WE CARE

Highlights of the Annual Financial Statements **2017**

bestMed™

personally yours

You are invited to attend Bestmed's 54th Annual General Meeting

Date:	Friday, 15 June 2018
Time:	Registration - 08:00 AGM - 08:45 - 11:30
Venue:	The Capital Menlyn Maine Hotel 194 Bancor Avenue Menlyn Maine Pretoria
RSVP:	Refilwe Moloisane on or before 1 June 2018.
E-mail:	bestmed-agm@bestmed.co.za

Should you wish to submit a motion for the AGM, kindly e-mail bestmed-agm@bestmed.co.za by no later than 8 June 2018.

During our 54 years of providing top-quality healthcare, we have learned that virtually everything we do in life is measured in numbers. Our age, weight, calorie intake, exam marks, and so much more. But we believe that we should care about more than spreadsheets. Although Bestmed measures itself on its numbers, we take pride in being unlike other medical schemes: we're self-administered and run by our members, for our members, and we have a vested interest in doing our absolute best for each and every one of our 199 382 beneficiaries. We believe that even though numbers are important, it's what's behind them that really matters – the thousands of lives we've helped to improve with personal and personalised care. As you page through this report, we're sure you'll agree that once again, our special brand of care works for our members as well as for our numbers.

Looking Forward

We Care

2017, like most years, was a year marked by many challenges and many opportunities. We successfully navigated these turbulent waters while actively improving members' wellness and increasing reserves once again. The economic downturn didn't care about member retention, and you might not care about a difficult regulatory environment – but we do. That's why, in business and in health, Bestmed is Personally Yours.

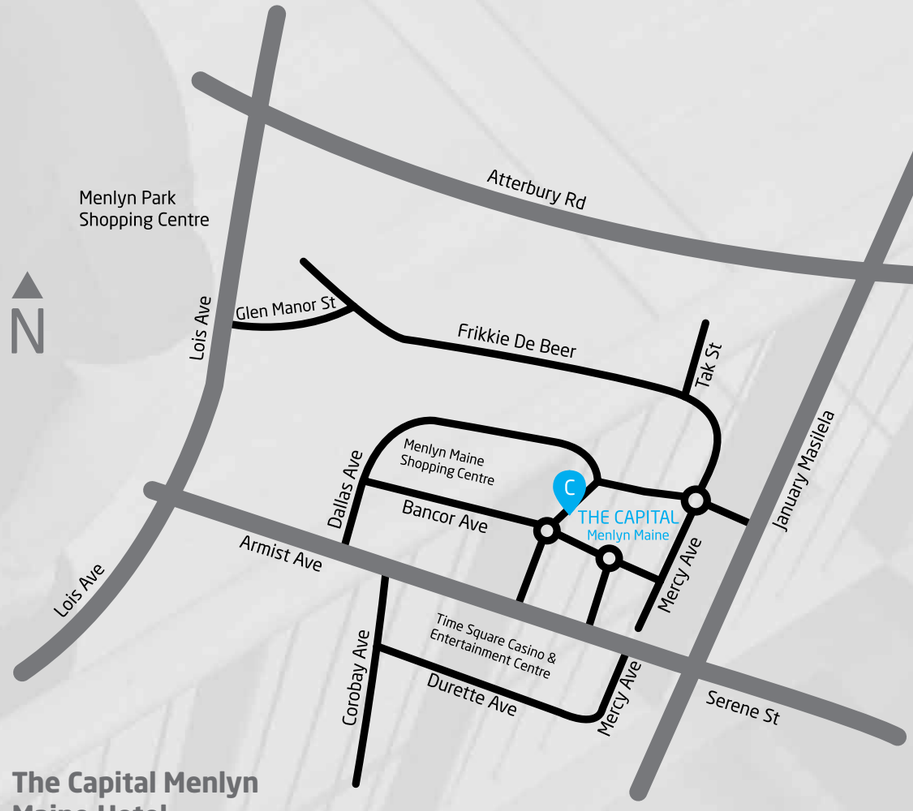
INDEX

Programme

54th Annual General Meeting

08:00 - 08:45 Registration
08:45 - 09:00 Opening
09:00 - 11:30 AGM

Directions



The Capital Menlyn Maine Hotel

194 Bancor Avenue
Menlyn Maine
Pretoria

GPS Coordinates:

