result of FWA since 2016 (2023: R1.2 billion)

R46.2 million gross recoveries due to proactive FWA mitigation (2023: R52.3 million)

Value created, preserved or eroded



Board and employees ↑



Members, broker and agents →



Service providers →



Government and regulatory bodies →

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.

Future availability and risk

The healthcare ecosystem remains vulnerable to energy- and water-shedding, and climate change may significantly impact health, wellness and the healthcare infrastructure.

Our value chain relies on natural inputs, particularly energy and water

Outcomes

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

We sponsor the establishment of boreholes in healthcare and other community facilities through our partnership with Gift of the Givers

Value created, preserved or eroded



Board and employees →



Members, brokers and agents ↑



Service providers ↑



Government and regulatory bodies →

Value created ↑

Value preserved →

Value eroded ↓

OUR VALUE CREATION MODEL CONTEXT

Our external environment and trends in healthcare

Page 20

Progress with the implementation of our strategy

Page 28

The effectiveness of our risk management and ability to identify and capture opportunities for growth

Page 41

Ethical leadership and effective governance structures, processes and controls

Page 67

Strong brand equity in a volatile environment

IFC

Solid financial performance

Page 52

HOW OUR OUTCOMES CONTRIBUTE TO THE SDGS



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 HEALTHCARE SERVICES AND ACCESS TO SAFE, EFFECTIVE, QUALITY AND AFFORDABLE ESSENTIAL MEDICINES AND VACCINES FOR ALL

Bonitas aims to make quality healthcare more affordable and accessible by increasing membership numbers, prudently investing funds, responding to healthcare trends and negotiating cost-effective solutions with service providers. Our members enjoy the value of private medical care while being protected against unexpected and expensive medical costs.

We believe universal healthcare is a right, not a privilege, and support healthcare reform that will address cost and quality while making healthcare widely accessible in South Africa. We lobby relevant stakeholders on the importance of a well-governed NHI system (see page 37) and contribute to the sustainability of the South African healthcare ecosystem through our partnership with Gift of the Givers (see page 37).

TARGET 3.B PROVIDE ACCESS TO AFFORDABLE ESSENTIAL MEDICINES AND VACCINES FOR ALL

Our healthcare plans meet a wide range of members' needs and cover 334 conditions, including:

- 271 diagnosis and treatment pairs based on the admission categories within hospital benefit management
- 27 prescribed minimum benefit (PMB) chronic conditions for all plans
- 36 additional conditions for certain plans from a chronic medicine management perspective

Our Be Better Benefit offers risk assessments and screening for early detection of health and wellness challenges and is funded completely from risk (see page 33).

All our plans include flu and human papillomavirus (HPV) vaccines, and all except BonStart and BonStart plus include pneumococcal vaccines.



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

We have a zero-tolerance approach to FWA as such acts are not only illegal but also increase the cost of healthcare, which translates to increased contribution costs for members. FWA is a primary risk management focus area and we collaborate with all relevant stakeholders to prevent, detect, investigate, manage and report on instances of FWA (see page 39).

Several policies guide ethical practice in Bonitas, including our Fraud, Waste and Abuse Policy, Code of Ethics and Professional Conduct for Trustees and Independent Members, Code of Ethics and Professional Conduct for Executives and Staff, Gifts Policy and Conflict of Interest Policy.

TARGET 16.6 DEVELOP EFFECTIVE, ACCOUNTABLE AND TRANSPARENT INSTITUTIONS AT ALL LEVELS

Bonitas adheres to the requirements of the MSA together with legislation and regulations published by the CMS and other regulatory bodies. Our Scheme Rules are regulated and registered with the CMS. We collaborate with the BHF in its endeavour to ensure the sustainability of the healthcare sector and cooperate with this body on areas of mutual interest.

Our focus is on continual improvement of the healthcare value chain. Our Procurement and Contract Management Policy provides guidance on seeking win-win solutions with service providers that improve healthcare outcomes for members (see page 36). Our Governance, Risk and Compliance (GRC) Framework has been developed in line with the requirements of the MSA, Scheme Rules and King IV™ (see page 68).

MATERIAL TRADE-OFFS

Affordable healthcare and long-term sustainability

We use member contributions and investment income to ensure sufficient capital to pay member claims. Healthy financial reserves and a high solvency level increase Bonitas's long-term sustainability; on the other hand, using these reserves to keep member contributions low contributes to the affordability of healthcare.

Bonitas aims to find the optimal balance between our two interdependent priorities:

1. Ensure financial sustainability while meeting the needs of our members
2. Make quality healthcare more affordable and accessible

From time to time, we may make a strategic decision to reduce our surpluses and erode some of our solvency to keep contribution increases as low as possible. Examples include curtailing or deferring annual price increases or adding additional benefits to our plans at no extra cost to the member.

Financial capital ↓
Intellectual capital ↑
Social and relationship capital ↑

Reducing loss-making options

Maintaining the affordability of our healthcare plans may lead to loss-making options (i.e. plans that are not self-supporting in terms of membership and financial performance). Although loss-making options are considered non-compliant with Regulation 29 of the MSA they are common in all medical schemes.

Our intent is to improve the financial viability of all our plans while continuing to meet members' healthcare needs. We do this through considered and plan-specific cost management across the value chain as well as member education and awareness.

Financial capital ↓
Intellectual capital ↑
Social and relationship capital ↑

Towards universal healthcare

We unequivocally support the principle of universal healthcare but remain concerned about the funding and administration of the NHI, as well as freedom of choice as entrenched in the South African Bill of Rights (see page 37).

Engaging with this issue and lobbying government and regulatory bodies 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.

Financial capital ↓
Human capital ↓
Intellectual capital ↓
Social and relationship capital ↑

VALUE-ADDED STATEMENT

Description	2024 R'000	%	2023 R'000	%
VALUE CREATED				
Insurance revenue	20 888 306	92.0%	19 461 328	94.4%
Investment Income & Other Revenue	1 380 546	6.1%	836 892	4.1%
- Investment income	1 385 696		829 915	
- Other income	44 020		38 690	
- Loss on Disposal of Investment Property	(13 500)		-	
Less: Asset Manager Fees	(35 669)		(31 714)	
Net income from risk transfer arrangements / reinsurance	433 320	1.9%	315 574	1.5%
Total Value Created	22 702 172	100.0%	20 613 794	100.0%
VALUE DISTRIBUTED				
Claims and Benefits (to members & providers)	(20 078 903)	88.4%	(18 179 013.89)	88.2%
- Hospitals	(7 931 341)		(7 200 513)	
- General Practitioners	(896 489)		(783 868)	
- Specialist	(6 087 252)		(5 504 357)	
- Other insurance service expenses	(5 078 971)		(4 619 438)	
- Interest on Personal Medical Savings Account (PMSA) balances	(84 852)		(70 838)	
Insurance acquisition costs (Broker Commissions)	(420 406)	1.9%	(395 201)	1.9%
Administration and Managed Care Benefits	(1 791 159)	7.9%	(1 669 841)	8.1%
Benefits and Remuneration for Employees and Trustees	(39 765)	0.2%	(35 521)	0.2%
Employees	(31 653)		(28 860)	
Trustees	(8 111)		(6 660)	
CSI Contributions	(4 960)	0.0%	(6 458)	0.0%
Corporate Social Investment (CSI)*	(3 300)		(3 380)	
Enterprise Development**	(1 660)		(3 078)	
Government	(16 805)	0.1%	(16 405)	0.1%
Council for Medical Schemes (CMS) Levies	(16 805)		(16 405)	
Other Operating Expenditure	(484 064)	2.1%	(576 669)	2.8%
Retained Surplus for Future Members (Transferred to Liability attributable to future members)	133 891	(0.6%)	265 314	(1.3%)
Total Value Distributed	(22 702 172)	100.0%	(20 613 794)	100.0%

* Amount paid to Gift of the Givers, amount paid as part of marketing expense – strategic partnership.

** Enterprise Development (ED) spend with ED beneficiaries, Techplo and Modjaji

Commentary

CREATING AND DISTRIBUTING VALUE FOR SUSTAINABLE HEALTHCARE

As a medical scheme, our core purpose is to create value for our members by ensuring access to quality healthcare while maintaining financial sustainability. Our Value Added Statement provides transparency on how contributions, investments, and other revenue sources generate value and how this value is distributed to key stakeholders, including members, healthcare providers, employees, regulators, and the broader community.

VALUE CREATION

During the financial year, we generated a total of R22.7 billion (2023: R20.6 billion) in value, primarily through contribution income from our members, supplemented by investment income and other revenue streams such as rental income from our investment property. The scheme strategically manages these funds to maximise returns while safeguarding liquidity and long-term financial stability.

Asset management fees of R35.4 million (2023: R30.4 million) were incurred to oversee our investment portfolio, ensuring optimal returns while mitigating risk.

A significant component of our value creation also stems from reinsurance (capitation agreements), which resulted in a net positive outcome of R433 million (2023: R316 million). These agreements reduce claims volatility and improve cost efficiency in high-risk areas, ultimately benefiting our members.

VALUE DISTRIBUTION

The largest portion of value distributed (88% of total value created) was allocated to claims and benefits paid to members and healthcare providers. This reflects our commitment to ensuring that members receive timely and high-quality medical care. Payments are made either directly to healthcare providers or reimbursed to members. Additionally, through our reinsurance agreements, a portion of these claims costs was recovered, reducing the overall claims burden.

Our commitment to operational excellence and governance is reflected in our operating expenditure, which is categorised as follows:

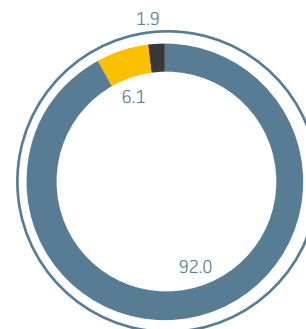
- Administration and Managed Care Costs (R1.8 billion (2023: R1.7 billion)) – Covers scheme administration, claims processing, and managed care initiatives to enhance healthcare affordability and accessibility.
- Employee and Trustee Benefits & Remuneration (R40 million (2023: R36 million)) – Ensuring a high-performing team that delivers value to members.
- Corporate Social Investment (CSI) (R5 million (2023: R6.4 million)) – Funding programmes that support the broader community.
- Council for Medical Schemes (CMS) Levies (R17 million (2023: R16 million)) – Compliance with regulatory requirements that protect member interests.
- Other Operating Expenditure (R484 million (2023: R573 million)) – Covering costs not included in the above categories.

We also continue to support members through broker commissions (R420 million (2023: R395 million)), which facilitate access to scheme benefits and ensure they receive expert advice on their medical aid options.

SECURING THE FUTURE FOR OUR MEMBERS

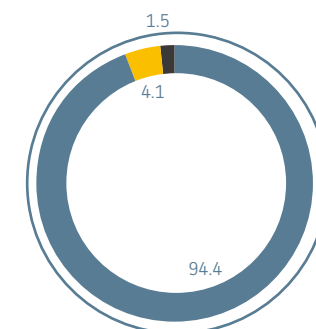
A portion of the value created is retained as surplus/amount attributable to future members (R133 million (2023: R265 million)) and transferred to a liability attributable to future members to ensure future sustainability. This reinforces our ability to absorb unforeseen risks, maintain regulatory solvency requirements, and keep contributions stable while continuously enhancing member benefits.

VALUE CREATED – 2024 (%)

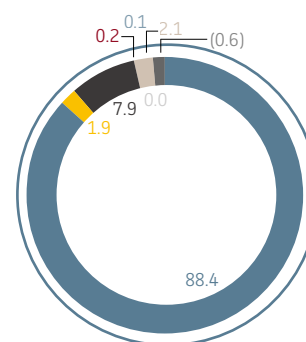


- Net Contribution income
- Investment Income & Other Revenue
- Net Positive Result on Reinsurance (Capitation)

VALUE CREATED – 2023 (%)

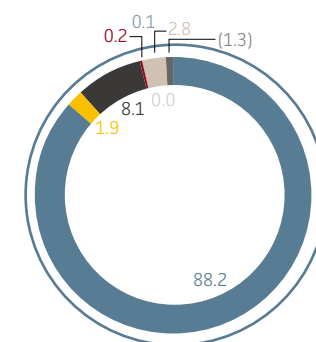


VALUE DISTRIBUTED – 2024 (%)



- Claims and Benefits (to members & providers)
- Acquisition costs (Broker Commissions)
- Administration and Managed Care Benefits
- Benefits and Remuneration for Employees and Trustees
- CSI Contributions
- Government
- Other Operating Expenditure
- Retained Surplus for Future Members

VALUE DISTRIBUTED – 2023 (%)



OUR MATERIAL MATTERS

We aim to meet members' healthcare needs in the short, medium and long term. This requires us to identify material trends in the healthcare sector and pivot accordingly to ensure Bonitas's ongoing relevance and sustainability.

HEALTHCARE AFFORDABILITY

Annual salary increases are usually based on the Consumer Price Index (CPI), but the cost of healthcare typically increases by between CPI+2% and CPI+4% each year. In other words, the cost of healthcare increases more rapidly than members' income.

Drivers for medical inflation include the following:

- The rising prevalence of **chronic/lifestyle diseases** such as diabetes, hypertension and obesity increase the demand for healthcare services, contributing to higher medical costs.
- Medical inflation often reflects the **rising cost** of medical technologies, equipment and pharmaceuticals. If imported, these costs are further impacted by **exchange rate fluctuations**.
- The elderly in South Africa's **ageing population** require more medical care, leading to increased demand and higher medical costs.
- This is compounded by high **youth unemployment**. For medical schemes, cross-subsidisation across the broader risk pool is compromised without a consistent intake of younger members.
- **Private healthcare costs** are unregulated in South Africa, so healthcare providers can and do set their prices independently. **Limited competition in healthcare** can also lead to higher prices.

IMPLICATIONS FOR OUR STRATEGY

Bonitas seeks to keep contribution increases as low as possible without reducing benefits or compromising the long-term sustainability of our reserves. We do this by:

- Investing member funds prudently
- Negotiating preferential rates with service providers
- Developing disease-specific managed care programmes
- Investing in preventative measures such as healthcare screenings and vaccinations
- Combating FWA

LINKED STRATEGIC PILLARS



Be a strategic purchaser



Integrate the value chain



Create value through innovation

UNIVERSAL HEALTHCARE AND NATIONAL HEALTH INSURANCE

The NHI is a health financing system designed to pool funds to provide access to personal health services for all South Africans based on their health needs, irrespective of their socio economic status. Funds are to be provided by general taxes and employee contributions.

Despite criticism and threats of litigation, President Cyril Ramaphosa signed the NHI Bill in May 2024, thus passing it into law. Once the NHI is fully implemented, medical schemes will only be able to provide cover for services that are not reimbursable by the NHI Fund.

The NHI will be implemented in a phased approach that could take decades, so private medical scheme membership is not at immediate risk. However, Bonitas remains concerned about funding, administration and continued freedom of choice as set out in the Bill of Rights. We also maintain that public-private collaboration is critical for universal healthcare to succeed in South Africa. See page 37 for more on our response to the NHI.

IMPLICATIONS FOR OUR STRATEGY

- Lobbying on the importance of a well-governed NHI
- Engaging with legislators and the BHF to influence the design of the NHI model
- Deeper collaboration with industry stakeholders
- Developing a risk mediation plan
- Continuing member education
- Exploring new opportunities and business models

LINKED STRATEGIC PILLARS



Integrate the value chain



Create value through innovation

INNOVATION AND TECHNOLOGICAL DISRUPTION

Emerging technologies are profoundly impacting the healthcare sector by transforming how care is delivered, accessed and managed.

- Artificial intelligence and machine learning can be used to process vast amounts of medical data, helping healthcare practitioners and others improve the accuracy of diagnoses, predict disease patterns and personalise treatment plans.
- Robotic-assisted surgeries offer precision and minimally invasive procedures, leading to faster recovery times and better outcomes.
- The automation of routine tasks frees healthcare professionals to focus on more complex tasks that require their expertise and training.
- Wearable devices, health monitoring, telemedicine and health apps enable proactive health management and real-time feedback.

These technologies have the potential to reduce healthcare costs and improve access to care, but there are also risks that must be managed effectively. These include privacy and cyber security risks (particularly relating to patient data), concerns around system stability and safety, and the need to ensure suitable good governance practices.

IMPLICATIONS FOR OUR STRATEGY

- Researching technological developments and trends
- Introducing technology-enabled solutions to members
- Revising good governance principles and practices to ensure effective oversight
- Ensuring the safety and security of member data
- Continuing member education

LINKED STRATEGIC PILLARS

-  Be a strategic purchaser
-  Connect with the customer
-  Create value through innovation
-  Apply best practice governance

WELLBEING AND MENTAL HEALTHCARE

Globally, mental wellbeing remains at its post-pandemic low with no sign of improvement, raising questions about the lasting impact of COVID-19 and how shifts in the way we live and work have pushed people into a space of poorer mental wellbeing.¹ In South Africa, this is compounded by poverty, unemployment, inequality, violence and political upheaval.

In a study of 71 countries, South Africa ranked second-lowest in terms of mental wellbeing, with 35% of respondents stating that they are distressed or struggling.²

Of particular concern is the increasing incidence of depression and anxiety among young people. A recent study found that 33% of those aged between 10 and 14 suffer from depression and 21% experience anxiety.³ Factors that affect mental health among adolescents include pressure to conform to peers, exploration of gender or sexual identity, quality of home life, exposure to violence and poor living conditions.⁴

Access to mental healthcare in South Africa remains unequal. Those in remote areas do not always have access to adequate mental health facilities and trained professionals, and public health services are often under-resourced and overburdened. Stigma also remains around mental health, which can prevent people from seeking help.⁵

IMPLICATIONS FOR OUR STRATEGY

- Continuing member education
- Adding mental health solutions to healthcare plans
- Developing disease-specific managed care programmes
- Using technology to increase access

LINKED STRATEGIC PILLARS

-  Connect with the customer
-  Create value through innovation

¹ Sapien Labs. 2024. 'The Mental State of the World in 2023: A Perspective on Internet-Enabled Populations'. 4 March. Available on: <https://sapienlabs.org/wp-content/uploads/2024/03/4th-Annual-Mental-State-of-the-World-Report.pdf>

² Ibid.

³ Mhize, M, Van der Westhuizen, C & Sorsdahl, K. 2024. 'Prevalence and factors associated with depression and anxiety among young school-going adolescents in the Western Cape Province of South Africa'. *Comprehensive Psychiatry*, Volume 131, May. Available on: <https://www.sciencedirect.com/science/article/pii/S0010440X24000208>

⁴ United Nations Children's Fund (UNICEF). 2024. 'Situation Analysis of Children and Adolescents in South Africa 2024'. Available on: <https://www.unicef.org/southafrica/media/10726/file/ZAF-UNICEF-situation-analysis-children-adolescents-SA-2024.pdf>

⁵ Employee Assistance Professionals Association of South Africa. 2024. 'The Current State of Mental Health in South Africa: 2024 Update'. 26 August. Available on: <https://www.eapasa.co.za/the-current-state-of-mental-health-in-south-africa-2024-update/>

MATERIAL MATTERS

Material matters are those issues that could substantially affect Bonitas's ability to create value over the short, medium and long term. These matters influence our strategy and how we identify and respond to risks and opportunities.

OUR MATERIALITY DETERMINATION PROCESS

We follow a structured process to review, prioritise and integrate material matters into our operations and strategy to ensure we respond appropriately.

1 Review

We identify all matters that could impact our ability to create value by investigating:

- Value drivers that impact the healthcare sector, our members, the Bonitas business model and our strategy
- Feedback from stakeholders
- Strategic risks and opportunities
- Our current and anticipated performance
- Changes in our external operating environment
- Our impact on stakeholders and society at large
- Our previous year's material matters

2 Prioritise

From the list of relevant matters, we identify those that are material by considering the magnitude of their impact on our stakeholders and Bonitas's ability to create value.

3 Integrate

Material matters are integrated to inform strategy and guide disclosures for integrated reporting.

The Bonitas Board is responsible for determining, approving and integrating the material matters in their oversight process. Following a structured and facilitated materiality determination process in 2022, the 2023 and 2024 reviews confirmed that all previous matters remain material and no new matters emerged as material in terms of Bonitas' ability to create and preserve value.



Our material matters provide insight into what matters most to our stakeholders. Material matters guide us on the information to include in our reporting to stakeholders, including the content in this integrated report.

OUR MATERIAL MATTERS



Successful and efficient healthcare reform

Although the Constitution guarantees access to healthcare services as a basic human right, access to quality healthcare in South Africa remains unequal. The NHI Bill, which was signed into law in May 2024, is a step in the right direction but its implications for medical schemes and their role remain unclear, and there are concerns about its funding model and governance.

Bonitas supports healthcare reform that will address cost and quality while making healthcare widely accessible in South Africa. We lobby for the importance of a well-governed NHI and request clarity on the implications of the NHI for medical schemes, members and the public at large. Simultaneously, we explore future-proof strategies and operating models that will enable us to continue serving our members.

See page 37 for more on our response to the NHI.

Relevant stakeholders:



Board and employees



Members, brokers and agents



Service providers



Government and regulatory bodies

Related external trend:

- Universal healthcare and National Health Insurance

Related strategic opportunity

- Improve relationships and collaboration between stakeholders
- Communicate and entrench the Bonitas value proposition
- Contribute to an NHI model that makes a lasting positive impact on South Africans and the healthcare ecosystem
- Improve cohesion and coherence in the healthcare ecosystem
- Increase transparency and good governance
- Innovate new solutions to meet members' needs



Trust and confidence in our ability to protect stakeholders' interests

In a world characterised by misinformation, our stakeholders need certainty that Bonitas can provide sustainable access to affordable and quality healthcare, manage our funds responsibly and practice good governance. Without this certainty, we will be unable to grow our membership base and negotiate favourable rates with service providers.

We manage member contributions with due care and diligence, in accordance with an investment strategy approved by the Board. Our Stakeholder Engagement and Communication Framework describes how we interact with stakeholders, and we aim to develop relationships that are purposeful, relevant, open, honest, inclusive and responsive. We consider stakeholder needs when developing our strategy, which improves collaboration and our ability to deliver maximum benefits to all stakeholders.

See page 8 for more on our stakeholders.

Relevant stakeholders:



Board and employees



Members, brokers and agents



Service providers



Government and regulatory bodies

Related external trend:

- Healthcare affordability
- Innovation and technological disruption

Related strategic opportunity

- Improve relationships and collaboration between stakeholders
- Communicate and entrench the Bonitas value proposition
- Increase transparency and good governance

Related strategic risk:

- Bonitas brand and reputation
- Stakeholder management

Strategic pillar response:



Connect with the customer



Apply best practice governance



Thought leadership in functional, clinical and specialist areas

The healthcare sector evolves rapidly as innovations in medical practice, diagnostics and treatment improve the range of products and services available to patients. To provide quality care, Bonitas must ensure that these products and services are made available to members, that members are educated on their use and that member contributions remain affordable.

We review service provider performance monthly, and our SLAs include outcomes-based measures to ensure that members receive tangible healthcare benefits. Our managed care programmes provide dedicated support to members suffering from specific illnesses or conditions, and we use data and analytics to ensure that the benefits included in our plans are appropriate to members.

In these efforts we are supported by a dedicated and experienced Board and Board Committees, Executive Management team and employees.

See page 36 for more on how we manage service providers.

Relevant stakeholders:



Board and employees



Members, brokers and agents



Service providers



Government and regulatory bodies

Related external trend:

- Innovation and technological disruption
- Wellbeing and mental healthcare

Related strategic opportunity

- Improve relationships and collaboration between stakeholders
- Promote integration of the healthcare value chain
- Innovate new solutions to meet members' needs
- Communicate and entrench the Bonitas value proposition
- Increase transparency and good governance

Related strategic risk:

- Bonitas's sustainability and stability
- Service provider partnerships
- Health risk management

Strategic pillar response:



Connect with the customer



Apply best practice governance



Making it easy for members to look after their health

Members are better able to look after their health when they are appropriately informed and have access to the products and services they need, when they need them.

We engage with our members through multiple touchpoints, and where appropriate we provide relevant information throughout the member's healthcare journey. We also apply the latest technology to facilitate communication between members and healthcare practitioners.

We offer wellness and preventative care benefits on all our plans, including vaccinations and an annual online wellness questionnaire or screening.

See page 33 for more on how we promote preventative care, and page 34 for more on how we are simplifying the road to health and wellness.

Relevant stakeholders:



Board and employees



Members, brokers and agents



Service providers



Government and regulatory bodies

Related external trend:

- Innovation and technological disruption
- Wellbeing and mental healthcare

Related strategic risk:

- Impact of NHI on our sustainability and structure
- Impact of increasing regulation or regulatory changes and/or lack thereof
- Bonitas's sustainability and stability

Strategic pillar response:



Connect with the customer



Integrate the value chain



Create value through innovation

Related strategic opportunity

- Improve relationships and collaboration between stakeholders
- Communicate and entrench the Bonitas value proposition
- Contribute to an NHI model that makes a lasting positive impact on South Africans and the healthcare ecosystem
- Improve cohesion and coherence in the healthcare ecosystem
- Increase transparency and good governance
- Innovate new solutions to meet members' needs
- Promote integration of the healthcare value chain



Leveraging our bargaining power, footprint and networks

Healthcare costs consistently outpace inflation, and the healthcare sector is regularly disrupted by new technology, innovations, legislation and regulations. To protect the interests of our members, Bonitas must represent them in our engagement with other stakeholders.

As the second-largest open medical scheme in South Africa (based on the number of members) we are able to negotiate favourable rates with service providers and expand our network in line with member needs. We onboard service providers that have innovative solutions to improving the quality and affordability of healthcare, and work with humanitarian organisation Gift of the Givers to improve health and wellness outcomes for the public at large.

We are a member of several industry organisations and associations, including the BHF, which deepens our channels of engagement with legislators and regulators.

See page 37 for more on how we are contributing to an affordable and sustainable South African healthcare ecosystem.

Relevant stakeholders:



Board and employees



Members, brokers and agents



Service providers



Government and regulatory bodies

Related external trend:

- Healthcare affordability
- Innovation and technological disruption

Related strategic risk:

- Bonitas's sustainability and stability
- Bonitas brand and reputation
- Stakeholder management
- Service provider partnerships

Strategic pillar response:



Be a strategic purchaser



Integrate the value chain

Related strategic opportunity

- Improve relationships and collaboration between stakeholders
- Promote integration of the healthcare value chain
- Innovate new solutions to meet members' needs
- Communicate and entrench the Bonitas value proposition
- Increase transparency and good governance



Protecting our financial sustainability

A medical scheme's financial sustainability depends on membership growth, a balanced membership profile, responsible investment and stability. Without these, the scheme risks a solvency level below the legislated 25%, which jeopardises members' continued healthcare coverage.

Bonitas's plans and contribution increases are aimed at attracting new members and retaining existing members through the appropriate balance between benefits and cost. We closely monitor the profile of our members and develop dedicated programmes to assist those with long-term healthcare needs.

We invest responsibly to protect member funds and increase our reserves and have a solvency level 13.6% above the required 25%. We monitor the impact of legislation and regulations and develop strategies and models to ensure we can continue meeting members' healthcare needs.

See page 52 for more on our financial performance.

Relevant stakeholders:



Board and employees



Members, brokers and agents



Service providers



Government and regulatory bodies

Related external trend:

- Healthcare affordability
- Universal healthcare and National Health Insurance

Related strategic risk:

- Impact of NHI on our sustainability and structure
- Bonitas's sustainability and stability

Strategic pillar response:



Be a strategic purchaser



Optimise investment returns



Integrate the value chain

Related strategic opportunity

- Improve cohesion and coherence in the healthcare ecosystem
- Increase transparency and good governance
- Innovate new solutions to meet members' needs
- Improve relationships and collaboration between stakeholders
- Promote integration of the healthcare value chain



Preventing fraud, waste and abuse

In the healthcare sector, FWA manifests in many forms including false claims, overbilling for services, providing unnecessary services, bribery and kickbacks. In addition to being illegal, such acts increase the cost of healthcare, which translates to increased contribution costs for members.

Bonitas has an integrated approach to prevent FWA across our value chain. All service providers are required to comply with our Anti-Fraud, Waste and Abuse Policy, and the Bonitas FWA Forum meets monthly with primary service providers to ensure sound FWA policies and practices.

We work with applicable stakeholders to assist in the investigation of allegations or cases of FWA, including the South African Police Service (SAPS) and the Specialised Commercial Crime Unit.

See page 39 for more on how we combat FWA.

Relevant stakeholders:



Board and employees



Members, brokers and agents



Service providers



Government and regulatory bodies

Related external trend:

- Innovation and technological disruption

Related strategic risk:

- Bonitas's sustainability and stability
- Service provider partnerships

Strategic pillar response:



Be a strategic purchaser



Integrate the value chain



Apply best practice governance

Related strategic opportunity

- Improve relationships and collaboration between stakeholders
- Promote integration of the healthcare value chain
- Innovate new solutions to meet members' needs



Cyber and information resilience

Organisations that work with people's data are under increasing pressure to secure and protect their systems from cyber attacks. This is particularly so in the healthcare sector since compromised data and systems can cost lives.

Bonitas is committed to protecting members' data by ensuring the security of internal systems as well as those of service providers. We ensure that audits and penetration testing are conducted where appropriate and confirm that service providers adhere to the I&T requirements specified in our SLAs. In the case of a data breach or system failure we ensure that root causes are identified and the appropriate corrective actions implemented.

See page 83 for more on I&T governance at Bonitas.

Relevant stakeholders:



Board and employees



Members, brokers and agents



Service providers



Government and regulatory bodies

Related external trend:

- Innovation and technological disruption

Related strategic risk:

- IT and data governance risks
- Bonitas's sustainability and stability
- Service provider partnerships

Strategic pillar response:



Apply best practice governance

Related strategic opportunity

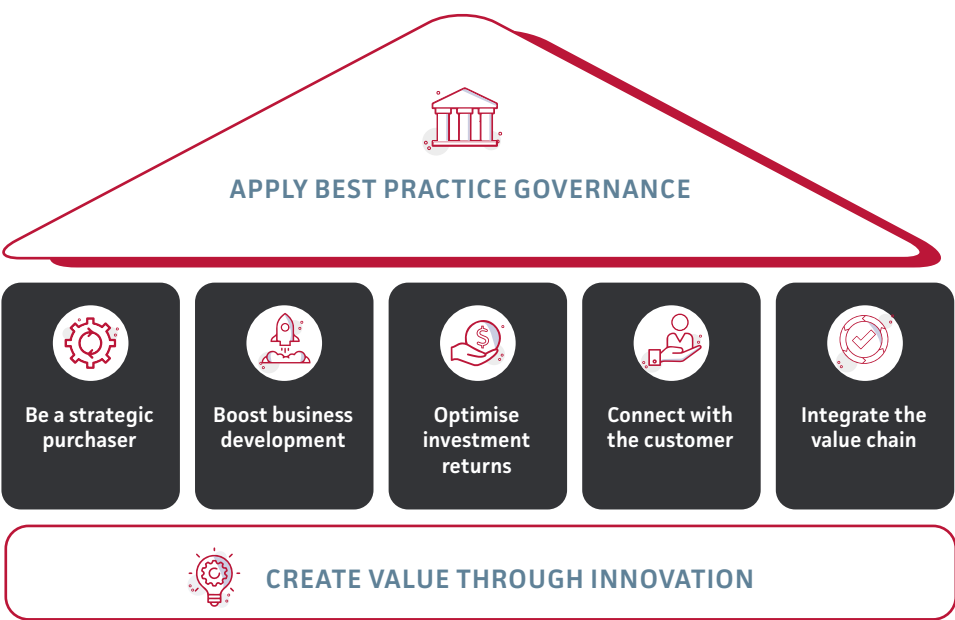
- Drive awareness of the confidentiality of personal data
- Improve the relevance of products and services by analysing member and other data
- Improve relationships and collaboration between stakeholders
- Instil good I&T practices among service providers
- Improve the quality of service provided to members

OUR STRATEGY

To ensure we deliver on our purpose, Bonitas has a detailed and robust strategy based on five core pillars, supported by governance and innovation – which are relevant to each pillar.

The Board and Executive Management team conduct a formal strategy review at least once a year to assess progress and evaluate the strategy against the current healthcare environment, trends, anticipated future changes and emerging risks. The Board approves the strategy and related tactical plans.

The Working and Strategy Committee directs and monitors strategy implementation. Progress is evaluated continually during meetings and workshops conducted by the five Board Committees and is presented to the Board during Board meetings.



During the 2023 formal strategy review, the Board agreed that the strategic intent for 2023/4 is to **create a high-performance culture with incentive-driven outcomes to enhance member acquisition and retention**. Several actions were identified to realise this intent, including the following:

Investigate strategic partnerships to provide a complete and integrated menu of products and services that support members' needs throughout all life stages.	See page 32
Empower and incentivise members to look after their own health and proactively identify potential health and wellness risks.	See page 33
Improve the ease with which members, brokers and healthcare providers do business with Bonitas.	See page 33
Implement a new operating model to support corporate growth and servicing.	See page 35

PERFORMANCE AGAINST OUR STRATEGY

We measure strategic performance against key indicators, as illustrated below. Thereafter follows a description of key initiatives undertaken in 2024 to support each strategic pillar.



BE A STRATEGIC PURCHASER

To ensure that our members have access to affordable healthcare, we contract service providers that offer quality services at value-for-money rates.

SHORT-TERM OBJECTIVES

- Create a seamless service experience
- Optimise collective bargaining with hospital groups
- Reduce co-payments and short payments to create a wallet-free experience for our members
- Integrate services to deliver on our new corporate service delivery model
- Expand our hospital-at-home initiatives
- Enhance outcomes-based measures with managed care providers to improve healthcare outcomes
- Implement focused initiatives to improve the performance of loss-making options

LONG-TERM OBJECTIVES

- 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 MATTERS

- Leveraging our bargaining power, footprint and networks



KEY PERFORMANCE INDICATORS

Estimated savings yielded through strategic purchasing (hospital negotiations):
R532 million
(2023: R475 million) ↑

Estimated savings due to managed care initiatives*: **R901.1 million**
(2023: R745.2 million) ↑

* Includes hospital negotiation savings.



BOOST BUSINESS DEVELOPMENT

Our membership base is key to our sustainability, so we work to acquire new members and retain existing members.

SHORT-TERM OBJECTIVES

- Develop a marketing strategy to improve market penetration at an acceptable cost of acquisition
- Simplify and streamline the member onboarding process
- Implement a focused corporate service delivery model to improve the reporting and servicing experience at paypoints
- Develop the Bonitas brand within identified target markets
- Improve the ease of doing business for all stakeholders
- Use member data to facilitate and support Bonitas's distribution channels to address gaps in member needs
- Implement a retention strategy to improve membership terminations and lapses

LONG-TERM OBJECTIVES

- Enhance distribution channels
- Improve retention (groups and DPMs)
- Grow corporate membership and the integration of value-added products
- Continue pursuing amalgamation opportunities

RELATED MATERIAL MATTERS

- Successful and efficient healthcare reform



KEY PERFORMANCE INDICATORS

Membership acquisitions:
61 290 | 21%
(2023: 50 729 | 7%) ↑

Membership terminations:
53 078 | 2%
(2023: 53 987 | 12%) ↓

Retention of terminations:
46%
(2023: 37%) ↑



OPTIMISE INVESTMENT RETURNS

We invest members' contributions for a return and use this money to keep pricing as low as possible.

SHORT-TERM OBJECTIVES

- Achieve a targeted net (of fees and taxes) return in excess of CPI+3.5% per annum over a rolling 36-month period
- Onboard a new asset manager

LONG-TERM OBJECTIVES

- 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
- Challenge the regulator regarding investment constraints in Regulation 30 of the MSA which amongst other things limits the investment exposure to specific asset classes.

RELATED MATERIAL MATTERS

- Protecting our financial sustainability



KEY PERFORMANCE INDICATORS

Return on investment:
13.4% (2023: 7.7%) ↑

Investment portfolio
value excluding cash:
R10.69 billion
(2023: R10.21 billion) ↑

Percentage of asset managers
who outperformed their
benchmarks net of fees:
80% (2023: 56%) ↑

¹ NPS is a metric to measure customer satisfaction and loyalty. It is calculated by asking the question: "On a scale of one to 10, how likely are you to recommend our product/service to a friend or colleague?" The NPS benchmark varies greatly between industries, and in the South African healthcare sector a healthy NPS is 20 or above.

² Captures member satisfaction with specific interactions.

³ Assesses the ease of the member experience.

⁴ Percentage of calls resolved on first contact without requiring follow-up.



CONNECT WITH THE CUSTOMER

Connecting with members helps us provide them with the services they need and gives us insight into evolving trends and requirements.

SHORT-TERM OBJECTIVES

- Meet Bonitas members' needs through all life stages
- Optimise digital platforms and engagements (such as during onboarding) to enhance the Bonitas experience
- Support regular, simplified communication to improve member understanding
- Implement an enhanced stakeholder communication strategy
- Implement a wellness strategy to drive health risk assessments that would create value and competitiveness through activation of the Bonitas Benefit Booster
- Enhance our NPS

LONG-TERM OBJECTIVES

- Educate and engage patients to take responsibility for their health and conditions
- Form partnerships with doctors, healthcare 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



KEY PERFORMANCE INDICATORS

Members

Net promoter score:
11.66
(2023: 8)¹ ↑

Customer satisfaction
score: **93.19%**
(2023: 87.7%)² ↑

Consumer experience
score: **74.94%**
(2023: 67.7%)³ ↑

Brokers

First call resolution score:
91.54%
(2023: 70.36%)⁴ ↑

Consumer experience
score: **75.84%**
(2023: 46.34%) ↑



INTEGRATE THE VALUE CHAIN

We provide members with a complete and integrated solution to their healthcare needs by forming strategic alliances with all stakeholders.

SHORT-TERM OBJECTIVES

- Implement a free-to-member strategy aimed at reducing out-of-pocket expenses
- Implement an integrated product and service strategy and solution to improve member retention, enhance the performance of our distribution channels and complement the Bonitas corporate service delivery model
- Actively build a future for NHI partnerships
- Improve our virtual services

LONG-TERM OBJECTIVES

- Provide a wallet-free experience for all members
- Integrate our product offering to improve retention
- 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



KEY PERFORMANCE INDICATORS

6.9% total weighted contribution increase for 2024
(2023: 4.7% after deferral) ↑

Insurance expenditure:
R22.29 billion
(2023: R20.23 billion) ↑

Insurance loss ratio:
106.7%
(2023: 103.9%) ↑



CREATE VALUE THROUGH INNOVATION

We adapt our strategy, processes and products to continue meeting members' needs, ensure Bonitas's sustainability, and increase the accessibility and affordability of healthcare.

SHORT-TERM OBJECTIVES

- Issue communication that is focused on aligning service providers in Bonitas's value chain
- Actively build a future for Bonitas to be part of the NHI in South Africa
- Develop a front-end I&T solution to enhance experience, access and convenience for potential new members

LONG-TERM OBJECTIVES

- 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



KEY PERFORMANCE INDICATORS

Insurance service deficit:
R965.7 million
(2023: R451 million) ↑

Non-healthcare expenditure as a percentage of risk contributions:
9.4% (2023: 9.3%) ↑

Hospital tariff savings:
R532 million
(2023: R475 million) ↑

Loss-making options:
8 (2023: 5) ↑



APPLY BEST PRACTICE GOVERNANCE

We adhere to industry best practices, comply with legislation and regulations, and manage risks to Bonitas's sustainability.

CORE ELEMENTS

- Governance
- Risk management
- Compliance management

RELATED MATERIAL MATTERS

- Trust and confidence in our ability to protect stakeholders' interests
- Preventing fraud, waste and abuse
- Cyber and information resilience



KEY PERFORMANCE INDICATORS

Amounts attributable to future members:
R133.9 million
 (2023: R265.3 million)¹ ↓

Non-healthcare expenditure as a percentage of risk contributions:
9.4% (2023: 9.3%)² ↑

Gross recoveries from FWA:
R46.2 million
 (2023: R52.3 million) ↓

Solvency ratio:
38.6%
 (2023: 41.5%) ↓



¹ Amounts attributable to future members represent the excess over fair value for the current financial period.

² The ratio of non-healthcare expenditure against insurance revenue refers to attributable, non-attributable and acquisition costs as a percentage of insurance revenue.

INITIATIVES SUPPORTING OUR STRATEGIC PILLARS

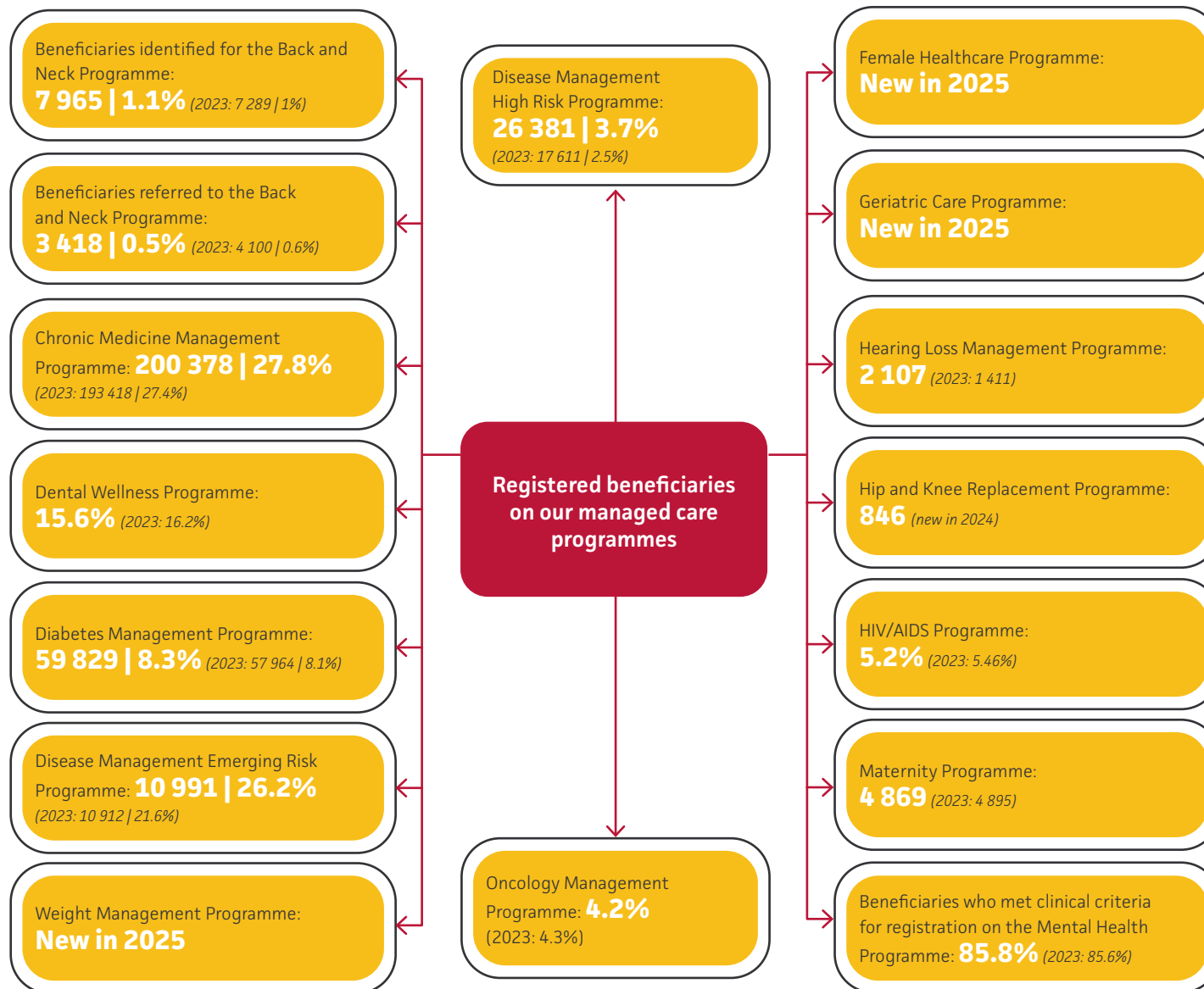
EXTEND COST-EFFECTIVE AND SPECIALISED SUPPORT AND CARE OFFERINGS

Strategic pillars

-  Be a strategic purchaser
-  Boost business development
-  Connect with the customer
-  Integrate the value chain
-  Create value through innovation

Each managed care programme focuses on a specific disease or wellbeing area, and we negotiate preferential rates with healthcare providers.