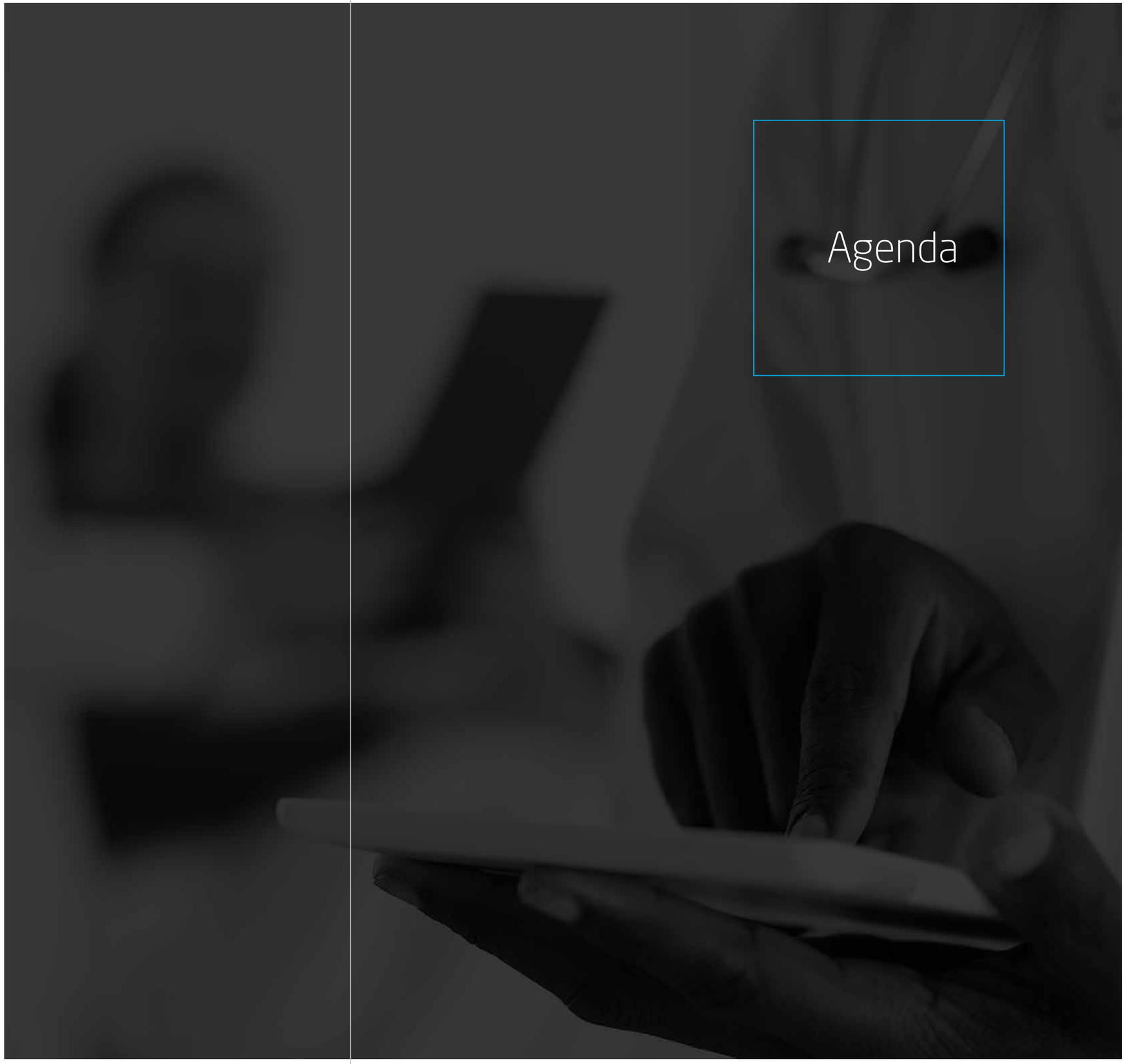
S - 25.786436 / E - 26.281669

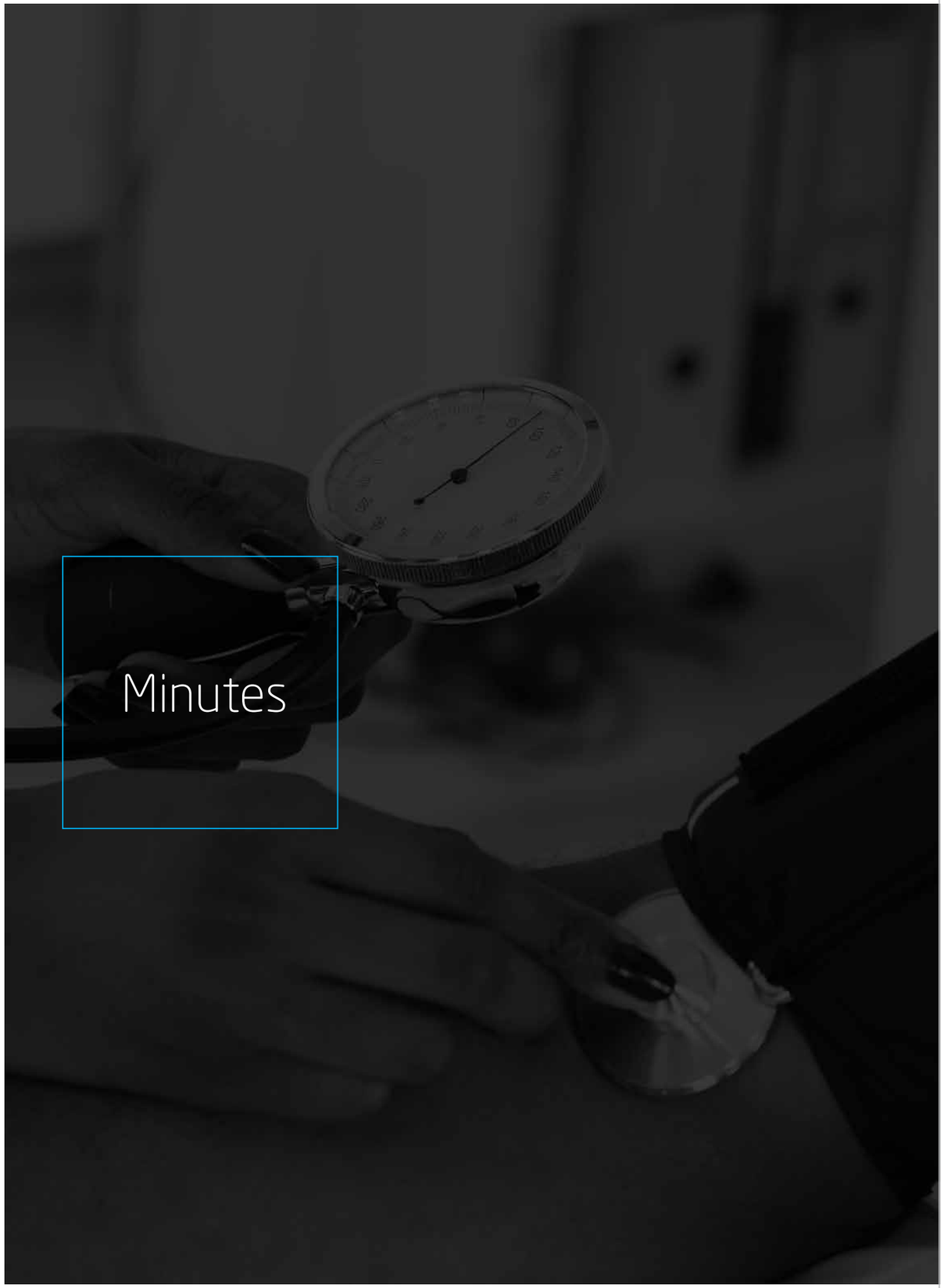
54th Annual General Meeting

Notice is hereby given that the 54th Annual General Meeting of the members of Bestmed Medical Scheme will be held at 08:45 on Friday, 15 June 2018 at The Capital Menlyn Maine Hotel, 194 Bancor Avenue, Menlyn Maine, Pretoria.

- Opening by Chairperson
- Finalisation of Agenda
- Minutes of the previous Annual General Meeting held on 2 June 2017
- Matters arising from previous Annual General Meeting
- Report of the Chairperson
- Financial statements and auditor's report
- Appointment of Auditors 2018/2019
- Motions received in terms of Rule 26.1.4
- Approval of Amended Trustee Remuneration
- Progress with the directives issued by the Council for Medical Schemes against the Scheme after the routine inspection during 2011
- Closure

PLEASE NOTE: Documents are printed in the language in which they were presented and submitted to the Registrar of Medical Schemes. A full set of the financial report is available electronically on request. For your copy, send an e-mail to: communications@bestmed.co.za





Minutes

Minutes of the 53rd Annual General Meeting of representatives of employers, employees and members held at the Capital Menlyn Maine Hotel, Pretoria on Friday, 2 June 2017 at 12:00.

1. OPENING BY CHAIRPERSON

1.1. PRESENT

1.1.1. 167 active voting members

1.1.2. 9 members of the Board of Trustees

1.1.3. 2 special guests from the Council for Medical Schemes (CMS)

APOLOGIES

No apologies had been received.

1.2 OPENING BY CHAIRPERSON

Mr Fred Camphor, Chairperson of the Board of Trustees (BoT), declared the meeting properly constituted, members and employers having been given adequate notice of the meeting in terms of Rule 26.1.1 of the Bestmed Rules and more than 25 members being present to constitute a quorum.

He welcomed, in addition to the Scheme's members, members of the Board of Trustees, as well as management and staff of Bestmed.

A warm welcome was also extended to Mr Dries la Grange, former Chief Executive Officer and Principal Officer (CEO and PO) of Bestmed, Adv Lappies Labuschagne, former Chairperson of the Bestmed BoT as well as Ms Annelize Hartzenberg and Mr Frank Dempsey, former BoT members of Bestmed.

Next, the Chairperson welcomed two esteemed guests, Mr Sibonelo Cele and Ms Avril Jacobs from the Council for Medical Schemes (CMS), and expressed his appreciation towards them for attending Bestmed's Annual General Meeting (AGM). Finally, the Chairperson welcomed representatives of the Scheme's external auditors, PricewaterhouseCoopers (PwC), Mr Johannes Grové and Ms Alex Müller.

2. FINALISATION OF AGENDA

The agenda was finalised. The following two matters arising from the previous AGM as indicated on the agenda would be addressed when discussing the Report of the Chairperson dealing with the highlights of the Scheme's activities in the 2016 financial year:

- The progress with the directives issued by the CMS after the routine inspection of 2011
- The progress with the complaints lodged against the Scheme with the CMS in 2014/2015

The Chairperson asked the members whether there were any matters arising from the minutes of the previous AGM which should be addressed at the meeting. Since no requests for the discussion of additional matters were made, the agenda was adopted without any further amendments.

3. REPORT OF THE CHAIRPERSON

A copy of the report from the Chairperson was available in the abridged version of the Annual Report. The following matters were highlighted:

BESTMED'S FINANCIAL PERFORMANCE IN 2016

- An overview of the 2016 financial year was given, in particular the challenging economic circumstances under which medical schemes functioned in 2016. The third quarter of 2016 delivered a mere 0.2% growth with estimated growth for the full year dwindling to below 0.5%. In addition to increased political instability in 2016, violent protests occurred at a number of academic institutions enrolled as participating employer groups with the Scheme.
- With regard to the healthcare environment, and the medical schemes industry in particular, medical schemes, including Bestmed, were conducting business in a highly competitive and regulated environment. Members of medical schemes were often guided by consultants and brokers, which could impact the Scheme's membership negatively. Despite these challenging circumstances, Bestmed had performed exceptionally well in 2016. Bestmed's balance sheet had strengthened to R2.161 billion, and the Scheme recorded a net healthcare result of R84.9 million in 2016. The net surplus, inclusive of investment returns, in 2016 increased to R161.3 million, and the Scheme concluded the 2016 financial year with a total comprehensive income of R182.4 million.

- Bestmed was one of a small number of open medical schemes, if not the only open medical scheme, to report a net healthcare surplus in 2016. The majority of medical schemes made a net healthcare loss in 2016. In addition, Bestmed's solvency ratio improved from 25.58% to 26.88% at 31 December 2016, exceeding the statutory required solvency level of 25%. Furthermore, the Scheme had earned investment returns on reserves amounting to R86.8 million, constituting 53.8% of its total net surplus of R161.3 million for 2016. All these factors were indicative of a sound medical scheme with adequate financial means to cover claims.

GOVERNANCE

- The King IV Report on Corporate Governance was released on 1 November 2016, which provided guidance on governance to organisations, including medical schemes. As indicated in the presentation delivered by the Legal, Risk and Governance Executive Manager, a number of matters had already been attended to and a significant amount of work had been done in this regard.
- With regard to the BoT, one of the Board members, Dr Joan Moncrieff, who had been terminally ill, had passed away and was sorely missed by all Board members. In addition, Mr Etienne Steenkamp resigned from the Board. As a result, two new Board members, Prof Kobus van Rooyen and Mr Johannes Lachmann were appointed in accordance with the Rules of the Scheme to fill the respective vacancies. Mr Lachmann emigrated in 2017, and since an equal number of elected and appointed members were serving on the Board, it was decided not to fill this vacancy immediately. In addition, the term of office of Mr Willem Myburgh had expired at the AGM in 2016, and Elmarie Marx was elected to fill this vacancy.

THE PROGRESS WITH THE COMPLAINTS LODGED AGAINST THE SCHEME WITH THE CMS IN 2014/2015

Possible transgressions of the Medical Schemes Act, 1998 (Act No 131 of 1998) by Bestmed were reported to the Board in 2015, resulting in the KPMG forensic investigation conducted in 2015/2016. At the 2016 AGM, the Chairperson delivered a detailed presentation on the investigation and the findings in the KPMG report as well as the resultant recommendations and subsequent actions taken by the Board, as recorded from page 18 to 27 in the minutes of the 2016 AGM. However, shortly after the AGM in 2016, the CMS informed the Scheme that it had ordered its own routine inspection on the same allegations investigated by KPMG in 2015. The Board took the decision to give its full cooperation to the investigator appointed by the CMS and provided all the required information to the investigator. It was anticipated that the investigation would be finalised in 2017. After finalisation, a draft report would be provided to Bestmed and its Board for comment.

THE PROGRESS WITH THE DIRECTIVES ISSUED BY THE CMS AFTER THE ROUTINE INSPECTION OF 2011

In January 2015, Bestmed launched an appeal in terms of Section 50 of the Medical Schemes Act, 1998 to verify the legality of the decisions of the CMS, taken on 29 October 2014, to remove nine of its Board members in terms of Section 46 of the Act. The Section 50 appeal was heard in March 2017 and dismissed on technical points in limine raised by the CMS. The Board decided not to proceed with a High Court review as this matter had now been finalised, although the former BoT may, in their personal capacity, continue with the process.

- A number of directives, following from the CMS investigation conducted in 2011, was issued to Bestmed. In the course of the year, the CMS confirmed in writing to Bestmed that all of those directives had either been met or the CMS would not pursue them any further. This eventually concluded the process started with the investigation in 2011 and the directives issued following the process.

FORMER CEO AND PO OF BESTMED MEDICAL SCHEME

- Mr La Grange, who served as Bestmed's CEO and PO over the past 21 years, had left the Scheme's employ on 31 March 2017. The Chairperson indicated that, as already mentioned, the healthcare industry required continuous assessment of and adaptation to environmental challenges. The Board assessed and considered the situation very carefully. Against the background of the operational imperatives, in particular the planned implementation of the new administration system, and in the best interest of the Scheme, its members, and Mr La Grange, the Board regarded it appropriate to enter into a separation agreement with Mr La Grange. At this point in time, after a highly successful year, it was deemed the most appropriate time for Mr La Grange to depart and he retired on 31 March 2017. The process of recruiting a new CEO/PO is underway. In the meantime, the Board requested Pieter van Zyl to act in the role of CEO/PO.
- As part of this process, and guided by the applicable conditions of service and labour law, the Board made a separation payment to Mr La Grange. Since the opinion was maintained that the Board's decisions should remain transparent, it was decided to disclose the payment in the notes to the Annual Financial Statements. The payment was also disclosed in the Annual Financial Statements on page 11, section 9 of the Board report as submitted to the CMS. The detail of the separation payment made to Mr La Grange had thus been explicitly and adequately disclosed to the CMS as well as members of the Scheme in the Annual Financial Statements.

NEW ADMINISTRATION SYSTEM (BiT SYSTEM)

- On 1 May 2017, Bestmed implemented a new administration system, referred to as the BiT system by staff. A medical scheme's administration system plays a pivotal role in the effective functioning of the scheme, as it performs a number of essential business functions. In 2011, Bestmed made a similar, but unsuccessful, attempt to implement a new IT system. This year, however, the migration to the new administration system proceeded smoothly. Although a number of teething problems were experienced, as anticipated, these were dealt with promptly and effectively. During the long weekend of 26 April to 3 May 2017, the majority of Bestmed staff members worked exceptionally long hours to do the migration from the Medware to the BiT system. This migration took place without the majority of the members even being aware of it. To date, a number of successful transactions had taken place:
  - Data was successfully transferred from the Medware to the BiT system.
  - Four successful claims runs took place.
  - Subscription fees were recovered and reconciled successfully.
  - The turnaround time for the processing of pharmacy claims was reduced from two seconds to 0.4 seconds.
  - As anticipated, the service levels in the Call Centre and Pre-authorisation Centre initially declined after the migration to the new system. However, within three weeks from the first weekend in May following the BiT system implementation, the service levels increased to 60%. It was anticipated that the service levels would revert to 80% within the next one to three months.
  - The Chairperson thanked all staff members and the service suppliers for their efforts to ensure the effective functioning of the BiT system in the interests of and to the benefit of all Bestmed members, employer groups, brokers and service providers.