- We appointed HearConnect to service members on our Hearing Loss Management Programme (previously the Audiology Benefit Management Programme), which provides hearing aids, audiology services and hearing aid acoustic services to members on BonComprehensive, BonClassic, BonComplete, Standard and Standard Select.
- Through our partnership with HearConnect, we provide free hearing screenings for all South Africans on the Bonitas website at <https://bonitas.co.za/hearingscreening>.
- We are working closely with PHA and our HIV medical advisor to manage high viral load (VL) counts through interventions such as treatment change regimes. Every BonCap prescription received for HIV medication authorisation must be accompanied by a VL test result and the HIV disease management nurses assist by providing further interventions.
- We introduced three new managed care programmes as part of our 2025 offering, namely a Weight Management Programme, a Female Healthcare Programme focusing on preventative care, and a Geriatric Care Programme for seniors over the age of 70.



PROMOTE PREVENTATIVE CARE FOR IMPROVED HEALTH AND WELLBEING

Preventative care allows for early detection of diseases, enabling timely interventions and improving treatment outcomes.

Strategic pillars



Boost business development



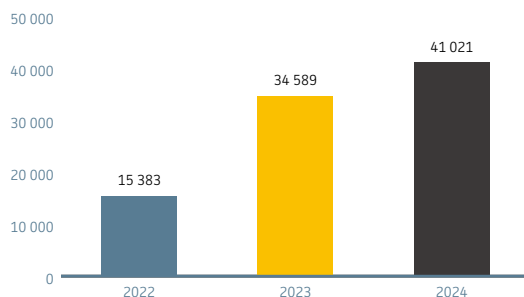
Connect with the customer



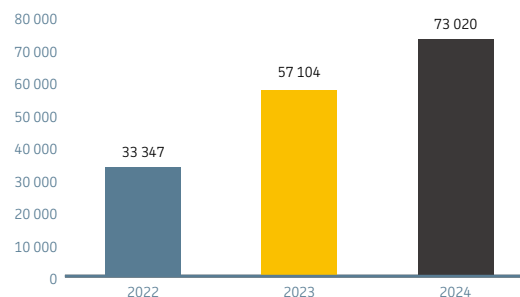
Create value through innovation

- The Bonitas Benefit Booster activates after a member completes an online wellness questionnaire and/or wellness screening. Once activated, out-of-hospital claims such as GP visits, over-the-counter medicine, X-rays and blood tests will first pay from the available Benefit Booster amount, up to a maximum of R5 000 annually. Bonitas also uses this data – with member consent – to identify potential health and wellness risks and recommend the member's enrolment on a managed care programme where appropriate.
- We introduced the Be Better Benefit, which provides a range of screening tests to allow for early detection of health and wellness challenges. The Be Better Benefit is funded completely from risk and is available on all plans except BonCap.
- We extended the HPV vaccine to all plans. We also cover an annual test for HIV+ members who had a positive cytology test, as well as a choice between a three-yearly basic cytology test or five-yearly HVP test.
- In 2025, we expanded preventative care benefits to include access to cutting-edge artificial intelligence (AI)-driven diabetic retinopathy screenings, diabetes consultations, vision screening tests for premature newborns, and additional coverage for antenatal vitamins for expecting mothers.

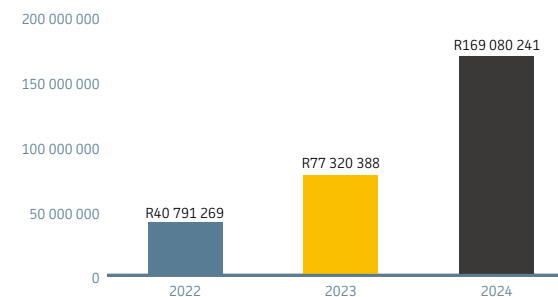
WELLNESS QUESTIONNAIRES COMPLETED



BENEFIT BOOSTER ACTIVATIONS



BENEFIT BOOSTER CLAIMS



BE BETTER BENEFIT

Women's health

Mammogram | Pap smear | HPV vaccinations

Men's health

Prostate screening

Mental health

Online mental health assessments

Physical health

Blood pressure | Glucose | Cholesterol |
Body mass index | Waist-to-hip ratio

Children's health

Hearing screening | Congenital hypothyroidism |
Paediatric or GP consultations | Child immunisation

General health

Flu vaccine | HIV test | Full lipogram | Pneumococcal vaccine | Bone density test | Whooping cough booster
| Colorectal cancer screening | Dental fissure sealants | Eye check-up | COVID-19 vaccinations



We aim to move from sick care to preventative care, and from a transactional approach to an outcomes-based managed care approach.



SIMPLIFY THE ROAD TO HEALTH AND WELLNESS

By reducing unnecessary complexity and focusing on effective, straightforward interventions, we simplify healthcare routines, improve customer satisfaction and use resources more effectively.

- Over 300 000 unique users visit the Bonitas website each month. We made significant website updates to enhance member education and ease of use. This includes Quick Find, a tool that helps members find answers to medical aid-related questions, as well as a 'request an ambulance' function that allows members to complete the necessary authentication to get an ambulance sent to them in an emergency and track its location in real time. In 2025 we will add real-time tracking through WhatsApp.
- In partnership with Pharmacy Direct and Scriptpharm, we implemented a doctor portal to assist with script renewal, prescribing medicines within the formulary and reducing co-payments.

CALL CENTRE INDICATORS



Strategic pillars

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

Our awards

	Best Operational Performance BHF Titanium Awards 2024 2023 2022		Best Integrated Annual Report BHF Titanium Awards 2024
	Number 1 Medical Aid Ask Afrika Orange Index 2024/2025 2021/2022 2019/2020		

GROW THE CORPORATE MEMBERSHIP BASE THROUGH AFFORDABLE AND INTEGRATED SOLUTIONS

We refined our value proposition for group businesses and implemented a new service delivery model to ensure a quality, seamless and integrated experience for corporate members.

Strategic pillars



Boost business development



Create value through innovation



Apply best practice governance

By implementing comprehensive corporate wellness programmes and partnering with a medical scheme, employers can foster a healthier, more engaged and productive workforce. This ultimately leads to reduced healthcare costs, lower absenteeism and improved employee morale.

Following extensive research that commenced in 2023, we implemented a seamless, integrated corporate service delivery model to increase the proportion of group members in our membership base. See more information in the message from our Chairperson on page 48.

Our corporate value proposition includes the following:

- Bespoke corporate servicing model
- Corporate health manager
- Tailored healthcare insight reports
- On-site corporate wellness
- Customised digital portals for human resources and brokers
- Value-added solutions/products

PROVIDE AFFORDABLE AND HOLISTIC MENTAL HEALTH SOLUTIONS

The COVID-19 pandemic significantly increased mental health issues, and middle-income countries such as South Africa are disproportionately affected. Our mental health solutions aim to provide cost-effective and personalised support to those in need.

Strategic pillars



Be a strategic purchaser



Boost business development



Connect with the customer



Create value through innovation

- We added the Bonitas Mental Health Programme to all plans. Registered members are assigned a dedicated Care Manager who assists them and collaborates with their treating doctor to ensure they get the support they need, including assistance with healthcare authorisations.
- Depression was added as a chronic condition on 11 healthcare plans.
- We offer October Health (previously Panda), a free-to-download virtual mental health programme available via the Bonitas member app that enables members to anonymously access live, audio-only sessions with mental health experts to better understand daily challenges, as well as access content and assessments to improve their mental wellbeing.
- In 2025, we will leverage our high-quality integrated chronic care family practitioner network by including a mental health service component to facilitate early disease detection and diagnosis of mental health conditions in members with chronic illness.

MENTAL HEALTH: WHAT YOU NEED TO KNOW

1 in 8

people worldwide live with a mental disorder¹

1 in 4

people in South Africa have symptoms of probable depression²

3.7% of Bonitas members are registered for chronic benefits related to depression

1 in 7

10- to 19-year-olds worldwide experience a mental disorder³

<25%

receive treatment⁴

>7.8%

apparent prevalence for depression

¹ World Health Organization. 2022. 'Mental disorders'. 8 June. Available on: <https://www.who.int/news-room/fact-sheets/detail/mental-disorders>

² Wits University. 2022. 'Mental health in SA is at shocking levels but people are not seeking help'. 14 November. Available on:

<https://www.who.int/news-room/fact-sheets/detail/mental-disorders> <https://www.wits.ac.za/news/latest-news/research-news/2022/2022-11/mental-health-in-sa-is-at-shocking-levels-but-people-are-not-seeking-help-.html>

³ World Health Organization. 2024. 'Mental health of adolescents'. 10 October. Available on: <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>

⁴ Ibid

PROMOTE TRANSPARENCY AND GOOD GOVERNANCE

We promote transparent decision-making on what matters most to our members, including our selection and management of service providers.

Strategic pillars



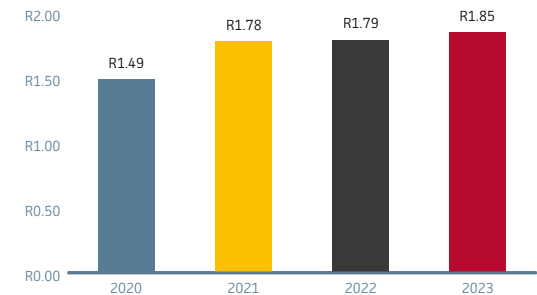
Create value through innovation



Apply best practice governance

- We held our virtual annual general meeting (AGM) on 21 August 2024 and our special general meeting (SGM) on 3 July 2024. See page 73 or more information.
- We commissioned Deloitte to conduct a Transactional and Relational Governance Review to ensure that our contracts – particularly those with primary service providers – are transacted at arm’s length. Deloitte found that Bonitas effectively monitors service providers’ performance and enforces penalties where applicable. It also calculated that for every R1.00 spent on administration and managed care, Bonitas derived R1.79 value in 2022 and R1.85 in 2023. These results excluded BonCap.
- In 2015, the CMS developed a framework on low-cost benefit options (LCBOs) that would allow medical schemes to offer healthcare plans that are exempt from providing PMBs – as is currently the case with insurance providers. We carefully monitored developments in this regard and eagerly await the release of the LCBO framework so we can design solutions that will benefit members now and in the future.
- Bonitas supported two enterprise development partners – Modjadji Pulane Communications and Techplo Branding and Signage – through orders totalling R1.7 million in line with our Procurement and Contract Management Policy. We empower these entities by paying them in advance for orders, offering access to Bonitas office equipment (such as printers and telephones), and providing exposure to potential business from Bonitas’s service providers. We hope to further develop these relationships and graduate them to be fully fledged Bonitas suppliers.

VALUE FOR MONEY



HOW WE SELECT AND MANAGE SERVICE PROVIDERS

We select and manage service providers in accordance with our Procurement and Contract Management Policy, which is regularly reviewed and approved by the Board.

1 Request for proposal

We determine whether an open or closed tender process will be followed, depending on the service required. In the case of an open tender process, we invite participation through an Expression of Interest notice in newspapers or newspaper adverts and on our website. For a closed process, we capture the details of the required products or services in a Request for Proposal (RFP). Weightings are carefully considered to ensure fairness in the process and empower bidders to place emphasis on relevant areas in their proposals. The Board approves the RFP and evaluation criteria, as well as the methodology for applying for an Expression of Interest. All bidders must sign a non-disclosure agreement and are provided with an information pack containing the RFP.

2 Briefing session if required

Depending on the complexity of the RFP, bidders might be invited to a briefing session. Bidders have an opportunity to ask questions or address concerns during and after the briefing session. Questions posed are responded to in writing and a copy is sent to all bidders.

3 Supplier selection

An evaluation panel is convened to review proposals against the RFP requirements and assign scores based on the weighting criteria. Any disclosed conflicts of interest are scrutinised, and independent legal opinion is obtained where required.

4 Contract negotiation

Bonitas enters negotiations with the preferred bidder to arrive at an agreement. Independent legal advice may be sought to guide the drafting of the contract and ensure that all objectives in the RFP are included.

Bonitas follows an outcomes-based approach to contracting, meaning that we measure the performance of service providers against a set of predetermined healthcare outcomes – such as hospital readmissions, patient engagements and patient-reported outcomes including SLAs. The contract may make provision for penalties for non-delivery against SLAs. The final contract is approved by the Board.

5 Performance management

We continually monitor service providers’ adherence to SLAs and outcome-based measures through (for example) meetings, progress reports, and internal and external assurance reports. Contracts are reviewed prior to their expiration date to ensure they remain fit for purpose and align with requirements. Independent actuaries may be commissioned to assess the contract value.

CONTRIBUTE TO AN AFFORDABLE AND SUSTAINABLE SOUTH AFRICAN HEALTHCARE ECOSYSTEM

We contribute to reshaping the healthcare ecosystem by giving access to affordable, quality healthcare to more South Africans and doing our part as a responsible corporate citizen.

Strategic pillars



Optimise investment returns



Create value through innovation



Apply best practice governance

Bonitas maintains that a citizen-centric, multi-funder, multi-provider system is the best way for universal healthcare to succeed in South Africa. This requires close collaboration between the public and private sectors (including medical schemes), strong leadership, accountability, and dealing with socioeconomic issues as an integral part of the process.

In response to the NHI, we:

- Actively pursue all avenues to address the unanswered questions and practical implications of the NHI in the best interest of our members.
- Identify and manage risks and opportunities relating to the NHI (see page 43).
 - Work with stakeholders such as the BHF to lobby government regarding the importance of an effective, efficient and well-governed NHI, and the critical role of the private sector in ensuring universal healthcare.
 - Engage with members regarding the impact of the NHI on medical scheme membership. At this stage, members are unaffected.
 - Investigate alternative strategies and models to ensure Bonitas's long-term sustainability and relevance.
 - Continue supporting various public healthcare initiatives in partnership with Gift of the Givers.

Responding to National Health Insurance

The NHI is the South African government's strategy to achieve universal health coverage. The intention is that government will purchase healthcare services through a centralised, national insurance fund that is funded through taxes and special contributions. Government acknowledges that it will take many years to fully implement the NHI but once this happens, medical schemes will only be able to offer 'complementary services' that are not available through the NHI.

The NHI has been plagued by criticism since the NHI Green Paper was published for public consultation in 2011. Detail is lacking on the funding and actual costs of the NHI, and it is not clear how government will ensure the required rigorous governance of the fund.

Additionally, all international concepts of universal healthcare make provision for freedom of choice, and we believe citizens should be allowed to purchase additional healthcare should they have the desire and means to do so.

Driving positive healthcare outcomes with Gift of the Givers

Bonitas is guided by a Board-approved Sponsorship and Donations Policy and annual Sponsorship Strategy. Sponsorships are financial in nature, and potential projects are evaluated and approved against the following criteria:

New member acquisition

Results in the acquisition of new members

Brand awareness

Provides the Bonitas brand with exposure through any medium, including public relations and social media

Support member retention

Impacts the current membership base or is focused on geographical split aligned to membership

Influence stakeholder action

Allows Bonitas to support or collaborate with strategic stakeholder groups

Contribute to the brand strategy and South African society

Positions Bonitas as the everyday hero and medical aid for South Africa, and supports our mission to make quality healthcare more affordable and accessible



We strongly believe that the public and private healthcare systems have a dual responsibility to deliver access to universal healthcare.



SPONSORSHIPS WITH GIFT OF THE GIVERS

Since 2018, Bonitas has had a strategic partnership with Gift of the Givers, a leading philanthropic organisation with a national footprint that was established in 1982. Once approved by the Board, we provide financial sponsorship for identified projects and monitor progress through quarterly return-on-investment reports. Sponsored projects may run over more than one year.

South Africa is a water-scarce country that receives less rainfall than the global average.¹ Water resources are unevenly distributed across regions, and the ageing water infrastructure is prone to leakages and losses. Municipalities often face challenges providing reliable water supplies due to financial constraints, with water interruptions and water-shedding becoming more commonplace.

Since 2023, Bonitas has sponsored Gift of the Givers to establish boreholes in healthcare and other community facilities. By providing access to clean, safe drinking water, boreholes reduce the spread of diseases such as cholera, diarrhoea, dysentery, hepatitis A, typhoid and polio.²

- In June 2024, a borehole was established in Kalafong Hospital, a 1 118-bed public teaching hospital in Atteridgeville, Pretoria. The borehole provides water to the hospital's reservoir and supplements the municipal water supply by 150 000 litres a day – over half the hospital's daily consumption.
- In November 2024, the solar-powered borehole was completed in Cwebeni, a village in rural Port St Johns in the Eastern Cape. The borehole yields 960 litres per hour, and two 5 000-litre storage tanks have been placed on site.
- In the first quarter of 2025, Gift of the Givers will complete a borehole at the Boitekong Community Health Centre in Rustenburg.

Other projects that commenced or concluded in 2024 include the following:

- Through our Audiology Screening Programme, which was launched in March 2023, we screened 15 680 learners for hearing impairments.
- We sponsored eight medical students in their final year of study at the University of KwaZulu-Natal Medical School.
- We distributed 10 000 sanitisers to 10 schools, 16 clinics and two hospitals in the Mpumalanga and Gauteng provinces to promote good hygiene practices and prevent the spread of diseases.

In 2024, the Board approved sponsorship for Sepahko Makato University to improve campus safety and accessibility, and upgrade clinic equipment and an emergency vehicle. Sepahko Makato is the only Health Sciences University in South Africa and graduates an average of 1 400 healthcare professionals each year. This project will run into 2025.



¹ Igamba, J. 2022. 'Water Crisis In South Africa'. Green Peace, 5 July. Available on: <https://www.greenpeace.org/africa/en/blogs/51757/water-crisis-in-south-africa/>

² Ritchie, H, Spooner, F and Roser, M. 2024. 'Clean Water'. Our World in Data, January. Available on: <https://ourworldindata.org/clean-water>

Fraud, waste and abuse

We have zero tolerance for FWA and follow a comprehensive FWA management process. Our Anti-Fraud, Waste and Abuse 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 providers must abide by this policy and non-compliance may result in sanctions and/or penalties.

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 in the forensic process to provide an auditable trail and assurance to all stakeholders.

Members can use our dedicated Whistle Blowers hotline reporting channels to report any suspected medical aid fraud. Reports can be made anonymously or in confidence via phone, SMS, WhatsApp, email, fax, mail, the Whistle Blowers app and online at www.whistleblowing.co.za.

FRAUD, WASTE AND ABUSE MANAGEMENT

Fraud prevention

- Industry information sharing
- Practice vetting and monitoring
- Awareness, training and communication
- Operational improvements

Fraud detection

- Proactive identification
- Tipoffs

Fraud investigation

- Forensic data analysis
- Field of work
- Practice engagement and communication
- Loss assessments

Fraud risk management

- Practice rehabilitation
- Payment status change
- Recovery mechanisms
- Fraud database listing
- Regulatory sanctioning
- Civil and criminal action

Fraud reporting

- Payment integrity weaknesses
- Impact analysis
- Service level adherence
- FWA Forum

NOTABLE 2024 EVENTS

The Chairperson and some service provider executives were victims of identity fraud when bank accounts were opened in their name. The investigation revealed that a syndicate operating across various industries was involved. A criminal case is still under investigation and one suspect is currently in custody. We identified an employee of the administrator who used his position of trust as a team leader to submit fraudulent details to claim saving refunds mainly related to late estates. A criminal case was opened, and the employee has since resigned from the employ of the administrator. We also observed an increase in identity theft, not limited to the healthcare industry. As a result, we increased our fraud awareness campaigns to members and the public at large.

	Amounts quantified, recovered and saved due to the FWA prevention programme (R'000)								2024	TOTAL
	2016	2017	2018	2019	2020	2021	2022	2023		
Quantified	79 559	111 612	106 208	85 881	64 920	75 869	102 037	89 056	74 238	789 380
Recoveries (gross)	17 529	26 469	39 847	39 875	37 060	26 642	44 141	34 236	30 847	296 646
Change in behaviour	83 000	85 000	60 000	165 219	237 309	272 710	200 225	89 200	22 903	1 215 566
Prepayment intervention	729	6 521	10 942	11 338	14 216	16 989	10 969	17 703	15 030	104 437
Reversals	1 804	371	424	182	401	461	393	343	334	4 713

INDICATORS

Investigations

443 practices under investigation (2023: 686) ↓

4 278 practices vetted (2023: 2 489) ↑

Risk mitigation and remedial action

1 658 practices in recovery (2023: 1 583) ↑

191 practices blocked (2023: 307) ↓

189 practices with existing regulatory matters or criminal sanctioning (2023: 170) ↑

Recoveries

R46.2 million recovered in 2024, including reversals, recoveries and claim interventions (target of R47.5 million) (2023: R52.3 million; target of R56 million) ↓

FUTURE PRIORITIES

Bonitas will continue investing in initiatives that support our strategic pillars so we can achieve our purpose of balancing growth and financial sustainability.

Initiatives planned for the short to medium term include the following:

- We aim to strengthen our capabilities to analyse member data – particularly the results of health risk assessments and preventative care screenings – to guide members on the most suitable healthcare plans and managed care programmes to meet their individual needs.
- We will continue improving our website to make it easier for members and other stakeholders to find what they need. In the short term, we plan to add interactive online brochures to the Member Information Hub to help members get essential information quickly and easily.
- Non-communicable diseases (NCDs) such as cardiovascular disease, cancers, chronic respiratory diseases and diabetes are on the increase, claiming an estimated 43 million lives globally in 2021 alone.¹ We will carefully monitor instances of NCDs among our members and the broader public, and adjust our chronic formularies and approach to healthcare benefits where necessary.
- In 2025, we will introduce a positron emission tomography (PET) scan network to ensure enhanced access to scanner facilities at a negotiated rate.
- The contracts of some primary service providers are coming to an end in 2025 and 2026. A key focus for the Working and Strategy Committee and Board will be to evaluate service provider outcomes, review and revise agreements, and implement the procurement process as specified in our Procurement and Contract Management Policy.
- We aim to substantially increase our footprint in the corporate sectors through implementing our integrated corporate service delivery model.



Despite the challenges in the healthcare industry, we remain on course to meet the diverse needs of our members with innovative benefits. We know health is not just a plan; it is a lifelong journey.

¹ World Health Organization. 2024. 'Noncommunicable diseases'. 23 December. Available on: <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>

RISKS AND OPPORTUNITIES

The Board is accountable for risk management and is guided by our Risk Management Framework to identify, evaluate and respond to key risks and opportunities consistently, efficiently and effectively.

APPROACH TO RISK MANAGEMENT

We take a comprehensive approach to risk management based on the following principles:

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 environment 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 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.
- **Governance, Risk and Compliance** 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

The Board-approved Risk Management Framework is based on the principles of the Committee of Sponsoring Organizations (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	Provides guidelines on risk management across Bonitas, and outlines roles and responsibilities
Risk Manual	Provides practical guidelines to ensure the alignment of risk management with day-to-day processes
Risk Universe	Lists all identified risks, i.e. acceptable, tolerable, high and unacceptable, together with risk mitigation actions
Risk Register	Lists high and unacceptable risks, together with risk mitigation actions
Risk Dashboard	Identifies trends and key risk indicators, and provides empirical evidence to support the risks in the Risk Register

The Risk Management Framework defines 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)

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.



We prioritise risks after considering related opportunities as well as the impact and likelihood in terms of levels: acceptable, tolerable, high or unacceptable.



STRATEGIC RISKS AND OPPORTUNITIES

Risk	Our response	Related opportunities
Impact of NHI on our sustainability and structure NHI remains a significant risk due to: • Uncertainty around the role of medical schemes and future access to private healthcare • Constitutional and legal implications including infringement of the Bill of Rights • Uncertainty around proposed NHI funding models • Governance implications • Impact of potential corruption and misuse of health funds • Implications around provider reimbursements • Uncertainties around the determination of service benefits	Following the signing of the NHI Bill into law in May 2024, Bonitas communicated with members to ensure them that their membership remained unchanged for now and that it is business as usual. We approached the CMS for guidance on compliance requirements. Industry actions will be considered and communicated to the Board before any participation or action is taken. Subsequently, a ministerial advisory committee has been established. The following continues: • Oversight by the Working and Strategy Committee and Audit and Risk Committee • Lobbying and engaging with legislative and regulatory bodies • Collaborating with the BHF to strengthen the national healthcare ecosystem and support its sustainability • Regular communication on the current and potential impact of the NHI to members, healthcare practitioners, corporates and other affected stakeholders Related strategic pillars  Boost business development  Apply best practice governance	• Improve relationships and collaboration between stakeholders • Communicate and entrench the Bonitas value proposition • Contribute to an NHI model that makes a lasting positive impact on South Africans and the healthcare ecosystem

Risk	Our response	Related opportunities
Impact of increasing regulation or regulatory changes and/or lack thereof Emerging legislation including CMS Circulars, the Medical Schemes Amendment Bill and the Conduct of Financial Institutions (CofI) Bill may impact compliance requirements, our business model and our products and services	The rising cost of medical scheme contributions remains a risk for the South African healthcare sector. Since passing a resolution in 2015 to adopt a framework for low-cost benefit options (LCBOs), the CMS has not made any further progress. However, recent developments include a call from the Department of Health for public comment on the LCBO report, which the CMS presented to the Minister of Health in October 2023. The timeframe allocated for public comments is three months. This matter therefore remains ongoing and is closely monitored. • Continued monitoring of applicable CMS circulars, regulations, legislation and court judgements • Consulting with legal experts as required • Implementing relevant amendments Related strategic pillars  Boost business development  Integrate the value chain  Apply best practice governance	• Improve cohesion and coherence in the healthcare ecosystem • Increase transparency and good governance • Innovate new solutions to meet members' needs

Risk	Our response	Related opportunities
IT and data governance risks These include cyber and information security threats and vulnerabilities due to lack of data protection and adequate user access management or insufficient IT change control and incident management	Policies and acceptable frameworks are in place with the administrators including cyber insurance, technical solutions, web application firewalls, endpoint protection and encryption, a security operations centre and penetration and vulnerability tests. Monthly I&T SteerCo meetings consider feedback from the administrators and other key service providers. Feedback on risks and opportunities identified flow into the Operations Committee meetings. A red team assessment for 2024 was completed and a report was issued. We continued with internal and external audits including an ISAE3402 report. Data ownership emerged as a risk this year. As mitigation, we commenced with setting up a data warehouse to secure Bonitas's ownership and access to member data. Related strategic pillars  Boost business development  Be a strategic purchaser  Connect with the customer  Integrate the value chain  Create value through innovation  Apply best practice governance	• Drive awareness of the confidentiality of personal data • Improve the relevance of products and services by analysing member and other data • Instil good I&T practices among service providers • Use big data to improve business intelligence through analytic-driven modelling and platforms, standardised protocols, predictive analysis etc.

Risk	Our response	Related opportunities
Bonitas's sustainability and stability We rely on membership growth, retention and affordability. The introduction of a revised corporate strategy and operating model may not result in the required growth balance between direct paying members vs groups. Growth can be impacted by social and economic factors, including healthcare inflation. Strategic changes to benefit design and pricing have to support our strategic objectives to reduce loss-making options and mitigate the impacts of our membership risk profile. This can result in poor financial performance.	We have a multi-disciplinary team approach to define products and pricing. Quantitative and qualitative market research inform these decisions, further supported by actuarial reviews at an option level. Bonitas offers efficiency discounted options and a range of value-added products to aid retention and create new business opportunities for brokers. The Board mandated the PO and the Working and Strategy Committee to develop solutions to address the challenges of retention and stakeholder experience. Bonitas is in the process of rolling out a revised digital strategy, corporate strategy and operating model. Related strategic pillars  Boost business development  Connect with the customer  Integrate the value chain  Apply best practice governance	• Improve relationships and collaboration between stakeholders • Improve the quality of service provided to members • Communicate and entrench the Bonitas value proposition • Increase transparency and good governance

Risk	Our response	Related opportunities
Bonitas brand and reputation Negative media publicity can lead to the potential loss of stakeholder confidence and brand or reputational damage	Bonitas receives ongoing guidance and input from our legal advisor in dealing with reputational issues and stakeholder concerns. Related strategic pillars  Connect with the customer  Apply best practice governance	• Improve relationships and collaboration between stakeholders • Increase transparency and good governance • Communicate and entrench the Bonitas value proposition

Risk	Our response	Related opportunities
Stakeholder management The lack of a stakeholder framework can result in a failure to actively manage the relationship between Bonitas and our key stakeholders. Key stakeholder relationships include those with the CMS, healthcare providers, unions, members and primary service providers.	We have a communication strategy that encompasses all stakeholders, including members, brokers and healthcare professionals. All operational member communication is reviewed to ensure effectiveness and relevance. We have a quarterly member newsletter to increase awareness and education. The change in contracted service providers resulted in an influx of member and broker escalations. This was exacerbated by some failures of third parties to deliver against service level agreements, including incorrect communications to members. These key operational risks have been addressed and close monitoring continues. This includes monitoring broker relations impacting member experience due to the delayed processing of membership applications, concessions and onboarding. Related strategic pillars  Boost business development  Connect with the customer  Apply best practice governance	• Improve relationships and collaboration between stakeholders • Improve the quality of service provided to members • Increase transparency and good governance

Risk	Our response	Related opportunities
Service provider partnerships Members expect effective and efficient service and administration, including claims processing and payments. Claims paid outside approved benefits and limits or in contravention of the MSA and Scheme Rules are a high risk to Bonitas.	We receive monthly claims exception reporting, audit reports and do monthly calculation and back testing of IBNRs. IBNR data is compared to that calculated by Medscheme Actuarial and NMG Actuaries and discrepancies are discussed and addressed. The COO monitors key claims exceptions and the PO signs off any non-compliance monthly. We also monitor claims processing speed, year on year comparisons in claims processing and do an independent monthly actuarial review. External claims reviews for 2025 have been scheduled. Numerous incidents where third parties did not deliver against service level agreements (SLAs) were addressed with several relating to the transitioning of service providers. There were also ongoing challenges with external providers' IT environments, which impacted service delivery. The Operations team monitor SLAs on an ongoing basis, with escalation to the I&T Steering Committee where relevant. Related strategic pillars  Connect with the customer  Integrate the value chain  Apply best practice governance	• Improve relationships and collaboration between stakeholders • Promote integration of the healthcare value chain • Innovate new solutions to meet members' needs • Instil good I&T among service providers

Risk	Our response	Related opportunities
Health risk management This risk relates to the failure to introduce the right managed care programmes and access to the programmes to ensure quality of care for our members. Ineffective disease control and management may result in increased healthcare spending.	We have an outcomes-based disease management approach for diabetes, hypertension and depression. The use of preventative care benefits is increasing, as is the success of our hospital-at-home, geriatric and transitional care programmes, leading to a reduction in hospital admissions and re-admission rates. We also developed and implemented automated disease management communication and digital health support to enhance Benefit Booster activation and uptake. Related strategic pillars  Boost business development  Connect with the customer  Apply best practice governance	• Improve relationships and collaboration between stakeholders • Promote integration of the healthcare value chain

MANAGEMENT OF INSURANCE RISK

Bonitas has a portfolio of insurance contracts that covers our risk in terms of member claims, enabling us to manage the healthcare risk exposure of our members and their dependants. Our risk exposure relates to 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, and further manage insurance risk through:

- Inclusion of benefit limits and sub-limits
- Approval procedures for transactions that involve pricing guidelines
- Underwriting
- Pre-authorisation and case management
- FWA management
- Monitoring of emerging issues through our Risk Management Framework
- 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.

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 and downstream costs such as hospital admissions.

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

SERVICE PROVIDER	RISK TRANSFER ARRANGEMENTS
DENIS	Dental benefits Standard, Standard Select, BonFit Select, BonComplete, BonSave and BonClassic
Europ Assistance	Ambulance and emergency services for all plans International travel benefits All members except those on BonCap
PHA	Non-hospital costs BonCap only
PPN	Optometry benefit management Standard, Standard Select, Primary, Primary Select, BonClassic and BonCap
Scriptpharm	Chronic medicine management for all plans

Bonitas will continue investigating risk transfer arrangements for loss-making options to increase value for our members. For more on our risk transfer arrangements, refer to note 15.7 in the annual financial statements.

In addition to reducing costs for members, risk transfer arrangements encourage service providers to put more effort into meeting their deliverables.



OUR PERFORMANCE

MESSAGE FROM THE CHAIRPERSON

The Board's key focus in 2024 was to guide and oversee the implementation of Bonitas's integrated corporate service delivery model and ensure value for money from our service provider relationships.

One of the measures of a medical scheme's sustainability is its membership profile. We evaluate health and wellbeing trends among our members, and consider membership mix and risk profiles of our membership base.

Corporate members appeal to medical schemes for several reasons. First, risk is pooled more effectively when spread across a larger group, and these members often benefit from employer subsidies that help cover contributions. Second, absenteeism, costs the South African economy anywhere from R12 billion to R19 billion each year¹ consequently negatively impacting productivity and economic growth.

In 2023, Bonitas began a Board-led investigation into attracting and retaining corporate members to ensure greater value creation for employers (corporates) and making a positive contribution to the South African economy at large. This resulted in a new corporate service delivery model that distinguishes between corporate segments and offers bespoke products and services, supported by dedicated processes and resources.

It will take some time to realise the full benefits of this model as work remains to be done. This year, we formalised the model, completed the RFP process to procure the necessary expertise and support, and began integrating processes to ensure the seamless onboarding of new members. System and data integration will continue into 2025, together with enhanced stakeholder engagement to communicate the journey of transforming and differentiating Bonitas as a medical scheme of choice.

MATURING GOVERNANCE PROCESSES

Over the years, the Board has focused on increased effectiveness in Bonitas's governance processes – from maintaining contract registers and reviewing policies, through to our work with combined assurance partners. Through the various Board Committees and other governance structures, the Board provides effective oversight of the Executive Management team, guiding them in strategy execution and ethical decision-making.

This year, service provider contracts took centre stage in many of the Board's discussions as contracts come up for renewal or new requirements emerge. These processes can be legally and logistically complex, and Board members were able to share their practical knowledge and experience, soliciting legal expertise where required. We expect this work to continue in the next two years as key service provider contracts – particularly with our primary administrator – are up for renewal. The diligent reviews are approached conscientiously as these also align to the Board members' duties and responsibilities. Regulatory guidelines guide us to critically consider the evergreen nature of agreements and value for money outcomes.

¹ Moonstone Information Refinery. 2024. 'Costly battle: Addressing absenteeism with corporate wellness programmes.' 15 July. Available on: [https://www.moonstone.co.za/costly-battle-addressing-absenteeism-with-corporate-wellness-programmes/#:~:text=Occupational%20Care%20South%20Africa%20\(OCSA,144bn](https://www.moonstone.co.za/costly-battle-addressing-absenteeism-with-corporate-wellness-programmes/#:~:text=Occupational%20Care%20South%20Africa%20(OCSA,144bn).



We are heartened by the results of the Deloitte Transactional and Relational Governance Review conducted this year, which confirmed that Bonitas's contracts with administrators and managed care organisations are concluded at arm's length. It also found that for every R1.00 spent on administration and managed care, Bonitas derived R1.79 value in 2022 and R1.85 in 2023. See page 36 for more information.

PARTNERING FOR QUALITY, AFFORDABLE HEALTHCARE

The Bonitas Board maintains that the private sector has a key role to play in the pursuit of universal healthcare, and we contribute to the proposed NHI model by collaborating with industry associations such as the BHF. The contribution of medical schemes during the COVID-19 pandemic is one of the most recent examples of how public-private partnerships can benefit all parties and reduce the burden on the public healthcare system.

Most major medical schemes (including Bonitas) covered COVID-19 testing costs for their members and collaborated in national vaccine distribution efforts. Medical schemes promoted virtual consultations to reduce physical interactions during lockdowns, helping maintain healthcare access while minimising exposure risks. Many schemes also facilitated home delivery of chronic medication through courier services to ensure continuity of care without exposing patients to potential infection hotspots.

In total, Bonitas spent over R2.7 billion on pandemic-related costs between 2020 and 2022.¹ Accumulated reserves resulting from the postponement of non-essential healthcare interventions were ploughed back to members in 2023 in the form of our first-ever contribution deferral and a contribution increase well below CPI.

Public-private partnerships during COVID-19 demonstrate that medical schemes can meet members' needs while simultaneously improving the sustainability of the public healthcare system.

The response of medical schemes to the pandemic reveals how collaboration between the public and private sectors can improve health and wellbeing outcomes for all South Africans, regardless of whether they are a member of a medical scheme. This is the foundation of our message to regulators and industry bodies in our engagement on the future of the healthcare ecosystem, particularly the NHI model.

CLOSING REMARKS

In the year ahead, the Board will continue monitoring implementation of our corporate service delivery model, as well as exploring growth through amalgamations as medical schemes continue to consolidate. Research to inform 2026 pricing and benefits will commence in the first quarter of 2025.

There were several Board and leadership changes at Bonitas in 2024. Mr C van Zyl, who served as Independent Member on three Board Committees, passed away in April 2024. Shortly after being voted onto the Board at our SGM, Mr PS Sotshangane also passed away in August 2024. On behalf of the Board, I wish to extend my heartfelt condolences to their loved ones.

Mr A Edwards was appointed as a Trustee with effect from 1 April 2024, and Mr T Bikitsha was appointed as Independent Member of the Investment Committee with effect from 1 December 2024. I welcome you both into the fold and look forward to your insights.

Finally, I would like to acknowledge the contribution of our Chief Financial Officer (CFO), Mr L Woodhouse, who served Bonitas with diligence and care since October 2019. In his place it is my pleasure to welcome Ms V Rikhotso, who took over the reins as CFO on 1 February 2025, having served on the Bonitas Board for more than two years.

Mr OJ Komane

Chairperson of the Board

22 April 2025

¹ 2022: R425.9 million; 2021: R2.6 billion; 2020: R974.7 million

REPORT FROM THE PRINCIPAL OFFICER

Bonitas showed resilient performance in 2024 despite a volatile claims environment and uncertainty on the political, economic and regulatory fronts. This is testament to our brand equity and ability to design healthcare plans that meet members’ evolving healthcare needs.

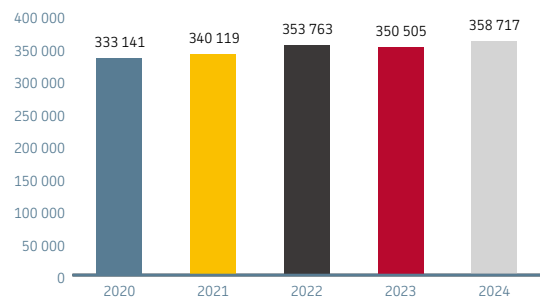
With 16 open medical schemes operating in South Africa, each with an average of seven benefit options,¹ potential members have their pick of healthcare plans. It can be challenging to grow the membership base in this environment, particularly considering the high rate of unemployment and financial hardships facing many South Africans.

It is rewarding to see that Bonitas’s membership base continued its upward trend this year. As at the end of 2024, we had enrolled 61 290 new members against a target of 52 667, bringing our total membership number to 358 717 and total beneficiaries to 731 576. This growth is what we call ‘organic’; in other words, it is not the result of an amalgamation.

The amalgamation of medical schemes is a notable trend in the South African private healthcare industry, with smaller schemes joining larger ones to secure financial stability, a broader national footprint and improved economies of scale. The increase in Bonitas’s membership base between 2021 and 2022 was due primarily to our amalgamation with the Nedgroup Medical Aid Scheme (NMAS) which resulted in an additional 14 585 Bonitas members.

While the pursuit of amalgamations remains a driver of long-term sustainability, our organic growth confirms the success of our 2024 pricing and benefits strategy, which was intended to gradually erode solvency by keeping contribution increases below the industry average while increasing benefits on healthcare plans.

PRINCIPAL MEMBERS



¹ CMS Industry Report 2023



DRIVING SUSTAINABLE GROWTH

In addition to organic membership growth, we consider several additional factors to ensure our long-term sustainability. The MSA requires medical schemes to keep at least 25% of their gross annual contributions in reserves, and Bonitas remains well above the legislated minimum with a solvency ratio of 38.6% (2023: 41.5%).

We also keep a close eye on membership demographics as this has a direct impact on healthcare expenses. Bonitas' member demographic profile continues to compare favourably with the industry, with the average age of beneficiaries standing at 35.9 and the pensioner ratio at 11.5%.

Member retention remains a key focus area for the Board and Executive Management team. We churned 53 078 members against a target of 49 238, mostly due to contribution defaults, resignation (in cases where the contribution is paid in full or part by an employer) and financial constraints due to micro-economic factors.

As healthcare costs continue to increase, we must manage member contributions in a way that maximises coverage and benefits. Our investment strategy is a key enabler in this regard, and despite uncertainty in local and global markets, the total value of our investment portfolio (excluding cash and cash equivalents) increased by 4.7% to R10.69 billion (2023: R10.21 billion).

We aim to substantially increase our footprint in the corporate sectors by implementing our integrated corporate service delivery model (see page 35). This year, we saw growing interest in our solutions which we will further explore in 2025.

PROTECTING AGAINST UNPREDICTABLE CLAIMS

The after-effects of COVID-19 continue to impact the healthcare environment, with members addressing healthcare needs that were delayed during the pandemic. Hospitalisations also increased due to upper respiratory infections in autumn 2024 and septicaemia in spring.

The claims environment increased deficits on some of our healthcare plans, and we ended the year with eight (2023: five) loss-making options. We are carefully monitoring erosion on our Standard, Primary and Primary Select plans, as well as upward trends in oncology claims.

Our 10.2% weighted average contribution increase for 2025 (2024: 6.9%) is in line with the increases announced by most medical schemes to protect against claims volatility, medical inflation and an ageing membership base.

OPPORTUNITIES FOR DEEPER COLLABORATION

Although we remain concerned about the impact of NHI on the healthcare sector, we are also unlocking emerging opportunities.

Medical schemes are collaborating with one another and industry bodies, particularly the BHF, to present a clear and coherent response to the NHI. The BHF represents 40 medical schemes (representing 4.5 million beneficiaries)¹ and is involved in several legal challenges regarding healthcare legislation:

- In May 2024, the BHF submitted a legal challenge to the NHI Act in the High Court.
- In 2025, the BHF will seek a court ruling to compel the CMS to allow schemes to offer LCBOs.
- The BHF also intends to submit an appeal against the Competition Commission's decision to reject an application that would allow medical schemes to collectively negotiate with healthcare service providers on pricing and PMBs.

Regarding the decision by the Competition Commission, this year alone we realised hospital tariff savings totalling R532 million (2023: R475 million) resulting primarily from tariff negotiations with network providers. We maintain that allowing medical schemes to collectively negotiate tariffs with healthcare providers – and make this information public – would lower member contributions and improve access to healthcare.

OUTLOOK

The healthcare industry in South Africa faces several uncertainties in the short to medium term. We are concerned about global political issues and the impact on healthcare funding, particularly primary healthcare and HIV/AIDS, and will closely monitor developments in this regard.

We look forward to increased policy certainty as the Government of National Unity stabilises, and will continue lobbying regulators for clarity on the functioning and implementation of the NHI, LCBO framework, collective bargaining and the investment constraints in Regulation 30 of the MSA.

Finally, the contract of our CFO, Mr L Woodhouse, ended in December 2024. I would like to thank him for his excellent stewardship of the financial business over the past five years and wish him well in his new venture.

In his place we welcome Ms V Rikhotso. Mr S Perumal has also been promoted from Head of Operations to Chief Operating Officer. I have every confidence that these skilled individuals will contribute to Bonitas' sustainability and service offering.

Mr LR Callakoppen

Principal Officer

22 April 2025

¹ Juta Medical Brief 2024. 'BHF's legal challenge to NHI taken to "wrong court", says Presidency'. 13 November. Available on : <https://www.medicalbrief.co.za/bhfs-legal-challenge-to-nhi-taken-to-wrong-court-says-presidency/>

FINANCIAL AND OPERATIONAL RESULTS

Despite a challenging year in terms of claims utilisation and insurance expenses, Bonitas managed to grow revenue and membership numbers through affordable healthcare plans and a robust investment strategy.

Bonitas showed strong performance in 2024 with a net increase in membership figures of 2.3% (2023: -0.9%) and a consequent increase in insurance revenue to R20.9 billion (2023: R19.5 billion).

Insurance service expenditure increased by 10.2% (2023: 2.2%) and the amounts attributable to future members decreased from R265.3 million to R133.9 million.

The total value of our investment portfolio (excluding cash and cash equivalents) is R10.69 billion (2023: R10.21 billion). Our solvency level has decreased to 38.6% (2023: 41.5%) which is significantly higher than the 25% minimum required by the regulator.

GCR Ratings, a leading African rating agency, completed their annual review and retained Bonitas's rating at AA+ (2023: AA+), indicating that we:

- Have very strong creditworthiness
- Have very high credit quality relative to comparable entities
- Have very strong financial security characteristics
- Possess very low levels of risk and demonstrate low to moderate volatility

DRIVERS FOR FINANCIAL HEALTH

Membership growth and contributions	Bonitas enrolled 61 290 new members against a target of 52 667.	Cost-saving initiatives	Bonitas increased estimated savings through strategic purchasing and managed care initiatives to R901.1 million.
Investment performance	Return on investment of 13.4% which is well above the strategic target of CPI+3.5%.	Fraud, waste and abuse	FWA recoveries started slowing after previous years' gains and mitigation efforts, amounting to R46.2 million in reversals, recoveries and claim interventions.
Claims trends	Net claims incurred increased by a steep 11.2% compared to 4.1% in 2023, with much higher hospital admissions.	Reserves and contributions	Our solvency level decreased from 41.5% in 2023 to 38.6%, enabling Bonitas to limit contribution increases.

KEY INDICATORS

R133.9 million for amounts attributable to future members ¹ (2023: R265.3 million)	106.1% insurance expense ratio ² (2023: 102.6%)	38.6% solvency ratio (2023: 41.5%)	9.4% ratio of non-healthcare expenditure against insurance revenue ³ (2023: 9.3%)	Eight loss-making options (2023: five)
--	---	---	---	---

¹ In accordance with IFRS and recognising Bonitas as a mutual entity, amounts attributable to future members represent the excess over fair value for the current financial period.

² Insurance service expense as a percentage of insurance revenue.

³ Attributable, non-attributable and acquisition costs (previously non-healthcare expenditure) as a percentage of insurance revenue.

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2024

	Notes	2024 R'000	2023 R'000
Insurance revenue	15	20 888 306	19 461 328
Insurance service expense	15	(22 287 304)	(20 227 945)
Claims incurred	15.1	(20 091 944)	(18 066 419)
Third party claims recoveries	15.8	58 387	57 698
Changes that relate to past service – adjustments to the LIC	15.2	173 396	165 859
Insurance acquisition costs	15.3	(420 406)	(395 201)
Accredited managed healthcare services	15.4	(664 000)	(606 668)
Losses on onerous contracts and reversal of those losses	15	–	–
Attributable expenses incurred	15.5	(1 208 846)	(1 117 900)
Amounts attributable to future members*	15.6	(133 891)	(265 314)
Net income from risk transfer arrangements/reinsurance	15.7	433 320	315 574
An allocation of premiums paid		(1 951 687)	(1 879 274)
Amounts recovered from risk transfer arrangement/reinsurance		2 385 007	2 194 848
Insurance service result		(965 678)	(451 043)
Other income		1 416 216	865 105
Investment income – Scheme	16.1	1 385 696	829 915
Change in fair value of investment property	16.2	–	(3 500)
Loss on sale of investment property	6	(13 500)	–
Sundry income	17	44 020	38 690
Net insurance finance expenses		(84 852)	(70 838)
Finance expenses from insurance contracts issued – PMSA	12.4	(84 852)	(70 838)
Other expenditure		(365 686)	(343 224)
Administration fees and other operating expenses	18	(324 501)	(306 257)
Asset management fees		(35 669)	(31 714)
Interest expense	4.2	(322)	(531)
Operating expenses on rental of investment property	6	(5 194)	(4 722)
Net surplus/deficit for the year		–	–
Total comprehensive income for the year		–	–

* In accordance with IFRS 17 and recognising the Scheme as a mutual entity, amounts attributable to future members represents the net surplus earmarked for the future benefit of existing and future members realised in the current financial period.

MEMBERSHIP AND RISK CONTRIBUTION INCOME

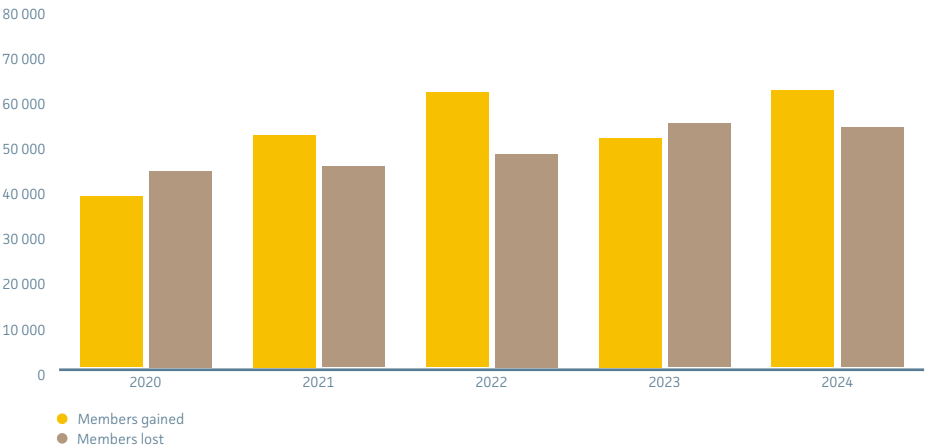
Bonitas enjoyed significant organic membership growth in 2024, with net membership (principal members) increasing by 2.3% to 358 717 (2023: 350 505) and total beneficiaries (lives covered) increasing by 2.1% to 731 576 (2023: 715 856).

Terminations improved year-on-year with 53 078 lost/terminated members (2023: 53 987), although this was higher than our target of 49 238 members. Overall, we retained 46% (2023: 37%) of total terminations against a target of 30% (2023: 30%).

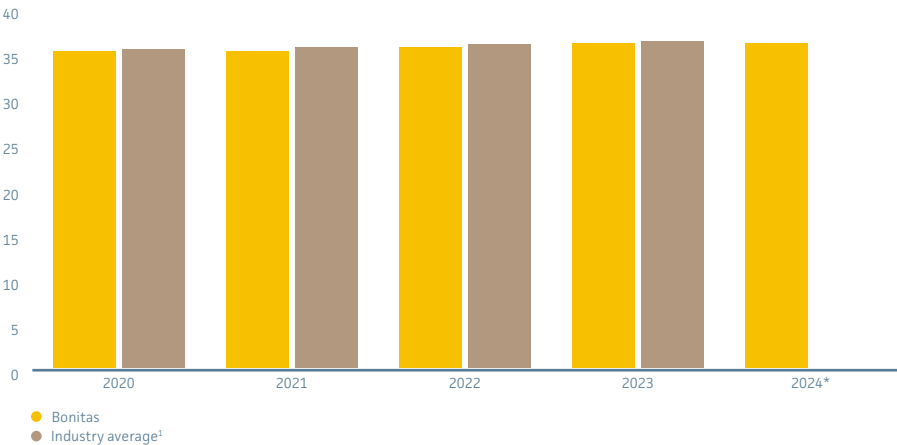
We also had several members buying up or down during the period December 2024 to January 2025, with 6 994 members moving to lower-cost plans (2023/24: 5 610) and 5 229 moving to higher-cost plans (2023/24: 5 355). The net buy-down of 1 765 members (2023/24: buy-down of 255) was against a target for a net buy-down of 1 729 members (the budgeted net buy-downs included an additional allowance of 6 492 buy-downs from the Primary option due to the network changes applied to this option with effect from 1 January 2025).

Bonitas's revenue grew by 7.3% (2023: 1.4%) as our net membership increased, exceeding our target of 5.6%. Risk contribution income ended the year at 95% (2023: 95%) and our membership profile continues to compare favourably to industry averages.

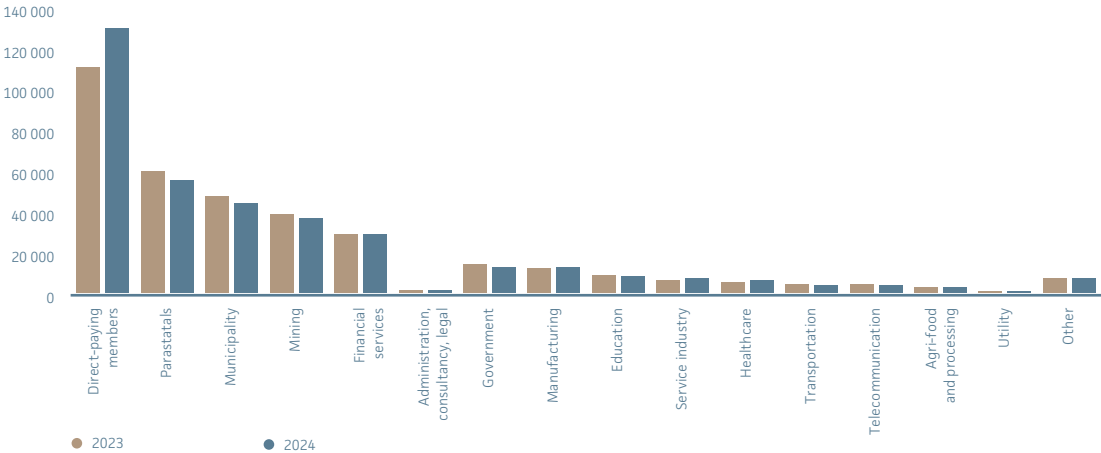
MEMBER RETENTION



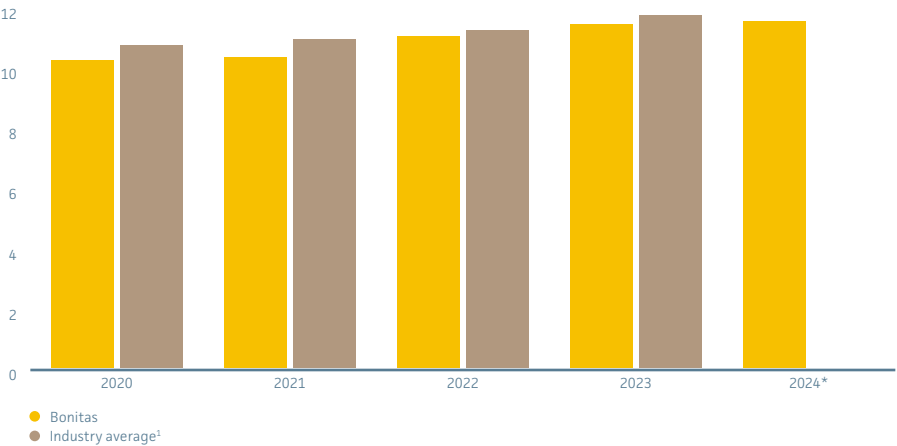
AVERAGE AGE OF BENEFICIARIES



MEMBERSHIP DISTRIBUTION BY INDUSTRY



PENSIONER RATIO



¹ Data based on CMS Industry Reports and refers to open medical schemes only.

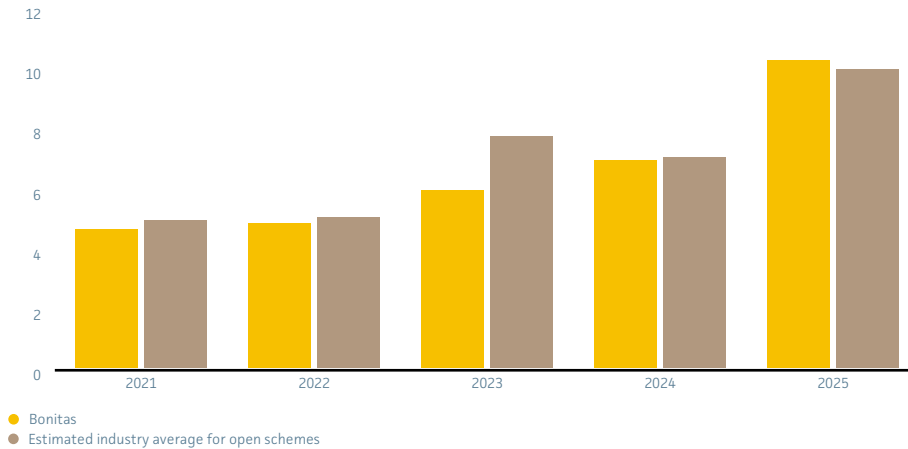
* 2024 industry number is not yet available.

HEALTHCARE PLAN PRICING AND AFFORDABILITY

We follow a rigorous product development process that considers healthcare trends, affordability for members, Bonitas's sustainability and pricing guidelines published by the CMS. We are also continuing our strategy to erode our reserves and solvency level by increasing benefits and ensuring that contribution increases are as low as possible.

The weighted average increase in membership contributions for 2025 is 10.2% (2024: 6.9%). The contribution increases range from 8.7% to 14.9% per healthcare plan, with the latter impacting only 1% of members. The weighted increase is higher than the increase of between 6.4% and 7.9% (4.4% plus 'reasonable' utilisation estimates) recommended by the CMS.

YEAR-ON-YEAR COMPARISON OF WEIGHTED CONTRIBUTION INCREASES (%)



Product development process

STATISTICAL ANALYSIS AND RESEARCH (JANUARY–APRIL 2024)

The Board Committees met to review and discuss statistical analyses, industry research and product scenarios. The following were considered:

- Market trends
- Membership trends and retention
- Performance of each healthcare plan
- Benefit utilisation patterns
- Chronic formulary
- Claims process
- Benefit Booster and wellness programme
- Customer touchpoints
- Key markets
- Corporate service delivery model
- Member education and communication
- Network alignment and short payments
- Value proposition
- Industry benchmarking
- International healthcare protocols

STAKEHOLDER ENGAGEMENT (MAY–JUNE 2024)

The Committees requested and considered input from a variety of stakeholders through independently commissioned research, including brokers, human resources representatives, corporates and local government.

Key focus areas emerging from the research included the need to further integrate managed care into product development, reduce member co-payments and ensure that healthcare plans are easy to understand.

BOARD APPROVAL (JULY–AUGUST 2024)

The Committees made a final recommendation to the Board on pricing and benefits for evaluation and approval. The following were considered:

- Full-year claims projection for 2024
- Claims and capitation fee estimates for 2025
- Other expenses such as administration and managed healthcare fees, and expected investment income
- Alignment to managed healthcare strategies
- Closing gaps identified during the analysis and research phase

Price increases were meticulously calculated by our actuaries, and the Board approved the 2025 pricing and benefits following a rigorous two-day review.

CMS APPROVAL (NOVEMBER 2024)

Proposed pricing and benefits were submitted to the CMS for approval. These may be communicated to agents, members and the media prior to CMS approval, subject to a disclaimer.

CLAIMS AND LOSS-MAKING OPTIONS

This year we had higher utilisation rates and claims ratios than anticipated. Traditional healthcare plans were impacted by abnormal events, particularly a high hospitalisation rate for upper respiratory tract infections and septicemia. We also ended the year with a 36.2% DPM ratio (2023: 31.5%), which had a negative effect on plans such as BonFit. We have eight loss-making options against a target of eight out of twelve (2023: five out of 12 against a target of seven).

Claims management is a regulatory compliance requirement, and internal audit plans focus on claims management as part of the combined assurance approach. Net claims incurred increased by 11.2% to R20.1 billion (2023: R18.1 billion) and the net claims ratio increased by 3.4% to 95.9% (2023: 92.5%)

The Fund experienced higher than expected general claims utilisation over the 2024 treatment year. This was driven by a few factors, including:

1. A more severe respiratory hospital admissions wave over April and May 2024 than expected, combined with higher than expected ICU- and High-care admissions rate for these respiratory admissions, leading to higher average costs per admission than expected;
2. An increase in the hospital admission rate for elective procedures, with the admission rate being higher than pre-COVID levels;
3. Significant increase in septicemia admissions as well as the associated costs.

Our largest claims categories for the year include:

- R8.1 billion hospital claims (2023: R7.2 billion)
- R2.6 billion medical specialists (2023: R2.3 billion)
- R1.0 billion day-to-day benefits (2023: R1.0 billion)
- R1.1 billion radiology (2023: R1.0 billion)
- R1.0 billion GPs (2023: R0.9 billion)
- R920.8 million pathology (2023: R811.1 million)

Bonitas closely monitors claims not paid within 30 days as these have a compliance impact. If a medical scheme does not make payment on a claim within 30 days after the day on which the account was submitted, and the member or provider has not been notified that the claim is erroneous or unacceptable for payment, then the member or provider is entitled to lodge a complaint with the CMS against the scheme.

We also monitor stale claims (claims not submitted within four months from the date of treatment). As per the MSA, after four months a scheme is responsible for paying a claim, but there is a risk that the scheme will then lose membership. Stale claims are closely monitored by the Audit and Risk Committee, and the implementation of remedial actions is tracking through internal audits and the Combined Assurance Forum.

INSURANCE EXPENDITURE

Insurance service expenses increased by 10.2% to R22.3 billion (R20.2 billion) and the insurance expense ratio ended the year on 106.1% (2023: 102.6%). Insurance revenue increased by 7.3% to R20.9 billion (2023: R19.5 billion).

The insurance service result excluding amounts attributable to future members increased to R1.1 billion deficit (2023: R716 million deficit) largely due to an increase in claims costs due to inflationary adjustments to hospital tariffs, increase in claims utilisation and increased burden of disease.

This year, cost savings were driven primarily through hospital negotiations. Overall, hospital costs per member per month (pmpm) increased by 6.6% to R1 843 (2023: R1 729 pmpm).

Accredited administration fees increased by 5.9% to R1.0 billion (2023: R954 million).

Our risk transfer agreements continue to yield benefits, with a net income of R433 million (2023: R315 million) across all arrangements.

Since 2023, PHA has taken on risks related to non-hospital claims on BonCap. While they reached their target of R41 million in 2023 they fell short of their target this year, realising a total savings of R42 million. We remain confident that this risk-sharing agreement is benefitting our members.

The ratio of non-healthcare expenditure against insurance revenue is 9.4% (2023: 9.3%).

Strategic purchasing and managed care initiatives realised an estimated reduction in healthcare costs of R901.1 million (2023: R745.2 million) which included R532 million (2023: R475 million) in hospital costs.

Savings in 2024 as a result of managed care programmes

Hospital negotiations	R532 million
Alternatives to hospitalisation	R100 million
Renal dialysis and networks	R60.3 million
High Risk Beneficiary Programme	R46 million
Pathology Management Programme	R33.3 million
Transitional Care Programme	R29 million
Specialist Outlier Engagement Programme	R21 million
Emerging Risk Beneficiary Programme	R17 million
Arthroplasty Programme	R12.1 million
Chronic medicine	R10.9 million
Integrated chronic care network	R10.4 million
Specialist network	R8.9 million
Oncology medicine and consumables	R8.5 million
Computed tomography (CT) angiogram	R7.4 million
Radiology discounts	R2.5 million
In-room procedures	R1.8 million
Total	R901.1 million

Attributable expenditure increased by 8.1% (2023: 4.3%).

Broker fees/insurance acquisition cash flows increased by 6.4% (2023: 3.5%) due to contribution, volume and price increase.

Third-party recoveries increased to R58.4 million (2023: R57.7 million) due to increase in recoveries from Mediclinic, Netcare and Life Healthcare related to settlement discounts.

In 2022, the Board resolved to dispose of our investment property, Bonitas Park. The property was sold in October 2024 for a total of R61.5 million and commission paid of R2.1 million.

FRAUD, WASTE AND ABUSE

For 2024, we invested R52 million (2023: R56 million) in the FWA programme with Medscheme and saw banked recoveries of R46.2 million (2023: R52.3 million). Although we did not reach the intended target of R47.5 million in 2024, we have realised an estimated saving of R1.2 billion (2023: R1.2 billion) from change in behaviour since the commencement of our FWA programme in 2016.

CONTRACT MANAGEMENT

Our contracts with service providers yielded good results this year and we achieved profits on two capitation agreements (when compared to estimated spending without capitation).

Sales, marketing and distribution services were moved from AfroCentric Distribution Services to Agile Alternative Business Solutions, providing us with customised solutions for member communication, marketing and onboarding. We also moved the courier services on some of our healthcare plans to Mara Health (Pty) Ltd to identify potential cost-savings and process efficiencies.

STATEMENT OF FINANCIAL POSITION

AS AT 31 DECEMBER 2024

	Notes	2024 R'000	2023 R'000
ASSETS			
Non-current assets			
Property and equipment	4	3 419	5 201
Investment properties	5	–	–
Financial assets held at fair value through profit or loss	7	5 932 586	4 757 012
		5 936 005	4 762 213
Current assets			
Investment property held for sale	6	–	72 700
Financial assets held at fair value through profit or loss	7	4 755 629	5 376 956
Reinsurance contract assets	13	95 384	86 198
Trade and other receivables	8	12 336	11 298
Cash and cash equivalents	9	848 715	767 601
		5 712 064	6 314 753
Total assets		11 648 069	11 076 966
LIABILITIES			
Non-current liabilities			
Lease liability	4.2	–	2 002
Long-term employee benefit obligation	10	2 927	–
Insurance liability for future members	11	9 029 093	8 895 202
		9 032 020	8 897 204
Current liabilities			
Insurance contract liabilities	12	2 583 210	2 126 489
Lease liability	4.2	2 405	2 730
Long-term employee benefit obligation	10	–	5 716
Trade and other payables	14	30 434	44 827
		2 616 049	2 179 762
Total liabilities		11 648 069	11 076 966

INVESTMENT PERFORMANCE

The investment strategy for 2023 was retained in 2024 with minor adjustments, and the portfolio was rebalanced in November 2024 with minor changes to strategic asset allocation. Our investment portfolio performed exceedingly well this year, and we achieved CPI+7.6% net of fees against a target of CPI+3.5%. These investment returns assisted Bonitas to offset some of the healthcare deficits experienced this year.

Investment income increased by 67% to R1.4 billion (2023: R830 million) and we achieved a return on investment of 13.4% (2023: 7.7%). We realised R642 million in fair value gains (2023: R148 million).

Asset managers performed well with 80% (2023: 56%) outperforming their benchmarks net of fees – among them Mergence Investment Managers, a black-owned asset management firm appointed in February 2024.

The market value of our investment portfolio, excluding cash and cash equivalents, stood at R 10.69 billion as at 31 December 2024 (2023: R10.21 billion) representing growth of 4.7% (2023: 2.4%).

AMOUNTS ATTRIBUTABLE TO FUTURE MEMBERS AND SOLVENCY RATIO

Amounts due to future members decreased to R134 million (2023: R265.3 million).

Reserves grew by 1.5% to R9.0 billion (R8.9 billion).

The solvency ratio has decreased to 38.6% (minimum required level of 25%) (2023: 41.5%) following strong membership growth of 2.3%.

CAPITAL MANAGEMENT

The Board's policy is to maintain a strong capital base to maintain investor, creditor and market confidence and sustain future growth. To assist us in achieving this objective, RisCura Solutions provides consulting on Bonitas's portfolio of investments and cash and cash equivalents.

We are required to maintain a minimum level of accumulated funds in terms of Regulation 29 of the MSA. 'Accumulated funds' is defined as Bonitas's net asset value, excluding funds set aside for specific purposes and unrealised non-distributable reserves. Accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review may not be less than 25.0%.

As per Regulation 29, cumulative net unrealised losses on remeasurement to fair value of investments and investment properties are excluded from the solvency calculation.

	2024 R'000	2023 R'000
Insurance Liability for future members	9 029 093	8 895 202
Adjusted for: Regulation 29 exclusion of unrealised gains on remeasurement of investments and investment property to fair value*	(543 800)	(421 318)
Accumulated funds per Regulation 29	8 485 293	8 473 884
Gross contributions (note 15)	22 003 483	20 435 010
Solvency ratio (%)	38.56%	41.47%
* Cumulative net (losses)/gains on remeasurement to fair value of investments are calculated as follows: At beginning of year	403 544	469 354
Movement in unrealised gains/(losses) on remeasurement to fair value of financial instruments included in accumulated funds (as per Regulation 29 of the Act)	140 256	(65 810)
At end of year	543 800	403 544
# Cumulative net gains on remeasurement to fair value of investment properties are calculated as follows: At beginning of year	17 774	21 274
Movement in unrealised losses on remeasurement to fair value of investment properties included in accumulated funds (as per Regulation 29 of the Act)	(17 774)	(3 500)
At end of year	–	17 774
Cumulative net gains on remeasurement of investments and investment property at the end of the year	543 800	421 318

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

LIABILITY FOR INCURRED CLAIMS

The best estimate liability for claims incurred but not yet reported (IBNR) for 2024 was R 1.10 billion (2023: R933 million) and risk adjustment was R151 million (2023: R145 million). This represents 6.2% (2023: 6.0%) of the claims expenditure (2022: 6.3%). Provisions have mainly been in the hospital and specialist categories.

The total of the best estimate provision for incurred claims including risk adjustment is R1.3 billion (2023: R1.1 billion). This is included in liability for incurred claims as part of insurance contract liabilities as per note 12 of the annual financial statements totalling R2.6 billion (2023: R2.1 billion).

The additional components of the liability for incurred claims comprise of the Personal Medical Savings Account (PMSA) liability of R1.4 billion (2023: R1.2 billion) and claims creditor of R254 million (2023: R118 million).

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 CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2024

	Notes	2024 R'000	2023 R'000
Cash flows from operating activities			
Cash receipts from members and providers		22 112 157	20 569 353
Cash receipts from members – contribution		21 967 054	20 408 915
Cash receipts from members and providers – other		145 103	160 438
Cash paid to providers, employees and members		(22 800 082)	(20 934 559)
Cash paid to providers and employees and members	20.1.5	(21 151 953)	(19 413 634)
Cash paid to providers and employees – non healthcare expenditure	20.1.6	(1 571 345)	(1 455 228)
Cash paid to members – savings plan refunds	12.4	(76 784)	(65 697)
Cash utilised in operating activities		(687 925)	(365 206)
Interest paid	12.4	(84 852)	(70 838)
Interest received	16.1	19 942	11 508
Net cash outflow from operating activities		(752 835)	(424 536)
Cash flows from investing activities			
Acquisition of property and equipment	4	(696)	(589)
Proceeds on disposal of investment property	6	61 500	–
Proceeds on disposal of property and equipment	17	–	12
Acquisition of financial assets held at fair value through profit or loss	7	(2 414 357)	(702 280)
Disposal of financial assets held at fair value through profit or loss	7	2 733 252	820 508
Interest received	20.1.1	290 231	255 038
Dividends received	20.1.2	192 703	195 628
Asset management fees paid	20.1.3	(35 359)	(30 437)
Rentals received	20.1.4	9 324	10 364
Net cash inflow from investing activities		836 598	548 243
Cash flows from financing activities			
Lease payments	4.2	(2 649)	(2 121)
Net cash outflow from financing activities		(2 649)	(2 121)
Net increase in cash and cash equivalents		81 114	121 586
Cash and cash equivalents at beginning of the year		767 601	646 015
Cash and cash equivalents at end of the year		848 715	767 601
Analysed as follows:			
Cash and cash equivalents	9	848 715	767 601
		848 715	767 601

FUTURE PERFORMANCE EXPECTATIONS

Looking ahead, we anticipate another challenging year as the South African population continues ageing, resulting in increased pressure on the healthcare system. We also expect a continued increase in the incidence of NCDs and are closely monitoring the resultant impact on mental health trends. Elective healthcare interventions are also set to continue post COVID-19.

As is evident in Bonitas's investment performance in 2024, our investment strategy remains sound and we retain our focus on preventative care and managed healthcare initiatives to help members be more proactive about health and wellness. We expect our managed care initiatives to assist with deficits on our loss-making options, and that we will realise further savings through collective bargaining on hospital tariffs.

A key focus in 2025 will be reviewing service provider agreements that are expiring. We will also work with service providers to establish FWA processes and targets that reflect the behaviour change we have realised to date.

Mr L Woodhouse

Chief Financial Officer (for the year ended 31 December 2024)

Ms V Rikhotso

Chief Financial Officer (appointed effective 1 February 2025)

22 April 2025

OPERATIONAL STATISTICS

Bonitas Medical Fund 2024	Consolidated total	Standard	BonSave	Primary	BonCap	Bon-Classic	BonComp	Bon-Essential	BonFit	Hospital Std	Bon-Complete	BonStart	BonStart Plus
Average number of members during the year (n)	356 713	95 359	41 155	97 818	53 857	7 070	3 686	13 445	18 616	3 688	7 217	9 309	5 493
Number of members at 31 December (n)	358 717	93 476	41 225	97 515	54 162	6 880	3 592	13 636	20 746	3 584	6 963	10 616	6 322
Average number of beneficiaries during the year (n)	727 946	200 202	95 330	224 519	78 367	11 939	6 030	30 024	41 452	6 597	13 598	10 310	9 577
Number of beneficiaries at 31 December (n)	731 576	196 376	95 584	224 141	78 893	11 573	5 851	30 427	46 220	6 391	13 115	11 850	11 155
Proportion of dependants at the end of the year (n)	1.04	1.10	1.32	1.30	0.46	0.68	0.63	1.23	1.23	0.78	0.88	0.12	0.76
Insurance revenue per average member per month (Rands)	4 880	7 508	4 110	4 556	2 075	8 195	11 323	3 615	3 006	4 806	6 726	1 527	2 587
Insurance revenue per average beneficiary per month (Rands)	2 391	3 576	1 774	1 985	1 426	4 853	6 921	1 619	1 350	2 687	3 570	1 379	1 484
Insurance service expense excluding amounts distributable to members per average beneficiary per month (Rands)	2 539	3 754	1 688	2 166	1 750	4 770	8 686	1 724	1 362	2 738	3 790	1 152	1 337
Relevant healthcare expenditure (Net claims incurred, Accredited managed healthcare services and Net income/(expense) from risk transfer arrangement/reinsurance) per average beneficiary per month (Rands)	2 300	3 450	1 480	1 965	1 519	4 256	8 402	1 535	1 185	2 480	3 489	995	1 219
Attributable insurance service expenses per average beneficiary per month (Rands)	138	152	136	134	105	189	195	135	138	179	170	137	86
Relevant healthcare expenditure ratio (Net claims incurred, Accredited managed healthcare services and Net income/(expense) from risk transfer arrangement/reinsurance) per average beneficiary per month as a percentage of insurance revenue (%)	96.2%	96.5%	83.4%	99.0%	106.5%	87.7%	121.4%	94.8%	87.8%	92.3%	97.7%	72.2%	87.0%
Attributable insurance service expenses (DAE) ratio as a percentage of insurance revenue (%)	5.8%	4.2%	7.7%	6.8%	7.4%	3.9%	2.8%	8.4%	10.2%	6.7%	4.8%	9.9%	4.8%
Insurance service expense ratio (excluding amounts distributable to members) as a percentage of insurance revenue (%)	106.1%	105.0%	95.1%	109.1%	122.7%	95.3%	125.5%	106.5%	100.8%	101.9%	106.2%	83.5%	95.5%
Non-attributable expenditure as a percentage of gross contributions (%)	1.5%	1.0%	1.4%	1.7%	3.7%	0.8%	0.5%	2.1%	2.2%	1.6%	1.0%	5.0%	3.1%
Attributable, non-attributable and acquisition costs (previously non-healthcare expenditure) as a percentage of risk contributions (%)	9.4%	6.6%	12.3%	10.8%	14.2%	5.7%	4.4%	13.2%	16.0%	10.7%	7.7%	18.2%	12.3%
Average beneficiary age (n)	35.9	42.1	32.5	31.9	36.1	56.0	57.7	37.4	29.1	51.2	47.6	35.2	27.3
Pensioner ratio at 31 December (%)	11.5%	18.3%	7.2%	6.1%	9.4%	44.5%	26.8%	12.9%	3.9%	32.9%	26.8%	4.0%	1.6%
Chronic profile at 31 December (%)	18.8%	31.0%	15.3%	14.8%	24.8%	52.5%	56.5%	12.1%	8.5%	22.1%	35.1%	5.0%	5.1%
Average amounts attributable to members (liability to members) per member at year-end (Rand)	2 098												

Bonitas Medical Fund 2023	Consolidated total	Standard	BonSave	Primary	BonCap	Bon- Classic	BonComp	Bon- Essential	BonFit	Hospital Std	Bon- Complete	BonStart	BonStart Plus
Average number of members during the year (n)	351 061	101 516	40 104	96 623	54 483	7 810	4 018	13 237	12 065	4 107	7 951	6 136	3 012
Number of members at 31 December (n)	350 505	99 642	39 578	96 492	54 298	7 566	3 935	13 340	13 198	3 985	7 773	7 113	3 585
Average number of beneficiaries during the year (n)	718 538	214 757	92 021	222 921	78 606	13 362	6 683	29 440	26 467	7 438	15 160	6 717	4 966
Number of beneficiaries at 31 December (n)	715 856	210 488	91 008	222 413	78 320	12 886	6 510	29 571	28 957	7 156	14 729	7 823	5 995
Proportion of dependants at the end of the year (n)	1.04	1.11	1.30	1.30	0.44	0.70	0.65	1.22	1.19	0.80	0.89	0.10	0.67
Insurance revenue per average member per month (rand)	4 620	6 858	3 814	4 223	1 923	7 377	10 238	3 324	2 891	4 408	6 077	1 461	2 257
Insurance revenue per average beneficiary per month (rand)	2 257	3 242	1 662	1 830	1 333	4 312	6 155	1 495	1 318	2 434	3 187	1 335	1 369
Insurance service expense excluding amounts distributable to future members per average beneficiary per month (rand)	2 315	3 312	1 555	1 873	1 594	4 368	7 386	1 597	1 178	2 427	3 328	961	1 113
Relevant healthcare expenditure ratio (net claims incurred, accredited managed healthcare services and net income/[expense] from risk transfer arrangement/reinsurance) per average beneficiary per month (rand)	2 103	3 051	1 377	1 687	1 381	4 072	7 184	1 430	1 010	2 199	3 072	813	1 000
Attributable insurance service expenses per average beneficiary per month (rand)	130	141	129	125	98	174	179	127	132	164	156	126	83
Relevant healthcare expenditure ratio (net claims incurred, accredited managed healthcare services and net income/[expense] from risk transfer arrangement/reinsurance) per average beneficiary per month as a percentage of insurance revenue (%)	93.2%	94.1%	82.9%	92.1%	103.6%	94.4%	116.7%	95.7%	76.6%	90.3%	96.4%	60.9%	73.1%
Attributable insurance service expenses (DAE) ratio as a percentage of insurance revenue (%)	5.7%	4.3%	7.8%	6.8%	7.4%	4.0%	2.9%	8.5%	10.0%	6.8%	4.9%	9.5%	6.1%
Insurance service expense ratio (excluding amounts distributable to members) as a percentage of insurance revenue (%)	102.6%	102.2%	93.6%	102.3%	119.6%	101.3%	120.0%	106.9%	89.4%	99.7%	104.4%	72.0%	81.3%
Non-attributable expenditure as a percentage of gross contributions (%)	1.5%	1.1%	1.5%	1.7%	3.8%	0.8%	0.6%	2.2%	2.1%	1.6%	1.0%	5.0%	3.2%
Attributable, non-attributable and acquisition costs (previously non-healthcare expenditure) as a percentage of risk contributions (%)	9.3%	6.9%	12.5%	11.0%	14.3%	6.0%	4.6%	13.4%	15.8%	10.7%	8.0%	17.6%	12.3%
Average beneficiary age (n)	35.9	41.2	32.3	31.4	36.1	54.8	56.8	36.8	29.3	50.2	46.5	34.2	27.4
Pensioner ratio at 31 December (%)	11.4%	16.8%	7.4%	5.7%	9.1%	41.7%	24.9%	12.7%	4.3%	31.1%	24.9%	3.3%	1.4%
Chronic profile at 31 December (%)	19.1%	29.1%	14.2%	13.6%	11.9%	49.9%	53.6%	11.7%	9.0%	21.2%	32.4%	4.7%	4.6%
Average amounts attributable to members (liability to members) per member at year-end (Rand)	2 115												

GOVERNANCE REPORT

BOARD OF TRUSTEES: PROFILES

TRUSTEES AS AT 31 DECEMBER 2024



MR OJ KOMANE (59) | Chairperson (Elected Trustee)

Mr OJ Komane is Independent Chairman of the Mineworkers Investment Trust, the 100% shareholder of the 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 and Engineering Services, and served two terms in the office as the Deputy General Secretary of the National Union of Mineworkers. He previously also held several positions on different boards of companies.

Appointed: 1 June 2021

First appointed as Trustee with effect 2 January 2016; appointed as Vice-Chairperson with effect 1 October 2017; appointed as Chairperson with effect 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; re-appointed as Chairperson with effect 21 September 2023; re-appointed as Chairperson with effect 18 September 2024.



MR R COWLIN (70) | Vice-Chairperson (Appointed Trustee)

Mr R Cowlin has over 36 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 10 years.

Appointed: 5 January 2021

Appointed as Vice-Chairperson with effect 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; re-appointed as Vice-Chairperson with effect 21 September 2023; re-appointed as Vice-Chairperson with effect 18 September 2024.



MR J BAGG (72) | (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) and appointed to the Bonitas Board pursuant to the amalgamation with LMS; re-appointed by the Board as a Trustee with effect 1 April 2019 as part of a casual vacancy (appointment was approved by the members at the AGM held on 19 August 2019); appointed as Vice-Chairperson with effect 4 December 2020; stepped down as Vice-Chairperson on 12 August 2022; Trustee term ended on 31 August 2022; appointed by the Board with effect 5 October 2022.



MR A EDWARDS (63) | (Elected Trustee)

Mr A Edwards has over 25 years' experience in financial services and private healthcare funding. He holds a Bachelor of Science in Human Physiology and a Postgraduate Higher Diploma in Education, which underpins his expertise in corporate wellness strategy, managed healthcare, clinical risk management, as well as sales, marketing and distribution.

During his decade-long tenure as Chief Executive of Liberty Medical Scheme, he served over 100 000 members and their families each year, demonstrating both ethical leadership and a deep understanding of healthcare economics. His executive roles in multibillion-rand medical schemes and private mergers further highlight his strategic acumen.

Today, Mr Edwards runs a successful coaching and consulting practice focused on executive coaching, resilience and corporate wellbeing – particularly addressing clinical burnout. This positions him as a trusted advisor to organisations and executives seeking sustainable growth and employee wellbeing.

Appointed: 1 April 2024

Appointed by the Board as a Trustee with effect 1 April 2024 as part of a casual vacancy (appointment was approved by the members at the AGM held on 21 August 2024, therefore regarded as an elected Trustee in terms of the Scheme Rules).



ADV RT MONENE (32) | (Elected Trustee)

Adv RT Monene completed her diploma in Law, LLB, and an additional module in Public International Law at the University of South Africa (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. 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



MR PJ RIBBENS (53) | (Elected Trustee)

Mr PJ Ribbens started his business in 1997 and has run it for the past 26 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 develops pricing strategies with the sales department. He has completed several Trustee training courses and is well-equipped to support the Board in terms of complex decision-making. He has served for several years on the Managed Healthcare and Investment Committees, and his experience in these areas assists him greatly in serving the Bonitas community.

Appointed: 1 July 2019

Re-elected with effect 17 July 2024.



MR MG NETSHISAULU (48) | (Elected Trustee)

Mr MG Netshisaulu holds an LLB and MCom in Taxation. He is a chartered tax advisor and a member of the Compliance Institute of South Africa. He gained extensive experience in the tax industry with the South African Revenue Service, 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 UNISA and serves as UNISA member of the Professional Research Committee. He also previously served as Nehawu Branch Chairperson and Deputy Chairperson.

Appointed: 1 September 2017

Re-elected with effect 9 September 2022.



MR JR VENTER (43) | (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 and has more than 16 years' ICT experience. Mr Venter is member-focused and drives SLA adherence from service providers thorough due diligence on contracts and value creation for members.

Appointed: 1 July 2019

Re-elected with effect 17 July 2024.

TRUSTEE MOVEMENTS



MR JD NGWANE | (Elected Trustee)

Mr JD Ngwane was employed by the National Union of Mineworkers as Unit Head: Social Benefits until his retirement on 31 December 2021. In recognition of his skills, the union renewed his term of Trusteeship in 2022 to the R33 billion Mineworkers Provident Fund up until 2025, and he was recently appointed as Chairperson of the Communications and Benefits Committee and is also a member of both the Audit and Risk Committee and Investment Committee. As part of his fiduciary duties at the Mineworkers Provident Fund, he assisted union-negotiated retirement funds to self-insure risk benefits, which ensures that profits which would traditionally accrue to underwriting service providers are instead reverted to members. He also assisted with medical aid comparisons across the mining industry to ensure that the selected options, benefits and costs are favourable to members and their families during difficult financial times.

Appointed: 1 July 2019

Appointed as Chairperson with effect 4 December 2020; stepped down as Chairperson on 28 September 2021; Trustee tenure ended 30 June 2024.



MS V RIKHOTSO | CA(SA) (Elected Trustee)

See profile information in Executive Management section below.

Appointed: 9 September 2022

Resigned as Trustee with effect 1 December 2024.



MR PS SOTSHANGANE | (Elected Trustee)

Mr PS Sotshangane completed his Grade 12 at Dumsie High in 2004 and had worked as Leaner Official at Sibanye Stillwater for the past 17 years. He held a Safety Management National Diploma from the Vaal University of Technology as well as a Mine Overseer Certificate. He also worked as national coordinator for the National Union of Mineworkers.

Appointed: 17 July 2024

Trustee term ended due to his untimely passing on 19 August 2024.

EXECUTIVE MANAGEMENT: PROFILES



MR LR CALLAKOPPEN (48) | 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 until recently served on the BHF Board and was Chair of the BHF Finance and Audit Committee.

Appointed: 1 May 2019



MS V RIKHOTSO (39) | Chief Financial Officer

Ms V Rikhotso is a chartered accountant registered with the South African Institute of Chartered Accountants. She has 16 years' experience in the public and private sectors with extensive leadership roles in risk, compliance and financial management. She played a vital role in establishing the financial services division within the Auditor-General of South Africa, serving as an audit manager for key entities including the Public Investment Corporation, Development Bank of Southern Africa and South African Revenue Service.

Prior to joining Bonitas, Ms Rikhotso held the position of Senior Specialist: Governance, Risk and Control at Transnet SOC Ltd. She was responsible for establishing and maintaining sustainably effective internal controls across the Transnet Corporate Centre operating division, identifying areas that require financial and operational improvements, and driving the development of appropriate models/solutions to sustainably address risks and compliance with applicable legislation.