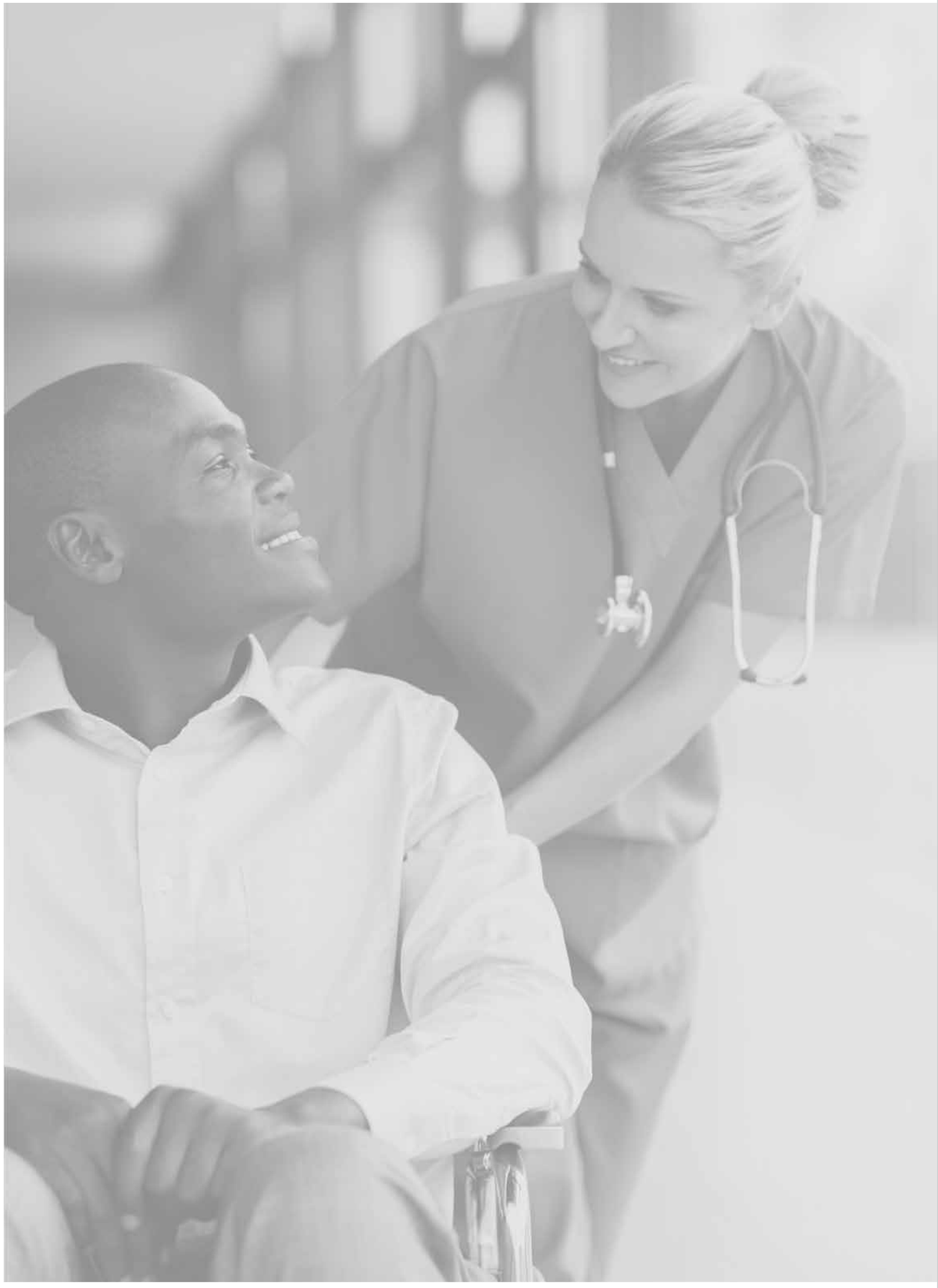
ACKNOWLEDGEMENTS

The Chairperson concluded his presentation by conveying his sincere appreciation to the following parties:

- The former CEO/PO, Mr La Grange, for his dedication to Bestmed over the past 28 years and his leadership as CEO/PO over the past 21 years.
- Bestmed management and staff members, for their loyalty and dedicated hard work to ensure the sustainability of the Scheme.
- Mr Van Zyl, for his willingness to take over the leadership as the Acting CEO/PO until the appointment of a new CEO/PO.
- Members of the Scheme, for entrusting Bestmed to the BoT to take care of certain decisions on members' behalf.
- The BoT, for their cooperation and support during his term as Chairperson, and for taking Bestmed through a difficult time. Their commitment and dedication had contributed significantly to the success of the Scheme.

> The Chairperson indicated that his term of office would expire at the conclusion of the AGM, which was the third AGM he was attending in this capacity. A new Chairperson would then be elected by the Board. He assured members that Bestmed was financially sound and that they could look forward to yet another good year.

Adv Labuschagne, membership number 0052140, congratulated the Chairperson, on behalf of the AGM, on delivering a comprehensive and transparent report on Bestmed's performance in 2016. He also congratulated him on the Scheme's exceptional solvency level of 26.8% and the membership growth achieved in 2016. He further commended the Chairperson on his commitment towards meeting the highest standards of compliance as stipulated in the King IV Report on Corporate Governance,



the manner in which he dealt with the Scheme's often strained relationship with the CMS, the Competition Commission's enquiry and the departure of the former CEO/PO. He then proposed that the Chairperson's report be adopted with acknowledgement to the Chairperson of the Board, the trustees and the Scheme's staff for their achievements. An eligible member seconded the approval of the Chairperson's report.

In response to a member's enquiries on details provided in the 2016 financial statements, the Chairperson indicated that the Chief Financial Officer would address these enquiries when presenting the Financial Statements to the meeting.

An eligible member requested the Chairperson to explain the reasons for the sudden departure of the former CEO/PO, who had served in this capacity for the past 21 years. He also enquired about the transitional arrangements made, since the Scheme had lost the institutional memory built over the past 21 years, which played a fundamental role in the key strategic decisions taken between AGMs.

The Chairperson responded by first emphasising the legacy of expertise which the former CEO/PO had created in the Scheme. The former CEO/PO left a skilled and experienced management team behind and, therefore, institutional memory had been preserved. In addition, an agreement had been reached between the Board and Mr La Grange that he would be available for assistance upon request.

When the Board entered into a process of discussions with the former CEO/PO on possible early retirement, a number of factors was taken into consideration, including the most appropriate time for leaving the Scheme's employment. In consultation with the former CEO/PO, it was decided that it would be inappropriate to leave the Scheme's employ on or after 1 May 2017 when staff would be engaged in the process of the migration to the new administration system.

As a result, it had been mutually agreed that an appropriate time would be prior to the migration. In addition, the Board had argued that the most appropriate time for leaving the Scheme's employ would be when the Scheme was at prime performance. As a result, the Board had entered into a separation agreement with the former CEO/PO, which had been mutually accepted in the best interests of the Scheme, its members and the former CEO/PO.

Mr Stanley Lesufi, membership number 1937634, then enquired whether it would be possible to disseminate information on matters of this nature to members prior to the AGM. The Chairperson replied that communication on this matter, although not as detailed as provided at the AGM, had been sent to all members. Similarly, communication on the implementation of the new administration system had been disseminated to members on more than one occasion.

4. MINUTES OF PREVIOUS ANNUAL GENERAL MEETING HELD ON 3 JUNE 2016

The minutes of the 53rd AGM were unanimously accepted as a fair and accurate record of the proceedings and signed by the Chairperson.

PROPOSED: Mrs A Hartzenberg, membership number 0337536

SECONDED: Mr AM La Grange, membership number 0360384

Mr Johannes Schutte, membership number 6140845, enquired who had submitted the allegations against Bestmed to the CMS. Since the enquiry had been made in Afrikaans, the Chairperson responded in Afrikaans by explaining that these had been submitted anonymously to the CMS and had been presented by the CMS to the Scheme. It was assumed that the CMS would know the identity of the person/s who had submitted the allegations. He then repeated his response in English.

5. MATTERS ARISING FROM THE PREVIOUS ANNUAL GENERAL MEETING

Since the progress with the directives and allegations against Bestmed had been reported on, there were no additional matters arising from the previous AGM to address. The meeting then proceeded with the discussion of the Annual Financial Statements and the Auditor's report.

6. FINANCIAL STATEMENTS AND AUDITOR'S REPORT

The Financial Statements for 2016 and the Auditor's report were presented by the Chief Financial Officer. He indicated that, before proceeding with the discussion of the financial statements, he would like to express his sincere gratitude to the following parties, in no particular order:

- Mr Grové from PwC, for the excellent service rendered to the Scheme.
- The Finance Department, headed by Ms Gao Dire, and her colleagues for the endless hours dedicated to ensure a smooth year end despite the challenges faced with the implementation of the new administration system.

- His predecessor, the Managed Healthcare Executive Manager, Mr Wicus Kotzé, for his continuous support and guidance.
- The rest of Executive Management for their support.
- The former CEO/PO, Mr La Grange, for his support during the period he had served under his guidance.
- The BoT, and especially Mr Kobus Scheepers, the outgoing Chairperson of the Audit Committee for the support and the valuable lessons learnt from Mr Scheepers.
- The CMS, in particular Mr Sameer Rajab, for the support of his team.

Members' attention was drawn to the full set of Financial Statements provided in the Annual report and the accompanying comprehensive notes.

AUDITOR'S REPORT

The auditors advised that, in their opinion, the Annual Financial Statements presented fairly, in all material respects, the financial position of Bestmed Medical Scheme as at 31 December 2016, its financial performance and its cash flows for the year then ended in accordance with International Financial Reporting Standards and in the manner required by the Medical Schemes Act, 1998, as amended, section 33(2).

In absolute terms compared to 2015, the risk contribution income had increased by 10.3%, benefits paid increased by 6.4% and the non-healthcare cost on a year-on-year basis as a percentage of gross contributions had remained at 8.3%.

Expressed on a per member basis, average membership increased by 2.2% year-on-year, the risk contributions had increased by 7.9%, whilst the benefits paid increased by 4.1%. Cost remained unchanged at 7.5% on a per member basis compared to 2015.

HIGHLIGHTS FROM THE STATEMENT OF COMPREHENSIVE INCOME

The Financial Statement reflected a total comprehensive contribution income of R4 630 884 for 2016. The risk contribution income increased by 10.3%, whilst the relevant healthcare expenditure increased by 6.4%. The net healthcare result of R85 million represented a significant increase of 314.2%, compared to a net healthcare deficit of R39.7 million in 2015 due to the higher benefit expenditure.

The Scheme recorded a net surplus of R161.3 million for the year. The total comprehensive income for the year after accounting for fair value adjustments was R182 million. The gross healthcare result increased from R311 million in 2015 to R470 million in 2016, representing a 51.2% increase. Non-healthcare costs increased by 9.8%.