She previously served on the Bonitas Board, where she was instrumental in providing strategic oversight and promoting financial stewardship.

Appointed: 1 February 2025



MR L WOODHOUSE (44) | Chief Financial Officer*

Mr L Woodhouse is a qualified chartered accountant (CA)SA and holds a BCompt (Hons) Accounting Science. He has over 14 years' experience in the healthcare sector, previously heading up finance and operational roles within the AfroCentric Group. He has a wealth of practical experience in managing technical finance matters relating to the medical scheme and healthcare industry.

Appointed: 1 October 2019

** Fixed-term contract as CFO ended 31 December 2024.*



MR S PERUMAL (50) | Chief Operations Officer**

Mr S Perumal holds an MBA (specialisation in Healthcare Management) from a reputable business school. He has been involved in the healthcare industry for the past 32 years and was employed by Medscheme and the AfroCentric Group in functions including I&T system support, business development and project leadership. Mr Perumal's passion for optimising business processes and improving operational efficiency led him to pursue a career in operations management. His expertise lies in analysing complex systems, identifying bottlenecks and implementing innovative solutions to drive efficiency and maximise performance. This is fuelled by his strong analytical skills and attention to detail.

Appointed: 1 January 2018

*** Promoted from Head of Operations to Chief Operations Officer (COO) with effect 1 January 2025.*



DR T HADEBE (41) | Clinical and Managed Care Executive

Dr T Hadebe is a qualified medical practitioner from Stellenbosch University. He also holds postgraduate qualifications, including in business studies and occupational health, and has a keen interest in global health matters. He has over 13 years' work experience in both the private and public healthcare sectors and has held numerous clinical managerial roles. Dr Hadebe's client-centred and value-based approach to healthcare ensures that he succeeds in his roles whilst delivering optimal healthcare to clients. He currently serves on the BHF Board.

Appointed: 6 November 2023

SENIOR MANAGEMENT: PROFILES



MS M MARAIS (45) | Head: Governance, Risk and Compliance

Ms M Marais holds a BCom (Financial Accounting) and BCom Honours (Internal Audit) from the University of Pretoria, and she is a qualified Certified Internal Auditor. Before joining Bonitas she was a Senior Manager in the Financial Services–Risk Assurance division at PwC. Ms Marais has over 22 years’ experience in internal audit, governance, compliance and risk management within the financial services sector, and more specifically the medical scheme and healthcare industry. She is a member of the Institute of Internal Auditors and through them has obtained certification in Risk Management Assurance.

Appointed: 15 October 2018



MS M MASILELA (44) | Scheme Secretary

Ms M Masilela holds a Professional Advanced Qualification in Governance and Administration, a Postgraduate Diploma in Management Practice from a reputable international business school, and Postgraduate Certificates in Company Law, Advanced Company Law, and Governance, Risk and Compliance from Wits University. Ms Masilela has over 21 years’ company secretarial experience working directly with Boards in the trade union environment, with nongovernmental healthcare organisations and in the medical schemes industry, and she specialises in Board administration, corporate governance, company law, compliance and King IV™.

Appointed: 14 February 2017

GOVERNANCE STRUCTURE AND PRACTICES

Bonitas is governed by an independent Board of Trustees that implements good governance principles and practices, provides oversight of financial and operational performance and ensures compliance with applicable laws and regulations.

Medical Schemes Act

All medical schemes in South Africa are governed by the MSA and related regulations (including the proposed Amendment Bill) which require 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
- Develop and adhere to Scheme Rules that are approved by and registered with the CMS

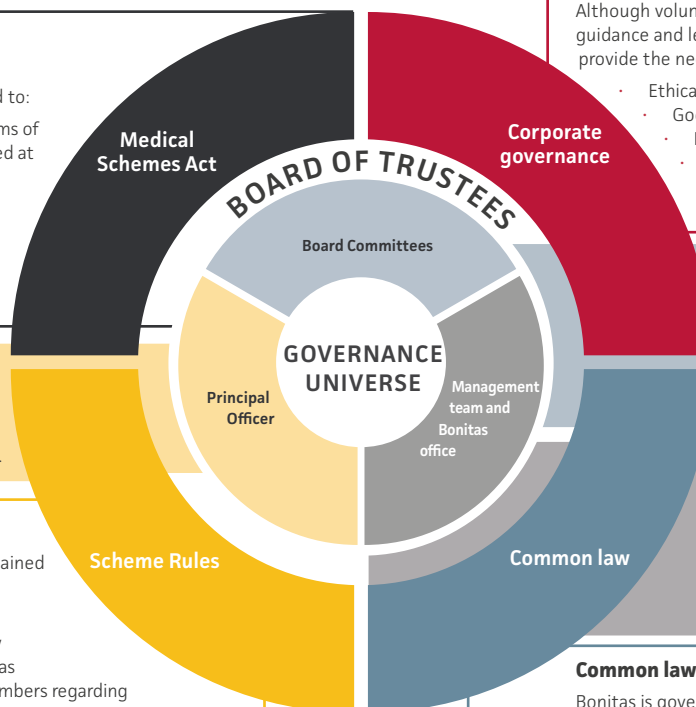
Principal Officer

The Principal Officer is appointed by the Board and must be fit and proper. The Principal Officer is responsible for Bonita's day-to-day management and is accountable for implementing strategy and any other decisions made by the Board.

Scheme Rules

Bonitas is governed according to Scheme Rules that are developed and maintained in accordance with the MSA, and approved by and registered with the CMS. Among others, these Rules require the Board to:

- Apply sound business principles and ensure Bonitas's financial sustainability
- Ensure that proper control systems are employed by and on behalf of Bonitas
- Ensure that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and duties



Corporate governance principles

Although voluntary for medical schemes, Bonitas subscribes to King IV™ for additional governance guidance and leading practice on good governance. King IV™ states that the Board is expected to provide the necessary leadership to realise the following governance outcomes for Bonitas:

- Ethical culture
- Good performance
- Effective control
- Legitimacy

See page 68 for more information on governance outcomes for Bonitas.

Board Committees

The Board is supported by five Board Committees to effectively fulfil its duties and responsibilities. These are the Audit and Risk Committee, Investment Committee, Managed Healthcare Committee, Remuneration Committee and Working and Strategy Committee. The Committees are mandated through defined charters and consist of Trustees and Independent Members.

Management team and Bonitas office

The Principal Officer is supported by the:

- Other members of the Executive Management team, namely the CFO, COO and the Clinical and Managed Care Executive
- Senior management team
- Other employees working at the Bonitas office

Common law

Bonitas is governed according to relevant common law principles such as fit and proper, public funds, position of trust, etc.

Board of Trustees

The Board is responsible for the proper and sound management of Bonitas, in the best interest of members, while safeguarding our long-term sustainability. It does this by providing direction, monitoring strategy implementation, guiding decision-making and adhering to the governing legislation and regulation of a medical scheme, including corporate governance principles.

Trustees are either elected by our members or appointed by the Board and must possess the required skills and capabilities to benefit Bonitas in their oversight role.

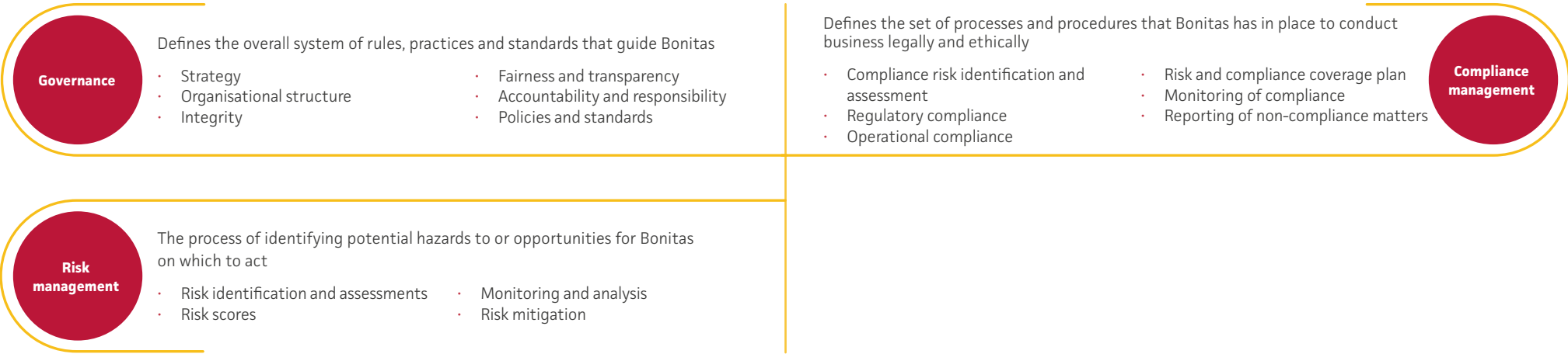
In terms of Scheme Rules, Trustees must be fit and proper and must be duly elected for a five-year term. The Board can appoint a maximum of three Trustees (see page 70).

- 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 Bonitas Board is committed to leading ethically and effectively and promoting the qualities of integrity, competence, responsibility, accountability, fairness and transparency.

CORE ELEMENTS OF OUR GOVERNANCE SYSTEM

Bonitas’s governance structures and processes are described in the Bonitas GRC Framework, which has been developed in line with the requirements of the MSA, Scheme Rules and King IV™. The Framework is implemented according to the following three functions and accountabilities:



GOVERNANCE OUTCOMES

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

Outcome	Bonitas practices and principles	Board focus areas
Ethical culture	• Bonitas and the Board promote an ethical environment in which employees, Trustees and Independent Members are encouraged to report violations, cooperate with investigations and seek advice when facing a difficult situation. See page 39 for information on FWA reporting and our Whistle Blowers hotline. • Ethics and professional conduct are governed by the following codes, each of which must be acknowledged annually by the target audience: • Code of Ethics and Professional Conduct – Trustees and Independent Members • Code of Ethics and Professional Conduct – Executives and Employees • Bonitas’s 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.	• Ensure that all actions and decisions are in the best interest of members

Outcome	Bonitas practices and principles	Board focus areas
Good performance	- 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 conducts a formal annual strategy review to assess the relevance of and progress against Bonitas's strategic pillars. - The Board approves targets for specific strategic indicators, including non-financial aspects. These targets form part of the approved annual Organisational Performance Matrix, which determines employee performance objectives and is implemented according to the Performance Management and Incentive Policies. - The Board ensures regular and transparent performance reporting to members through the AGM and integrated reports.	- Maintain financial sustainability to ensure that members' healthcare costs are covered - Drive membership growth and retention - Promote healthcare affordability, cost efficiency and accessibility - Educate and empower members in terms of healthcare
Effective control	Bonitas has a Combined Assurance Framework that applies the four layers of defence governance model (see page 80). This enables 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.	- Ensure consistent and sustainable business operations that adhere to the following: - Agreed strategy and risk appetite/tolerance - Agreed business objectives - Agreed policies and processes - Applicable laws and regulations
Legitimacy	- Bonitas exists to serve our members and therefore we must maintain their trust and respond to the legitimate concerns of all our stakeholders. See page 8 for more on the nature of our relationships and outcomes of engagements. - We aim to enhance the healthcare ecosystem and psychosocial landscape for all South Africans. In 2024 this included the following : - Extending cost-effective and specialised support and care offerings - Promoting preventative care for improved health and wellbeing - Simplifying the road to health and wellness - Growing our corporate membership base through affordable and integrated solutions - Providing affordable and holistic mental health solutions - Promoting transparency and good governance - Contributing to an affordable and sustainable South African healthcare ecosystem - Promoting universal healthcare - We do not sponsor political parties or entities involved in extreme sports that are controversial or disruptive. - We offer learnerships related to business administration and wealth management and aim to facilitate the placement of learners in permanent employment positions upon completion of their studies. This year, Bonitas hosted three learners on learnerships, all of whom obtained their qualifications in November 2024. One learner was appointed by Bonitas and another was appointed by a Bonitas service provider.	- Promote corporate responsibility and position Bonitas effectively as a good corporate citizen - Effectively incorporate environmental, social and governance (ESG) from an investment and Bonitas perspective, with a particular focus on the SDGs we have identified as part of our value creation model (see page 17)

BOARD COMPOSITION

The Board is responsible for ensuring that Bonitas operates in the best interest of members and maintains long-term sustainability. The Board operates in accordance with a Board Charter that sets out its roles, responsibilities and key governance requirements.

The Board can appoint a maximum of three Trustees without undergoing elections. Such an appointed Trustee must be a member of Bonitas 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.

As at 31 December 2024, the Board consisted of eight Trustees: six elected by members and two appointed by the Board. The following changes were made to the Board composition this year:

- Mr A Edwards was appointed to the Board on 1 April 2024 to fill the casual vacancy that arose after the resignation of Dr PW Hill in October 2023. As per Scheme Rules, the tenure associated with Mr A Edwards's incumbency will end on 31 May 2026, which is the unexpired period of office of Dr PW Hill. Thereafter he will be eligible for election or appointment to the Board. Members voted in favour of Mr A Edwards's appointment to the Board at the AGM on 21 August 2024, and he is therefore regarded as an elected Trustee in terms of the Scheme Rules.
- Mr PJ Ribbens and Mr JR Venter were re-elected to the Board for a second term during the SGM held on 3 July 2024, effective 17 July 2024.
- During the SGM held on 3 July 2024, Mr PS Sotshangane was elected to serve his first term as a Trustee effective 17 July 2024 but he tragically passed away on 19 August 2024.
- Ms V Rikhotso resigned as Trustee effective 1 December 2024.

All current Trustees are Bonitas members.

The Board aims to ensure that Trustees have the appropriate skills and experience to effectively govern Bonitas and strives for both racial and gender diversity in order to adequately represent all South Africans.

BOARD AND EXECUTIVE MANAGEMENT SKILLS PROFILE

Skills	Trustees as at 31 December 2024								Trustees movements			Executive Management				
	Mr J Bagg	Mr R Cowlin	Mr A Edwards ¹	Mr OJ Komane	Adv RT Monene	Mr MG Netshisaulu	Mr PJ Ribbens	Mr JR Venter	Mr JD Ngwane ²	Ms V Rikhotso ³	Mr PS Sotshangane ⁴	Mr LR Callakoppen	Ms V Rikhotso ⁵	Dr T Hadebe	Mr L Woodhouse ⁶	Mr S Perumal ⁷
Corporate governance	✓	✓	✓	✓		✓		✓		✓	✓	✓	✓	✓	✓	✓
Medical and retirement funds	✓	✓	✓						✓			✓		✓	✓	✓
Strategy		✓	✓	✓		✓	✓			✓		✓	✓	✓	✓	✓
Financial management	✓	✓	✓			✓	✓	✓		✓		✓	✓		✓	✓
Business development		✓	✓				✓	✓				✓				✓
Law					✓	✓										
Marketing		✓	✓				✓									✓
Taxation						✓				✓			✓		✓	
Skills development	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓		✓	✓	✓
Clinical		✓	✓											✓		
Actuarial science	✓															
Leadership	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
I&T								✓								✓

¹ Appointed by the Board as a Trustee with effect 1 April 2024 as part of a casual vacancy (appointment was approved by the members at the AGM held on 21 August 2024 and he is therefore regarded as an elected Trustee in terms of the Scheme Rules).

² Trustee term ended 30 June 2024.

³ Resigned as Trustee with effect 1 December 2024.

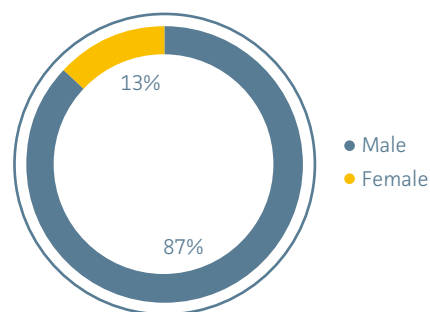
⁴ Trustee term ended due to his untimely passing on 19 August 2024.

⁵ Appointed as CFO with effect 1 February 2025.

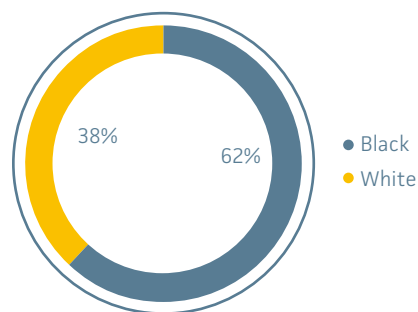
⁶ Fixed-term contract as CFO ended 31 December 2024.

⁷ Promotion from Head of Operations to COO with effect 1 January 2025.

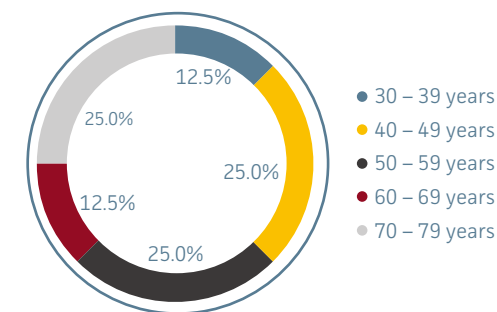
GENDER PROFILE AS AT 31 DECEMBER 2024



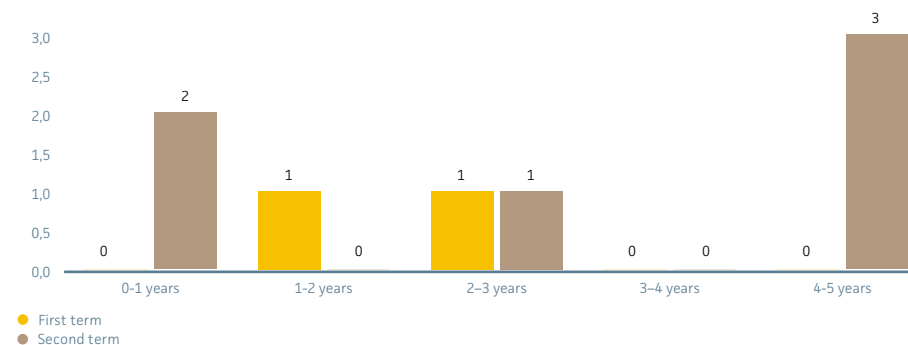
RACE PROFILE AS AT 31 DECEMBER 2024



AGE PROFILE AS AT 31 DECEMBER 2024



TENURE AS BOARD MEMBER





 In line with King IV™, independent performance assessments of the Board and its Committees are conducted biennially to evaluate the effectiveness of their performance against accepted good corporate governance principles and standards. The next assessment is scheduled for 2025 and will cover the 2023 and 2024 financial years.



KEY BOARD AREAS OF OVERSIGHT

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

Financial

- Evaluated financial performance, including going concern status, loss-making options, unknown and unclaimed deposits, stale claims, the claims ratio, and provision for IBNR claims.
- Approved the annual financial statements and Board of Trustees report, including the Arm's Length Assertion.
- Approved the Bonitas Investment Strategy and Policy and the rebalancing of the investment portfolio.
- Reviewed financial forecasts and approved the 2025 budget.
- Appointed the external auditor and approved the audit fee.
- Tracked performance, and determined remuneration increases and incentives against the Organisational Performance Matrix.
- Oversaw Bonitas's adoption of the IFRS accounting standard.
- Approved yearly fee increases for service providers.
- Participated in the Investment Committee workshop in February 2024.

Operational

- Reviewed the product development process, and considered and approved the pricing and benefit option design for 2025.
- Tracked membership numbers, membership trends, claims history and projections.
- Monitored engagements regarding potential amalgamations.
- Monitored the sale of the Bonitas Park property.

Stakeholders

- Arranged the virtual AGM, including online voting, with a particular focus on ensuring inclusivity and maximum participation by members.
- Monitored the performance of and engagement with key service providers.
- Approved contract renewals and monitored the process of procuring new service providers.
- Monitored resignations, recruitment and selection – both at Bonitas and at key service providers – to ensure that positions are suitably filled, and that institutional knowledge is retained.

Governance

- Scrutinised reports from the Board Committees, and approved their priorities and workplans.
- Approved revised policies, the Board Charter and Charters for the Board Committees.
- Approved appointments to the Board and its Committees as follows:
 - Mr OJ Komane and Mr R Cowlin were re-appointed as Chairperson and Vice-Chairperson of the Board respectively with effect from 18 September 2024.
 - Mr PJ Ribbens and Mr JR Venter were re-elected to the Board for a second term with effect from 3 July 2024.
 - Mr A Edwards was appointed as a Trustee with effect from 1 April 2024 to fill the casual vacancy that arose after the resignation of Dr PW Hill in October 2023.
 - Prof DP van der Nest's tenure as Chairperson of the Audit and Risk Committee was extended by one year with effect from 1 August 2024.
 - Mr T Poho and Prof DP van der Nest's tenures as Independent Members of the Audit and Risk Committee were extended by five years with effect from 1 August 2024.
 - Mr T Bikitsha was appointed as an Independent Member of the Investment Committee with effect from 1 December 2024.

Strategy, people and performance

- Approved the 2024 Organisational Performance Matrix.
- Reviewed and approved the Principal Officer's performance rating.
- Approved employee salary increases, the short-term incentive allocation and long-term incentive formulae.
- Approved the appointment of Ms V Rikhotso as the CFO with effect from 1 February 2025, and the promotion of Mr S Perumal to COO with effect from 1 January 2025.
- Evaluated key service provider contracts.
- Introduced a revised corporate growth strategy which included the appointment of a new sales and marketing service provider.

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.
- Considered updates on legal proceedings.

KEY GOVERNANCE DECISIONS AND DELIBERATIONS FOR 2024

AGM, SGM and governance appointments

The Bonitas AGM was held on 21 August 2024, in line with the Scheme Rules and in compliance with CMS guidelines. An extensive engagement strategy was deployed to drive member awareness and increase participation, and over 180 members were in attendance via the Live Streaming Webcast platform. PwC was appointed as the independent oversight body.

Members voted on four resolutions:

- Resolution 1: Appoint Deloitte as the auditor for 2024 [members voted in favour]
- Resolution 2.1: Trustee Remuneration Policy – Increase the fees of the Chairperson of the Board above the CPI rate [members voted against so the fees defaulted to a CPI increase]
- Resolution 2.2: Trustee Remuneration Policy – Increase the fees of Trustee members of the Managed Healthcare Committee above the CPI rate [members voted against so the fees defaulted to a CPI increase]
- Resolution 3: Approve the appointment of Mr A Edwards to the Board [members voted in favour]

An SGM was held on 3 July 2024 and PwC again acted as the independent oversight body. The purpose of the SGM was to conduct the voting of three members onto the Board, and the following members were duly appointed:

- Mr PJ Ribbens, who was also appointed to the Managed Healthcare Committee and Investment Committee
- Mr JR Venter, who was also appointed to the Audit and Risk Committee
- Mr PS Sotshangane, who sadly passed away on 19 August 2024

It is our conclusion that the 2024 Trustee elections were carried out in accordance with the relevant and applicable Scheme Rules and the MSA.

Corporate service delivery model

In 2023, the Board oversaw an evaluation of the Bonitas business model aimed at driving membership growth in the corporate environment while addressing retention risk. The following emerged as key focus areas:

- Increase corporate membership relative to DPMs
- Improve the ease of doing business with Bonitas, with a particular focus on the activation and onboarding of new members
- Implement clear and integrated digital, marketing and communication strategies to ensure consistency across all touchpoints and improve stakeholder relationships
- Ensure a high-quality Bonitas experience through competitive, value-added product and service solutions and a total quality management approach
- Secure and manage data to enable insightful data analytics that improve decision-making, innovation and members' experience

This year, the Board approved an integrated corporate service delivery model to address these focus areas. The model is owned and overseen by the Board, driven by the Bonitas Executive Management team, and executed by a dedicated service provider.

Social and ethics responsibilities

King IV recommends that all organisations should ensure governance of their social and ethical performance. This responsibility can be performed by the governing body, assigned to a dedicated committee or added to the responsibilities of an existing committee.

The Board considered these recommendations as well as Bonitas's current governance structure and the cost implications of establishing a new Board Committee, and decided as follow:

- The governance of social and ethics performance remains the responsibility of the Board.
- Responsibilities regarding oversight of and reporting on organisational ethics, responsible corporate citizenship, sustainable development and stakeholder relationships have been added to the mandate of the Working and Strategy Committee, given that some of these responsibilities already sit within the Committee's mandate and the Committee's composition aligns with King IV's recommendation.

Policy approvals

The Board reviewed and approved several policies, charters and strategy documents to provide for ongoing process enhancements and an effective governance and control environment. These include:

- Board Charter and all Board Committee Charters
- Business Continuity Management and Disaster Recovery Policy and Plan
- Code of Ethics and Professional Conduct – Executives and Employees
- Code of Ethics and Professional Conduct – Trustees and Independent Members
- Combined Assurance Framework
- Conflict of Interest Policy
- Credit Control Policy
- Delegation of Authority
- Employee Remuneration Policy
- Fraud, Waste and Abuse Policy
- GRC Framework
- I&T Governance Charter and Framework
- Impairment Policy
- Incentive Scheme Policy
- Investment Policy Statement
- Petty Cash and Travel Cards Policy
- Procurement and Contract Management Policy
- Recruitment, Selection and Appointment Policy
- Risk Management Policy
- Trustee Remuneration Policy

MEETING ATTENDANCE

The schedule below summarises mandatory Board and Board Committee meetings held during 2024.¹ This includes special meetings and attendance by invitation.

Trustee and/or Independent Member	Board	Audit and Risk Committee	Investment Committee	Managed Healthcare Committee	Remuneration Committee	Working and Strategy Committee
Number of meetings	15 (including 2 days' workshop and 4 special meetings)	6	6 (including 1 workshop and 1 special meeting)	10 (including 1 special meeting and 2 workshops)	5 (including 1 special meeting)	10 (including 2 special meetings)
Mr J Bagg	15/15	2/2	6/6	2/2		10/10
Mr T Bikitssha*						
Dr YO Carrim				10/10		
Mr R Cowlin**	15/15		6/6	10/10		10/10
Mr A Edwards***	12/12			7/7		
Ms P Kekana	2/2				5/5	
Ms W Kirima			6/6			
Mr OJ Komane^	15/15	6/6	6/6	10/10	5/5	10/10
Adv RT Monene	15/15		1/1		5/5	
Ms D Msomi^^					2/2	
Mr MG Netshisaulu	15/15		1/1		5/5	10/10
Mr JD Ngwane^^^	7/7		1/1			
Ms S Padayachy		6/6				
Mr T Poho*^		6/6				
Mr PJ Ribbens#	15/15		6/6	10/10		
Ms V Rikhotso*^^^	15/15	6/6	1/1	2/2		10/10
Mr PS Sotshangane^*	2/2					
Prof DP van der Nest^**	2/2	6/6				
Mr C van Zyl^***			3/3		3/3	
Mr JR Venter#	15/15	6/6	1/1	2/2		

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

* Appointed as Independent Member of the Investment Committee with effect from 1 December 2024.

** Re-appointed as Vice-Chairperson of the Board with effect from 18 September 2024.

*** Appointed as Trustee with effect from 1 April 2024 to fill the casual vacancy that arose after the resignation of Dr PW Hill in October 2023.

^ Re-appointed as Chairperson of the Board with effect from 18 September 2024.

^^ Appointed to the Remuneration Committee with effect from 1 July 2024.

^^^ Trustee term ended 30 June 2024.

*^ Tenure as Independent Member of the Audit and Risk Committee extended by five years with effect from 1 August 2024.

*^^^ Resigned from the Board with effect from 1 December 2024.

^* Elected to the Board with effect from 17 July 2024 and passed away on 19 August 2024.

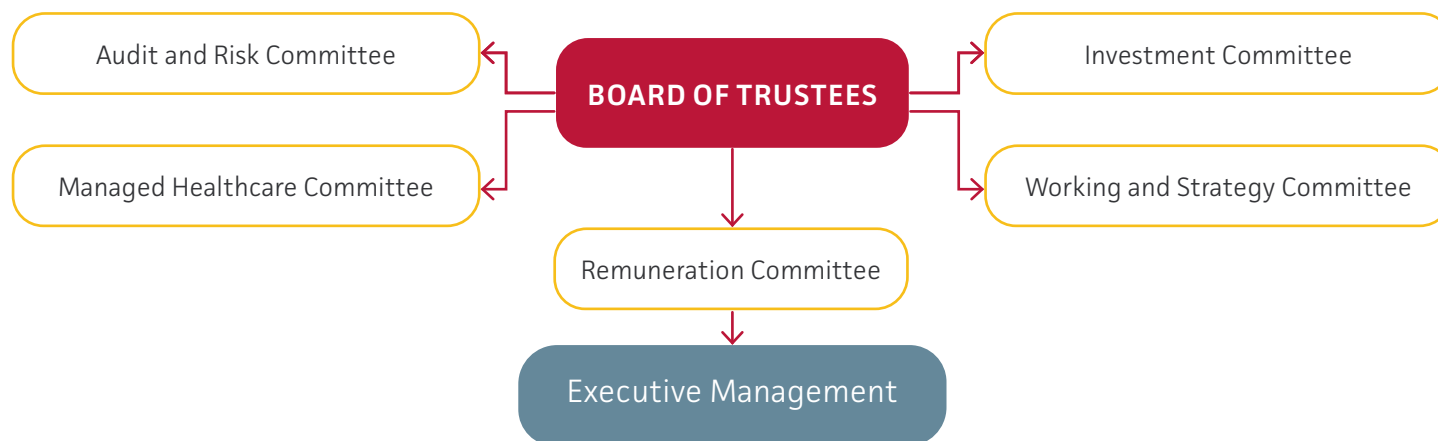
^** Tenure as Chairperson of the Audit and Risk Committee extended by one year with effect from 1 August 2024; tenure as Independent Member of the Audit and Risk Committee extended by five years with effect from 1 August 2024.

^*** Passed away in April 2024.

Re-elected to the Board for a second term with effect from 17 July 2024.

BOARD COMMITTEES AND ACTIVITIES FOR 2024

The Board is assisted by five Committees consisting of Trustees and Independent Members. The Board and Committees reviewed their performance in terms of their respective mandates and were satisfied that they 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. This 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 GRC functions
- Provision of advice on any matter referred to the Committee by the Board

KEY ACTIVITIES FOR 2024

- Assessed financial and investment performance
- Provided oversight of risk management and compliance reporting
- Oversaw the internal and external audit plans, processes and reports
- Monitored the audit and risk processes of key service providers and followed up on related assessments, reports, action plans and commitments
- Conducted a thorough risk analysis of Bonitas's medium- and long-term strategy
- Oversaw I&T governance matters, processes and reports, particularly the safekeeping of member information
- Provided oversight of combined assurance reporting and approved the revised Combined Assurance Framework.
- Considered all matters relating to ethics, contracts and SLAs, legal matters and litigation, FWA and non-compliance with laws and regulations
- Recommended the following to the Board for approval: Audited annual financial statements and related disclosures (including the report of the Board), external audit plan and fees, external auditors' report, going concern status, IBNR methodology, updated Committee Charter, and updated policies, i.e. Risk Management Policy, Credit Control Policy, Impairment Policy, GRC Framework, and Petty Cash and Travel Card Policy.

IMPORTANT DISCLOSURES

The Audit and Risk Committee has assessed and is satisfied that our external auditor, Deloitte, is sufficiently independent of Bonitas. Bonitas conducted a procurement process for external audits as the previous contract expired at the end of 2024, after the completion of the procurement process, Deloitte was the winning bidder. The Committee recommended the appointment of the external auditor for the 2024 financial year to the Board and members at the AGM, where it was approved. The provision of non-audit services by the external auditor is limited and any such request must be approved by the Committee with the required motivation and guarantees of independence. The 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, partner rotation contributed to this. The Committee has reviewed the financial statements and received assurance on key figures, including liability for incurred claims (IBNR claims). The Committee received the external audit report from Deloitte as well as the management representation letter. The Committee is comfortable with the assurance provided, the quality of the audit work conducted and the un-modified audit report.

Bonitas has an outsourced internal audit function that is provided by PwC. The Committee approved a risk-based coverage plan that was completed for the financial year and is satisfied with the assurance provided by the internal auditor. An annual internal audit effectiveness assessment on the outsourced internal auditor was conducted and the results were satisfactory. The Committee has received assurance on the quality of the system of internal control. The GRC 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 Committee as part of the assurance required.

Notable fraudulent activities conducted by an employee of the administrator were identified and reported for 2024. A criminal case is still under investigation.

The Committee is satisfied with the capacity and skills of the finance function and the CFO. The annual assessment of the CFO's performance was conducted, and the results were satisfactory.

Members as at 31 December 2024	Capacity	Member since
Prof DP van der Nest*	Independent Member (Chairperson)	1 August 2019
Mr MG Netshisaulu**	Trustee Member	28 January 2025
Ms S Padayachy	Independent Member	6 February 2023
Mr T Poho***	Independent Member	1 August 2019
Ms V Rikhotso^	Trustee Member	5 October 2022
Mr JR Venter^^	Trustee Member	1 August 2019

* Appointed as Chairperson of the Committee with effect from 1 February 2021; appointment as Chairperson was extended from 1 August 2022 to 31 July 2023, 1 August 2023 to 31 July 2024, and 1 August 2024 to 31 July 2025; tenure as Independent Member extended by five years with effect from 1 August 2024.

** Appointed to ARC effective 28 January 2025.

*** Tenure as Independent Member extended by five years with effect from 1 August 2024.

^ Resigned as Trustee of the Board effective 1 December 2024.

^^ Re-appointed to the Committee with effect from 16 August 2024.

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 interest.

KEY ACTIVITIES FOR 2024

- Conducted an Investment Committee workshop in February 2024 to revisit the strategic asset allocation
- Developed and recommended the investment strategy for 2024 following consideration of market and economic developments and trends, as well as Bonitas's overall strategy
- Reviewed Bonitas's investment mandates, strategic asset allocations, expected risks and returns, and financial position
- Discussed Bonitas's response to the investment constraints in Regulation 30 of the MSA, which does not permit medical schemes to hold foreign equities exceeding 2.5% of their investment portfolio (in comparison, the Pension Funds Act permits pension funds to invest 45% offshore)
- Scrutinised the performance of Bonitas's investments, investment consultant and asset managers, and negotiated favourable fees with service providers
- Scrutinised asset managers' due diligence processes
- Recommended an updated Investment Committee Charter and Investment Policy Statement to the Board for approval

Members as at 31 December 2024	Capacity	Member since
Mr R Cowlin*	Trustee Member (Chairperson)	30 June 2016
Mr J Bagg**	Trustee Member	15 October 2016
Mr T Bikitsha***	Independent Member	1 December 2024
Ms W Kirima^	Independent Member	1 June 2014
Mr PJ Ribbens^^	Trustee Member	16 November 2019
Mr C van Zyl^^^	Independent Member	1 July 2016

* Trustee term ended on 4 January 2021 and appointed by the Board with effect from 5 January 2021; re-appointed by the Board to the Committee with effect from 5 January 2021.

** 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 Committee with effect from 27 October 2022.

*** Appointed as Independent Member with effect from 1 December 2024.

^ Re-appointed as Independent Member for another term with effect from 1 June 2020.

^^ Re-appointed to the Committee with effect from 16 August 2024.

^^^ Passed away in April 2024.

Managed Healthcare Committee

MANDATE

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

KEY ACTIVITIES FOR 2024

- Monitored the changing healthcare environment and provided advice to the Board on the implications for Bonitas
- Conducted a workshop in February 2024 to consider the performance of healthcare plans and disease management programmes, identify gaps and recommend solutions
- Implemented and evaluated outcomes-based measures through service provider performance audits and analytical reviews
- Reviewed the strategies and operational plans of key service providers, particularly from a managed healthcare organisation perspective
- Considered fee increases and expiring contracts, and recommended renewal or extension where appropriate
- Monitored the results of pilot programmes and recommended new managed care programmes to the Board
- Discussed 2025 healthcare plans and pricing
- Monitored membership and financial data, and loss-making options, to ensure the ongoing relevance of managed care interventions
- Recommended an updated Managed Healthcare Committee Charter to the Board for approval.

Members as at 31 December 2024	Capacity	Member since
Mr R Cowlin*	Trustee Member (Chairperson)	16 July 2020
Dr YO Carrim	Independent Member	5 October 2022
Mr A Edwards**	Trustee Member	19 April 2024
Mr PJ Ribbens***	Trustee Member	16 July 2020

* Trustee term ended 4 January 2021 and appointed by the Board with effect from 5 January 2021; re-appointed by the Board to the Committee with effect from 5 January 2021.

** Appointed to the Committee with effect from 19 April 2024.

*** Re-appointed to the Committee with effect from 16 August 2024.

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 2024

- Engaged with independent consultants regarding market-related data and benchmarking to be used in reviewing remuneration practices
- Recommended employee grade weighting adjustments following benchmarking research
- Considered and recommended annual employee salary increases and the overall short-term incentive amount on the basis of the Organisational Performance Score, employee performance scores, affordability, and salary benchmark source data and comparison ratios
- Made recommendations regarding the next cycle of the long-term incentive scheme
- Recommended updates to Chairperson and Trustee remuneration where appropriate
- Discussed succession planning for key roles, as well as progress regarding the learnerships offered by Bonitas
- Reviewed Bonitas's Remuneration Strategy and Philosophy
- Reviewed the learning and development budget and planned training for the year.
- Recommended the following updated policies to the Board for approval: Employee Remuneration Policy, Incentive Scheme Policy, Remuneration Committee Charter and Trustee Remuneration Policy.

Members as at 31 December 2024	Capacity	Member since
Ms P Kekana*	Independent Member (Chairperson)	2 January 2016
Mr A Edwards**	Trustee Member	28 January 2025
Adv RT Monene	Trustee Member	5 October 2022
Ms D Msomi***	Independent Member	1 July 2024
Mr MG M Netshisaulu^	Trustee Member	16 July 2020
Mr C van Zyl^^	Independent Member	1 March 2018

* Appointed as Chairperson 1 October 2017; re-appointed as Independent Member and Chairperson with effect from 2 January 2021; re-appointed as Independent Member and Chairperson for another term with effect from 2 January 2021.

** Appointed to the Committee with effect from 28 January 2025.

*** Appointed with effect from 1 July 2024 as an Independent Member.

^ Term as Trustee ended 31 August 2022 and re-elected as Trustee with effect from 9 September 2022; continued as member of the Committee until 27 January 2025.

^^ Passed away in April 2024.

Working and Strategy Committee

MANDATE

The Working and Strategy Committee directs and monitors the implementation of Bonitas's strategy and is responsible for overseeing procurement and contract management processes, and recommending the budget to the Board for consideration and approval. In 2024, the Committee's mandate was extended to include oversight of and reporting on organisational ethics, responsible corporate citizenship, sustainable development and stakeholder relationships for implementation during 2025.

KEY ACTIVITIES FOR 2024

- Monitored the performance of key service providers and recommended contract renewals where appropriate
- Compiled evaluation criteria and briefing documents for service provider RFPs, reviewed evaluation scores and made recommendations to the Board
- Monitored engagements regarding potential amalgamations
- Finalised the 2023 Organisational Performance Score and the 2024 Organisational Performance Scorecard targets
- Conducted the Principal Officer's performance evaluation according to an approved scorecard
- Monitored progress regarding regulatory reports and enquiries, including CMS matters and NHI developments
- Considered key risks relating to succession and the Bonitas membership profile
- Considered I&T governance reports
- Considered FWA reports
- Recommended the following to the Board for approval: Delegation of Authority, Anti-Fraud Waste and Abuse Policy, Business Continuity Management and Disaster Recovery Policy and Plan, Code of Ethics and Professional Conduct – Executives and Employees, Code of Ethics and Professional Conduct – Trustees and Independent Members, Conflict of Interest Policy, Procurement and Contract Management Policy, Recruitment, Selection and Appointment Policy, I&T Charter and Framework, Board Charter, and Working and Strategy Committee Charter.

Members as at 31 December 2024	Capacity	Member since
Mr OJ Komane*	Trustee Member (Board Chairperson and Chairperson of this Committee)	1 June 2021
Mr R Cowlin**	Trustee Member (Board Vice-Chairperson)	1 October 2017
Mr J Bagg***	Trustee Member	4 December 2020
Mr MG Netshisaulu^	Trustee Member	16 November 2019
Mr LR Callakoppen	Principal Officer	1 May 2019
Dr T Hadebe	Clinical and Managed Care Executive	6 November 2023
Mr S Perumal^^	Chief Operations Officer	1 January 2025
Ms V Rikhotso^^^	Chief Financial Officer	1 February 2025
Mr L Woodhouse*^	Chief Financial Officer	1 October 2019

* Trustee term ended 4 January 2021; re-elected as Trustee with effect from 1 June 2021 and appointed as Chairperson on 28 September 2021; re-elected as Chairperson of the Board with effect from 12 August 2022; term as Chairperson of the Board extended with effect from 21 September 2023 and again with effect from 18 September 2024.

** Trustee term ended 4 January 2021 and appointed by the Board with effect from 5 January 2021; re-elected as Vice-Chairperson of the Board with effect from 12 August 2022; term as Vice-Chairperson of the Board extended with effect from 21 September 2023 and again with effect from 18 September 2024.

*** 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 Committee with effect from 5 October 2022.

^ Term as Trustee ended 31 August 2022 and re-elected as Trustee with effect from 9 September 2022; continued as member of the Committee.

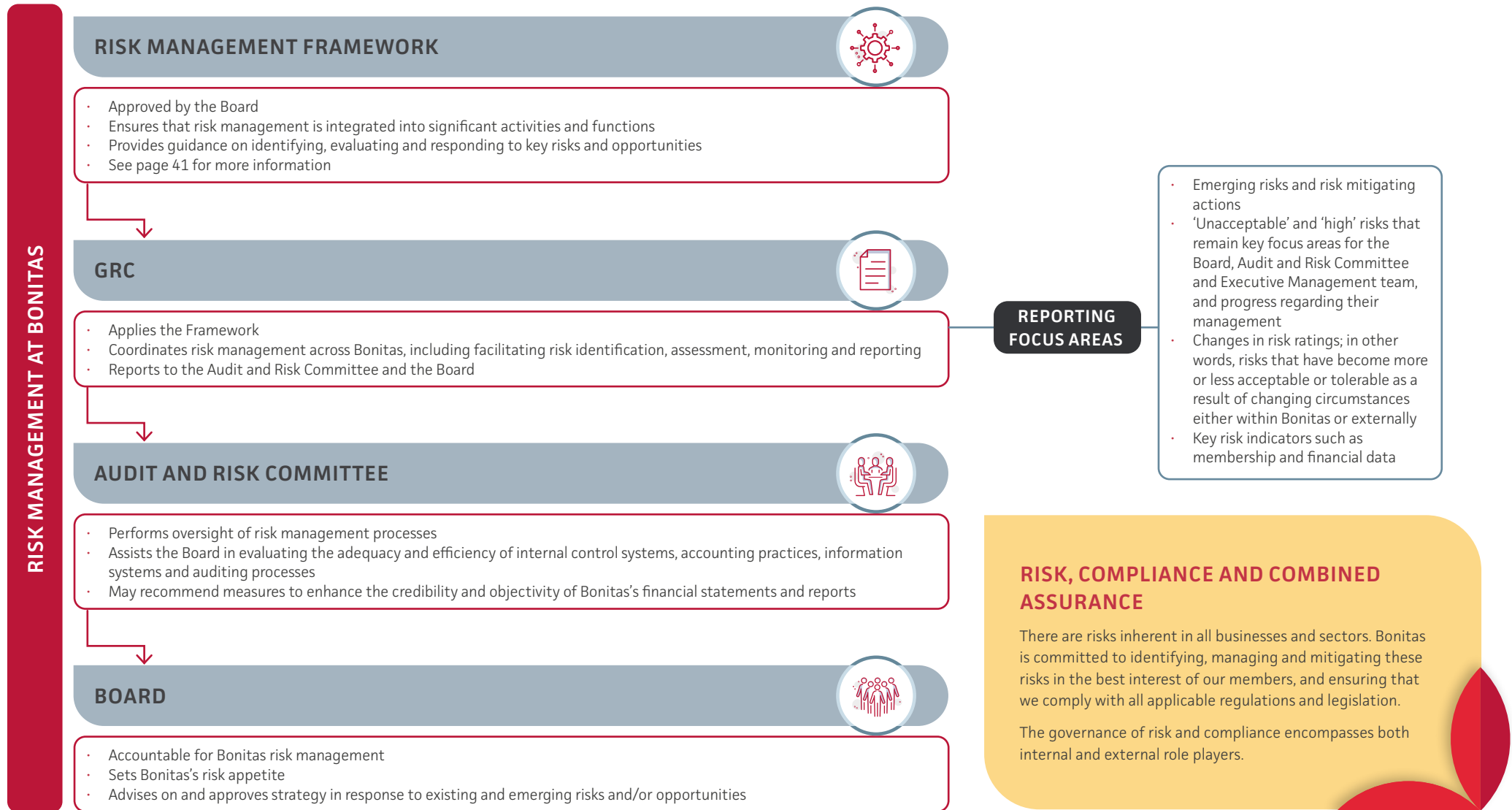
^^ Promoted from Head of Operations to COO with effect from 1 January 2025.