'Other income' related largely to investment income of R161.3 million, compared to R38.6 million in 2015, constituting an increase of 317.8%. The external investment funds were managed by asset managers who were paid investment management fees determined by the Board's Investment Committee, based on advice received from Willis Towers Watson, an independent consultancy firm. In 2016, this fee amounted to R6.2 million. Sundry income of R3.098 million included unclaimed cheques written back.

Taking into consideration the fair value adjustments, the Scheme managed to earn an income of R21.2 million, equalling a total comprehensive income of R182.4 million in 2016, compared to R14.7 million the previous year. This increase in the total comprehensive income represented a staggering 1 138% turnaround. These achievements were indicative of the exceptional financial performance of the Scheme. In contrast with companies that paid their dividends to their shareholders, Bestmed, as a mutual, not-for-profit organisation, returned most of its income to members in the form of benefits. Costs were, of course, involved, but it was pointed out that since returning to self-administration in 2012, significant cost reductions had been made.

'Other expenses' referred to the cost of running the medical facilities taken over from Minemed Medical Scheme following their amalgamation with Bestmed. This cost was offset by the fact that benefits could be provided more cost-effectively by those facilities to all members of the Scheme who chose to use them.

The bulk of the Scheme's liabilities consisted of members' personal medical savings account (PMSA) funds, on which they received interest and which were used to pay for their day-to-day benefits.

The average number of members enrolled with the Scheme in 2016 stood at 95 085, compared to 93 066 members in 2015, representing an average increase of 2.2%. Income increased by 7.9%, whilst the net investment income declined slightly by 2.4%. The average total income per member was R3 505 per month.

HIGHLIGHTS FROM THE STATEMENT OF FINANCIAL POSITION

Available-for-sale investments increased from R991 million in 2015 to R1.1 billion in 2016, whilst total assets increased slightly from R1.908 billion in 2015 to R2.161 billion in 2016. Assets in respect of property and equipment amounted to R20 million. Loans and receivables referred to loans granted to employees in the past. This practice, however, was discontinued. With regard to long-term liabilities, the retirement fund obligations in respect of former employees were increasing.

'Other assets and liabilities' referred to provisions created by the Scheme as well as certain member funds received in advance, which had not yet been allocated. The Scheme's liabilities consisted of R583 million of assets held in trust from members' PMSAs.

SOLVENCY

The solvency ratio at 31 December 2016 was 26.88%, compared to the statutory requirement of 25%. The solvency ratio equalled the ratio of the net asset value of the Scheme (R1.333 billion) to the gross contributions of R4.630 billion. This was a clear message that the Scheme was financially strong and well able to pay its dues on behalf of its members. It was anticipated that the solvency level might increase to 27% towards the end of 2017.

The cash cover of risk benefits in terms of months was 5.7%, assuming that all liabilities had been settled, which implied that, should no subscription income be received, the Scheme would be able to cover its liabilities for a period of five months.

INVESTMENTS

The Scheme's net worth now stood at R1.3 billion. Its investment strategy showed a net return of 7.9% per annum since inception (132 months), which was 3.3% per annum ahead of inflation, compared to the mandate of 3%. This was a clear indication that funds were invested sensibly to the benefit of the Scheme's members. The Chief Financial Officer congratulated the Bestmed Investment Committee, headed by Mr Colin Mowatt, on the good work done by the Committee.

With regard to the PMSA referred to previously, an amount of R443 million was managed in the money market investments, in addition to R123.3 million held in a current account, totalling R566.3 million. The Scheme had once again achieved a return of 8.3% ahead of inflation. This performance confirmed that funds were well managed.

A comparative analysis of the Scheme's performance in relation to its competitors was then given, based on the information available from the audited financial statements up to 1 June 2017. Bestmed was the only self-administered scheme included in the analysis.

According to the analysis, Bestmed had achieved an average principal member growth of 2.2%, compared to an average principal member growth of 2.4% achieved by Discovery Medical Scheme. Momentum Health and Bonitas had achieved an average principal member growth of 7.3% and 17.8% respectively. It was, however, pointed out that, in reality, Bonitas had achieved a -0.2% membership growth year on year prior to the amalgamation with Liberty Health Medical Scheme. In the case of Momentum Health, the 7.3% growth in membership had been mainly achieved in the student market, specifically students from abroad who were studying in the country, as these students were required to be enrolled as a member of a medical scheme. These students were also enrolled on an entry-level option.

With regard to the claims ratio percentage, which constituted the portion of risk benefits paid to risk contribution income, an average of 88.9% had been recorded in the medical schemes industry. Bestmed had recorded an average claims ratio percentage of 88.01%, very close to Momentum Health at 88.14%, whilst Discovery and Bonitas had recorded average claims ratio percentages of 87.19% and 92.08% respectively.

> The Scheme's non-healthcare costs as a percentage of risk contribution was 9.8%, which was well below the average of 11.7% recorded by the schemes included in the analysis.

The Scheme had recorded a net healthcare result of R84.9 million, compared to R102 million recorded by Discovery. However, calculated based on the number of principal members enrolled – 95 000 and 1.2 million in the cases of Bestmed and Discovery respectively – the Scheme had recorded an exceptional net healthcare result

in 2016. In addition, Bestmed's solvency level stood at 26.88%, compared to 26.33% recorded by Discovery, which was a significantly larger scheme than Bestmed. These results were indicative of the Scheme's sound financial performance.

An eligible member enquired about the 8.3% interest earned in the money market portfolio, since this interest rate seemed exceptionally high. The Healthcare Executive Manager explained that the investment had been made in a money market-related portfolio offering a higher interest rate, compared to the 6.5% to 7% interest earned in a money market portfolio.

In response to a question raised by Mrs Annelize Hartzenberg, membership number 0337536, it was indicated that Willis Towers Watson was the Scheme's current investment consultants.

Mr Simide Nkosi, membership number 1755544, raised the question whether any challenges were foreseen when making a projection of increasing the Scheme's solvency level to 27%, compared to a statutory required solvency level of 25%, in view of an anticipated downgrade of the country's economy to junk status.

The Chief Financial Officer thanked the member for the valid question and indicated that a solvency level of 27% was a mere target set for the Scheme and not a definite outcome and depended largely on the manner in which funds were managed in the Scheme. He indicated that a downgrade to junk status could have a negative effect on the Scheme's performance. He added it was a significant challenge to manage risks and control expenses carefully to prevent any detrimental effects to the Scheme.

Mr Stanley Lesufi, membership number 1937634, enquired whether broker fees were included in the Scheme's non-healthcare costs and, if so, whether the Scheme had quantified the value added by the brokers to the Scheme's performance.

The Chairperson, addressing Mr Cele in his response, replied by indicating that broker fees were included in the non-healthcare cost, but were limited to a maximum of 3% of the monthly subscription fees payable per individual member. He indicated that calculating the contribution made by brokers in terms of the monetary value in respect of the service they rendered was a complex matter.

Brokers enrolling and rendering a service to members were paid a commission fee for the duration of the enrolled members' membership. When taking into consideration the net growth of members and the growth of Bestmed members over the past 10 years, the largest portion of membership growth, except for the large amalgamation with Telemed and one or two smaller amalgamations, had been effected by brokers who, in turn, were paid broker fees.

Mr Stephan Pietersen, membership number 11254373, enquired whether Bestmed had effected a saving when reverting to a self-administered scheme. The Chairperson replied by indicating that a self-administered scheme's administration costs were less expensive, compared to those of administered schemes. This was reflected in the Scheme's non-healthcare costs that were lower compared to the industry.

If a scheme's administration was outsourced, 14% VAT was charged on the administration fees. Since Bestmed was a self-administered scheme, it was not required to pay administration fees. The Chief Financial Officer added that the average administration costs of other self-administered schemes had stood on 11.7% in 2016, compared to Bestmed's administration costs of 9.8%.

Ms Karin Weiss, membership number 34379100, requested that the notion 'savings' be clarified, as all expenses were paid from a member's PMSA first before payments were made from the day-to-day benefits. The Chief Financial Officer explained that, depending on the benefit option on which a member was enrolled, it comprised a PMSA component linked to a risk contribution component.

The funds in the PMSA accumulated with the monthly subscription fees paid by the member. These funds belonged to the members and were retained by the Scheme until needed by the member for the payment of medical expenses incurred and no cross-subsidisation was involved.

Although the funds in the PMSA accumulated monthly, the total annual amount in the PMSA was made available to members at the beginning of a financial year. The member replied by indicating that it was not clear why all claims were paid from the PMSA first.