^^^ Resigned as Trustee with effect from 1 December 2024; appointed as CFO with effect from 1 February 2025.

*^ Fixed-term contract as CFO ended 31 December 2024.

RISK MANAGEMENT

Bonitas's approach to risk management is as follows:

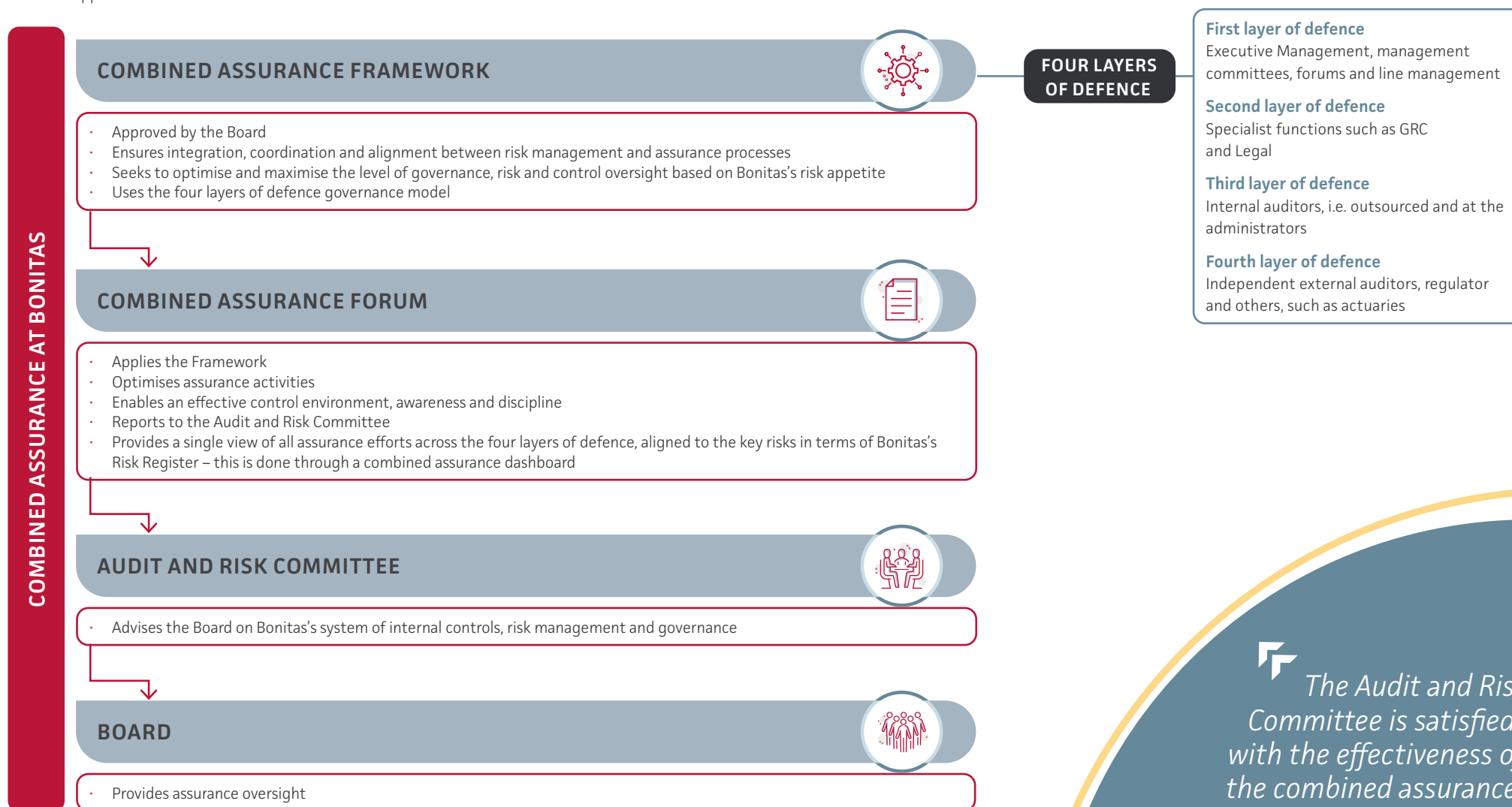


Read more about Bonitas's strategic risks and opportunities on page 41.

COMBINED ASSURANCE

The term 'combined assurance' refers to the coordinated activities of both internal and external parties to develop a holistic view of an organisation's alignment between risk management and assurance processes. For example, instead of the Executive Management and external audit teams working in silos, they communicate and collaborate (together with all other relevant role players) to improve risk management, control, reporting and accountability.

Bonitas's approach to combined assurance is as follows:

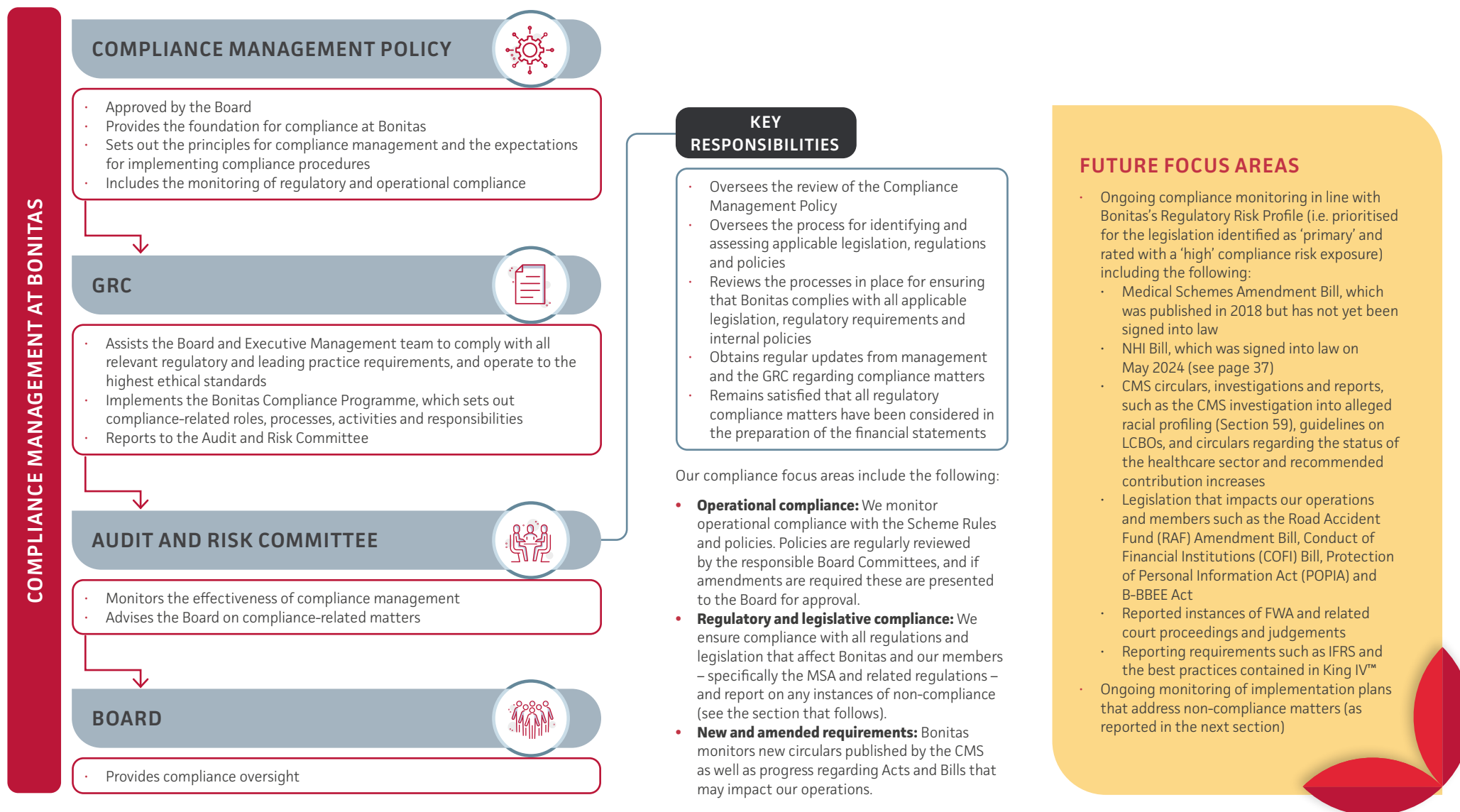


The Audit and Risk Committee is satisfied with the effectiveness of the combined assurance arrangements.

COMPLIANCE MANAGEMENT

The South African healthcare sector is complex and highly regulated, and Bonitas has a formal process in place to identify applicable legislation and regulations and ensure compliance. Since we use a BPO healthcare model for our main activities – including administration – we also ensure that our service providers remain compliant.

Bonitas's approach to compliance management is as follows:



NON-COMPLIANCE WITH THE MSA

The following areas of non-compliance with the Medical Schemes Act were identified during the course of the financial year (refer to note 26 of the annual financial statements):

Contravention of Section 33(2) of the Act

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 2024 the Scheme reported the following loss making options as defined by the Council of Medical Schemes on eight (2023: five) of its benefit options:

	2024 R'000	2023 R'000
Standard	(179 042)	–
Primary	(434 641)	(67 359)
BonCap	(227 588)	(176 922)
BonFit	(8 409)	–
BonComprehensive	(125 951)	(101 578)
BonEssential	(34 610)	(36 274)
BonComplete	(25 265)	(18 319)
Hospital Standard	(2 983)	–

Options that are considered loss making by the Council of Medical Schemes are benefit options that report a insurance service result deficit after excluding amounts attributable to future members.

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.

CORRECTIVE COURSE OF ACTION

The Scheme continues to monitor the performance of the eight benefit options listed above on a monthly basis. 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. In 2025 the Scheme has budgeted to have seven loss making options.

Contravention of Section 26(7) of the Act

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.

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.

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.

Exemption of Section 35(8) of the Act

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.

POSSIBLE IMPACT

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

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.

Contravention of Section 59(2) of the Act

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.

POSSIBLE IMPACT

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

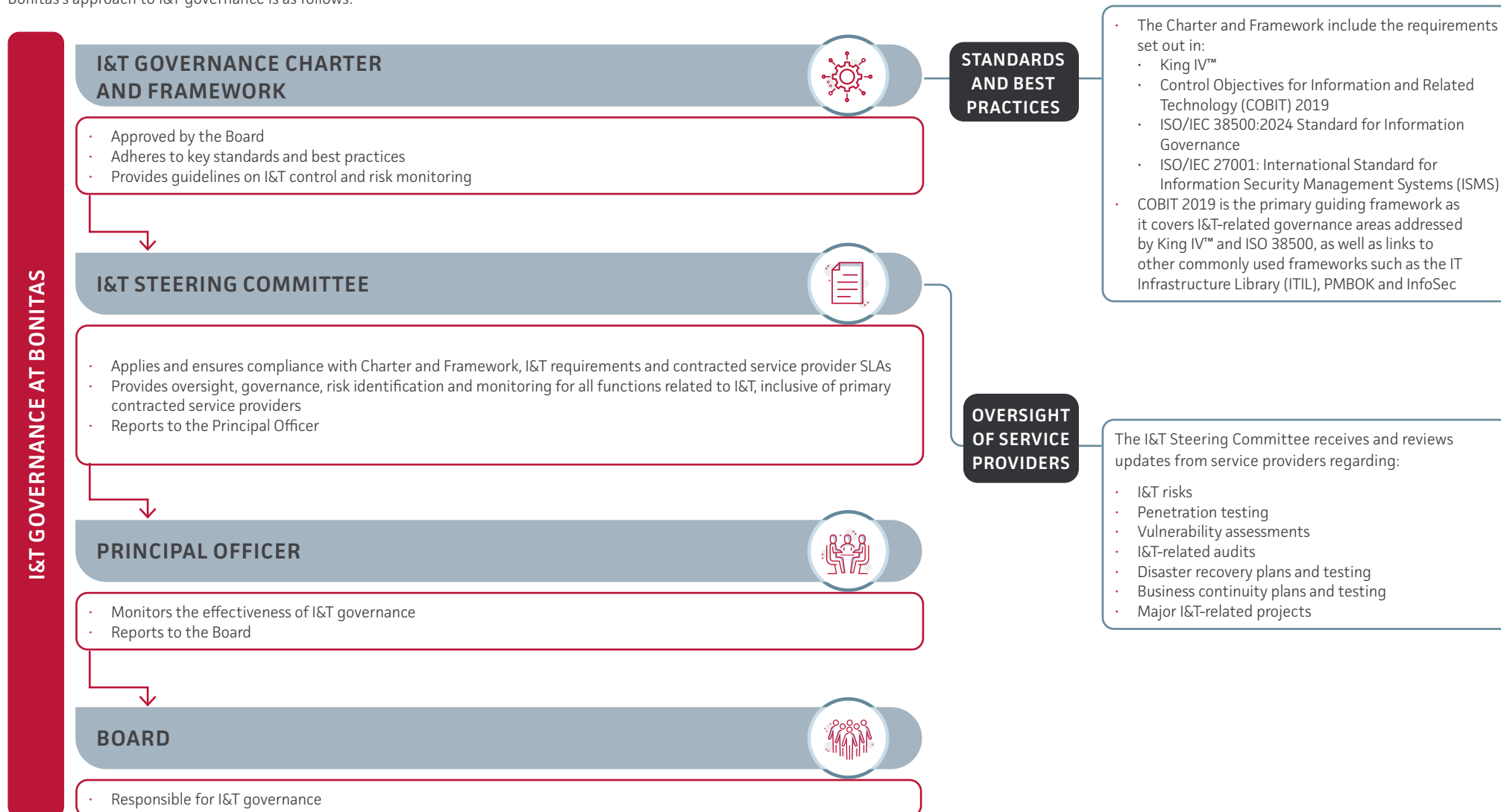
CORRECTIVE COURSE OF ACTION

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. The system issues related to workflow approval issues were subsequently resolved. 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.

INFORMATION AND TECHNOLOGY

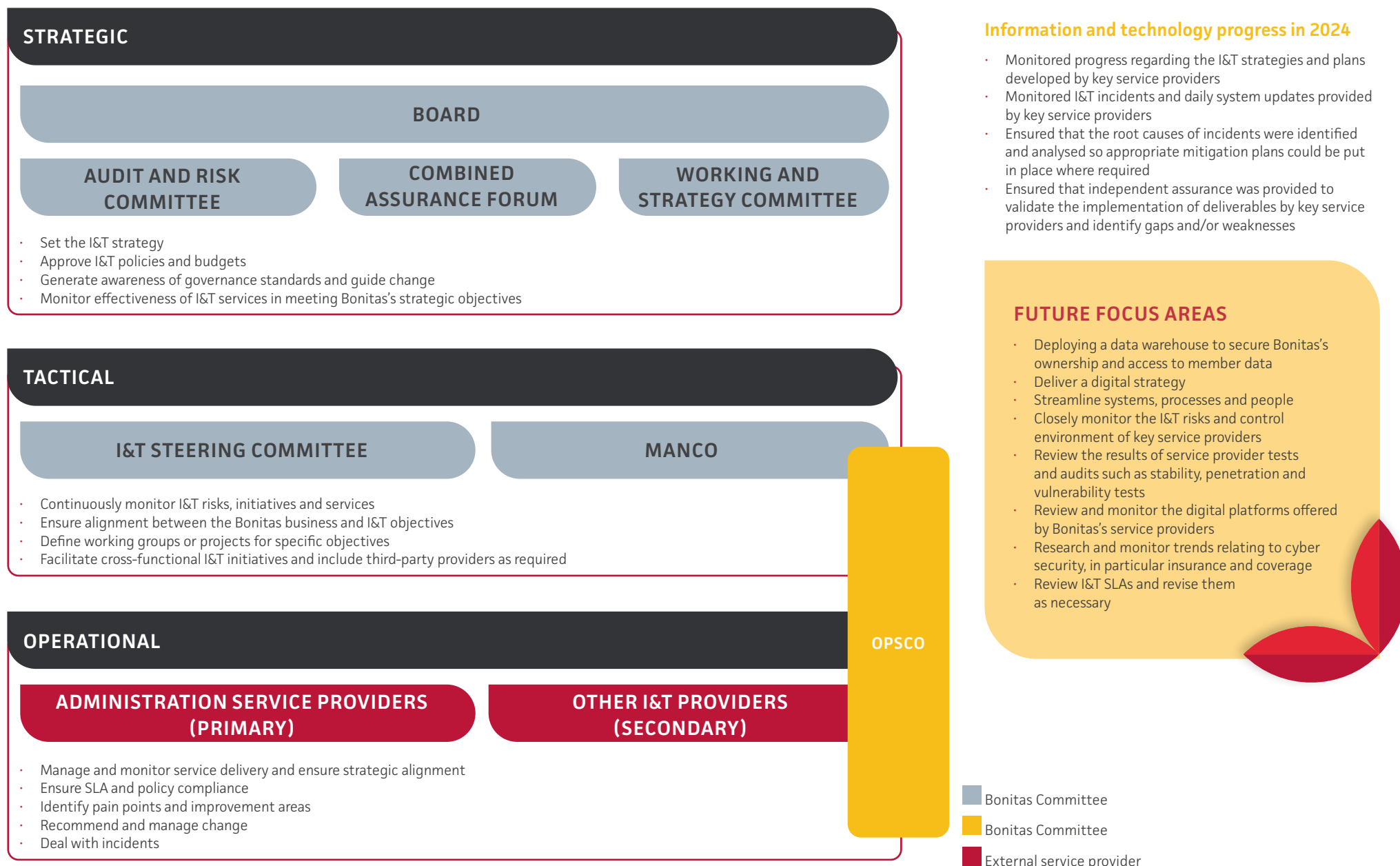
Information and technology governance structures

Bonitas's approach to I&T governance is as follows:



Information and technology operating model

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



REMUNERATION REPORT

INTRODUCTION AND BACKGROUND STATEMENT

Our approach to remuneration aims to attract and retain talent, reward performance and align with industry benchmarks and stakeholder expectations. The Board provides leadership on Bonitas's remuneration approach and implementation.

A Board-approved Remuneration Strategy and Philosophy sets out Bonitas's 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 Remuneration Strategy and Philosophy is based on the following principles:

- Ensure alignment with the Bonitas business strategy and purpose
- 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 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, mandate and key activities for the past year are set out on page 77 and meeting attendance is set out on page 74.

REMUNERATION CONTEXT AND BENCHMARKING

Unlike restricted medical schemes, Bonitas is in a very small but competitive industry that is shrinking every year. Given changes in legislation and regulatory controls, our employees, Board and Committee members must 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.

Our Employee Remuneration Policy and Remuneration Strategy and Philosophy ensure remuneration governance and best practices. The Employee Remuneration Policy is reviewed at least biennially for good governance. However, industry salary benchmarking best practices are applied 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.

Bonitas endeavours to participate in medical scheme-specific Trustee remuneration benchmarking at least biennially. For the second consecutive year we participated in Willis Towers Watson benchmark research on the remuneration guidelines for the Board of Trustees and Board Committees of medical schemes. In both years the peer group utilised for the research included eight medical schemes, with four participating in 2023 and five in 2024 (including Bonitas).

The Trustee Remuneration Policy is reviewed annually by the Executive Management team and Remuneration Committee. Bonitas members are required to approve the Trustee Remuneration Policy and any material amendments, as well as above CPI remuneration fee increases. Such approval must be granted at the AGM which, as per the Scheme Rules, must be held before 31 August every year. If approved, fee changes apply from 1 September.

REMUNERATION IN PRACTICE

Chairperson remuneration

The 2023 benchmarking research conducted by Willis Towers Watson indicated that the fees for the Chairperson of the Bonitas Board were not aligned to the average paid by the peer group, especially when considering that all the medical schemes that formed part of the group were much smaller in size than Bonitas.

The Remuneration Committee, which is an independent body, recommended a staggered approach to align the Chairperson's fee per meeting over a period of time as opposed to a once-off increase. At the 2023 AGM, members approved an increase of 20% to the Chairperson's retainer and meeting fee.

The 2024 benchmarking research confirmed that, despite the adjustment made following the 2023 AGM, there was still a material lag in the Chairperson's fees when compared to the peer group. In line with the staggered approach recommended by the Remuneration Committee in 2023, an above CPI increase of 15% on the retainer fee and meeting fee respectively was put to members at the AGM held on 21 August 2024.

Members voted against the increase and therefore the Chairperson's fees defaulted to a CPI increase.

Trustee remuneration

The Bonitas management team conducted benchmarking research as part of the annual review process of the Trustee Remuneration Policy, and the Remuneration Committee subsequently recommended that the per-meeting fee for the Managed Healthcare Committee be increased by 57.8% to match that of the Audit and Risk Committee. As the increase is above CPI, members were required to vote on the recommendation at the AGM.

Members voted against the increase and therefore the per-meeting fee for Trustees of the Managed Healthcare Committee defaulted to a CPI increase.

2019 AGM	Members approved the Trustee Remuneration Policy and fees
2020 AGM	
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
2022 AGM	
2023 AGM	Members: • Approved an amendment of the definition of CPI¹ • Approved an increase in the fees of the Chairperson above the CPI rate
2024 AGM	Members: • Voted against an increase in the fees of the Chairperson above the CPI rate • Voted against an increase in the fees of the Trustee members of the Managed Healthcare Committee above the CPI rate

Independent Member remuneration

The Independent Member Remuneration Policy and fees are reviewed annually by the Executive Management team and recommended for approval to the Board if an increase above CPI is considered. As the Remuneration Committee Chairperson 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 if the proposed fee increase is above CPI.

The Board approved an above CPI fee increase (with a rand value of R6 416) per meeting fee for Independent Members of the Managed Healthcare Committee to align with the per meeting fee of the Audit and Risk Committee.

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.

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.

ONGOING FOCUS AREAS

The Bonitas Remuneration Strategy and Philosophy implemented during 2022 continues to direct future remuneration, reward and employee value proposition decisions based on best practice. The Strategy and Philosophy was reviewed and revised at the end of 2024 and recommended by the Remuneration Committee to the Board for approval on 27 February 2025.

¹ Bonitas recognises CPI as the annual headline consumer price inflation published by StatsSA as at April of the current year.

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 promoting 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 • Bonitas pension rules • Bonitas medical aid rules • Bonitas 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 performance.	• Employee Remuneration Policy • Incentive Scheme Policy • Performance Management Policy • Talent and Succession Management Policy and 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.	• Employment Equity and 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 that is conducive to productivity, performance, strong relationships, health, and commitment to organisational culture and values.	• Bonitas values • Code of Conduct and Ethics • Leave Policy • Flexible work arrangements • Employee Wellness programme
Other			
Additional benefits and reimbursement	Travel expenses Cellular and 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. The Policy is reviewed at least every second year, with the next review scheduled for the first quarter of 2025.

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 optimal mix of competencies
- Is aimed at securing employee commitment to Bonitas'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 policies:

- Basic Conditions of Employment Act, No 11 of 2002 (as amended)
- Labour Relations Act, No 127 of 1998 (as amended)
- Employment Equity Amendment Act, No 4 of 2002, including provisions on equal pay for equal work
- 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 28 February 2024. The Policy is reviewed annually, with the next review scheduled for the first quarter of 2025.

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 incentive

Payment of the short-term incentive (STI) 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, STI pool calculation and all conditions for awards, including for new hires, after promotions and during disciplinary proceedings. Bonitas must also achieve a minimum score per the approved Organisational Performance Scorecard to provide for an incentive pool. The STI pool is capped at a maximum of 30% of Bonitas's annual salary cost to company total for the financial year.

The incentive pool is the maximum total STI that Bonitas can pay in a financial period. The calculation of the incentive pool and final incentive awards is subject to approval by the Remuneration Committee and the Board.

Long-term incentive

The aim of the long-term incentive (LTI) is to attract, retain, motivate and reward executives and identified employees who can influence Bonitas's performance. It supports our purpose by attracting and retaining the right talent and correlating with our long-term growth plans and financial performance.

The LTI Scheme has a three-year fixed cycle, and the value of the incentive is determined by Bonitas's performance over a three-year period. LTI targets are agreed and approved by the Board. These targets focus on Bonitas's medium- to long-term sustainability.

The final calculation of the LTI vested amount for the three-year performance period ended 31 December 2023 was signed-off by the Remuneration Committee and approved by the Board following the sign-off of Bonitas's 2023 annual financial statements. Refer to the Remuneration Implementation Report on page 91. The new LTI performance targets for January 2024 to December 2026 have been approved by the Board.

BOARD COMMITTEES' INDEPENDENT MEMBER REMUNERATION POLICY

Approved by the Board on 27 June 2024.

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 our 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

This Policy only requires approval by the Board for subsequent years if there are material changes or if remuneration increases are above CPI. The Remuneration Committee recommended an above CPI fee increase for Independent Members of the Managed Healthcare Committee and therefore Board approval was required.

Our approach and model

In setting fees related to Independent Member remuneration, Bonitas ascribes to the process set out in 2020 by the Institute of Directors South Africa.¹ We also consider the requirements of the Companies Amendment Act, No 16 of 2024, and Companies Second Amendment Act, No 17 of 2024.

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 non-executive directors.

However, as Bonitas is a not-for-profit organisation, Independent Member remuneration is not comparable to that of private companies or those listed on the Johannesburg Stock Exchange. 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, including SGM attendance. Independent Members may also be required to attend specific Board meetings and/or ad hoc meetings, such as interviews or tender evaluations, for which an Independent Member will be entitled to a Per Hourly Meeting Fee that 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 as follows:

Committee meetings	Meeting fee from 1 June 2023	Meeting fee from 1 June 2024
Audit and Risk Committee: Chairperson	R40 390	R42 490
Audit and Risk Committee: Member	R34 620	R36 420
Investment Committee: Member	R30 004	R31 564
Remuneration Committee: Chairperson	R34 620	R36 420
Remuneration Committee: Member	R30 004	R31 564
Managed Healthcare Committee: Member	R30 004	R36 420

Ad hoc ² meetings	Hourly meeting fee from 1 June 2023	Hourly meeting fee from 1 June 2024
Ad hoc meeting: Chairperson	R5 424	R5 706
Ad hoc meeting: Invitee	R4 616	R4 856

¹ Institute of Directors South Africa. 2020. 'Managing Conflicts and Tensions at the Remuneration Committee: Remuneration Committee Guidance'. Available on: https://cdn.ymaws.com/www.iodsa.co.za/resource/collection/57F28684-0FFA-4C46-9AD9-EBE3A3DFB101/Paper_3_Managing_conflicts_and_tensions_at_the_Remuneration_Committee.docx.pdf

² 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 was recommended by the Remuneration Committee on 15 July 2024 and adopted by the Board on 30 July 2024.

This Policy aims to remunerate Trustees appropriately, in line with sound corporate governance principles and based on market-leading practices.

The Policy is 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

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.

Trustees' fees

Fees are reviewed annually. The fees below demonstrate a comparative analysis for FY2023 and FY2024 aligned to Bonitas's Trustee Remuneration Policy.

Name	2023		2024		%	2023	2024	%
	Retainer fee (monthly) R	Retainer fee (annual) R	Retainer fee (monthly) R	Retainer fee (annual) R		Meeting fee R	Meeting fee R	
Board of Trustees – Chairperson	33 750	405 000	35 505	426 060	5.2%	25 511	26 838	5.2%
Board of Trustees – Trustee	21 623	259 476	22 747	272 964	5.2%	15 137	15 924	5.2%
Audit and Risk Committee – Member						15 137	15 924	5.2%
Investment Committee – Chairperson						18 704	19 677	5.2%
Investment Committee – Member						10 092	10 617	5.2%
Remuneration Committee – Member						7 568	7 962	5.2%
Working and Strategy Committee – Chairperson						18 704	19 677	5.2%
Working and Strategy Committee – Member						10 092	10 617	5.2%
Managed Healthcare Committee – Chairperson						18 704	19 677	5.2%
Managed Healthcare Committee – Member						10 092	10 617	5.2%
Sales and Marketing Committee* – Member						7 568	7 962	5.2%

* Management committee with Trustee members.

¹ Institute of Directors South Africa. 2020. 'Managing Conflicts and Tensions at the Remuneration Committee: Remuneration Committee Guidance'. Available on: https://cdn.ymaws.com/www.iodsa.co.za/resource/collection/57F28684-0FFA-4C46-9AD9-EBE3A3DFB101/Paper_3_Managing_conflicts_and_tensions_at_the_Remuneration_Committee.docx.pdf

Trustees are elected from among Bonitas members or appointed by the Board and must be fit and proper to manage Bonitas's business. Trustees carry substantial accountabilities and risks and assume substantial fiduciary duties and responsibilities. As such, it is crucially important to attract and retain suitable and qualified individuals to serve as Trustees who are able to dedicate the appropriate time to serve Bonitas and our members. 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 Institute of Directors South Africa in determining the fees of non-executive directors as set out in 2020.¹ 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 ensures that Trustees dedicate enough time to Bonitas while avoiding unnecessary meetings that could increase costs.

REMUNERATION IMPLEMENTATION REPORT

EXECUTIVE REMUNERATION

Executive remuneration summary (including the Principal Officer)

	2023	2024
Executive remuneration	R10 360 367	R11 438 049
Performance bonus (STI)	R3 271 273	R3 407 787
Performance bonus (LTI)	R2 055 370	R2 587 776
Defined contribution benefits	R564 184	R681 683

The Principal Officer's salary increase of 6.25% was approved by the Board.

Members of the Executive Management team are employed by Bonitas on fixed-term contracts. The Principal Officer's contract was renewed for a further five years in March 2024. The CFO's contract was not renewed, and the incumbent CFO assumed the position on 1 February 2025.

Short-term incentives

- STIs are determined by performance against an agreed Organisational Performance Scorecard and targets. Bonitas met the minimum required organisation score for the purposes of an STI. The total bonus pool was calculated as R7.23 million and the final STI value totalled R7.36 million before tax. Surpluses in the bonus pool are not carried over to the next financial period.
- We benchmarked the STI allocations as part of our annual policy review to ensure they are aligned with market and industry benchmarks. Amendments were made to align STI allocations to these benchmarks and to increase the weightings applied to organisation performance across all grade levels.

Long-term incentives

- The three-year LTI cycle ended in December 2023. The vesting conditions pertaining to specific key performance indicators were satisfied and settlement took place at the end of April 2024 for eligible participants, in line with Bonitas's incentive policy. The full settlement value was accrued in the 2023 financial statements.
- The LTI value payable to eligible participants in April 2024 for the three-year cycle ending December 2023 was R5 713 199. This was allocated as follows:
 - Executives: R5 109 368
 - Employees: R603 831
- The LTI performance targets for the period January 2024 to December 2026 were implemented and approved by the Board.

Independent Member fees

- Independent Member fees included fees for attendance at Committee meetings, the AGM and workshops.
- A fee increase of 5.2% was implemented as of 1 June 2024.
- There were no deviations from the Independent Member Remuneration Policy.

Independent Member	Audit and Risk Committee	Investment Committee	Managed Healthcare Committee	Remuneration Committee	Other	Total
Prof DP van der Nest	R291 129	–	–	–	R30 817	R321 946
Dr YO Carrim	–	–	R302 115	–	–	R302 115
Mr T Poho	R213 119	–	–	–	–	R213 119
Mr C van Zyl*	–	R60 008	–	R90 011	R4 616	R154 635
Ms W Kirima	–	R153 140	–	–	–	R153 140
Ms P Kekana	–	–	–	R213 119	R41 665	R254 785
Ms S Padayachy	R178 500	–	–	–	–	R178 500
Ms D Msomi	–	–	–	R63 128	–	R63 128

* Passed away in April 2024.

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, meaning that Trustees would have completed a 12-month cycle since the date of the previous AGM.
- A fee increase of 5.2% was implemented as of 1 September 2024 for all Trustees. The fees for the 2024 financial year are set out in note 18.2 of the annual financial statements.
- Meeting attendance by Trustees and Independent Members is set out in on page 74.



ANNUAL FINANCIAL STATEMENTS 2024

ANNUAL FINANCIAL STATEMENTS

STATEMENT OF RESPONSIBILITY OF THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2024

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 2024, 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 100 to 161 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 95. 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.

NON-ASSURANCE SERVICE

During 2023, the Board approved a non-assurance review as recommended by the Audit and Risk Committee to be performed by Deloitte, who are also the external auditor of the Scheme. The engagement included a review of the Scheme's relational governance. In addition to this, a review was performed on the Scheme's transactional governance with respect to its administration and managed care contracts. The review provides the Audit and Risk Committee and the Board with insights into the arms-length nature of services provided by the administrator and managed care providers when compared to industry.

The review is performed every two years and the cost for the review which took place early 2024 was R2.4 million excluding Vat.

A concern was raised by the Audit and Risk Committee given the external audit fee as to whether the review may pose a threat to the independence of the external auditor or result in a conflict of interest.

Following an inquiry into the matter with the external audit partner, the Audit and Risk Committee considered all potential threats to independence resulting from this engagement and assessed the relevant safeguards put in place by Deloitte and have concluded that the independence of the external auditor will not be impaired.

APPROVAL OF THE ANNUAL FINANCIAL STATEMENTS

The annual financial statements of the Scheme were approved by the Board on 22 April 2025.

Mr OJ Komane
Chairperson of the Board

22 April 2025

Mr LR Callakoppen
Principal Officer

22 April 2025

Mr R Cowlin
Vice-Chairperson of the Board

22 April 2025

STATEMENT OF CORPORATE GOVERNANCE

FOR THE YEAR ENDED 31 DECEMBER 2024

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. 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 28 March 2025) for the year ended 31 December 2024 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 2024, to the extent that the individual reviews considered governance areas, PricewaterhouseCoopers concluded that no significant concerns were noted in this regard." In addition, internal audit reviews are also conducted by the administrators with regular reporting to Executive Management, including the Audit and Risk Committee of the Scheme.

Mr OJ Komane
Chairperson of the Board
22 April 2025

Mr LR Callakoppen
Principal Officer
22 April 2025

Mr R Cowlin
Vice-Chairperson of the Board
22 April 2025

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 100 to 161, which comprise the statement of financial position as at 31 December 2024, and the statement of comprehensive income, and the statement of cash flows, for the year then ended, and notes to the financial statements, including a summary of material accounting policy information.

In our opinion, these financial statements present fairly, in all material respects, the financial position of Bonitas Medical Fund as at 31 December 2024 and its financial performance and cash flows for the year then ended, in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board and the requirements of the Medical Schemes Act of South Africa.

Basis for Opinion

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of 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.

In terms of the IRBA Rule on Enhanced Auditor Reporting for the Audit of Financial Statements of Public Interest Entities, published in Government Gazette No. 49309 dated 15 September 2023 (EAR Rule), we report:

Final Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the nature and extent of our audit work and in evaluating the results of our work.



• National Executive: *R Redfearn Chief Executive Officer *GM Berry Chief Operating Officer JW Eshun Managing Director Businesses LN Mahluza Chief People Officer *N Sing Chief Risk Officer AP Theophanides Chief Sustainability Officer *NA le Riche Chief Growth Officer *ML Tshabalala Audit & Assurance AM Babu Consulting TA Odukoya Financial Advisory G Rammego Risk Advisory DI Kubeka Tax & Legal

• A full list of partners and directors is available on request * Partner and Registered Auditor

B-BBEE rating: Level 1 contribution in terms of the DTI Generic Scorecard as per the amended Codes of Good Practice

Associate of Deloitte Africa, a Member of Deloitte Touche Tohmatsu Limited

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality:	R209 million (2023: R193 million).
How we determined it:	1% of insurance revenue for the year
Rationale for the materiality benchmark applied:	A key judgement in determining materiality is the appropriate benchmark to select, based on our perception of the needs of the members of Bonitas Medical scheme, the users of the financial statements. We chose insurance revenue as the primary benchmark as it is the benchmark against which the performance of the Scheme is measured by users.

Key Audit Matters

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

In terms of the EAR Rule, we are required to report the outcome of audit procedures or key observations with respect to the key audit matters and these are included below.

Key audit matter	How the matter was addressed in the audit
Best Estimate Liability - Incurred But Not Reported (IBNR) and Risk Adjustment (RA) components of the Liability for Incurred Claims (LIC) <u>IBNR</u> As disclosed in Note 12.1, the carrying amount of the best estimate liability – incurred but not reported claims at year end is R1 102 360 000 (2023: R932 689 000) of which R1 049 193 619 (2023: R855 638 542) relates to the Scheme’s computed IBNR, which is the focus of the key audit matter. 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 and related external claims handling expenses. The Basic Chain Ladder (BCL) method, in combination with the Bornhuetter-Ferguson (BF) method, has been used to determine the IBNR as at 31 December 2024. The IBNR calculation is based on several factors, which include: • The level of homogeneity of the data; • Changes in patterns of claims and claims processing;	In evaluating the valuation of the IBNR and RA components of the LIC, we evaluated the calculations approved by the board of trustees and performed procedures which included: • Considered the design and implementation of the Scheme’s controls relating to the preparation of the IBNR and RA calculation though gaining an understanding of the end-to-end claims and LIC calculation business process; • Obtained the report of the Scheme’s actuary relating to the LIC at year end and tested the appropriateness of the estimate as follows: ○ Evaluated the competence, capabilities and objectivity of the Scheme’s actuary; ○ Obtained an understanding of the methodology and assumptions used in estimating the LIC. With the assistance of our actuarial specialists, assessed the appropriateness of the methodology and assumptions used in determining the IBNR and RA components of the LIC in terms of acceptable methodologies, industry standards, and the measurement objectives of IFRS 17. ○ Evaluated the integrity of the information used in the calculation of the LIC by performing substantive procedures to test the accuracy and

• Changes in the composition of the Scheme i.e. distribution of members and their beneficiaries across various options; • Changes in benefit limits; and • Changes in prescribed minimum benefits. <u>RA</u> As disclosed in Note 12.1, the carrying amount of the risk adjustment relating to insurance contract claims at year end is R150 500 000 (2023: R145 351 000) of which R146 288 171 (2023: R140 901 995) relates to the Scheme's computed RA, which is the focus of the key audit matter. In terms of IFRS 17: Insurance Contracts (IFRS 17), the risk adjustment reflects the compensation that the entity requires for bearing the uncertainty related to the amount and the timing of the cash flows that arise from non-financial risk. The risk adjustment was determined by applying the deterministic sensitivity approach. This methodology is referred to as a 'Provision for Adverse Deviation'. The confidence level has been set at the 90th percentile reflecting the Scheme's risk attitude towards the level of conservatism considered in its liability reserving, solvency management and pricing practices. We considered the LIC as a key audit matter due to: • The materiality of the liability; and • Significant judgement and estimation uncertainties in determining the future cash flow projections and the risk adjustment.	○ completeness of data used in the valuation of the IBNR and RA components of the LIC; ○ Our actuarial specialists performed an independent calculation of the estimated LIC by utilising historical claims data and trends. We used this estimate as a basis of assessing the reasonableness of the board of trustees' estimate of the LIC. • Assessed the presentation and disclosure in respect of the LIC and considered the adequacy of these disclosures against the requirements of IFRS17 and relevant industry guidance. Based on the procedures performed, we are satisfied that the valuation of the IBNR and RA components of the LIC is appropriate.
---	--

Other Information

The Scheme's trustees are responsible for the other information. The other information comprises the information included in the Integrated 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 Scheme's Trustees for the Financial Statements

The Scheme's trustees are responsible for the preparation and fair presentation of the financial statements, in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board and the

requirements of the Medical Schemes Act of South Africa, and for such internal control as the Scheme's 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 Scheme's 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.

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the 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.

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.

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 South Africa

As required by the Council for Medical Schemes, we report that there are no material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa that have come to our attention during the course of our audit.

Audit tenure

As required by the Council for Medical Schemes' Circular 38 of 2018, *Audit Tenure*, we report that Deloitte & Touche has been the auditor of Bonitas Medical Fund for eight years.

The engagement partner, Claudette van der Merwe, has been responsible for Bonitas Medical Fund audit for one year.

DocuSigned by:
 Deloitte & Touche
390CA36F22BE458...

Deloitte & Touche

Registered Auditors

Per: Claudette van der Merwe

Partner

25 April 2025

5 Magwa Crescent
Waterfall City
2090

STATEMENT OF FINANCIAL POSITION

AT 31 DECEMBER 2024

	Notes	2024 R'000	2023 R'000
ASSETS			
Non-current assets			
Property and equipment	4	3 419	5 201
Investment properties	5	–	–
Financial assets held at fair value through profit or loss	7	5 932 586	4 757 012
		5 936 005	4 762 213
Current assets			
Investment property held for sale	6	–	72 700
Financial assets held at fair value through profit or loss	7	4 755 629	5 376 956
Reinsurance contract assets	13	95 384	86 198
Trade and other receivables	8	12 336	11 298
Cash and cash equivalents	9	848 715	767 601
		5 712 064	6 314 753
Total assets		11 648 069	11 076 966
LIABILITIES			
Non-current liabilities			
Lease liability	4.2	–	2 002
Long-term employee benefit obligation	10	2 927	–
Insurance liability for future members	11	9 029 093	8 895 202
		9 032 020	8 897 204
Current liabilities			
Insurance contract liabilities	12	2 583 210	2 126 489
Lease liability	4.2	2 405	2 730
Long-term employee benefit obligation	10	–	5 716
Trade and other payables	14	30 434	44 827
		2 616 049	2 179 762
Total liabilities		11 648 069	11 076 966

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2024

	Notes	2024 R'000	2023 R'000
Insurance revenue	15	20 888 306	19 461 328
Insurance service expense	15	(22 287 304)	(20 227 945)
Claims incurred	15.1	(20 091 944)	(18 066 419)
Third party claims recoveries	15.8	58 387	57 698
Changes that relate to past service – adjustments to the LIC	15.2	173 396	165 859
Insurance acquisition costs	15.3	(420 406)	(395 201)
Accredited managed healthcare services	15.4	(664 000)	(606 668)
Losses on onerous contracts and reversal of those losses	15	–	–
Attributable expenses incurred	15.5	(1 208 846)	(1 117 900)
Amounts attributable to future members*	15.6	(133 891)	(265 314)
Net income from risk transfer arrangements/reinsurance	15.7	433 320	315 574
An allocation of premiums paid		(1 951 687)	(1 879 274)
Amounts recovered from risk transfer arrangement/reinsurance		2 385 007	2 194 848
Insurance service result		(965 678)	(451 043)
Other income		1 416 216	865 105
Investment income – Scheme	16.1	1 385 696	829 915
Change in fair value of investment property	16.2	–	(3 500)
Loss on sale of investment property	6	(13 500)	–
Sundry income	17	44 020	38 690
Net insurance finance expenses		(84 852)	(70 838)
Finance expenses from insurance contracts issued – PMSA	12.4	(84 852)	(70 838)
Other expenditure		(365 686)	(343 224)
Administration fees and other operating expenses	18	(324 501)	(306 257)
Asset management fees		(35 669)	(31 714)
Interest expense	4.2	(322)	(531)
Operating expenses on rental of investment property	6	(5 194)	(4 722)
Net surplus/deficit for the year		–	–
Total comprehensive income for the year		–	–

* In accordance with IFRS 17 and recognising the Scheme as a mutual entity, amounts attributable to future members represents the net surplus earmarked for the future benefit of existing and future members realised in the current financial period.