The Acting CEO/PO replied to this question, indicating that changes had been made to the benefit structures of the various options, mainly due to financial reasons. In this regard, a number of possible solutions had been considered: the subscription fees could either be increased to provide for the additional risk, or a self-payment gap could be introduced.

A combination of these two options could also be introduced. Alternatively, amendments to the benefit structure of the options could be made. As stipulated by legislation, each benefit option should be self-sustaining and cross-subsidisation between the options was not allowed.

For this reason, amendments had been made to the manner in which the PMSA was managed. The Chairperson added to his explanation, indicating that, in essence, the risk contribution component could either be increased significantly in order to pay more benefits from the risk pool or members could be required to pay certain benefits from the PMSA with a lower risk contribution increase. The costs of benefits were covered through a balance of risk contribution and contribution to the PMSA. An increase in benefits would require an increase in subscription fees.

Mr Ayandamaswazi Simelane, membership number 11961673, raised a personal issue on a complaint that he had submitted to the CMS regarding the payment of benefits from the vested savings account. The Chairperson replied that the matter would be attended to by Bestmed Management and requested the meeting to return to the discussion of the financial statements.

Mr Walter Maaba, membership number 10303303, indicated that, although Bestmed's membership had increased by 2.2% in 2016, Momentum Health had achieved a 7.3% membership growth in the student market. He enquired whether there were any specific reasons why the Scheme would not consider selling its products in the student market.

In addition, in view of the Scheme's good financial performance in 2016, he enquired how members would benefit from the performance from a financial perspective. The Marketing and Distribution Executive Manager responded to the first question by indicating that Momentum Health's significant membership growth had been achieved by a focused marketing strategy in a market segment in which Bestmed did not engage, since it was a fairly low margin environment. He added that the Scheme's strategy to grow by 2.2% in a more general and more sustainable market should give members greater peace of mind.

The Chairperson added that, overall, there was not material growth in the number of members enrolled with medical schemes over the last few years. As a result, the number of members joining medical schemes had remained fairly stable, resulting in lower membership growth. Instead, there was a high tendency of member movement within the medical schemes industry.

The Chief Financial Officer responded to the member's second question on the Scheme's financial performance, indicating that the Scheme's reserve level would definitely be taken into account when determining the annual increase in subscription fees. In 2017, Bestmed's average subscription increase had compared favourably to the market, which was definitely to the members' advantage.

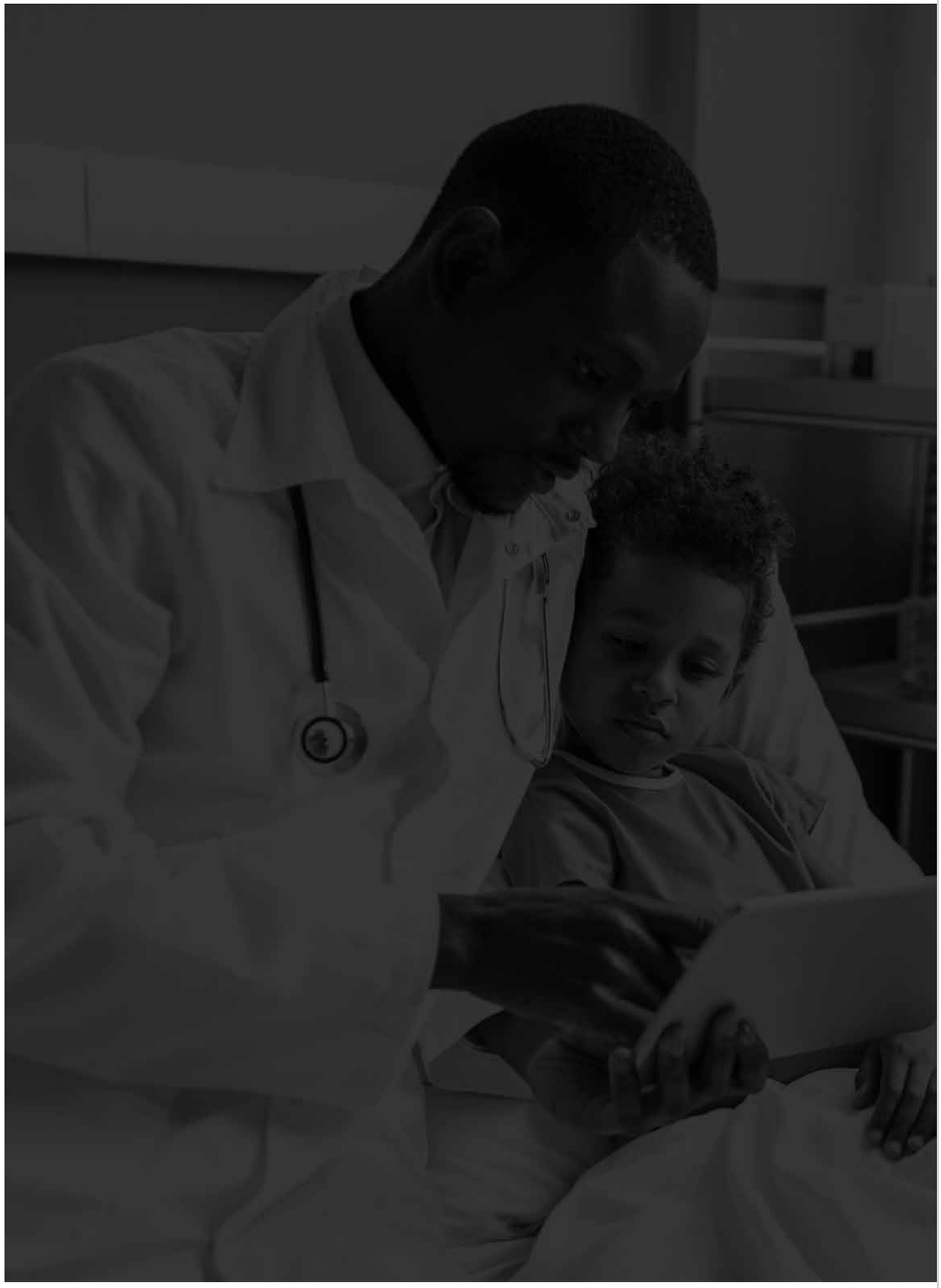
The Chairperson added that in terms of legislation, medical schemes were not allowed to reward members in the form of payments. Introducing a lower percentage increase in subscription fees for the next financial year, which was also lower than the average subscription increase in the industry, as was the case this year, was an effective measure to ensure members would benefit from the good financial performance of the previous year.

Mr Charl Joubert, membership number 1136631, indicated that, although it was appreciated that the Scheme was liquid, amendments to the Scheme's benefit options should not be made at the members' expense.

Certain members could not afford the amendments made to the benefit options and the Rules, as they did not have sufficient financial means to pay any expenses in addition to the subscription fees that were increased annually.

The Chairperson responded by indicating that Management would be requested to consider this factor when designing the benefit structures for 2018. The rules of the 2017 benefit options had been registered with the CMS and, therefore, the benefit options could only be amended with effect from 2018.

Mr Johannes Schutte, membership number 6140845, inquired in Afrikaans whether it could be considered to introduce a principle similar to the no-claim bonus applied in the



insurance industry by granting an incentive to low-claiming members. This request was made in view of the fact that the annual pension increase was significantly lower than the annual increase in subscription fees.

Since the question was asked in Afrikaans, the Chairperson first responded in Afrikaans and then repeated his response in English. He explained that the principles of a no-claim bonus or decreased monthly premiums applied in the short-term insurance industry were aimed at rewarding beneficiaries with a low claims risk.

However, in the highly regulated healthcare industry, legislation prohibited medical schemes from charging lower subscription fees to low-claiming members. The monthly subscription fees were calculated based on the member's income, the number of registered dependants and, in certain instances, the member's monthly contribution to the PMSA. The only manner in which medical schemes could compensate members for a lower claims ratio was by lowering the Scheme's annual increase in subscription fees, provided that its reserve level was significantly higher than the statutory requirement of 25%.

Mr Frank Dempsey, membership number 1198310, elaborated on the Chairperson's explanation by indicating that the fact that self-funded payment contributions had been incorporated in the benefit options' design implied that in the case of a low claims ratio, the self-funded payment on a specific claim would not apply.

Alternatively, a significant increase in annual subscription fees would be required to prevent self-funded payments. In addition, Mr Dempsey requested from Management that the solvency level should not exceed 27% and that surplus funds should rather be used to lower annual increases in subscription fees, as alluded to by the Chief Financial Officer.

Mr Chris Pelser, membership number 1837001, requested Management to come up with more innovative solutions, which did not necessarily involve a lower increase in the annual subscription fees. In this manner, those members who could not afford the increasing subscription fees and additional medical expenses could be supported.

The Chairperson replied by indicating that, as already explained to members, the medical schemes industry was a highly regulated environment offering very limited opportunity for implementing innovative ideas due to the restrictions imposed on medical schemes. However, he invited Mr Pelser to discuss any suggestions he might have with Management for consideration.

Mr Enoch Peprah, membership number 442364, made an inquiry about the principles applied in utilisation review in order to make an informed decision on the validity of a specialist's diagnosis and granting benefits for the prescribed treatment accordingly.

The Acting CEO/PO replied by indicating that it was difficult to provide a meaningful response without having all the relevant information about the illness and the prescribed medication available to him. He explained that decisions whether or not the prescribed treatment for a specific illness qualified for benefits were taken by the Scheme's Medical Advisers and Benefit Management Specialists, based on its algorithms and medicine formularies. The Acting CEO/PO invited the member to escalate the query to him. After investigating the matter based on the information received, feedback on whether or not benefits could be granted for the prescribed treatment would be given to the member. The Chairperson responded by requesting that individual problems be addressed with Management.

APPROVAL AND ADOPTION OF THE FINANCIAL STATEMENTS

No further questions were raised and the annual Financial Statements presented to the meeting were unanimously adopted and approved.

PROPOSED: Mr Frank Dempsy, membership number 1198310

SECONDED: Mrs Annelize Hartzenberg, membership number 0337536)

7. APPOINTMENT OF AUDITORS FOR FINANCIAL YEAR ENDING 31 DECEMBER 2017

The meeting was informed that the members present at the AGM should appoint the external auditors for the next financial year. PwC had served as the Scheme's auditors for the financial year ending 31 December 2016. The Board of Trustees and the Audit Committee recommended that PwC be reappointed as auditors for the Scheme for the financial year ending 31 December 2017.

A motion was tabled that PwC be retained as the Scheme's external auditors for the financial year ending 31 December 2017 in view of their expert knowledge of the medical schemes industry. No objections were raised and the motion was unanimously accepted.

PROPOSED: Mr AM La Grange, membership number 360384.

SECONDED: Mr BWD Heinichen, membership number 034309310.

Mr Johannes Grové thanked the meeting and indicated that PwC looked forward to working with the Scheme.

8. MOTIONS RECEIVED IN TERMS OF RULE 26.1.4

Two motions, seconded by two registered members, had been received in terms of Rule 26.1.4 as stipulated in the Rules of the Scheme. The Chairperson indicated that Rule 27 of the Bestmed Rules provided that voting at an AGM could take place either by show of hands or by secret ballot.

Should 10 or more members prefer to vote on the motions by secret ballot, ballot papers would be used for this purpose. The Chairperson requested members to indicate by show of hands if they would prefer to vote by secret ballot. Since 14 members indicated their preference to vote by means of secret ballot, the Chairperson informed the meeting that according to the Scheme Rules, the ballot papers, which had been issued to members on the two motions upon registration would be used for this purpose.

An eligible member enquired in which respect could using the issued ballot papers for voting purposes be regarded a secret ballot if he was required to indicate his membership number on the ballot paper. The Chairperson indicated that the ballot papers had been prepared prior to the meeting and members need not indicate their membership number on the ballot should they prefer not to do so.

Furthermore, the Chairperson indicated that members had signed a form to indicate that the ballot paper had been issued to them. Should they not have a ballot paper, they had either failed to register to vote or they were not entitled to vote.

Prior to addressing the two motions received, the Chairperson indicated that he acknowledged members' right to propose a motion for consideration by members at an AGM. His responsibility as the Chairperson of the Board was to present the motion to members in the format it had been received before requesting them to cast a vote either in favour or not in favour of the motion.

The Chairperson, however, requested from the members that motions should be formulated in a clear, unambiguous manner to ensure it would result in logical and meaningful decision making. He indicated that he would explain what was meant with this request in the instance of both the motions received. The Chairperson then proceeded with the discussion of the first motion, which read as follows:

MOTION 1:

We hereby submit a motion to review and change the number of terms that the members of the Bestmed Board may be reappointed to a maximum of two terms.

The Chairperson then explained that from the wording of the motion, it could be deduced that the intention of the motion was to limit the number of terms a member may serve on the BoT.

However, he pointed out that the manner in which the motion was presented could pose a number of questions and different interpretations could apply. For example, it was not clearly stated in the motion whether the proposed limitation to be imposed would be applicable to the terms of office of both appointed and elected members of the Board. In terms of the Bestmed Rules, an individual may be appointed as a Board member to replace a Board member who had resigned or passed away to serve in this capacity for the remainder of the resigned or deceased Board member's term of office.

It was, however, not clearly specified whether that period would be regarded as the Board member's first term. Furthermore, should the motion propose reappointment of a Board member to a maximum of two terms, it could be interpreted as appointment on the Board for a first term, followed by a maximum of two reappointments, totalling three terms. In view of these inconsistencies, the Chairperson requested that the wording of motions submitted to the AGM should reflect the exact meaning of the motion in an unambiguous manner.

After commenting on the first motion, the Chairperson requested the members to vote either in favour or not in favour of the motion by ticking the applicable space on the pink ballot paper for motion 1.

He indicated that Bestmed's Internal Audit Department would collect and count the votes and the results would be provided to members once these were available. After giving members the opportunity to cast their votes on motion 1, the Chairperson asked the Acting Internal Audit Head and her staff members to collect the votes.

The meeting then proceeded with the second motion, which read as follows:

MOTION 2:

We hereby submit a motion to reverse the rule change submission to the CMS of 2015 referring to rules 33.12, 3.4 and 3.5 of Annexure B3 of Schedule 3 for Pace 1, 2 and 3. We strongly believe that Bestmed and Bestmed Board did not act in the best interest of its members.

The Chairperson indicated that a similar motion was submitted at the AGM in 2016. He explained that certain over-the-counter medicine qualified for payment from members' PMSA. He informed the meeting that, due to operational requirements, the rules of benefit options could not be amended retroactively. In addition, amending the rules of one or more benefit options retroactively would require amendments to the approved Financial Statements for approval at a special AGM.

No questions were asked and members were requested to vote on the yellow ballot paper either in favour or not in favour of the motion. The Chairperson then asked the Acting Internal Audit Head and her staff members to collect the votes.

All of the matters listed in the agenda and set out in the notice regarding voting at the 2017 AGM were voted on by a poll and were duly passed.

The results of the voting on the two motions were given at the end of the meeting prior to the adjournment of the meeting. Details of the votes cast are as follows:

MOTION 1:

To review and change the number of terms so that the members of the Bestmed Board may be reappointed to a maximum of two terms.

Votes in favour of the motion:	55
Votes against the motion:	59
Abstain:	11
Spoilt ballot papers:	0
Total votes cast:	125

Motion 1 was rejected with a majority vote.

MOTION 2:

To reverse the rule change submission to the CMS of 2015 referring to rules 33.12, 3.4 and 3.5 of Annexure B3 of Schedule 3 for Pace 1, 2 and 3.

Votes in favour of the motion:	19
Votes against the motion:	94
Abstain:	11
Spoilt ballot papers:	1
Total votes cast:	125

Motion 2 was rejected with a majority vote.

9. APPROVAL OF THE TRUSTEE REMUNERATION

The last item on the agenda was then discussed, namely the approval of the trustee remuneration. The Chairperson indicated that the Board preferred not to get involved in discussions on trustee remuneration. However, the Acting CEO/PO had requested that he be allowed the opportunity to deliver a presentation to the AGM on this matter.