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2024

	Notes	2024 R'000	2023 R'000
Cash flows from operating activities			
Cash receipts from members and providers		22 112 157	20 569 353
Cash receipts from members – contribution		21 967 054	20 408 915
Cash receipts from members and providers – other		145 103	160 438
Cash paid to providers, employees and members		(22 800 082)	(20 934 559)
Cash paid to providers and members	20.1.5	(21 151 953)	(19 413 634)
Cash paid to providers and employees – non healthcare expenditure	20.1.6	(1 571 345)	(1 455 228)
Cash paid to members – savings plan refunds	12.4	(76 784)	(65 697)
Cash utilised in operating activities		(687 925)	(365 206)
Interest paid	12.4	(84 852)	(70 838)
Interest received	16.1	19 942	11 508
Net cash outflow from operating activities		(752 835)	(424 536)
Cash flows from investing activities			
Acquisition of property and equipment	4	(696)	(589)
Proceeds on disposal of investment property	6	61 500	–
Proceeds on disposal of property and equipment	17	–	12
Acquisition of financial assets held at fair value through profit or loss	7	(2 414 357)	(702 280)
Disposal of financial assets held at fair value through profit or loss	7	2 733 252	820 508
Interest received	20.1.1	290 231	255 038
Dividends received	20.1.2	192 703	195 628
Asset management fees paid	20.1.3	(35 359)	(30 437)
Rentals received	20.1.4	9 324	10 364
Net cash inflow from investing activities		836 598	548 243
Cash flows from financing activities			
Lease payments	4.2	(2 649)	(2 121)
Net cash outflow from financing activities		(2 649)	(2 121)
Net increase in cash and cash equivalents		81 114	121 586
Cash and cash equivalents at beginning of the year		767 601	646 015
Cash and cash equivalents at end of the year		848 715	767 601
Analysed as follows:			
Cash and cash equivalents	9	848 715	767 601
		848 715	767 601

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

1 GENERAL INFORMATION

The Scheme is a registered non-profit, open medical Scheme in terms of the Medical Schemes Act 131 of 1998 ("the Act") and is domiciled in the Republic of South Africa. The Scheme is administered by Medscheme Holdings Proprietary Limited. Private Health Administrators (PHA) Proprietary Limited handles the Scheme's benefit option, Boncap claims. This also includes associated administration and managed care services relating to the Boncap option.

2 MATERIAL ACCOUNTING POLICIES

The material 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 IFRS Accounting Standards as issued by the International Accounting Standards Board and interpretations issued by the IFRS Interpretations Committee, 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 basis 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 and insurance and reinsurance assets and liabilities that are measured in terms of IFRS 17 current estimates.

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

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

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

2.1.3 Functional and presentation currency

The annual financial statements are prepared in South African Rand which is the Scheme's functional and presentation currency. All financial information presented has been rounded to the nearest thousand (R'000), unless otherwise stated.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

2 MATERIAL ACCOUNTING POLICIES (continued)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.4 New standards, amendments to published standards and interpretations

The following standards, amendments and interpretations are effective for the current financial year. The Scheme has complied with the new standards and interpretations from the various effective dates:

(a) **New standards, amendments to published standards and interpretations issued and effective in 2024 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 IASB 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. The Scheme has assessed the accounting policies and deem all standards to be material either qualitatively or quantitatively.	1 January 2024
IFRS 16 Lease Liability in a Sale and Leaseback	Amendments to IFRS 16: Leases impact how a seller-lessee accounts for variable lease payments that arise in a sale-and-leaseback transaction. The amendments introduce a new accounting model for variable payments and will require seller-lessees to reassess and potentially restate sale-and-leaseback transactions entered into since 2019.	1 January 2024

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

2 MATERIAL ACCOUNTING POLICIES (continued)

2.1 BASIS OF PREPARATION (CONTINUED)

2.1.4 New standards, amendments to published standards and interpretations (continued)

(b) New standards, amendments and interpretations issued and not yet effective in 2024 and relevant to the Scheme:

Standard	Details of amendment	Effective date Periods beginning on or after
IFRS 18 Presentation and Disclosure in Financial Statements	Introduction of IFRS 18: IFRS 18 introduces three sets of new requirements to improve companies' reporting of financial performance and give members a better basis for analysis: a) Improved comparability in the statement of profit or loss through the introduction of three defined categories for income and expenses (operating, investing, and financing) – to improve the structure of the profit or loss, and a requirement for all companies to provide new defined subtotals, including operating profit. b) Enhanced transparency of management – defined performance measures with a requirement for companies to disclose explanations of those company-specific measures that are related to the income statement. c) Aggregation and disaggregation of information, including the introduction of overall principles for how information should be aggregated and disaggregated in financial statements. This Standard replaces IAS1 Presentation of Financial Statements. It carries forward many requirements from IAS 1 unchanged.	1 January 2027
IFRS 9 Financial Instruments	Amendments to IFRS 9: Narrow scope amendments to address diversity in accounting practice by making the classification and measurement requirements of IFRS 9 more understandable and consistent, by: a) Clarifying the classification of financial assets with environmental, social and corporate governance (ESG) and similar features; and b) Clarifying the date on which a financial asset or financial liability is derecognised when a liability is settled through electronic payment systems. These amendments also introduce an accounting policy option to allow a company to derecognise a financial liability before it delivers cash on the settlement date if specified criteria are met. Financial instruments are a material balance to the Scheme, the Scheme is in the process of determining the impact of these amendments. This change is not expected to have a material impact considering no change in business model anticipated and the majority of the Scheme's assets are already measured at Fair value.	1 January 2026

2.2 EVENTS AFTER REPORTING DATE

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

2.3 PROPERTY AND EQUIPMENT

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

2 MATERIAL ACCOUNTING POLICIES (continued)

2.3 PROPERTY AND EQUIPMENT (CONTINUED)

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 valuers 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 INVESTMENT PROPERTY HELD FOR SALE

Assets are classified as held-for-sale if the carrying amount will be recovered principally through a sale transaction, rather than through continuing use. The condition is regarded as met only when the sale is highly probable and the asset is available for immediate sale in its present condition. Upon initial classification as held for sale, current assets are recognised at the lower of carrying amount and fair value less costs to sell.

2.6 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.

2.7 FINANCIAL INSTRUMENTS

2.7.1 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; Financial assets held at amortised cost and Financial liabilities. The Scheme has classified its financial instruments into the following classes:

- Financial assets held at fair value through profit or loss;
- Trade and other receivables (non-insurance related);
- Cash and cash equivalents; and
- Trade and other payables.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

2 MATERIAL ACCOUNTING POLICIES (continued)

2.7 FINANCIAL INSTRUMENTS (CONTINUED)

2.7.1 Classification, recognition and measurement (continued)

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 the 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) Financial assets held at amortised cost

Financial assets held at amortised cost 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 financial assets held at amortised cost. 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.

Financial assets held at amortised cost comprise of 'Trade and other receivables' (excluding prepaid expenses) and 'Cash and cash equivalents'.

Financial assets held at amortised cost are initially measured at fair value plus transactional costs and are subsequently measured at amortised cost using the effective interest method, less impairment losses. The effective interest rate method is a method of calculating the amortised cost of a financial asset and of allocating the corresponding interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash flows through the expected life of the financial asset or where appropriate a shorter period.

a) Trade and other receivables (does not include members that are in arrears)

Trade and other receivables balances are reviewed for impairment as part of the impairment review conducted on financial assets held at amortised cost.

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 Trade and other payables.

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.

iii) Financial liabilities

a) Trade and other payables

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Accounts payable are classified as current liabilities if payment is due within one year or less (or in the normal operating cycle of the business if longer). If not, they are presented as non-current liabilities. Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

2 MATERIAL ACCOUNTING POLICIES (continued)

2.7 FINANCIAL INSTRUMENTS (CONTINUED)

2.7.2 Impairment of financial assets

i) Financial assets held at amortised cost

The Scheme's financial assets held at amortised cost 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.

If it is determined that a possible impairment loss will be incurred on financial assets 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.

2.7.3 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.

2.7.4 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.

2.8 INSURANCE CONTRACTS

2.8.1 Identification of insurance contracts

The contracts issued by medical Schemes (the issuer) indemnify covered members (the policyholder) and their covered dependants against the risk of loss arising from the occurrence of a health event (insured event). The timing, frequency and severity of the health event covered is uncertain. These contracts fall under the scope of IFRS 17.

Whilst the timing, frequency, severity and type of health events are uncertain, the ultimate insurance risk covered by a medical Scheme can be defined as a single risk – that of providing cover for a health event that the member may incur. The risk under the insurance contracts issued by medical Schemes can be expressed as the probability that an insured event ("health event") occurs, multiplied by the expected amount of the resulting claim. Risk transfer arrangements are dealt with in note 2.9 and all sections are with reference to gross contracts unless stated otherwise.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

2 MATERIAL ACCOUNTING POLICIES (continued)

2.8 INSURANCE CONTRACTS (CONTINUED)

2.8.2 Separating components from an insurance contract

An investment component and an insurance component are highly interrelated if, and only if:

- 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
- 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.

The Personal Medical Savings Account (PMSA) meets the definition of an investment component in IFRS 17 as it requires the medical Scheme to repay a member in all circumstances, regardless if an insured event occurred. The investment component is not distinct and has to be accounted for in terms of IFRS 17.

The cash flows relating to the PMSA are not recorded in the statement of comprehensive income, but are considered in assessing onerous contracts.

2.8.3 Level of aggregation

The Scheme as a whole was identified as a portfolio. All contracts issued by a Scheme are subject to similar risks and managed together. As the Act specifically constrains the entity's practical ability to set a different price or level of benefits for members with different characteristics the Scheme as whole was also identified as the group. The Scheme assesses if the group as whole is onerous or profitable. Where the following year's deficit exceeds the value attributable to members – the most residual interest – the contracts written would be onerous and an onerous contract liability raised. Where the amounts attributable to members exceed the following year's deficit the contracts would not be determined as onerous, and no provision raised as a liability is already recognised (as the Scheme is regarded as a mutual entity for accounting purposes).

2.8.4 Contract boundary

The Scheme uses the concept of contract boundary to determine what cash flows should be considered in the measurement of groups of insurance contracts. This assessment is reviewed every reporting period.

Cash flows are within the boundary of an insurance contract if they arise from the rights and obligations that exist during the period in which the member is obligated to pay contributions, or the Scheme has a substantive obligation to provide the member with insurance coverage or other services. A substantive obligation ends when both of the following criteria are satisfied:

- The Scheme has the practical ability to reprice the group of contracts so that the price fully reflects the reassessed risk of that portfolio; and
- the pricing of contributions related to coverage to the date when risks are reassessed does not reflect the risks related to periods beyond the reassessment date.

In assessing the practical ability to reprice, risks transferred from the member to the Scheme are considered.

IFRS 17(35) Cash flows outside the insurance contracts boundary relate to future insurance contracts and are recognised when those contracts meet the recognition criteria.

The Scheme has assessed all its contracts and determined all contracts have a boundary of one year.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

2 MATERIAL ACCOUNTING POLICIES (continued)

2.8 INSURANCE CONTRACTS (CONTINUED)

2.8.5 Recognition and derecognition

Insurance contracts issued shall be recognised from the earliest of the following:

- (a) The beginning of the coverage period;
- (b) The date when the first payment from a policyholder becomes due; and
- (c) For onerous contracts, when the contracts become onerous.

An insurance contract is derecognised when it is extinguished (i.e. when the obligation specified in the insurance contract expires or is discharged or cancelled).

2.8.6 Premium allocation approach (PAA)

The contract coverage period for contracts issued does not exceed 12 months and consequently the Scheme elected to apply the PAA.

The classification of medical schemes as mutual entities does not impact the extent of insurance cover/insurance contract services to be provided by the medical Scheme in terms of the member contracts and therefore the PAA is still applicable.

In applying the PAA, the medical Scheme chose to recognise any insurance acquisition cash flows as expenses when it incurs those costs.

The Scheme measures the liability for incurred claims at the fulfilment cash flows relating to incurred claims. The future cash flows are not adjusted for the time value of money and the effect of financial risk as these cash flows are expected to be paid in one year or less from the date the claims are incurred. There is no significant financing component included in the liability for remaining coverage and thus the Scheme is not required to apply a discounted value.

2.8.7 Initial and subsequent measurement

For insurance contracts issued, on initial recognition, the Scheme measures the Liability for remaining coverage (LRC) at the amount of contributions received. The amount of insurance revenue recognised in the reporting period depicts the transfer of promised services at an amount that reflects the portion of consideration the Scheme expects to be entitled to in exchange for those services and increased the LRC. Debtors that paid in advance and for which no service has yet been provided are included in the LRC. Debtors in arrears and for which services and coverage have been provided but not yet paid are included in LRC.

The carrying amount of the group of insurance contracts issued at each reporting period is the sum of:

- a. the LRC, including a loss component for onerous contracts where applicable; and
- b. the Liability for incurred claims (LIC), comprising the future fulfilment cash flows related to past service allocated to the group at the reporting date.

For insurance contracts issued, at each of the subsequent reporting dates, the LRC is:

- a. increased for contributions received in the period; and
- b. decreased for the amounts of expected contributions received recognised as insurance revenue for the services provided in the period.

For insurance contracts issued at each of the subsequent reporting dates the LIC is:

- a. best estimate of cash flows and
- b. risk adjustment.

The Scheme has chosen to account for the accounts payable related to the attributable expenses under the currently applicable accounting standard, which is IFRS 9, rather than IFRS 17. Consequently, the attributable expenses payable are disclosed as financial liabilities, specifically under the category of trade and other payables.

Refer to note 3.1 for the significant judgements and estimates used to determine the LIC and the estimates to determine the fulfilment cash flow.

Onerous contract assessment:

In the consideration of whether facts and circumstances indicate that a group of insurance contracts is onerous, the Scheme considers whether the expected deficit of the following year exceeds the insurance liability attributable to future members. In the rare scenario where the following year's deficit exceeds the insurance liability attributable to future members – the contracts written would be onerous and an onerous contract liability raised. Where the amounts attributable to future members exceed the following year's deficit the contracts would not be determined as onerous, and no provision raised as a liability is already recognised.

2.8.8 Insurance revenue

Insurance revenue for the period is the amount of expected premium receipts (excluding the PMSA) allocated to the period. The expected contribution receipts include the risk of non-payment by the member. The Scheme allocates the expected premium receipts to each period of insurance contract services on the basis of the passage of time.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

2 MATERIAL ACCOUNTING POLICIES (continued)

2.8 INSURANCE CONTRACTS (CONTINUED)

2.8.9 Insurance expenses

Insurance service expenses include:

- (a) incurred claims and benefits excluding investment components;
- (b) other incurred directly attributable insurance service expenses;
- (c) changes that relate to past service (i.e., changes in the fulfilment cash flows (FCF) relating to the LIC); and
- (d) changes that relate to future service (i.e., losses/reversals on onerous groups of contracts from changes in the loss components).

Cash flows that are not directly attributable to a group of insurance contracts, such as some product development and training costs, are recognised in other operating expenses as incurred.

The Scheme includes the following acquisition cash flows within the insurance contract boundary that arise from selling, underwriting and starting a group of insurance contracts and that are:

- (a) costs directly attributable to individual contracts and the group of contracts; and
- (b) costs directly attributable to the group of insurance contracts, which are allocated on a reasonable and consistent basis.

Insurance acquisition costs are expensed by the Scheme when it incurs the cost.

2.8.10 Insurance interest income and expenses

The non-distinct investment component (PMSA) accrues interest. This is disclosed within the insurance finance expense line item.

2.9 RISK TRANSFER ARRANGEMENTS

2.9.1 Definition

Risk transfer arrangements are contractual arrangements entered into by the Scheme with a provider. The provider is paid a fixed fee per member or beneficiary to cover the risk of the number of incidents that occur during a specified period and the cost of providing the service. Risk transfer arrangements do not reduce the Scheme's primary obligations to its members and their dependants.

2.9.2 Level of aggregation

Groups of reinsurance contracts held are assessed for aggregation separately from groups of insurance contracts issued. Applying the grouping requirements to reinsurance contracts held, the Scheme aggregates reinsurance contracts held concluded within a calendar year (annual cohorts) into (i) groups of contracts for which there is a net gain at initial recognition, if any; (ii) contracts for which at initial recognition there is no significant possibility of a net gain arising subsequently; and (iii) remaining contracts in the group, if any.

Reinsurance contracts held are assessed for aggregation requirements on an individual contract basis. The Scheme tracks internal management information reflecting historical experiences of such contracts' performance. This information is used for setting pricing of these contracts such that they result in reinsurance contracts held in a net gain position.

2.9.3 Recognition and derecognition

The reinsurance contract held that covers the losses of separate insurance contracts on a proportionate basis is recognised at the later of:

- the beginning of the coverage period of the group; or
- the initial recognition of any underlying insurance contract.

The Scheme does not recognise their reinsurance contract held until it has recognised at least one of the underlying insurance contracts.

2.9.4 Initial and subsequent measurement

For reinsurance contracts held, on initial recognition, the Scheme measures the remaining coverage at the amount of ceding contributions paid.

The carrying amount of a group of reinsurance contracts held at the end of each reporting period is the sum of:

- a. the remaining coverage; and
- b. the incurred claims, comprising the FCF related to past service allocated to the group at the reporting date.

Subsequent measurement of the remaining coverage for reinsurance contracts held is:

- a. increased for ceding contributions paid in the period; and
- b. decreased for the amounts of ceding contributions recognised as reinsurance expenses for the services received in the period.

The Scheme does not adjust the asset for the remaining coverage for reinsurance contracts held for the effect of the time value of money. The reinsurance contributions are due within the coverage period which are one year or less. The LRC is not discounted and there are no significant financing components.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

2 MATERIAL ACCOUNTING POLICIES (continued)

2.9 RISK TRANSFER ARRANGEMENTS (CONTINUED)

2.9.5 Boundary

For groups of reinsurance contracts held, cash flows are within the contract boundary if they arise from substantive rights and obligations that exist during the reporting period in which the Scheme is compelled to pay amounts to the reinsurer or in which the Scheme has a substantive right to receive services from the reinsurer.

The Scheme's capitation agreements held have a duration of one year but are cancellable with a 30-day notice period by either party.

2.9.6 Net income/(expense) from reinsurance contracts held

Reinsurance income consists of the amount that depicts the value the insurer benefits from entering into a risk transfer arrangement (i.e. the value of services received from the capitation provider).

Reinsurance expenses consist of:

- a. reinsurance expenses; and
- b. effect of changes in risk of reinsurer non-performance.

Reinsurance expenses are recognised similarly to insurance revenue. The amount of reinsurance expenses recognised in the reporting period depicts the transfer of received services at an amount that reflects the portion of ceding contributions the Scheme expects to pay in exchange for those services.

For groups of reinsurance contracts held measured under the PAA, the Scheme recognises reinsurance expenses based on the passage of time over the coverage period of a group of contracts.

2.10 EMPLOYEE BENEFITS

2.10.1 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.

2.10.2 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.

2.10.3 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 most likely outcome basis, with the corresponding expense recognised over the service period.

2.11 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

2 MATERIAL ACCOUNTING POLICIES (continued)

2.11 LEASES (CONTINUED)

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.

2.12 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 and losses 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.

2.12.1 Interest income

Interest income is recognised on a yield to maturity basis, taking into 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.

2.12.2 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.

2.12.3 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.

2.13 ALLOCATION OF INCOME AND EXPENSES TO BENEFIT OPTIONS

The following items are directly allocated to benefit options:

- Insurance revenue;
- Claims incurred;
- Net income from risk transfer arrangements/reinsurance;
- Attributable expenses incurred;
- Accredited managed healthcare services;
- Acquisition costs; and
- Finance expenses from insurance contracts issued – PMSA

The remaining non-healthcare expenses and income 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;
- Investment income;
- Sundry income; and
- Asset management fees.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

3 USE OF ESTIMATES AND JUDGEMENTS

Consistent with other IFRS, financial reporting under IFRS 17 is, to a larger extent, based on estimates, judgements and models rather than exact depictions. The IFRS Conceptual Framework establishes the concepts that underlie those estimates, judgements and models. Where an application of a particular standard requires judgements or provides options, it is expected that the preparers of financial information will choose among the alternatives in a way that achieves the objective of financial reporting: to provide financial information about the reporting entity that is useful to the trustees, Council for Medical Schemes (CMS) and members.

In addition to the existing requirement in IFRS to disclose critical judgements made in applying accounting policies (IAS 1(122)) and major sources of estimation uncertainties (IAS 1(125)), IFRS 17 requires the following specific disclosures with respect to contracts in the scope of the standard:

- the methods used to measure insurance contracts and the processes used for estimating inputs to those methods, including quantitative information about those inputs when practicable, and specifically approaches used to determine the risk adjustment for non-financial risk,
- any changes in the above method and process, together with an explanation of the reason for each change and the type of contracts affected.

If an entity uses a technique other than the confidence-level technique for determining the risk adjustment, it is required to disclose a translation of the result of that technique into a confidence level to allow users of financial statements to see how the entity's own assessment of its risk aversion compares to that of other entities.

3.1 SIGNIFICANT JUDGEMENTS AND ESTIMATES FOR INSURANCE CONTRACTS: ASSETS AND LIABILITIES

3.1.1 Assessment as to whether a Scheme is a mutual entity

A medical Scheme is not legally defined as a mutual entity and the assessment as to whether a medical scheme is a mutual entity was done based on the principles set out in IFRS.

IFRS 3 defined a "mutual entity" as "An entity, other than an investor-owned entity, that provides dividends, lower costs or other economic benefits directly to its owners, members or participants. For example, a mutual insurance company, a credit union and a co-operative entity are all mutual entities".

IFRS 17 does not define a "mutual entity" however it provides a key characteristic of a mutual entity in the basis of conclusion to the standard. IFRS 17 paragraph BC265 explains that "a defining feature of an insurer that is a mutual entity is that the most residual interest of the entity is due to a policyholder and not a shareholder." The Act is not explicit that members (i.e. policyholders) hold a residual interest or are entitled to the residual interest upon the liquidation of the medical Scheme. Section 64 of the Act requires the medical Scheme rules to be followed in the event of liquidation.

The rules of the Scheme do not contain specific guidance on how the assets of the Scheme should be distributed on liquidation. The Act prohibits the disposal of assets of a medical Scheme except in limited, listed circumstances, one of them being the liquidation of the Scheme. Members can opt for voluntary liquidation and can distribute the Scheme's remaining assets amongst themselves. As Bonitas does not have shareholders, the current members will access the reserves through economic benefits such as funding reductions in contributions or deferral of contribution increases.

Although the rules do not specify how the assets should be distributed on liquidation, IFRS 17 states that contracts can be written, oral or implied by an entity's customary business practices. Contractual terms include all terms in a contract, explicit or implied, but an entity shall disregard terms that have no commercial substance (i.e. no discernible effect on the economics of the contract). Implied terms in a contract include those imposed by law or regulation" (IFRS 17.2). Therefore, based on customary business practices, the remaining assets of Bonitas should be distributed to the members on liquidation if there are any and if the Scheme does not amalgamate with another Scheme. Even if the assets are distributed by a regulator or by the policyholders to an independent third party e.g. another medical scheme, an administrator or a charity, the important aspect is that the choice resides with the members or the regulator acting on behalf of the members, not with an equity holder.

The substance of the legal framework issued regarding insurance contracts and observed practice is that once a contribution is paid to the medical scheme, the contribution is used to provide benefits to members. The benefits are provided by the medical Scheme (or amalgamated schemes) through insurance coverage, reduced contributions, or payment to members on liquidation (based on votes taken by members).

It is therefore expected that the remaining assets of the Scheme will be used to pay current and future members. Based on the above, Bonitas meets the definition of a mutual entity in IFRS. Bonitas has therefore developed an accounting policy in terms of the IFRS 17 guidance for mutual entities and the educational material as issued by the IASB and the Scheme recognises any cumulative profit or losses as part of the insurance liability attributable to future members (which forms part of the insurance contract liabilities on the face of the statement of financial position).

Consequently, the statement of comprehensive income reflects no total comprehensive income for the year. The movement in the insurance liability attributable to future members are included in the insurance service expenses. Refer to note 11 and 15 for detailed disclosure.

Due to the Scheme being a mutual entity, the assessment of onerous contracts is also affected.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

3 USE OF ESTIMATES AND JUDGEMENTS (continued)

3.1 SIGNIFICANT JUDGEMENTS AND ESTIMATES FOR INSURANCE CONTRACTS: ASSETS AND LIABILITIES (CONTINUED)

3.1.2 Level of aggregation

Judgement has been applied to how the Scheme determined the level of aggregation for the measurement of its insurance contracts. Management has assessed their portfolio as the Scheme as a whole due to the holistic pricing methodologies and risk management strategy that manages the risk on a Scheme level.

The above is demonstrated by the following:

- Hospital claims are managed on a Scheme level.
- Chronic conditions are managed on a Scheme level, i.e. no matter the option the member will have access to the chronic condition management benefit.
- Risk transfer arrangements are based on conditions and not on benefit options.
- Pricing and benefit option changes are determined at a Scheme level to ensure sustainability for the Scheme overall, given inherent cross-subsidies in the medical Scheme environment.
- Risk (utilisation and concentration) is managed holistically.

3.1.3 Risk adjustment – liability for incurred claims (LIC)

The biggest risk inherent in run-off models are the run-off assumptions applied. Any processing changes and/or delays between providers and the administrator (relative to the input assumptions) would impact on the best estimate value of fulfilment cash flow provided.

Therefore, provision for such adverse experience is made in the form of a risk adjustment (that is, where the model relies on run-off assumptions).

The risk adjustment was determined by applying sensitivity testing to the run-off input assumptions used to calculate the best estimate reserve value, i.e. a deterministic sensitivity approach. This methodology is referred to as a 'Provision for Adverse Deviation'.

Stochastic claims modelling (based on simulations of multiple prior year outstanding claim reserve distributions of the Scheme) was used to assess this overall risk adjustment value by attaching an upper confidence interval to the value. In other words, it was also stochastically assessed what the required risk adjustment would be to ensure that the Scheme is not under-reserved with a certain confidence level, relative to its unique reserving history and claims run-off patterns. The risk adjustment, relative to this level, was assessed to be greater than 90.0%.

The risk adjustment reflects the Scheme's risk attitude towards the levels of conservatism considered in its liability reserving, solvency management and pricing practices. Changes in the risk adjustment for non-financial risk are not disaggregated and included in the insurance service result. Refer to note 12 for detailed disclosure.

3.1.4 Risk adjustment – risk transfer arrangements

For reinsurance contracts held, the risk adjustment for non-financial risk represents the amount of risk being transferred by the Scheme to the reinsurer. A confidence interval level of 90% was applied with regards to the determination of the risk adjustment for the risk transfer arrangements per service provider. Refer to note 13 for detailed disclosure.

3.1.5 Estimates of future cash flows to fulfil insurance contracts

Included in the measurement of the group of contracts are all the future cash flows within the boundary of the group of contracts. The estimates of these future cash flows are based on probability weighted expected future cash flows. The Scheme estimates which cash flows are expected and the probability that they will occur as at the measurement date. In making these expectations, the Scheme uses information about past events, current conditions and forecasts of future conditions. The Scheme's estimate of future cash flows is the mean of a range of scenarios that reflect the full range of possible outcomes. Each scenario specifies the amount, timing and probability of cash flows. The probability weighted average of the future cash flows is calculated using a deterministic scenarios representing the probability weighted mean of a full range of scenarios.

The uncertainty in the insurance contracts lies in the number, severity and timing of claims.

Assumptions used to develop estimates about future cash flows are reassessed at each reporting date and adjusted where required, refer note 12.

3.1.6 Methods used to measure the insurance contracts

Judgement is involved in assessing the most appropriate technique to estimate insurance liabilities, refer note 12. A 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 are 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

3 USE OF ESTIMATES AND JUDGEMENTS (continued)

3.1 SIGNIFICANT JUDGEMENTS AND ESTIMATES FOR INSURANCE CONTRACTS: ASSETS AND LIABILITIES (CONTINUED)

3.1.6 Methods used to measure the insurance contracts (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. For the most recent treatment months the outstanding claims can be significant, and therefore very sensitive to the run-off assumptions.

A further technique, called the Bornhuetter-Ferguson method, can also be employed for the most recent months, which are the most sensitive to the run-off factors. This method allows for an independent estimate of the expected claims to have an impact on the projected amount and, thus, reduces the sensitivity of the projection to the run-off factors. The Scheme's claims budget is typically used as the original independent estimate. The estimate can be refined as the year progresses based on more recent claims experience (i.e. using an approach called 'credibility theory').

Information from the managed healthcare provider, on hospital pre-authorisations can also be 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.

As the reserving model can rely on independent estimates (for example, budgeted claims or independently estimated hospital amounts from pre-authorisation models), this would reduce the sensitivity to run-off assumptions. The 2023 and 2024 Financial years primarily used the chain ladder method, with independent estimates incorporated into the model as well (Bornhuetter-Ferguson).

The following was 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 i.e. distribution of members and their beneficiaries across various options;
- Changes in benefit limits; and
- Changes in prescribed minimum benefits.

The Scheme is not required to disclose information about the development of claims for which uncertainty about the amount and timing of the claims payments is typically resolved within one year.

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. Refer to note 6, 7 and 12 for further detailed disclosure.

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, valued the Scheme's investment property portfolio in the prior year.

Valuations reflected, 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. Refer to note 5.

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, refer note 22.5.

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

4 PROPERTY AND EQUIPMENT

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

R'000	Note	2024	2023
Property and equipment	4.1	1 725	1 247
Right of use asset	4.2	1 694	3 954
		3 419	5 201

4.1 PROPERTY AND EQUIPMENT

R'000	Motor Vehicles	Leasehold Improvements	Computer Equipment	Office Equipment	Furniture and Fittings	Total
Cost						
Balance at 31 December 2022	359	4 365	5 659	1 161	5 199	16 743
Additions	–	344	205	–	40	589
Disposals/scrappings	–	–	–	–	–	–
Balance at 31 December 2023	359	4 709	5 864	1 161	5 239	17 332
Additions	–	–	280	198	218	696
Disposals/scrappings	–	–	–	–	–	–
Balance at 31 December 2024	359	4 709	6 144	1 359	5 457	18 028
Accumulated depreciation						
Balance at 31 December 2022	359	4 365	5 490	777	4 576	15 567
Disposals/scrappings	–	–	–	–	–	–
Depreciation for the period	–	52	106	163	197	518
Balance at 31 December 2023	359	4 417	5 596	940	4 773	16 085
Disposals/scrappings	–	–	–	–	–	–
Depreciation for the period	–	–	156	42	20	218
Balance at 31 December 2024	359	4 417	5 752	982	4 793	16 303
Carrying amount						
Balance at 31 December 2023	–	292	268	221	466	1 247
Balance at 31 December 2024	–	292	392	377	664	1 725

4.2 LEASE

The Scheme leases the building from which it operates its head office. The remaining lease term on 31 December 2024 was determined to be 9 months (2023: one year and 9 months), ending 30 September 2025. 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 2023	6 214
Depreciation charge for the year	(2 260)
Balance at 31 December 2023	3 954
Depreciation charge for the year	(2 260)
Balance at 31 December 2024	1 694

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

4 PROPERTY AND EQUIPMENT (continued)

4.2 LEASE (CONTINUED)

Lease liabilities

R'000	Building	Total
Maturity analysis – contractual undiscounted cash flows:		
Not later than one year	2 662	2 662
Later than one year and not later than five years	2 085	2 085
Total undiscounted lease liabilities as at 31 December 2023	4 747	4 747
Not later than one year	2 085	2 085
Later than one year and not later than five years	–	–
Total undiscounted lease liabilities as at 31 December 2024	2 085	2 085

The Scheme 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 9 months as at 31 December 2024 (2023: one year and 9 months):

	2024 R'000	2023 R'000
Current lease liability	2 405	2 730
Non-current lease liability	–	2 002
	2 405	4 732

The Scheme's interest rate per the lease contract of 8% was used to discount the cash flows 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 87% of the total 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 2024:

	2024 R'000	2023 R'000
Interest on lease liability	(322)	(531)
Rental costs – variable in nature	(2 100)	(1 962)
	(2 422)	(2 493)

Total cash outflow with respect to the head office lease for 31 December 2024 is as follows:

	2024 R'000	2023 R'000
Lease liability cash flows	(2 649)	(2 121)
Rental costs – variable in nature	(2 100)	(1 962)
	(4 749)	(4 083)

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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

5 INVESTMENT PROPERTIES

	2024 R'000	2023 R'000
Balance at the beginning of the year	–	78 500
Fair value decrease in investment property	–	(3 500)
Reclassified as investment property held for sale (note 6)	–	(75 000)
Balance at the end of the year	–	–

In the prior year Management performed an assessment and determined that the investment property should be recognised as a non-current asset held for sale as all the recognition criteria had been met as per IFRS 5 at 31 December 2023 given that the Board had resolved to realise the value of the property through sale and the property had been actively marketed during the 2023 financial period. For that reason, the investment property was reclassified to 'Investment Property held for sale' and valued at R75 million. Refer to note 6 of the financial statements.

6 INVESTMENT PROPERTY HELD FOR SALE

	2024 R'000	2023 R'000
Balance at the beginning of the year	72 700	–
Transfer from investment property at fair value (note 5)	–	75 000
Reversal of provision for selling costs	2 300	–
Provision for selling costs	–	(2 300)
Proceeds from sale of the property	(61 500)	–
Loss on sale of investment property	(13 500)	–
Net fair value less costs to sell at the end of the year	–	72 700
Direct operating expenses incurred in the generation of rental income applicable to investment property held for sale	5 194	4 722

Investment property held for sale comprised commercial properties that were leased to third parties. The properties were leased for various periods up until 30 September 2024. No contingent rents were charged. Lease rental receipts amounting to R9.4 million (2023: R10.7 million) relating to the lease of investment properties were included in profit or loss, refer to note 16 of the financial statements.

In the prior year, after an extended period exceeding 12 months of actively marketing the property, and the economic conditions prevalent in the commercial property sector, management, with advice from industry experts, determined that the realisable selling price of the property was R75 million excluding VAT. Management estimated the costs associated to sell the property at R2.3 million. The net fair value less costs to sell of the property were therefore determined at R72.7 million.

The property was sold for R61.5 million in August 2024 and the transfer took place on 31 October 2024. The proceeds from disposal amounted to R59.4 million after commission payable of R2.1 million. A loss on sale of investment property was recognised representing the write down from R75 million to selling price of R61.5 million.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

7 FINANCIAL ASSETS HELD AT FAIR VALUE THROUGH PROFIT OR LOSS

	2024 R'000	2023 R'000
Balance at the beginning of the year	10 133 968	9 896 410
Additions/reinvestments	2 414 357	702 280
Withdrawals	(2 733 252)	(820 508)
Interest income reinvested	230 954	207 700
Dividend income reinvested	215	1 594
Asset management fees capitalised to investments	(310)	(1 277)
Net fair value gains on fair value assets through profit or loss (note 16)	642 283	147 769
Balance at the end of the year	10 688 215	10 133 968
Non-current	5 932 586	4 757 012
Current	4 755 629	5 376 956
	10 688 215	10 133 968
Comprises:		
Listed equities	4 105 840	4 569 302
Bonds	3 825 090	3 924 002
Money market instruments	2 757 285	1 640 664
	10 688 215	10 133 968

8 TRADE AND OTHER RECEIVABLES

	2024 R'000	2023 R'000
Trade and other receivables		
Prepaid expenses	6 093	5 815
Amount owing from related parties	1 061	–
Other receivables	5 182	5 483
Interest receivables	117	1 847
Rent receivables	821	777
Rent deposit	1 210	1 210
Sundry receivables	3 034	1 649
Total trade and other receivables	12 336	11 298

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

9 CASH AND CASH EQUIVALENTS

	2024 R'000	2023 R'000
Cash with investment managers	414 711	235 119
Call accounts with investment managers	187 251	123 295
Current accounts with banks	246 753	409 187
Total cash and cash equivalents	848 715	767 601

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 8.1% (prior year: 6.0%) on call account balances.

10 LONG-TERM EMPLOYEE BENEFIT OBLIGATION

Eligible executive and staff qualify for a long-term incentive that runs over a fixed three-year cycle. The vesting criteria is dependent upon both service and performance elements. The three year cycle/vesting period runs from January 2024 to December 2026.

	2024 R'000	2023 R'000
Unvested long-term employee benefit obligation	2 927	5 716
Balance at the end of the year	2 927	5 716

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.

	2024 R'000	2023 R'000
Current	–	5 716
Non-current	2 927	–
	2 927	5 716

11 INSURANCE LIABILITY FOR FUTURE MEMBERS

	2024 R'000	2023 R'000
Balance at the beginning of the year	8 895 202	8 629 888
Excess over net asset value (Note 15.6)	133 891	265 314
Balance at the end of the year	9 029 093	8 895 202

The Scheme is budgeting a surplus for the year ending 31 December 2025. Therefore the balance as at 31 December 2024 is considered a non-current liability (2023: Scheme budgeted a surplus for the year ending 31 December 2024 and therefore the balance in the prior year was considered a non-current liability). The liability for future members has been determined on the basis that administration costs are covered by future contributions.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

12 INSURANCE CONTRACT LIABILITIES

The Scheme as a whole is identified as a portfolio. All the contracts issued by the Scheme are subject to similar risks and are managed together. The breakdown at a portfolio level of the Liability for remaining coverage and Liability for incurred claims are set out below:

RECONCILIATION OF LIABILITY FOR REMAINING COVERAGE AND LIABILITY FOR INCURRED CLAIMS

	Liability for remaining coverage (LRC)		Liability for incurred claims (LIC)		Total 2024 R'000
	Excluding loss component R'000	Loss component R'000	Best Estimate Liability R'000	Risk Adjustment R'000	
Opening insurance contract assets	–	–	–	–	–
Opening insurance contract liabilities	(242 174)	–	2 223 312	145 351	2 126 489
Net insurance contract liabilities as at 1 January 2024	(242 174)	–	2 223 312	145 351	2 126 489
<i>Changes in the statement of comprehensive income</i>					
Insurance revenue	(20 888 306)	–	–	–	(20 888 306)
Insurance revenue from contracts measured under the PAA (note 15)	(20 888 306)	–	–	–	(20 888 306)
Insurance services expense	–	–	22 282 155	5 149	22 287 304
Incurred claims and other insurance service expenses (note 15)	–	–	22 310 200	150 500	22 460 700
Changes that relate to past service – adjustments to the LIC (note 15)	–	–	(28 045)	(145 351)	(173 396)
Losses on onerous contracts and reversal of those losses (note 15)	–	–	–	–	–
Insurance service result	(20 888 306)	–	22 282 155	5 149	1 398 998
Finance expense from insurance contracts issued (note 12.4)	–	–	84 852	–	84 852
Total changes in the statement of comprehensive income	(20 888 306)	–	22 367 007	5 149	1 483 850
Investment components*	(1 115 177)	–	1 115 177	–	–
<i>Cash flows</i>					
Contributions received**	21 967 054	–	–	–	21 967 054
Claims and other directly attributable expenses paid***	–	–	(22 573 777)	–	(22 573 777)
Insurance acquisition cash flows paid	–	–	(420 406)	–	(420 406)
Total cash flow	21 967 054	–	(22 994 183)	–	(1 027 129)
Net insurance contract liabilities as at 31 December 2024	(278 603)	–	2 711 313	150 500	2 583 210
Closing insurance contract assets	–	–	–	–	–
Closing insurance contract liabilities	(278 603)	–	2 711 313	150 500	2 583 210
Net insurance contract liabilities as at 31 December 2024	(278 603)	–	2 711 313	150 500	2 583 210
*Savings contributions received	21 967 054				
**Contributions received					
Risk contributions	20 851 877				
PMSA contributions	1 115 177				
***Claims and other directly attributable expenses paid	(22 573 777)				
Risk claims	(17 819 484)				
PMSA claims	(927 066)				
Expenses	(1 341 314)				
PMSA refunds	(76 784)				
Claim recoveries ¹	(2 409 129)				

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

12 INSURANCE CONTRACT LIABILITIES (continued)

The Scheme as a whole is identified as a portfolio. All the contracts issued by the Scheme are subject to similar risks and are managed together. The breakdown at a portfolio level of the Liability for remaining coverage and Liability for incurred claims are set out below:

RECONCILIATION OF LIABILITY FOR REMAINING COVERAGE AND LIABILITY FOR INCURRED CLAIMS (CONTINUED)

	Liability for remaining coverage (LRC)		Liability for incurred claims (LIC)		Total 2024 R'000
	Excluding loss component R'000	Loss component R'000	Best Estimate Liability R'000	Risk Adjustment R'000	
Opening insurance contract assets	–	–	–	–	–
Opening insurance contract liabilities	(171 645)	–	2 081 154	132 150	2 041 659
Net insurance contract liabilities as at 1 January 2023	(171 645)	–	2 081 154	132 150	2 041 659
<i>Changes in the statement of comprehensive income</i>					
Insurance revenue	(19 461 328)	–	–	–	(19 461 328)
Insurance revenue from contracts measured under the PAA (note 15)	(19 461 328)	–	–	–	(19 461 328)
Insurance services expense	–	–	20 214 744	13 201	20 227 945
Incurred claims and other insurance service expenses (note 15)	–	–	20 248 453	145 351	20 393 804
Changes that relate to past service – adjustments to the LIC (note 15)	–	–	(33 709)	(132 150)	(165 859)
Losses on onerous contracts and reversal of those losses (note 15)	–	–	–	–	–
Insurance service result	(19 461 328)	–	20 214 744	13 201	766 617
Finance expense from insurance contracts issued (note 12.4)	–	–	70 838	–	70 838
Total changes in the statement of comprehensive income	(19 461 328)	–	20 285 582	13 201	837 455
Investment components*	(973 682)	–	973 682	–	–
<i>Cash flows</i>					
Contributions received**	20 364 481	–	–	–	20 364 481
Claims and other directly attributable expenses paid***	–	–	(20 721 905)	–	(20 721 905)
Insurance acquisition cash flows paid	–	–	(395 201)	–	(395 201)
Total cash flow	20 364 481	–	(21 117 106)	–	(752 625)
Net insurance contract liabilities as at 31 December 2023	(242 174)	–	2 223 312	145 351	2 126 489
Closing insurance contract assets	–	–	–	–	–
Closing insurance contract liabilities	(242 174)	–	2 223 312	145 351	2 126 489
Net insurance contract liabilities as at 31 December 2023	(242 174)	–	2 223 312	145 351	2 126 489
**Contributions received	20 364 481				
Risk contributions	19 390 799				
PMSA contributions	973 682				
***Claims and other directly attributable expenses paid	(20 721 905)				
Risk claims***	(16 389 990)				
PMSA claims	(805 937)				
Expenses***	(1 293 987)				
PMSA refunds	(65 697)				
Claim recoveries ¹	(2 166 292)				

***The claims and other directly attributable expense paid amounts have been re-represented in the prior period to enhance the presentation and reconcile the cash flows to the Statement of Cash Flows and notes.

¹ Claims recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

12 INSURANCE CONTRACT LIABILITIES (continued)

12.1 RECONCILIATION OF NET INSURANCE CONTRACT LIABILITIES BALANCES

The breakdown of the net insurance contract liabilities are set out below:

	Liability for remaining coverage (LRC) R'000	Liability for incurred claims (LIC) R'000	Total 2024 R'000
Net insurance contract liabilities			
Contributions outstanding	(658 034)	–	(658 034)
Recoveries due from members for co-payments	–	(1 344)	(1 344)
Service provider receivables	–	(6 038)	(6 038)
Savings plan account advances	–	(831)	(831)
Contributions received in advance	366 461	–	366 461
Credit balances due to members – overpayments	12 971	–	12 971
Reported claims not yet paid	–	253 977	253 977
Personal medical savings accounts liability (note 12.4)	–	1 363 188	1 363 188
Best estimate liability – incurred but not reported	–	1 102 360	1 102 360
Risk adjustment	–	150 500	150 500
Total net insurance contract liabilities as at 31 December 2024	(278 602)	2 861 812	2 583 210

	Liability for remaining coverage (LRC) R'000	Liability for incurred claims (LIC) R'000	Total 2023 R'000
Net insurance contract liabilities			
Contributions outstanding	(630 989)	–	(630 989)
Recoveries due from members for co-payments	–	(1 359)	(1 359)
Service provider receivables	–	(5 884)	(5 884)
Savings plan account advances	–	(728)	(728)
Contributions received in advance	377 975	–	377 975
Credit balances due to members – overpayments	10 840	–	10 840
Reported claims not yet paid	–	117 928	117 928
Personal medical savings accounts liability (note 12.4)	–	1 180 666	1 180 666
Best estimate liability – incurred but not reported	–	932 689	932 689
Risk adjustment	–	145 351	145 351
Total net insurance contract liabilities as at 31 December 2023	(242 174)	2 368 663	2 126 489

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

12 INSURANCE CONTRACT LIABILITIES (continued)

12.2 LIABILITY FOR REMAINING COVERAGE (LRC)

During the reporting period, the LRC was reduced by the amount of insurance revenue recognised for the services provided in the period. The composition of insurance revenue is disclosed in the analysis of insurance revenue provided in note 15. The amount of insurance revenue recognised in the reporting period depicts the transfer of promised services at an amount that reflects the portion of consideration the Scheme expects to be entitled to in exchange for those services and increased the LRC. Debtors that paid in advance and for which no service has yet been provided are included in the LRC. Debtors in arrears and for which services and coverage have been provided but not yet paid are included in LRC.

12.3 LIABILITY FOR INCURRED CLAIMS (LIC)

For insurance contracts issued at each of the subsequent reporting dates the LIC is:

- a. best estimate of cash flows and
- b. risk adjustment.

- (i) 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 (i.e. to “run off”).

Run-off patterns are therefore calculated by considering the Scheme’s unique experience on the pattern of when claims occur and when they are ultimately settled, categorised into groups for which one can expect a homogenous run-off pattern to emerge.

The best estimate of cash flow provision is based on information available as at the measurement date, which includes amounts already settled (processed) as at the measurement date, the run-off input assumptions outlined above, as well as any other available estimates (for example, budgeted claims or independently estimated hospital amounts from pre-authorisation case estimate models).

Risk adjustment:

The biggest risk inherent in run-off models are the run-off assumptions applied. Any processing changes and/or delays between providers and the administrator (relative to the input assumptions) would impact on the best estimate value of fulfilment cash flow provided.

Therefore, provision for such adverse experience is made in the form of a risk adjustment (that is, where the model relies on run-off assumptions).

The risk adjustment was determined by applying sensitivity testing to the run-off input assumptions used to calculate the best estimate reserve value, i.e. a deterministic sensitivity approach. This methodology is referred to as a ‘Provision for Adverse Deviation’.

Stochastic claims modelling (based on simulations of multiple prior year outstanding claim reserve distributions of the Scheme) was used to assess this overall risk adjustment value by attaching an upper confidence interval to the value. In other words, it was also stochastically assessed what the required risk adjustment would be to ensure that the Scheme is not under-reserved with a certain confidence level, relative to its unique reserving history and claims run-off patterns. The risk adjustment, relative to this level, was assessed to be greater than 90.0%.

The risk adjustment reflects the Scheme’s risk attitude towards the levels of conservatism considered in its liability reserving, solvency management and pricing practices.

Claims sensitivity:

Refer Note 22.4 for the claims sensitivity analysis.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

12 INSURANCE CONTRACT LIABILITIES (continued)

12.4 RECONCILIATION OF MEMBERS' PMSA BALANCE

The PMSA is a non-distinct investment component with the balances included in either insurance contract assets or liabilities in the statement of financial position. The Members' PMSA Reconciliation in line with Regulation 10 of the Act:

	2024 R'000	2023 R'000
Balance of Personal medical savings account liability at 1 January	1 180 666	1 016 135
Less: Personal medical savings plan advances	(1 339)	(1 300)
Balance of Personal medical savings account liability at 1 January	1 179 327	1 014 835
Add: Savings account contributions received (note 15)	1 115 177	973 682
Savings plan liabilities transferred to the Scheme from other Schemes in terms of Regulation 10 (4)	2 232	1 678
Net interest paid on savings plan account	84 852	70 838
Interest paid	103 571	86 864
Investment fees	(1 648)	(1 411)
Recovery of personal medical savings account investment and administrative expense (note 17)	(17 071)	(14 615)
Less: Claims paid on behalf of members	(927 066)	(805 937)
Refunds on death or resignation in terms of Regulation 10 (5)	(76 784)	(65 697)
Personal medical savings plan advances	1 529	1 339
Unclaimed Personal medical savings account liability written off to Scheme funds (note 17)	(16 079)	(10 072)
Balances due to members on Personal medical savings accounts held at 31 December	1 363 188	1 180 666

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, 15.0% on BonFit, 15.0% on BonComplete, 25.0% 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) 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 enrolls in another benefit option or medical Scheme without a PMSA, or does not enrol in another medical Scheme.

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 9.0% (2023: 8.8%) and 7.5% was allocated to the PMSA balances.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

13 REINSURANCE CONTRACT ASSETS

RECONCILIATION OF ASSET FOR REMAINING COVERAGE AND ASSET FOR INCURRED CLAIMS FOR REINSURANCE CONTRACTS

	Asset for remaining coverage (ARC)		Asset for incurred claims (AIC)		Total 2024 R'000
	Excluding loss recovery component R'000	Loss recovery component R'000	Best Estimate Asset R'000	Risk Adjustment R'000	
2024					
Opening reinsurance contract assets as at 1 January 2024	4 698	–	77 051	4 449	86 198
Changes in the statement of comprehensive income:					
Allocation of RTA premiums paid* (note 15.7)	(1 951 687)	–	–	–	(1 951 687)
Amounts recoverable from reinsurers (note 15.7)			2 385 244	(237)	2 385 007
Recoveries for incurred claims	–	–	2 462 295	4 212	2 466 507
Changes that relate to past service – adjustments to incurred claims	–	–	(77 051)	(4 449)	(81 500)
Total changes in the statement of comprehensive income	(1 951 687)	–	2 385 244	(237)	433 320
Cash flows					
Premiums paid	1 984 995	–	–	–	1 984 995
Recoveries from reinsurance**	–	–	(2 409 129)	–	(2 409 129)
Total cash flow	1 984 995	–	(2 409 129)	–	(424 134)
Closing reinsurance contract assets as at 31 December 2024	38 006	–	53 166	4 212	95 384

* FY2024 includes a refund owing of capitation fees totalling R38 million, comprising of R10 million due by Scriptpharm Risk Management Proprietary Limited and R28 million due by Preferred Provider Negotiators Proprietary Limited.

** Recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction.

	Asset for remaining coverage (ARC)		Asset for incurred claims (AIC)		Total 2024 R'000
	Excluding loss recovery component R'000	Loss recovery component R'000	Best Estimate Asset R'000	Risk Adjustment R'000	
2023					
Opening reinsurance contract assets as at 1 January 2023	61 468	–	50 045	2 899	114 412
Changes in the statement of comprehensive income:					
Allocation of RTA premiums paid* (note 15.7)	(1 879 274)	–	–	–	(1 879 274)
Amounts recoverable from reinsurers (note 15.7)			2 193 298	1 550	2 194 848
Recoveries for incurred claims	–	–	2 243 343	4 449	2 247 792
Changes that relate to past service – adjustments to incurred claims	–	–	(50 045)	(2 899)	(52 944)
Total changes in the statement of comprehensive income	(1 879 274)	–	2 193 298	1 550	315 574
Cash flows					
Premiums paid	1 822 504	–	–	–	1 822 504
Recoveries from reinsurance**	–	–	(2 166 292)	–	(2 166 292)
Total cash flow	1 822 504	–	(2 166 292)	–	(343 788)
Closing reinsurance contract assets as at 31 December 2023	4 698	–	77 051	4 449	86 198

* FY2024 includes a refund owing of capitation fees totalling R38 million, comprising of R10 million due by Scriptpharm Risk Management Proprietary Limited and R28 million due by Preferred Provider Negotiators Proprietary Limited.

** Recoveries from reinsurance represent the value of the services provided by the risk transfer provider. This represents a non-cash transaction.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

14 TRADE AND OTHER PAYABLES

	2024 R'000	2023 R'000
14.1 TRADE AND OTHER PAYABLES		
Accrual of external audit fees	2 925	2 973
Accrual of internal audit fees	1 721	1 045
Amounts owing to administrator	2 344	3 774
Amounts owing to related entities (including marketing costs)	4 549	16 562
South African Revenue Service	–	272
Accrual for advertising and marketing expenses (excluding related entity)	4 935	8 073
Sundry payables	13 960	12 128
Total trade and other payables	30 434	44 827
Total arising from any financial payable	30 434	44 827

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

15 INSURANCE REVENUE AND SERVICE EXPENSES

	2024 R'000	2023 R'000
Insurance revenue		
Gross contributions from contracts	22 003 483	20 435 010
Savings contributions from contracts (note 12)	(1 115 177)	(973 682)
Total insurance revenue	20 888 306	19 461 328
Less: Insurance service expenses		
Claims incurred (note 15.1)	20 091 944	18 066 419
Third party claims recoveries (note 15.8)	(58 387)	(57 698)
Changes that relate to past service – adjustment to the LIC (note 15.2)	(173 396)	(165 859)
Insurance acquisition cash costs (note 15.3)	420 406	395 201
Accredited managed healthcare services (note 15.4)	664 000	606 668
Losses on onerous contracts and reversal of those losses	–	–
Attributable expenses incurred (note 15.5)	1 208 846	1 117 900
Amounts attributable to future members (note 15.6)	133 891	265 314
Total insurance service expenses	22 287 304	20 227 945
Net income from risk transfer arrangement/reinsurance contract held		
Net income from risk transfer arrangement/reinsurance (note 15.7)	433 320	315 574
Total insurance service result	(965 678)	(451 043)
15.1 CLAIMS INCURRED		
Incurred claims	20 091 944	18 066 419
Total claims incurred	20 091 944	18 066 419
15.2 CHANGES THAT RELATE TO PAST SERVICE – ADJUSTMENT TO THE LIC		
Changes that relate to past service – adjustment to the LIC	(173 396)	(165 859)
Total changes that relate to past service – adjustment to the LIC	(173 396)	(165 859)
15.3 INSURANCE ACQUISITION COSTS		
Broker fees	420 406	395 201
Total Insurance acquisition costs	420 406	395 201

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

15 INSURANCE REVENUE AND SERVICE EXPENSES (continued)

	2024 R'000	2023 R'000
15.4 ACCREDITED MANAGED HEALTHCARE SERVICES		
Hospital benefit management	227 466	211 163
Medicine benefit management	111 335	103 347
Disease management	130 152	112 157
HIV/AIDS management	62 223	59 131
Provider network management	109 266	98 843
Dental risk management	23 558	22 027
Total Accredited managed healthcare services	664 000	606 668
15.5 ATTRIBUTABLE EXPENSES INCURRED		
Accredited Administrator service fees	1 010 512	954 308
Member record management	140 639	133 298
Contribution management	54 549	51 279
Claims management	240 134	226 248
Financial management	43 634	41 027
Information management and data control	152 687	143 547
Broker remuneration management	109 060	102 534
Customer services	269 809	256 375
Other expenses	198 334	163 592
Marketing costs	148 831	128 674
Benefit management services	35 534	17 000
RAF administration expense	2 344	6 746
Wellness expenses	9 132	9 129
Actuarial services	2 493	2 043
Total Attributable expenses incurred	1 208 846	1 117 900
15.6 AMOUNTS ATTRIBUTABLE TO FUTURE MEMBERS		
Excess over net asset value	133 891	265 314
Total amounts attributable to future members	133 891	265 314
NET INCOME FROM RISK TRANSFER ARRANGEMENT/REINSURANCE CONTRACT HELD		
15.7		
An allocation of premiums paid	1 951 687	1 879 274
Dental Information Systems Proprietary Limited	338 785	346 269
Scriptpharm Risk Management Proprietary Limited*	811 330	769 874
Preferred Provider Negotiators Proprietary Limited*	249 768	244 848
Europ Assistance Worldwide Services (South Africa) Proprietary Limited – EMS	159 529	141 952
Europ Assistance Worldwide Services (South Africa) Proprietary Limited – Travel	14 866	14 179
Private Health Administrators Proprietary Limited	377 409	362 152
Amounts recovered from risk transfer arrangement/reinsurance	(2 385 007)	(2 194 848)
Claims recoveries	(2 385 007)	(2 194 848)
Total Net income from risk transfer arrangement/reinsurance contract held	(433 320)	(315 574)

* FY2024 includes a refund owing of capitation fees totalling R38 million, comprising of R10 million due by Scriptpharm Risk Management Proprietary Limited and R28 million due by Preferred Provider Negotiators Proprietary Limited.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

15 INSURANCE REVENUE AND SERVICE EXPENSES (continued)

15.7 NET INCOME FROM RISK TRANSFER ARRANGEMENT/REINSURANCE CONTRACT HELD (CONTINUED)

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

	2024 R'000	2023 R'000
Dental Information Systems Proprietary Limited	(128 668)	(75 702)
Scriptpharm Risk Management Proprietary Limited	(159 121)	(90 344)
Preferred Provider Negotiators Proprietary Limited	(43 259)	(47 947)
Europ Assistance Worldwide Services (South Africa) Proprietary Limited – EMS	(45 368)	(47 033)
Europ Assistance Worldwide Services (South Africa) Proprietary Limited – International Travel	6 399	3 662
Private Health Administrators Proprietary Limited	(63 303)	(58 210)
Total Net income from risk transfer arrangement/reinsurance contract held	(433 320)	(315 574)

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 Europ Assistance Worldwide Services (South Africa) Proprietary Limited;
- International travel benefits provided by Europ Assistance Worldwide Services (South Africa) Proprietary Limited; and
- Non-hospital events for Boncap provided by Private Health Administrators 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.

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 remainder to 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.

Private Health Administrators Proprietary Limited (“PHA”)

The Scheme has entered into a risk transfer arrangement with PHA to provide non-hospital benefits to members belonging to the Boncap option. The Scheme pays PHA a monthly fixed fee per beneficiary on Boncap option.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

15 INSURANCE REVENUE AND SERVICE EXPENSES (continued)

15.8 THIRD PARTY CLAIM RECOVERIES

Third party claim recoveries of R58.4 million (2023: R57.7 million) are included in insurance services expenses as part of net claims incurred. Included in this are third party recoveries for motor vehicle accident ("MVA") and injury on duty ("IOD") claims of R1.4 million (2023: R11.9 million). The timing and consideration of MVA or Road Accident Fund recoveries is uncertain. These claims are currently being administered by Gildenhuis Malatji Attorneys and Karl Els Attorneys. The claims recoveries in the current year includes R34.5 million (2023: R35.8 million), net of recovery fees, in relation to forensic recoveries pertaining to the fraud, waste and abuse services provided by the Administrator, R0.2 million (2023: R0.5 million) in relation to clawbacks from diabetes programme and R22.2 million (2023: R9.5 million) in recoveries from Mediclinic, Netcare and Life Healthcare related to settlement discounts.

16 INVESTMENT INCOME

	2024 R'000	2023 R'000
16.1 INVESTMENT INCOME – SCHEME		
Cash and cash equivalents interest income	19 942	11 508
Financial assets held at fair value through profit or loss	714 103	659 960
Interest income	521 185	462 738
Dividend income	192 918	197 222
Net fair value gains on financial assets held at fair value through profit or loss	642 283	147 769
Rental income	9 368	10 678
Contractual rental	9 368	10 302
Straight-lining of lease accrual	–	376
Total investment income – Scheme	1 385 696	829 915
16.2 CHANGE IN FAIR VALUE OF INVESTMENT PROPERTY		
Change in fair value of investment property	–	(3 500)
Total change in fair value of investment property	–	(3 500)

17 SUNDRY INCOME

	2024 R'000	2023 R'000
Profit on sale of property and equipment	–	12
Sundry income	44 020	38 678
Unclaimed personal medical savings account write backs (note 12.4)	16 079	10 072
Recovery of personal medical savings account investment and administration expense (note 12.4)	17 071	14 615
Service Level Agreement penalty recoveries from Administrator	9 655	13 228
Other income	1 215	763
Total sundry income	44 020	38 690

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 15.8 third party claims recoveries which includes recoveries as a result of fraud, waste and abuse services provided by the Administrator.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

18 ADMINISTRATION FEES AND OTHER OPERATING EXPENSES

	2024 R'000	2023 R'000
Other administration services provided by Accredited Administrator (note 18.1)	116 647	108 865
Actuarial services	3 046	2 078
Annual general meeting costs	1 356	1 760
Audit remuneration – external	6 694	4 333
Audit fees	3 657	4 333
Fees for non-audit services	2 761	–
Prior year under provision	276	–
Audit remuneration – internal	4 691	3 526
Audit fees	4 569	3 526
Prior year under provision	122	–
Bank charges	4 095	4 001
Communication expenses	219	205
Consulting fees	7 236	6 175
Council for Medical Schemes levies	16 805	16 405
Committee fees – Independent members	1 646	1 500
Audit and risk committee fees	714	611
Investment committee fees	222	291
Managed care committee fees	302	234
Remuneration committee fees	408	364
Computer maintenance	5 650	2 649
Depreciation	2 478	2 778
Fidelity, professional indemnity and other insurance premiums	1 579	1 459
Hire of equipment	148	133
Human resourcing and payroll management fees	154	366
Legal fees and inspection costs	2 685	2 372
Marketing and advertising expenses	82 409	91 431
Meeting venue and catering costs	198	189
Office expenses	355	338
Postage and courier service	47	65
Principal Officer short-term employee benefits	9 369	8 672
Principal Officer remuneration	5 391	5 210
Performance incentive	2 215	1 724
Unvested long term employee benefit	1 246	1 306
Defined contribution benefits	318	291
Other disbursements	199	141
Printing and stationery	768	1 318
Professional services	1 133	1 254
Rental costs	2 100	1 962
Repairs and maintenance	4	23
Staff short-term employee benefits	31 653	28 860
Staff remuneration	22 073	20 877
Performance incentive	5 143	4 361
Unvested long term employee benefit	1 681	961
Defined contribution benefits	1 318	1 197
Other disbursements	1 438	1 464
Subscription fees	3 658	3 508
Sundry expenses	402	2 744
Travel, accommodation and conferences	813	628
Trustee elections	8 352	–
Trustees' remuneration and other disbursements (note 18.2)	8 111	6 660
Trustees' remuneration	7 460	6 103
Other disbursements	651	557
	324 501	306 257

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

18 ADMINISTRATION FEES AND OTHER OPERATING EXPENSES (continued)

	2024 R'000	2023 R'000
OTHER ADMINISTRATION SERVICES PROVIDED BY ACCREDITED		
18.1 ADMINISTRATOR		
Internal audit services	32 914	31 293
Forensic investigations and recoveries	40 521	37 742
Governance and compliance services rendered	43 212	39 830
Total other administration services provided by Accredited Administrator	116 647	108 865

18.2 TRUSTEES' REMUNERATION AND CONSIDERATIONS

2024

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
Mr O Komane	669 850	412 020	567 631	1 649 501	52 362	23 940	1 725 803
Mr J Bagg	297 899	263 972	188 274	750 145	31 676	8 572	790 393
Mr MG Netshisaulu	412 872	263 972	35 321	712 165	31 297	36 290	779 752
Mr R Cowlin	374 638	263 972	410 431	1 049 041	114 705	8 572	1 172 318
Mr JD Ngwane	105 959	129 738	32 796	268 493	25 516	35 853	329 862
Mr JR Venter	324 173	254 904	30 276	609 353	68 566	8 572	686 491
Mr P Ribbens	272 670	254 904	71 694	599 268	47 702	8 572	655 542
Ms V Rikhotso*	226 841	241 225	260 488	728 554	37 574	8 572	774 700
Ms RT Monene	230 990	263 972	63 988	558 950	28 312	37 140	624 402
Mr A Edwards	186 366	199 103	87 356	472 825	23 212	2 265	498 302
Mr PS Sotshangane	30 274	31 388	–	61 662	8 238	3 759	73 659
	3 132 532	2 579 170	1 748 255	7 459 957	469 160	182 107	8 111 224

2023

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
Mr O Komane	398 054	359 968	491 697	1 249 719	35 622	19 210	1 304 551
Mr J Bagg	269 065	248 460	58 623	576 148	10 932	7 110	594 190
Mr MG Netshisaulu	256 011	248 460	30 707	535 178	21 627	18 460	575 265
Mr R Cowlin	241 362	248 460	343 263	833 085	63 193	18 460	914 738
Mr JD Ngwane	145 586	248 460	38 275	432 321	29 008	19 210	480 539
Mr JR Venter	170 172	248 460	89 763	508 395	86 476	18 461	613 332
Mr P Ribbens	193 474	248 460	76 878	518 812	32 718	7 110	558 640
Dr PW Hill	124 761	205 214	80 959	410 934	29 730	6 901	447 565
Ms V Rikhotso	225 900	248 460	125 086	599 446	27 702	40 637	667 785
Ms RT Monene	145 586	248 460	45 361	439 407	23 763	40 637	503 807
	2 169 971	2 552 862	1 380 612	6 103 445	360 771	196 196	6 660 412

* Term ended 1 December 2024

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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

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 Select, 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 Select	BonClassic
2024						
Insurance revenue	8 591 633	2 029 908	5 348 235	1 340 938	671 608	695 243
Insurance service expense	(9 019 561)	(1 931 176)	(5 836 503)	(1 645 463)	(677 303)	(662 436)
<i>Net claims incurred</i>	(8 451 373)	(1 665 087)	(5 153 602)	(1 435 458)	(550 852)	(626 005)
Claims incurred	(8 466 974)	(1 671 810)	(5 169 625)	(1 444 286)	(553 895)	(627 161)
Third party recoveries	15 601	6 723	16 023	8 828	3 043	1 156
Changes that relate to past service – adjustments to the LIC	110 854	20 650	6 374	9 659	(5 330)	11 370
Insurance acquisition costs	(118 435)	(57 083)	(127 878)	(41 713)	(21 846)	(6 469)
Accredited managed healthcare services	(195 875)	(73 614)	(199 226)	(79 289)	(30 701)	(14 238)
Losses on onerous contracts and reversal of those losses	–	–	–	–	–	–
Attributable expenses incurred	(364 732)	(156 042)	(362 171)	(98 662)	(68 574)	(27 094)
Amounts attributable to future members	–	–	–	–	–	–
Net income from risk transfer arrangements/reinsurance	248 886	25 062	53 627	76 937	(2 714)	19 142
An allocation of premiums paid	(838 592)	(113 808)	(278 629)	(468 446)	(32 292)	(69 430)
Amounts recovered from risk transfer arrangement/reinsurance	1 087 478	138 870	332 255	545 383	29 577	88 572
Insurance service result	(179 042)	123 794	(434 641)	(227 588)	(8 409)	51 949
Other income	352 747	192 095	364 445	201 207	75 964	44 905
Investment income – Scheme	344 671	188 550	356 019	196 577	74 394	44 294
Sundry income	11 728	5 076	12 057	6 644	2 331	868
Loss on sale of investment property	(3 652)	(1 529)	(3 631)	(2 014)	(761)	(257)
Net insurance finance expenses	–	(38 981)	–	–	(4 035)	(18 812)
Finance expenses from insurance contracts issued – PMSA	–	(38 981)	–	–	(4 035)	(18 812)
Other expenditure	(97 231)	(42 084)	(100 029)	(56 025)	(19 169)	(7 217)
Administration fees and other operative expenses	(86 375)	(37 316)	(88 699)	(49 779)	(16 986)	(6 401)
Interest expense	(86)	(37)	(88)	(49)	(17)	(6)
Asset management fees	(9 504)	(4 113)	(9 771)	(5 386)	(1 887)	(704)
Operating expenses on investment property	(1 266)	(618)	(1 471)	(811)	(279)	(106)
Net surplus/(deficit) for the year	76 474	234 824	(170 225)	(82 406)	44 351	70 825
Average number of members (n)	95 359	41 155	97 818	53 857	18 616	7 070

* This includes R134 million relating to the surplus/funds attributable to future members as reported in the Statement of comprehensive income.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

Bon Compre- hensive	Bon Essential	Bon Complete	Hospital Standard	BonStart	BonStart Plus	Scheme Total (Excluding Amounts attributable to future members)	Other*	Scheme Total (Including Amounts attributable to future members)
500 819 (628 514)	583 185 (621 197)	582 525 (618 381)	212 708 (216 715)	170 566 (142 499)	160 938 (153 666)	20 888 306 (22 153 413)	– (133 891)	20 888 306 (22 287 304)
(607 140)	(540 414)	(569 192)	(196 773)	(105 586)	(132 076)	(20 033 557)	–	(20 033 557)
(607 743)	(542 613)	(570 374)	(197 376)	(107 112)	(132 976)	(20 091 944)	–	(20 091 944)
603	2 199	1 182	603	1 526	900	58 387	–	58 387
5 810 (4 666)	5 132 (15 853)	3 674 (10 757)	5 729 (5 185)	(1 436) (5 568)	910 (4 953)	173 396 (420 406)	– –	173 396 (420 406)
(8 397)	(21 257)	(14 417)	(6 340)	(12 991)	(7 655)	(664 000)	–	(664 000)
– (14 121)	– (48 805)	– (27 689)	– (14 146)	– (16 918)	– (9 892)	– (1 208 846)	– –	– (1 208 846)
–	–	–	–	–	–	–	(133 891)	(133 891)
1 744 (52 049)	3 402 (23 855)	10 591 (52 643)	1 024 (9 945)	(3 139) (7 167)	(1 241) (4 831)	433 320 (1 951 687)	– –	433 320 (1 951 687)
53 793 (125 951)	27 257 (34 610)	63 234 (25 265)	10 969 (2 983)	4 028 24 928	3 590 6 031	2 385 007 (831 787)	– (133 891)	2 385 007 (965 678)
24 450	50 276	38 797	13 608	36 044	21 676	1 416 216	–	1 416 216
24 131 453 (134)	49 120 1 662 (506)	38 171 886 (260)	13 288 453 (133)	35 267 1 168 (391)	21 214 693 (231)	1 385 696 44 020 (13 500)	– – –	1 385 696 44 020 (13 500)
(10 826)	–	(12 198)	–	–	–	(84 852)	–	(84 852)
(10 826)	–	(12 198)	–	–	–	(84 852)	–	(84 852)
(3 763)	(13 761)	(7 366)	(3 764)	(9 601)	(5 675)	(365 686)	–	(365 686)
(3 338) (3) (367)	(12 201) (12) (1 346)	(6 532) (7) (718)	(3 339) (3) (367)	(8 506) (8) (947)	(5 028) (5) (559)	(324 501) (322) (35 669)	– – –	(324 501) (322) (35 669)
(55)	(202)	(109)	(55)	(140)	(83)	(5 194)	–	(5 194)
(116 090)	1 905	(6 032)	6 861	51 371	22 032	133 891	(133 891)	–
3 686	13 445	7 217	3 688	9 309	5 493		–	356 713

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

19 SURPLUS/(DEFICIT) PER BENEFIT OPTION (continued)

For management purposes the traditional Scheme is organised into the following twelve benefit options: Standard, BonSave, Primary, BonCap, BonFit Select, 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 Select	BonClassic
2023						
Insurance revenue	8 354 315	1 835 460	4 896 571	1 257 300	418 488	691 325
Insurance service expense	(8 535 248)	(1 717 494)	(5 009 408)	(1 503 282)	(374 252)	(700 453)
<i>Net claims incurred</i>	(7 929 876)	(1 472 956)	(4 414 009)	(1 305 921)	(302 488)	(659 001)
Claims incurred	(7 946 512)	(1 479 534)	(4 429 891)	(1 314 874)	(304 503)	(660 278)
Third party recoveries	16 636	6 578	15 882	8 953	2 015	1 277
Changes that relate to past service – adjustments to the LIC	70 457	16 048	39 295	10 105	2 641	6 912
Insurance acquisition costs	(124 617)	(51 938)	(118 516)	(39 074)	(13 515)	(6 751)
Accredited managed healthcare services	(188 979)	(66 243)	(182 721)	(75 742)	(18 963)	(13 698)
Losses on onerous contracts and reversal of those losses	–	–	–	–	–	–
Attributable expenses incurred	(362 233)	(142 405)	(333 457)	(92 650)	(41 927)	(27 917)
Amounts attributable to future members	–	–	–	–	–	–
Net income from risk transfer arrangements/reinsurance	185 153	2 135	45 478	69 060	(1 870)	12 929
An allocation of premiums paid	(841 164)	(112 011)	(243 935)	(448 565)	(21 758)	(74 869)
Amounts recovered from risk transfer arrangement/reinsurance	1 026 317	114 146	289 413	517 625	19 888	87 798
Insurance service result	4 220	120 101	(67 359)	(176 922)	42 366	3 801
Other income	228 537	119 100	218 135	123 644	31 259	34 621
Investment income – Scheme	218 372	115 081	208 440	118 194	30 042	33 840
Sundry income	11 177	4 419	10 658	5 993	1 337	859
Change in fair value of investment property	(1 012)	(400)	(963)	(543)	(120)	(78)
Net insurance finance expenses	–	(28 790)	–	–	(3 093)	(17 084)
Finance expenses from insurance contracts issued – PMSA	–	(28 790)	–	–	(3 093)	(17 084)
Other expenditure	(99 248)	(39 209)	(94 466)	(53 266)	(11 797)	(7 635)
Administration fees and other operative expenses	(88 560)	(34 986)	(84 291)	(47 530)	(10 525)	(6 813)
Interest expense	(154)	(61)	(146)	(82)	(18)	(12)
Asset management fees	(9 169)	(3 623)	(8 729)	(4 921)	(1 091)	(705)
Operating expenses on investment property	(1 365)	(539)	(1 300)	(733)	(163)	(105)
Net surplus/(deficit) for the year	133 509	171 202	56 310	(106 544)	58 735	13 703
Average number of members (n)	101 516	40 104	96 623	54 483	12 065	7 810

* This includes R265 million relating to the surplus/funds attributable to future members as reported in the Statement of comprehensive income.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

Bon Compre- hensive	Bon Essential	Bon Complete	Hospital Standard	BonStart	BonStart Plus	Scheme Total (Excluding Amounts attributable to future members)	Other*	Scheme Total (Including Amounts attributable to future members)
493 623 (592 329)	528 021 (564 209)	579 791 (605 453)	217 264 (216 670)	107 583 (77 485)	81 587 (66 344)	19 461 328 (19 962 631)	– (265 314)	19 461 328 (20 227 945)
(569 363)	(491 384)	(558 111)	(192 876)	(56 677)	(56 059)	(18 008 721)	–	(18 008 721)
(570 021)	(493 562)	(559 413)	(193 548)	(57 713)	(56 570)	(18 066 419)	–	(18 066 419)
658	2 178	1 302	672	1 036	511	57 698	–	57 698
4 510 (4 729)	5 760 (14 231)	5 837 (10 800)	2 609 (5 084)	702 (3 450)	983 (2 496)	165 859 (395 201)	– –	165 859 (395 201)
(8 418)	(19 525)	(14 010)	(6 649)	(7 886)	(3 832)	(606 668)	–	(606 668)
– (14 329)	– (44 829)	– (28 369)	– (14 670)	– (10 174)	– (4 940)	– (1 117 900)	– –	– (1 117 900)
–	–	–	–	–	–	–	(265 314)	(265 314)
(2 872)	(86)	7 343	675	(1 665)	(707)	315 574	–	315 574
(52 623)	(14 095)	(53 459)	(10 439)	(4 110)	(2 248)	(1 879 274)	–	(1 879 274)
49 751	14 009	60 802	11 114	2 445	1 541	2 194 848	–	2 194 848
(101 578)	(36 274)	(18 319)	1 269	28 433	14 536	(185 729)	(265 314)	(451 043)
19 475	30 056	29 322	9 224	14 569	7 163	865 105	–	865 105
19 073	28 728	28 527	8 813	13 947	6 858	829 915	–	829 915
442	1 460	874	452	683	336	38 690	–	38 690
(40)	(132)	(79)	(41)	(61)	(31)	(3 500)	–	(3 500)
(10 415)	–	(11 456)	–	–	–	(70 838)	–	(70 838)
(10 415)	–	(11 456)	–	–	–	(70 838)	–	(70 838)
(3 928)	(12 942)	(7 773)	(4 015)	(5 999)	(2 946)	(343 224)	–	(343 224)
(3 505)	(11 548)	(6 936)	(3 583)	(5 352)	(2 628)	(306 257)	–	(306 257)
(6)	(20)	(12)	(6)	(9)	(5)	(531)	–	(531)
(363)	(1 196)	(718)	(371)	(555)	(273)	(31 714)	–	(31 714)
(54)	(178)	(107)	(55)	(83)	(40)	(4 722)	–	(4 722)
(96 446)	(19 160)	(8 226)	6 478	37 003	18 753	265 314	(265 314)	–
4 018	13 237	7 951	4 107	6 136	3 012		–	351 061

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

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.

	2024 R'000	2023 R'000
20.1.1 Interest received		
Finance income (note 16)	521 185	462 738
Interest capitalised in investments	(230 954)	(207 700)
	290 231	255 038
20.1.2 Dividends received		
Dividend income (note 16)	192 918	197 222
Dividends capitalised in investments	(215)	(1 594)
	192 703	195 628
20.1.3 Asset management fees		
Asset management fees per statement of comprehensive income	(35 669)	(31 714)
Fees capitalised in investments	310	1 277
	(35 359)	(30 437)
20.1.4 Rental income		
Rentals income (note 16)	9 368	10 678
Straight-lining of lease receivables	–	(376)
(Increase)/decrease in rent receivables	(44)	62
	9 324	10 364
20.1.5 Cash paid to providers and members*		
Cash paid to providers and members – claims (risk and PMSA) (note 12)	18 746 550	17 195 929
Cash paid to providers – premiums paid (note 13)	1 984 995	1 822 504
Cash paid to providers – acquisition costs (note 15.3)	420 406	395 201
	21 151 951	19 413 634
20.1.6 Cash paid to providers and employees – non healthcare expenditure*		
Cash paid to providers and employees – directly attributable expenses (note 12)	1 341 314	1 293 987
Cash paid to providers and employees – other operating expenses	230 031	161 241
	1 571 345	1 455 228

* The cash paid to providers and members 20.1.5 and the cash paid to providers and employees 20.1.6 have been included the financial statements for the current year and prior year to reconcile the cash flows in Note 12 to the Statement of Cash Flows. The prior year note disclosure has been represented to enhance the presentation for the amount of R19.4 billion and R1.5 billion respectively.

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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

21 INSURANCE RISK MANAGEMENT (continued)

21.1 RISK MANAGEMENT OBJECTIVES, POLICIES AND STRATEGIES TO MITIGATE INSURANCE RISK (CONTINUED)

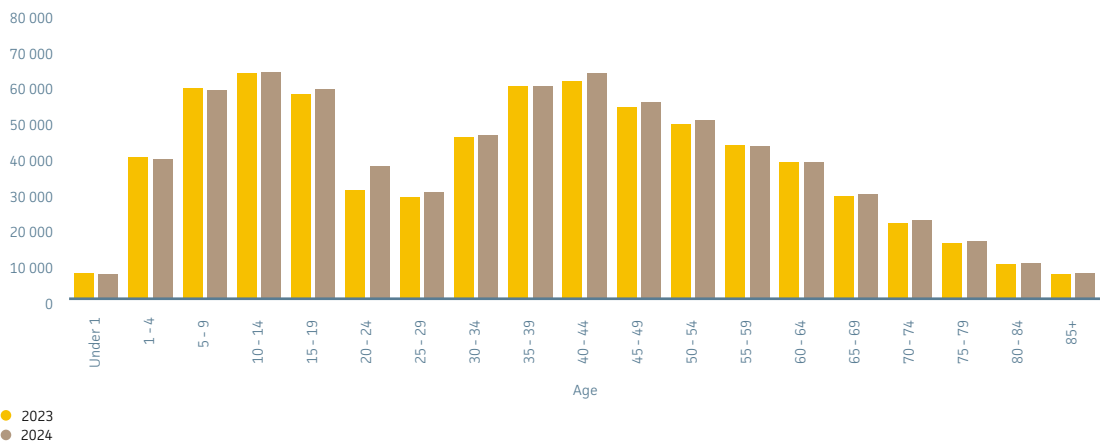
A major risk affecting the future sustainability of the Scheme is the possibility of deterioration in the risk profile of members. Schemes with a better member risk profile can offer the same benefits at a lower contribution rate than other Schemes, as their members will be claiming less.

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.

The chart below provides an overview of the Scheme’s beneficiaries demographic profile:

BENEFICIARY 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 five 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.

21.2 CONCENTRATIONS OF INSURANCE RISK

The Scheme’s concentrations of insurance risk can be split into the following three benefit categories:

o 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.

o In-hospital benefits

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

21 INSURANCE RISK MANAGEMENT (continued)

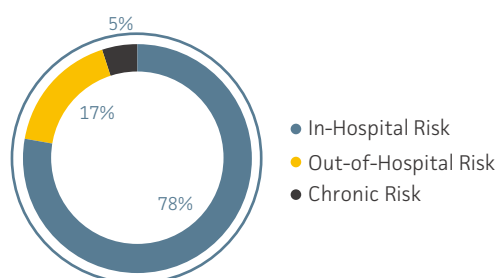
21.2 CONCENTRATIONS OF INSURANCE RISK (CONTINUED)

o Chronic illness benefit

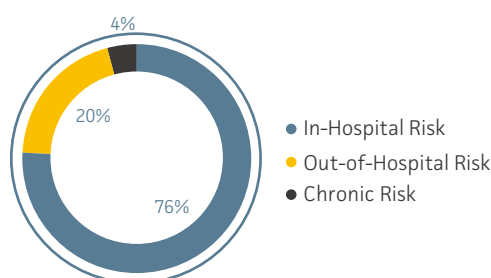
The Chronic Illness Benefit (CIB) covers approved medication for listed conditions, including the 27 PMB chronic conditions.

The following charts summarise the concentrations of insurance risk in relation to the type of risk covered/benefits provided:

CONCENTRATION OF INSURANCE RISK: 2023



CONCENTRATION OF INSURANCE RISK: 2024

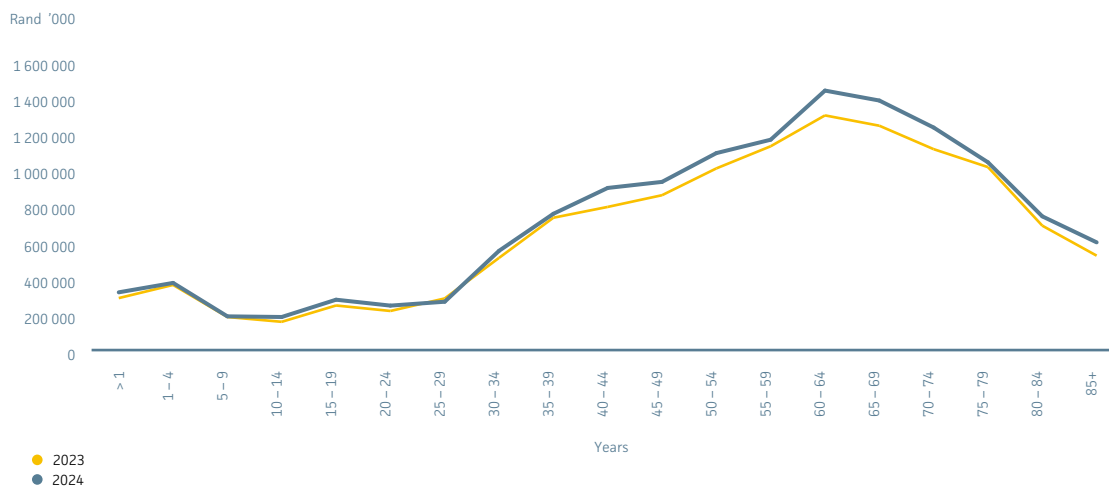


The following graphs summarise the concentrations of insurance risk, with reference to the carrying amount of the insurance claims incurred (before risk transfer arrangements), by age category in years of the Scheme and in relation to the benefit category.

The health status of the membership is a primary determinant of demand for health services which subsequently affects total cost of care. Therefore mitigation strategies are focused on positively influencing the utilisation and price of such services, to ensure overall system-wide cost-containment of quality care. These strategies for each benefit category are also summarised below.

21.2.1 In-hospital risk

CONCENTRATION OF INSURANCE RISK: IN-HOSPITAL RISK



Hospital and major medical expenses make up a significant part of overall expenditure and require close management. Therefore, there is a strong focus on ensuring appropriate treatment during the hospital stay (including level of care and length of stay), as well as post-discharge, which improves patient outcomes and reduces the likelihood of readmission for high risk admissions.

Initiatives used by the Scheme include:

- Hospital Benefit Management Programme – focusing on patient care co-ordination, from pre-admission to six weeks post-discharge, in order to ensure best and appropriate care.
- Reviewing and updating of clinical funding protocols as well as criteria for recognising specific healthcare professionals as being able to perform certain procedures.
- Health technology assessments (HTA) on existing and new technologies entering the market, within a framework of clinical validity and economic appropriateness of the healthcare intervention, based on a systematic review of the evidence base and costing considerations.
- Specialised case management – providing a dedicated focus on psychiatric cases, neonates, high cost cases and cases involving alternatives to hospitalisation (e.g. step down facilities).
- “Call-me-back” functionality to promote treating Doctor and/or Medical Advisor engagement in answering questions and offering choice in terms of funding alternatives.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

21 INSURANCE RISK MANAGEMENT (continued)

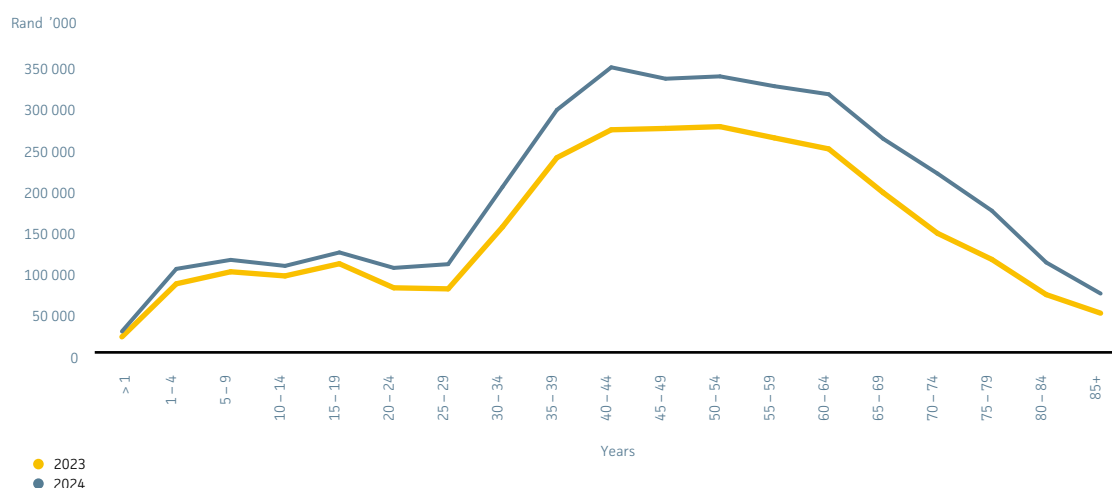
21.2 CONCENTRATIONS OF INSURANCE RISK (CONTINUED)

21.2.1 In-hospital risk (continued)

- Monitoring compliance to care pathways to reduce the risk of readmission. This involves a follow-up process where, in the case of non-compliance, support is provided to assist the beneficiary to return to the care pathway.
- Innovative reimbursement models with hospitals/hospital groups to ensure the most appropriate level of risk is transferred through reimbursement such as:
 - Efficiency gain share
 - Claims increase protection
 - Rewarding providers for efficiency and quality care
- Entering into risk-based contracting with specialists where specific risks within the member population can be addressed e.g. arthroplasty (global fee).
- Contracting of a specialist network at agreed reimbursement rates.
- Clinical audit and re-pricing of claims to ensure that claims are paid against the contracted hospital rates and the pre-authorised level of care.
- 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.

21.2.2 Out-of-hospital risk

CONCENTRATION OF INSURANCE RISK: 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 coordinating care for segments of the population who are likely to present for medical care, with associated high claim costs, have been implemented. Such initiatives include:

- Active Disease Risk Management Programme – An integrated care coordination programme enabling high and emerging risk beneficiaries to improve their health and quality of life by empowering the beneficiary through information sharing and counselling, to take responsibility for his or her own health and wellness.
- Back Rehabilitation Programme – An evidence-based physiotherapy and active rehabilitation programme that concentrates primarily on back and neck ailments, thus reducing the need for surgical intervention.
- High Risk Maternity Case Management – Pregnant mothers with potentially high risk pregnancies are supported and additional benefits are provided where this is deemed necessary to reduce the risk of high-cost hospitalisation and premature deliveries.
- Oncology Disease Management – Complex or unusual patient-specific requirements are managed on a case-by-case basis ensuring that beneficiaries access funding for appropriate and cost-effective oncology therapy before, during and after active treatment.
- Palliative care for oncology – Most terminally ill patients indicate a wish to spend their remaining days at home, but in the 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 multidisciplinary 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

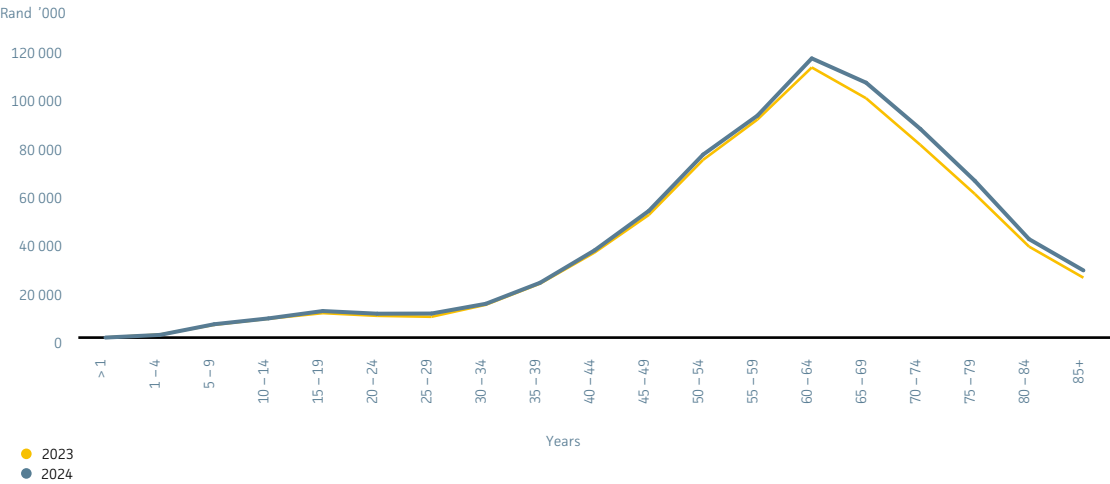
FOR THE YEAR ENDED 31 DECEMBER 2024

21 INSURANCE RISK MANAGEMENT (continued)

21.2 CONCENTRATIONS OF INSURANCE RISK (CONTINUED)

21.2.3 Chronic Illness Risk

CONCENTRATION OF INSURANCE RISK: CHRONIC 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.

21.3 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 8.8% (2023: 9.3%) of the Scheme's Insurance service expenditure.

The Scheme entered into capitation agreements directly with DENIS, Scriptpharm, PPN, PHA 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

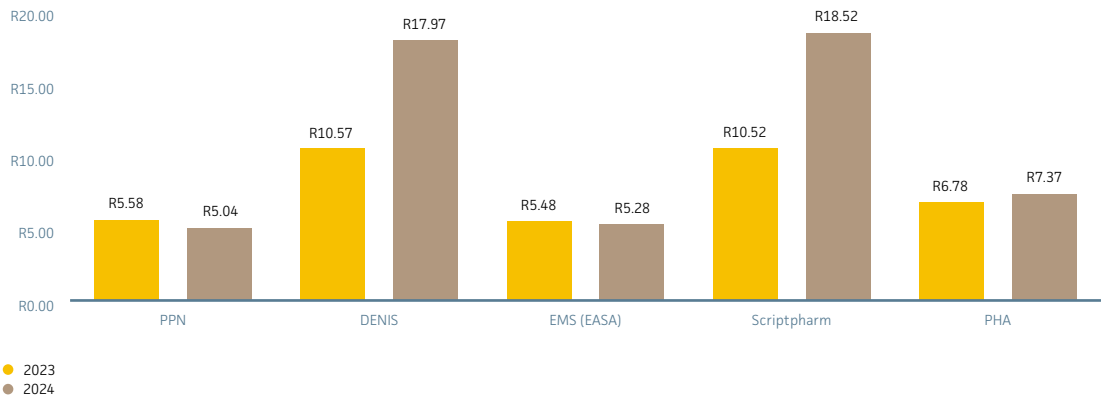
FOR THE YEAR ENDED 31 DECEMBER 2024

21 INSURANCE RISK MANAGEMENT (continued)

21.3 RISK TRANSFER ARRANGEMENTS (CONTINUED)

The graph below outlines the net income (i.e. capitation premiums less cost recoveries) incurred per beneficiary relevant to services provided in accordance with the capitation agreements.

AVERAGE NET INCOME PER AVERAGE BENEFICIARY PER MONTH



21.3.1 Dental Information Systems Proprietary Limited (“DENIS”)

The Scheme contracts DENIS to manage all aspects of dental claims administration, including the payment of all approved claims from service providers. Services rendered by DENIS are limited to all aspects of dental benefits including related hospitals, clinic and anaesthetist cost and any claim administration related to such dental and related services excluding services, benefits and claims classified under PMB as defined by the Medical Scheme Act, or amendments of the Act applicable to PMBs. DENIS also provides the Scheme with monthly financial reports reflecting all transactions related to fees paid by the Scheme and services rendered by DENIS.

The Scheme pays DENIS a monthly fixed fee, in advance for beneficiaries on Standard, BonSave, BonClassic, BonComplete and BonFit options.

The current contract took effect from 1 January 2023 for a period of 3 years. Fees and benefits have been agreed for the 2025 benefit year.

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 contract commenced on 1 February 2020 and was renewed on 1 January 2022 and extended to 31 December 2023. The contract was renewed for a further 12 months to 31 December 2024 and again extended for 12 months to 31 December 2025. Fees for the 2025 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. 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 a RFP process, on 1 January 2023 and remained in force until 31 December 2024. This contract has been renewed for a 24 month period until 31 December 2026. Fees and benefits have been agreed for the 2025 financial year.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

21 INSURANCE RISK MANAGEMENT (continued)

21.3 RISK TRANSFER ARRANGEMENTS (CONTINUED)

21.3.4 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. This contract applies to all members of the Scheme except for those on the BonCap Option.

The contract commenced on 1 July 2022 and remained in force until 31 December 2024. The contract was renewed and extended for a 12 month period up until 31 December 2025. Fees and benefits were agreed upon for 2025.

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 contract commenced on 1 July 2022 and remained in force until 31 December 2024. The contract was renewed and extended for a 12 month period up until 31 December 2025. Fees and benefits were agreed upon for 2025.

21.3.5 Private Health Administrators Proprietary Limited ("PHA")

The Scheme has entered into a risk transfer arrangement with PHA for the provision of non-hospital benefit services for BonCap option.

The contract commenced on 1 January 2023 with an original term of 36 months. A new contract has been negotiated effective 1 January 2024 for a period of 24 months with an option to renew for a further 24 months. Fees have been agreed for the 2025 financial period.

21.4 SENSITIVITY DISCLOSURE

21.4.1 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 2025 Budget.

Claims category	Change in variable	Estimated impact on expected 2025 claims R'000	Estimated impact on expected 2025 solvency %
Inflation assumptions <i>Represents the increase in the price of service units rendered</i>			
In-hospital claims (ward/theatre/consumables)	Tariff inflation 1% higher	79 809	-0.34%
Ageing assumptions <i>Represents the expected claims increase due to members getting older on average</i>			
In-hospital claims (ward/theatre/consumables)	Average member age 0.5 years higher	116 083	-0.49%
Acute Medicine claims	Average member age 0.5 years higher	5 594	-0.02%
Utilisation assumptions <i>Represents expected claims increases over and above what is explained by inflation, ageing and benefit changes</i>			
In-hospital claims (ward/theatre/consumables)	Utilisation rate 1% higher	82 380	-0.35%
Specialist costs	Utilisation rate 1% higher	26 098	-0.11%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

21 INSURANCE RISK MANAGEMENT (continued)

21.4 SENSITIVITY DISCLOSURE (CONTINUED)

21.4.2 Risk adjustment sensitivity

The following table provides a sensitivity on the insurance contract liabilities. The table provides the sensitivity before and after the impact of the Scheme being a mutual entity. As the Scheme is a mutual entity, the impact of any changes in the insurance liability to current members would impact the insurance liability to future members. The table presents information on how reasonably possible changes in risk confidence level made by the Scheme will impact the risk adjustment.

	2024 R'000			2023 R'000		
	LIC as at 31 December	Impact on LIC	Impact on SOCI	LIC as at 31 December	Impact on LIC	Impact on SOCI
Insurance contract liabilities						
Net insurance contract liabilities	2 583 210			2 126 489		
Unpaid claims and expenses – 5% increase						
Insurance contract liabilities (before mutualisation)		129 160	129 160		106 324	106 324
Insurance contract liabilities (after mutualisation)		–	–		–	–
Expenses – 5% increase						
Insurance service expense (before insurance service expense relating to future members)	(22 153 413)			(19 962 631)		
Insurance service expenses			(1 107 671)			(998 132)

Sensitivity description	Method	Change in variable	Effect of change in risk adjustment and Risk mitigation by RTA		Comment
			2024 R'000	2023 R'000	
Change in run-off speeds	Deterministic – December process month (with a confidence interval of 90% as reported)	15%	146 288	140 902	Also adopted as Risk Adjustment Value
Change in run-off speeds	Deterministic – December process month (with a confidence interval of 99%)	20%	199 993	192 888	
Hospital & Specialist Utilisation (higher)	Deterministic – December service month	5%	32 021	26 852	Assuming run-off speeds remain unchanged Capitation Arrangement (Risk Transfer Arrangement), therefore no change to LIC (demonstrates impact of RTA on LIC)
Chronic Utilisation (higher)	Deterministic – December service month	2%	–	–	

Any change in the risk adjustment will impact the incurred claims and other directly attributable expenses in insurance service expenses with an equal and opposite impact on the amounts attributable to future members in insurance services expenses. The net impact on profit or loss for any change in the risk adjustment would therefore be nil.

The analysis is based on a change in an assumption while holding all the assumptions constant. In practice, this is unlikely to occur, and changes in some of the assumptions may be correlated. No changes were made by the Scheme in the methods and assumptions used in preparing the above analysis. To further demonstrate the sensitivity to insurance risk, the risk adjustment at a 99% confidence level has also been disclosed.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

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 an 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 56 of the Annual Report for further details on the Scheme's investment strategy.

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 amount of financial and insurance assets represents the maximum credit exposure. The maximum exposure to credit risk at the reporting date was:

R'000	2024 R'000	2023 R'000
Investments (current and non-current)*	6 582 375	5 564 666
Trade and other receivables (excluding prepayments)	6 243	5 483
Reinsurance contract assets**	95 384	86 199
Insurance contract assets	666 247	638 960
Cash and cash equivalents	848 715	767 601
	8 198 964	7 062 909

* The Equity investments were erroneously included in the prior year, the carrying amount of the Scheme's financial assets at FVTPL as disclosed in note 7 best represents their respective maximum exposure to credit risk. The Scheme holds no collateral over any of these balances. These have been excluded in the current year and the prior year note disclosure has been restated for the amount of R4.6 billion.

** Reinsurance contract assets, previously included in insurance contracts, have been disclosed separately as required by IFRS 17.

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 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

22 FINANCIAL RISK MANAGEMENT (continued)

22.2 CREDIT RISK (CONTINUED)

22.2.2 Investments (continued)

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. There were no open positions on derivatives at year end 31 December 2024 or 31 December 2023. The Scheme did not trade any derivatives during the 2023 or 2024 financial period.

22.2.3 Insurance contracts, 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 contracts and trade and other receivables:

R'000	Not past due	Past due 1 – 30 days	Past due 61 – 90 days	Past due more than 90 days	Total
2024					
Financial assets					
Trade and other receivables (excluding prepayments)	3 338	–	–	2 905	6 243
Reinsurance assets					
Reinsurance contract assets	95 384	–	–	–	95 384
Insurance assets					
Insurance contract assets	642 390	18 627	4 860	370	666 247
	741 112	18 627	4 860	3 275	767 874

R'000	Not past due	Past due 1 – 30 days	Past due 61 – 90 days	Past due more than 90 days	Total
2023					
Financial assets					
Trade and other receivables (excluding prepayments)	2 628	–	–	2 855	5 483
Reinsurance assets					
Reinsurance contract assets	86 199	–	–	–	86 199
Insurance assets					
Insurance contract assets	634 034	662	1 967	2 297	638 960
	722 861	662	1 967	5 152	730 642

With respect to the financial and 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. With respect to past due financial and insurance assets, these balances are disclosed net of the related impairment after taking into account default risk using the ECL (expected credit loss) impairment model, where material.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

22 FINANCIAL RISK MANAGEMENT (continued)

22.2 CREDIT RISK (CONTINUED)

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. Any expected credit loss on cash and cash equivalent is immaterial.

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.

22.3 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 aims to hold approximately 25% of its total investment assets to be invested in cash which provides a high degree of liquidity on investments. Additionally, the other equity 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 and insurance liabilities at reporting date are tabled below and includes Available cash and investments in order to meet its financial obligations. The financial assets at fair value have been included to match against the financial liabilities. All financial assets and liabilities have been considered in the analysis. The time bands within 3 months, and up to 12 months, and over one year were included as claims are generally settled in a short period, approximately 95% in the first 3 months after the claim was incurred and the remainder are expected to be settled within 1 year and there are no estimated cash flows other than the long-term employee obligation greater than 1 year. The insurance liability for future members is considered greater than 5 years as this is only payable on liquidation. The amounts are gross and undiscounted and in the case of Financial assets held at fair value through profit or loss, exclude accrued interest:

R'000	Within three months	Three to twelve months	Over one year	Total
2024				
Liabilities				
Trade and other payables (note 14)	(30 434)	–	–	(30 434)
Liability for remaining coverage (note 12)	(379 432)	–	–	(379 432)
Liability for incurred claims (note 12)	(1 462 547)	(1 407 477)	–	(2 870 024)
Insurance contract assets (note 12)	665 875	371	–	666 246
Lease liability (note 4.2)	(650)	(1 755)	–	(2 405)
Long-term employee benefit obligation (note 10)	–	–	(2 927)	(2 927)
Insurance liability for future members (note 11)	–	–	(9 029 093)	(9 029 093)
Total liabilities	(1 207 188)	(1 408 861)	(9 032 020)	(11 648 069)
Cash and Cash Equivalents (note 9)	848 715	–	–	848 715
Financial Assets held at fair value through profit or loss (note 7)	4 178 194	577 435	5 932 586	10 688 215
Other receivables (note 8)	12 336	–	–	12 336
Available cash and investments	5 039 245	577 435	5 932 586	11 549 266
Liquidity surplus/(gap)	3 832 057	(831 426)	(3 099 434)	(98 803)

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

22 FINANCIAL RISK MANAGEMENT (continued)

22.3 LIQUIDITY RISK (CONTINUED)

R'000	Within three months	Three to twelve months	Over one year	Total
2023				
Liabilities				
Trade and other payables (note 14)	(44 827)	–	–	(44 827)
Liability for remaining coverage (note 12)	(388 815)	–	–	(388 815)
Liability for incurred claims (note 12)	(1 160 420)	(1 216 214)	–	(2 376 633)
Insurance contract assets (note 12)*	636 662	2 297	–	638 959
Lease liability (note 4.2)*	(554)	(1 250)	(2 927)	(4 732)
Long-term employee benefit obligation (note 10)*	–	(5 716)	–	(5 716)
Insurance liability for future members (note 11)*	–	–	(8 895 202)	(8 895 202)
Total liabilities*	(957 954)	(1 220 883)	(8 898 129)	(11 076 966)
Cash and Cash Equivalents (note 9)*	767 601	–	–	767 601
Financial Assets held at fair value through profit or loss (note 7)*	4 634 116	742 840	4 757 012	10 133 968
Other receivables (note 8)*	11 298	–	–	11 298
Available cash and investments*	5 413 015	742 840	4 757 012	10 912 867
Liquidity surplus/(gap)	44 55 061	(478 043)	(4 141 117)	(164 099)

Liquidity analysis assumptions:

- The carrying amount of the insurance and financial liabilities equals the undiscounted contractual values of these instruments due to the short period to maturity.
- PMSA balances are included in Liability for incurred claims and payable on demand when a member exits the Scheme.

* The prior year note disclosure has been represented in order to match financial assets with the respective financial liabilities to enhance the presentation to the users of the financial statements.

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, bonds and 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 and other receivables and payables as they are all settled or fall due within one year.

R'000	2024 R'000	2023 R'000
Interest-bearing instruments		
<i>Financial assets</i>	7 431 090	6 332 266
Investments – interest-bearing assets (note 7)	6 582 375	5 564 665
Cash and cash equivalents	848 715	767 601
<i>Insurance contract liabilities</i>		
Personal medical savings account liability	(1 363 188)	(1 180 666)
	6 067 902	5 151 600

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

22 FINANCIAL RISK MANAGEMENT (continued)

22.4 MARKET RISK (CONTINUED)

22.4.2 Interest rate risk (continued)

Interest rate sensitivity analysis

At the end of December 2024, the Scheme earned interest income of R541 million (2023: R474 million) from its investments in bonds, cash and cash equivalents 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):

(R'000)

Decrease in interest rate	-2.5%	-2.0%	-1.5%	-1.0%	-0.5%	-0.25%	0.0%
2024							
Scheme impact (surplus) (R'000)	604 141	483 313	362 485	241 656	120 828	60 414	–
Solvency impact	2.75%	2.20%	1.65%	1.10%	0.55%	0.27%	–
2023							
Scheme impact (surplus) (R'000)	601 505	481 204	360 903	240 602	120 301	60 150	–
Solvency impact	2.94%	2.35%	1.77%	1.18%	0.59%	0.29%	–

(R'000)

Increase in interest rate	0.0%	0.25%	0.5%	1.0%	1.5%	2.0%	2.5%
2024							
Scheme impact (surplus) (R'000)	–	(60 414)	(120 828)	(241 656)	(362 485)	(483 313)	(604 141)
Solvency impact	–	-0.27%	-0.55%	-1.10%	-1.65%	-2.20%	-2.75%
2023							
Scheme impact (surplus) (R'000)	–	(60 150)	(120 301)	(240 602)	(360 903)	(481 204)	(601 505)
Solvency impact	–	-0.29%	-0.59%	-1.18%	-1.77%	-2.35%	-2.94%

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

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

(R'000)

Increase in interest rate	2.5%	2.0%	1.5%	1.0%	0.5%	0.25%	0.0%
2024							
Scheme impact (surplus) (R'000)	90 150	72 120	54 090	36 060	18 030	9 015	–
Solvency impact	0.41%	0.33%	0.25%	0.16%	0.08%	0.04%	–
2023							
Scheme impact (surplus) (R'000)	60 207	48 165	36 124	24 083	12 041	6 021	–
Solvency impact	0.29%	0.24%	0.18%	0.12%	0.06%	0.03%	–

(R'000)

Decrease in interest rate	0.0%	0.25%	0.5%	1.0%	1.5%	2.0%	2.5%
2024							
Scheme impact (surplus) (R'000)	–	(9 015)	(18 030)	(36 060)	(54 090)	(72 120)	(90 150)
Solvency impact	–	-0.04%	-0.08%	-0.16%	-0.25%	-0.33%	-0.41%
2023							
Scheme impact (surplus) (R'000)	–	(6 021)	(12 041)	(24 083)	(36 124)	(48 165)	(60 207)
Solvency impact	–	-0.03%	-0.06%	-0.12%	-0.18%	-0.24%	-0.29%

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

22 FINANCIAL RISK MANAGEMENT (continued)

22.4 MARKET RISK (CONTINUED)

22.4.3 Market price risk

Market price risk arises from fair value through profit or loss in equity securities held for partially meeting the Scheme's financial obligations. 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 total reported as Insurance liability for future members 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.

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 in order to ensure 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

22 FINANCIAL RISK MANAGEMENT (continued)

22.4 MARKET RISK (CONTINUED)

22.4.3 Market price risk (continued)

Sensitivity analysis

The analysis presented below assumes all other factors remain constant and is performed on the same basis for 2024 and 2023.

Listed equities

At the end of December 2024, the Scheme had 38.4% (2023: 45.1%) 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:

(R'000)

Decrease	-35.0%	-25.0%	-15.0%	-10.0%	-5.0%	-2.0%	0.0%
2024							
Scheme impact (surplus) (R'000)	(1 437 044)	(1 026 460)	(615 876)	(410 584)	(205 292)	(82 117)	–
Solvency impact	-6.53%	-4.66%	-2.80%	-1.87%	-0.93%	-0.37%	–
2023							
Scheme impact (surplus) (R'000)	(1 599 256)	(1 142 325)	(685 395)	(456 930)	(228 465)	(91 386)	–
Solvency impact	-7.83%	-5.59%	-3.35%	-2.24%	-1.12%	-0.45%	–

(R'000)

Increase	0.0%	2.0%	5.0%	10.0%	15.0%	25.0%	35.0%
2024							
Scheme impact (surplus) (R'000)	–	82 117	205 292	410 584	615 876	1 026 460	1 437 044
Solvency impact	–	0.37%	0.93%	1.87%	2.80%	4.66%	6.53%
2023							
Scheme impact (surplus) (R'000)	–	91 386	228 465	456 930	685 395	1 142 325	1 599 256
Solvency impact	–	0.45%	1.12%	2.24%	3.35%	5.59%	7.83%

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

22.5 FAIR VALUE

For financial assets held at fair value, disclosure is required of the 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).

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

22 FINANCIAL RISK MANAGEMENT (continued)

22.5 FAIR VALUE (CONTINUED)

The following table presents the Scheme's assets held at fair value:

R'000	Level 1	Level 2	Level 3	Total
at 31 December 2024				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	4 105 840	–	–	4 105 840
Bonds	3 825 090	–	–	3 825 090
Money market instruments*	–	2 757 285	–	2 757 285
Investment properties held for sale*	–	–	–	–
Total assets	7 930 930	2 757 285	–	10 688 215

R'000	Level 1	Level 2	Level 3	Total
at 31 December 2023				
Assets				
Financial assets held at fair value through profit or loss				
Listed equities	4 569 302	–	–	4 569 302
Bonds	3 924 002	–	–	3 924 002
Money market instruments*	–	1 640 664	–	1 640 664
Investment properties held for sale*	–	–	72 700	72 700
Total assets	8 493 304	1 640 664	72 700	10 206 668

There were no changes in levels noted in the current year.

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

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 valuers.

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 2024:

R'000	Investment property held for sale	Total
Opening balance	72 700	72 700
Reversal of provision for selling costs	2 300	2 300
Proceeds on sale of investment property held for sale	(61 500)	(61 500)
Loss on sale of investment property	(13 500)	(13 500)
Closing balance	–	–

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 2024 include:

Investment property held for sale

The property was sold for R61.5 million in August 2024 and the transfer took place on 31 October 2024. The proceeds from disposal amounted to R59.4 million after commission was payable of R2.1 million. A loss on sale of investment property was recognised representing the write down from R75 million to selling price of R61.5 million. Refer to note 6.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

22 FINANCIAL RISK MANAGEMENT (continued)

22.5 FAIR VALUE (CONTINUED)

Unconsolidated investment structures

The asset managers invest the Scheme's monies in reputable funds which target returns to the Scheme. The Scheme views these funds as unconsolidated structured entities. The Scheme monitors the performance of the funds closely to ensure the Scheme earns high returns without unnecessary exposure to risk.

The Scheme has investments in pooled investment products and collective investment Schemes (the Funds) as listed in the table below. The exposure the Scheme has to these funds is listed in the table below in terms of Regulation 30 of the Act. The Scheme's maximum exposure to loss from its interests in the fund is limited to the total fair value of its investments as detailed below:

Fund	at 31 December 2024		at 31 December 2023	
	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	612 821	6%	563 801	6%
Nedgroup Investments Corporate Money Market Fund Class C4	286 279	3%	186 305	2%
Nedgroup Investments Money Market Fund Class C4	211 125	2%	483 773	5%
Nedgroup Investments Core Income Fund Class C4	118 021	1%	104 194	1%
	1 228 246	12%	1 338 073	14%

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 (as per Regulation 29 of the Act) 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.

	2024 R'000	2023 R'000
Insurance Liability for future members	9 029 093	8 895 202
Adjusted for:		
Regulation 29 exclusion of unrealised gains on remeasurement of investments and investment property to fair value*	(543 800)	(421 318)
Accumulated funds per Regulation 29	8 485 293	8 473 884
Gross contributions (note 15)	22 003 483	20 435 010
Solvency ratio (%)	38.56%	41.47%
* Cumulative net (losses)/gains on remeasurement to fair value of investments are calculated as follows:		
At beginning of year	403 544	469 354
Movement in unrealised gains/(losses) on remeasurement to fair value of financial instruments included in accumulated funds (as per Regulation 29 of the Act)	140 256	(65 810)
At end of year	543 800	403 544
* Cumulative net gains on remeasurement to fair value of investment properties are calculated as follows:		
At beginning of year	17 774	21 274
Movement in unrealised losses on remeasurement to fair value of investment properties included in accumulated funds (as per Regulation 29 of the Act)	(17 774)	(3 500)
At end of year	–	17 774
Cumulative net gains on remeasurement of investments and investment property at the end of the year	543 800	421 318

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

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

23 COMMITMENTS

	2024 R'000	2023 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	2 405	2 730
Later than one year and not later than five years	–	2 002
	2 405	4 732
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	–	4 728
Later than one year and not later than five years	–	1 607
	–	6 335

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 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, Clinical Executive and Chief Operations Officer.

24.1.2 Key service provider

Medscheme Holdings Proprietary Limited is a key service provider for the Scheme as it has a significant role in the administering of Scheme's financial, actuarial and operating activities.

Medscheme Holdings Proprietary Limited is also the accredited managed care service provider.

Afrocentric Distribution Services Proprietary Limited, is a key service provider as it handles the Scheme's advertising and marketing activities. It is a fellow subsidiary of the Scheme's administrator.

Aids for Aids Management Proprietary Limited, is a key service provider for the Scheme as it participates in providing managed care services to the Scheme's members. It is a fellow subsidiary of the Scheme's administrator.

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.

Private Health Administrators (PHA) Proprietary Limited, is a key service provider as it handles the Scheme's benefit option, Boncap claims. This also includes associated administration and managed care services relating to the Boncap option. It is an associate 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.

Agile Alternative Business Solutions Proprietary Limited, is a key service provider that provides the Scheme's marketing, communication, onboarding, underwriting, product development, digital platforms, technical actuarial marketing and related activities.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

24 RELATED PARTY TRANSACTIONS (continued)

24.2 TRANSACTIONS WITH RELATED PARTIES

All transactions with related parties are at arms-length.

	2024 R'000	2023 R'000
24.2.1 Parties with significant influence over the Scheme		
Medscheme Holdings Proprietary Limited – Scheme administrator		
Statement of comprehensive income		
<i>Administration fees paid</i> 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.	1 040 775	979 015
<i>Service Level Agreement penalty recoveries from Administrator</i> 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.	(9 655)	(14 615)
<i>Third party recoveries</i> As part of the administration agreement, the Administrator was entitled to 25% on fraud, waste and abuse recoveries.	11 553	11 934
Statement of financial position		
<i>Balances payable to related party</i> The balances payable bear no interest, are unsecured and are due within 30 days.	(2 344)	(3 774)
Medscheme Holdings Proprietary Limited – Managed care provider		
Statement of comprehensive income		
<i>Managed care fees (including wellness)</i> 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.	487 289	454 034
Statement of financial position		
<i>Balances (payable to)/owed by related party</i> The balances (payable)/owed bear no interest, are unsecured and are owed upon presentation of an approved invoice (managed care).	–	(1 953)
Medscheme Holdings Proprietary Limited – Actuarial service provider		
Statement of comprehensive income		
<i>Actuarial consulting fees</i> 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.	2 553	2 912
Statement of financial position		
<i>Balances owed to related party</i> The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice.	–	–
Afrocentric Distribution Services Proprietary Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
Contract terminated 31 August 2024		
Statement of comprehensive income		
<i>Sales and marketing fees</i>	91 512	128 674
Statement of financial position		
<i>Balances payable to related party</i> The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice.	–	(10 706)

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

24 RELATED PARTY TRANSACTIONS (continued)

24.2 TRANSACTIONS WITH RELATED PARTIES (CONTINUED)

	2024 R'000	2023 R'000
24.2.1 Parties with significant influence over the Scheme (continued)		
Aid for Aids Management Proprietary Limited (a fellow subsidiary of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
<i>Managed care fees</i>		
The managed care agreement between Aid for Aids Management Proprietary Limited and the Scheme stipulates that Aid for Aids Management Proprietary Limited renders management services to the Scheme in terms of the rules of the Scheme and in accordance with the instructions given by the Board of Trustees.	54 335	59 131
Statement of financial position		
<i>Balances payable to related party</i>		
The balances payable bear no interest, are unsecured and are payable upon presentation of an approved invoice.	(4 549)	(4 918)
Pharmacy Direct Proprietary Limited (a subsidiary of ACT Healthcare Assets Proprietary Limited, the holding company of Medscheme Holdings Proprietary Limited)		
Statement of comprehensive income		
<i>Claims paid during the year</i>	313 723	331 807
Statement of financial position		
<i>Balances payable to related party</i>		
The balance payable bears no interest, is unsecured and is due within 30 days.	–	(1 394)
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		
<i>An allocation of premiums paid</i>		
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.	821 525	774 572
Refund of capitation fees	(10 195)	(4 698)
Statement of financial position		
<i>Balances owing by related party</i>		
The balance owing by bears no interest, is unsecured and is due within 30 days.	10 195	4 698
Dental Information Systems Proprietary Limited		
Statement of comprehensive income		
<i>An allocation of premiums paid</i>		
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)	351 177	357 836
<i>Managed care services</i>		
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 Select options of the Scheme.		
Dental risk management	23 559	22 027
Statement of financial position		
<i>Balances payable to related party</i>		
The balance owing by bears no interest, is unsecured and is due within 30 days.	–	–

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

24 RELATED PARTY TRANSACTIONS (continued)

24.2 TRANSACTIONS WITH RELATED PARTIES (CONTINUED)

	2024 R'000	2023 R'000
24.2.1 Parties with significant influence over the Scheme (continued)		
Private Health Administrators (Pty) Ltd Effective 1 January 2023 the Scheme entered into an agreement with Private Healthcare Administrators (Pty) Ltd to provide administration, managed care services and capitation services (non-hospital) for BonCap option. Statement of comprehensive income <i>Administration fees paid</i> The administration agreement between Private Health Administrators (Pty) Ltd and the Scheme stipulates that Private Health Administrators (Pty) Ltd administers BonCap option in terms of the rules of the Scheme and in accordance with the instructions given by the Board of Trustees.	86 383	84 157
<i>Managed care fees (including wellness)</i> The managed care agreement between Private Health Administrators (Pty) Ltd and the Scheme stipulates that Private Health Administrators (Pty) Ltd renders managed healthcare services for the BonCap option in terms of the rules of the Scheme and in accordance with the instructions given by the Board of Trustees.	89 253	68 693
<i>An allocation of premiums paid</i> The capitated risk management agreement between the Scheme and Private Health Administrators (Pty) Ltd, as an accredited managed care organisation, stipulates that Private Health Administrators (Pty) Ltd renders all associated non-hospital benefits to beneficiaries of the Boncap option of the Scheme on a capitated basis.	377 409	362 152
Statement of financial position <i>Balances receivable from related party</i> The balance payable bears no interest, is unsecured and is due within 30 days.	1 061	–
Tendahealth (Pty) Ltd (a subsidiary of Afrocentric Distribution Services (Pty) Ltd, a fellow subsidiary of Medscheme Holdings (Pty) Ltd) Statement of comprehensive income <i>Insurance acquisition cash flows/broker fees</i>	29 659	24 415
Statement of financial position <i>Balances payable to related party</i> The balance payable bears no interest, is unsecured and is due within 30 days.	–	–
Agile Alternative Business Solutions Proprietary Limited Effective 1 September 2024 the Scheme entered into an agreement with Agile Alternative Business Solutions Proprietary Limited to provide the Scheme's marketing and related activities Statement of comprehensive income <i>Sales and marketing fees</i> Wellness Fees	57 257 3 057	– –
Statement of financial position <i>Balances payable to related party</i> The balance payable bears no interest, is unsecured and is due within 30 days.	–	–

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

24 RELATED PARTY TRANSACTIONS (continued)

24.2 TRANSACTIONS WITH RELATED PARTIES (CONTINUED)

	2024 R'000	2023 R'000
24.2.2 Key management personnel and their close family members		
Key management compensation		
Trustee's remuneration and other disbursements (note 18)	8 111	6 660
Principal Officer's remuneration and other disbursements (note 18)	9 369	8 672
Executive remuneration and other disbursements	8 497	7 436
	25 977	22 768
Statement of comprehensive income		
<i>Contributions received</i>		
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.	1 103	943
<i>Claims paid</i>		
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.	820	402
<i>Trustee savings balances</i>		
This constitutes savings balances held by the Scheme on behalf of the trustees.	–	–

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 R670 million (2023: R582 million).

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 2024 the Scheme reported the following loss making options as defined by the Council of Medical Schemes on eight (2023: five) of its benefit options:

	2024 R'000	2023 R'000
Standard	(179 042)	–
Primary	(434 641)	(67 359)
BonCap	(227 588)	(176 922)
BonFit	(8 409)	–
BonComprehensive	(125 951)	(101 578)
BonEssential	(34 610)	(36 274)
BonComplete	(25 265)	(18 319)
Hospital Standard	(2 983)	–

Options that are considered loss making by the Council of Medical Schemes are benefit options that report a insurance service result deficit after excluding amounts attributable to future members.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

26 NON-COMPLIANCE WITH THE ACT (continued)

26.1 CONTRAVENTION OF SECTION 33(2) OF THE ACT (CONTINUED)

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 continues to monitor the performance of the eight benefit options listed above on a monthly basis. 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. In 2025 the Scheme has budgeted to have seven loss making 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.

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.

26.3 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.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2024

26 NON-COMPLIANCE WITH THE ACT (continued)

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.

26.4.2 Possible impact

Providers and/or members not settled timeously 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. The system issues related to workflow approval issues were subsequently resolved. 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 EVENTS AFTER STATEMENT OF FINANCIAL POSITION DATE

27.1 LIABILITY FOR INCURRED CLAIMS

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. However, changes past reporting period would be adjusted in a subsequent period for past services.

27.2 OTHER EVENTS AFTER STATEMENT OF FINANCIAL POSITION DATE

There are no other events subsequent to the Statement of financial position date that affect the financial statements of the Scheme and that require amendment to or disclosure in the financial statements.

OTHER INFORMATION

OUR CONTACT DETAILS

Bonitas officers

Chief Operations Officer	Principal Officer	Chief Financial Officer	Clinical and Managed Care Executive
Mr S Perumal	Mr LR Callakoppen	Ms V Rikhotso	Dr T Hadebe
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	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	Postal address PO Box 3496 Cramerview 2060

Bonitas registered office and postal address

	Administrator	Managed care provider	Administrator and Managed care provider
Bonitas Medical Fund	Medscheme Holdings Proprietary Limited	Medscheme Holdings Proprietary Limited	Private Health Administrators (Pty) Ltd
	Accreditation nr MCO53	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	Physical address Pharos House 70 Buckingham Terrace Westville 3630
Postal address PO Box 3496 Cramerview 2060	Postal address PO Box 1101 Florida Glen 1708	Postal address PO Box 38632 Pinelands 7430	Postal address PO Box 343 Westville 3630

Asset/investment managers

Taquanta Asset Management Proprietary Limited	Allan Gray Investment Managers	M&G Investments (Prudential Portfolio Managers)	Fairtree Investment Manager	Sesfikile Capital
FSP nr 618	FSP nr 40592	FSP nr 615	FSP nr 25917	FSP nr 39946
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 Cnr Carl Cronje Drive and Old Oak Bellville 7530	Physical address 2nd Floor 18 The High Street Melrose Arch Johannesburg 2076
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 Tygervally Cape Town 7536	Postal address Suite 334 Private Bag X1 Melrose Arch 2076

Asset/investment managers

All Weather Capital (Pty) Limited	Catalyst Fund Managers	Vunani Fund Managers	Aluwani Capital Managers	Mergence Investment Managers (Pty) Limited
FSP nr 36722	FSP nr 36009	FSP nr 49846	FSP nr 46196	FSP nr 16134
Physical address 9th Floor Katherine Towers 1 Park Lane Wierda Valley Sandton 2196	Physical address 4th Floor Protea Place Protea Road Claremont 7708	Physical address 1st Floor Cavendish Links 1 Cavendish Street Claremont 7708	Physical address EPPF Office Park 24 Georgian Crescent East Bryanston East 2152	Physical address 2nd Floor Cape Town Cruise Terminal Duncan Road V&A Waterfront Cape Town 8001
Postal address PO Box 44845 Claremont Cape Town 7735				

Actuaries

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

External auditor

Deloitte	PwC
Physical address 5 Magwa Crescent Waterfall City 2090	Physical address 4 Lisbon Lane Waterfall City Jukskei View 2090
Postal address Private Bag x6 Gallo Manor 2052	Postal address Private Bag x36 Sunninghill 2157

ABBREVIATIONS AND DEFINITIONS

AfA	Aid for Aids
AGM	Annual general meeting
AI	Artificial intelligence
AIDS	Acquired immunodeficiency syndrome
B-BBEE	Broad-Based Black Economic Empowerment
BPO	Business Process Outsourcing
BHF	Board of Healthcare Funders
Board	Board of Trustees
Bonitas	Bonitas Medical Fund
CFO	Chief Financial Officer
CMS	Council for Medical Schemes
COBIT	Control Objectives for Information and Related Technology
COFI	Conduct of Financial Institutions
COO	Chief Operations Officer
COSO	Committee of Sponsoring Organizations
COVID-19	Coronavirus disease
CPI	Consumer Price Index
CT	Computed tomography
DBC	Documentation Based Care
Deloitte	Deloitte & Touche
DENIS	Dental Information Systems Proprietary Limited
DPM	Direct-paying member
EDO	Efficiency discounted option
ESG	Environmental, social and governance
Europ Assistance	Europ Assistance Worldwide (South Africa) Services Proprietary Limited
FY	Financial year
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
ISMS	International Standard for Information Security Management Systems
ITIL	IT Infrastructure Library
King IV™	King IV Report on Corporate Governance™ for South Africa, 2016 ¹
LCBO	Low-cost benefit option
LTI	Long-term incentive
MANCO	Management Committee
Medscheme	Medscheme Holdings Proprietary Limited
MSA	Medical Schemes Act, No 131 of 1998, as amended
NCD	Non-communicable disease
NHI	National Health Insurance
NMAS	Nedgroup Medical Aid Scheme
NPS	Net promoter score
OPSCO	Operations Committee
PET	Positron emission tomography
PMB	Prescribed minimum benefit

PMBOK	Project Management Body of Knowledge
pmpm	per member per month
PMSA	Personal Medical Savings Account
PHA	Private Health Administrators
POPIA	Protection of Personal Information Act, No 24 of 2013
PPN	Preferred Providers Negotiators Proprietary Limited
PwC	PricewaterhouseCoopers
RAF	Road Accident Fund
the report	2024 Integrated Report
RFP	Request for Proposal
RisCura Solutions	RisCura Solutions Proprietary Limited
SAMA	South African Medical Association
SAPS	South African Police Service
Scriptpharm	Scriptpharm Risk Management Proprietary Limited
SDG	Sustainable Development Goal
SGM	Special general meeting
SLA	Service level agreement
SMS	Short messaging service
STI	Short-term incentive
UNICEF	United Nations Children's Fund
the year	Financial year ended 31 December 2024

¹ Copyright and trademarks are owned by the Institute of Directors in South Africa NPC and all of its rights are reserved.



Phone 0860 002 108



Message 060 070 2491



www.facebook.com/BonitasMedical



www.instagram.com/bonitasmedicalaid



x.com/bonitasmedical



www.bonitas.co.za

Medical Emergency Services: Bonitas SOS

call 0860 555 505

Pharmacy Direct Registration

call 0860 027 800

email care@pharmacydirect.co.za

or visit www.pharmacydirect.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

Optical Benefits (PPN)

call 041 065 0650

email bonitas@ppn.co.za

or visit www.ppn.co.za

International Travel Benefit

call 087 135 4795 / +27 (10) 211 4958

or email bonitas-assist@linkham.com

Hip and Knee Programme (JointCare)

call 011 568 3334

or visit www.joint-care.co.za

Mental Health Programme

call 0860 106 155

or email mentalhealth@bonitas.co.za

Hip and Knee Programme (ICPS)

call 011 327 2599

or visit www.icpservices.co.za

Diabetes Programme

call 0860 002 108

or email diabeticcare@bonitas.co.za

Dental Programme (DENIS)

call 0860 336 346

or email denis@bonitas.co.za

Oncology Management Programme (Cancer)

call 0860 100 572

or email oncology@bonitas.co.za

Back and Neck Programme (DBC)

call 0860 105 104

or visit www.dbcsa.co.za

Babyline and Baby Bags

call 0860 999 121

BonCap (all services)

call 0861 239 333

or email BonCap@bonitas.co.za

for HIV email BonCapCares@bonitas.co.za

Palliative Care Programme

email info@alignd.co.za



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



 **Bonitas WhatsApp 060 070 2491**

 bonitas.co.za/member

 **www.bonitas.co.za**

 **Bonitas Member App**

 **Bonitas Medical Fund**

 **@BonitasMedical**