The Acting CEO/PO indicated that PwC had done a review of trustee remuneration paid by the largest open administered and self-administered schemes. The benchmarking methodology used by PwC was explained and the following matters were highlighted:

- Trustees' roles could be described as that of strategic oversight, dealing with long-term sustainability issues of the Scheme.
- In the complex environment of the medical schemes industry, the existence of risk should not be underestimated. As a result, the remuneration payable to trustees should take into account the level of risk assumed by the trustees in fulfilling their duties.
- Bestmed's current Chairperson fees were positioned below the lower quartile of the comparator group with a comparative ratio of 48%.
- Board member fees were positioned below average with a comparative ratio of 50%.
- Both the Chairperson and Board members were below the lower quartile at a comparative ratio of 47% and 33% respectively.
- The trustee remuneration had not been increased since 2014, since the new Board had taken the decision not to increase the trustee remuneration in 2015 or 2016.

In terms of the Trustee Remuneration Policy, an increase in trustee remuneration should be approved by members at an AGM. Management recommended that a 10% increase in trustee remuneration be approved at the AGM, as the Board had indicated that the increase should not exceed 10%. If approved, this increase would be phased in over a number of years.

It was proposed that the 10% increase for Board and committee members be approved with immediate effect from 2 June 2017 in accordance with the Trustee Remuneration Policy and that the trustee remuneration be reviewed annually in order to align it with the trustee remuneration of the comparative group.

Should a 10% increase in trustee remuneration be approved, it would imply that the comparative ratio would increase by approximately 10% to 15%, meaning that it would not even be at the level of 40% and that an additional two increases would be required in order to equal a market-related trustee remuneration.

Mr Walter Maaba, membership number 10303303, inquired about the annual percentage increase in Bestmed staff members' remuneration and indicated that this information was required in order to make an informed decision about the proposed 10% increase in trustee remuneration.

The Acting CEO/PO explained that differentiated remuneration increases applied, since Bestmed, like most corporate organisations, participated in the annual PwC Remchannel remuneration surveys. The annual increase in staff remuneration was approximately 6%, based on market figures. The Acting CEO/PO emphasised, however, that the staff qualified for annual salary increases, based on market-related remuneration increases, whilst the trustee remuneration had not been increased since 2014.

Mr Johan Richter, membership number 0182508, inquired what the base amount was on which a 10% increase would be calculated. The Acting CEO/PO explained that the 10% increase would be calculated based on the current trustee remuneration approved in 2014, as stipulated in Bestmed's Trustee Remuneration Policy.

The member further inquired what the median for trustee remuneration in the market was. In response to these questions, the Chief Financial Officer referred the member to note 32 in the table on page 51 of the Annual Financial Statements where the trustee remuneration was disclosed.

He indicated the proposed 10% increase would imply a total increase of R90 000 for all the trustees. Mr Frank Dempsey, membership number 1198310, then proposed that the meeting proceed with voting on the matter and that members could elect to vote either in favour or not in favour of the proposed increase in trustee remuneration. After giving members the opportunity to cast their vote, all ballot papers were collected.

The results of the voting on the proposed 10% increase in trustee remuneration were given at the end of the meeting prior to the adjournment of the meeting. Details of the votes cast are as follows:

TRUSTEE REMUNERATION

To approve the proposed 10% increase for Board and committee members with immediate effect from 2 June 2017 in accordance with the Trustee Remuneration Policy and to increase the trustee remuneration by 10% annually until such time when Bestmed Board members were remunerated at the median and level of the comparative group.

Votes in favour of the proposed increase in trustee remuneration:	77
Votes against the proposed increase in trustee remuneration:	34
Abstain:	10
Spoilt ballot papers:	2
Total votes cast:	125

The proposed 10% increase in trustee remuneration was approved with a majority vote.

The Chairperson then indicated that all the matters on the agenda had been attended to at the meeting. Prior to the conclusion of the meeting, a number of members commented on certain matters pertaining to the meeting.

Mrs Annelize Hartzenberg, membership number 0337536, expressed her discontent with the manner in which the two motions had been presented at the AGM. She was of the opinion that it was Management's responsibility to clarify the meaning of motions in advance in order to eliminate any ambiguity and inconsistencies, since members were not conversant with the business of a medical scheme.

She suggested that, should the deadline for submitting motions not allow sufficient time for clarification, the date should be brought forward. The Acting CEO/PO replied to this statement, indicating that upon receipt of the motions seven days prior to the AGM, as stipulated in the Rules registered with the CMS, employees had contacted the members who had submitted the motions in order to clarify the inconsistencies identified in the motions.

However, since no response had been received from these members, the Scheme was compelled to submit the motions in the format received. In addition, a third motion had been received well in advance. Bestmed staff had contacted the member who had proposed the third motion in order to clarify certain inconsistencies in the motion and in view of these inconsistencies the member had decided to withdraw the motion.

Although it was not explicitly stipulated in the Bestmed Rules that members could obtain Management's assistance with formulating motions in a manner that would ensure logical decision-making at the AGM, there was no rule stipulating the contrary. As a result, the Chairperson invited members to contact Management for assistance in this regard. The registered Rules of the Scheme were also available on the website for easy reference.

Mr Stanley Lesufi, membership number 1937634, requested that the next AGM be held at a venue with side screens to facilitate interaction with the presenters. In addition, he requested that a functionality be developed on the BiT system that would allow greater interaction between members prior to the meeting.

The Chairperson indicated that although the necessary equipment could be arranged to facilitate interaction with the presenters at the AGM, there would be cost involved, resulting in an increase in the Scheme's non-healthcare expenditure. The Chairperson then addressed Mr Cele of the CMS, informing him that should the Scheme's non-healthcare cost increase due to spend at the AGM, it would be as a result of a request by the Scheme's members.

With regard to the request to establish a more interactive functionality on the BiT system, the Acting CEO/PO advised members to download the Bestmed App. Although the App did not allow interaction with members, it enabled members to interact with the system.

The possibility of establishing this functionality on the BiT system could be investigated, although it would have a cost implication. He also indicated that providing for such a functionality could be contradictory to the stipulations of the Protection of Personal Information (PoPI) Act, 2013 (Act No 4 of 2013) as medical schemes were required to maintain the confidentiality of their members' information.

Mrs Boitumelo Molete, membership number 11894232, asked the Chairperson that questions asked in Afrikaans be repeated in English before responding to the question. In addition, she indicated that the meeting had not observed a minute of silence for the late Dr Moncrieff.

The Chairperson indicated that in the instances of questions asked in Afrikaans, he had responded in both Afrikaans and English and that he would remind the Chairperson for the next two years to do the same, as his term of office as Chairperson of the Board would expire at the end of the AGM. A moment of silence was then observed in remembering the late Dr Moncrieff and the contribution she had made to Bestmed.

Mr Dieter Bruijns, membership number 0901113, indicated that the App had been downloaded on his cell phone with the assistance of Bestmed staff members. He encouraged members to download the App, as it contained meaningful information on claims, among other things, to enable members to solve any inquiries themselves.

Mrs Clarette Lombard, membership number 11641288, indicated that she wanted to express her sincere appreciation towards the Scheme for all the payments made, especially to her family for operations and chronic medication. She also addressed the members and requested them to use the Medical Scheme in a sensible manner in order to prevent any unnecessary increases in subscription fees.

CLOSURE

The Chairperson thanked those present for their keen interest in Bestmed and wished them well for the coming year.

The proceedings concluded at 14:32.

Signed in Pretoria on this _____day of _____ 2018.

RF Camphor (Mr)
Chairperson
Bestmed Board of Trustees

Chairperson's Report 2018

OVERVIEW

It is my privilege, once again, to present the highlights of the activities of Bestmed Medical Scheme during the 2017 financial year to all stakeholders. For Bestmed, 2017 was indeed an eventful year, yet as the year progressed it clearly became a good year for the Scheme.

The year under review was a turbulent one for South Africa with a still highly depressed economic climate, to which political turmoil added even more uncertainty. However, the first responses to changes we have seen in both the political and economic arena at the end of the year look very promising with respect to both political stability and an improvement in the economic climate. Time will tell to what extent this will materialise in 2018 and further.

Protests at academic institutions as a result of the promised free tertiary education for the poor may remain a significant matter in 2018. This may still have an impact on Bestmed, with a meaningful portion of its members employed at academic institutions.

FINANCIAL PERFORMANCE

Despite a challenging environment, however, I am pleased to report that Bestmed achieved a satisfactory performance. Reserves improved once again and members will be happy to learn that we maintained the reserve level above the prescribed statutory 25% of gross contributions. Like a significant number of other medical schemes, Bestmed too experienced a reduced claims ratio. It is believed that a marked contribution to this improvement is due to a specific drive to curb fraudulent claims.

Bestmed's balance sheet improved to R2 562 million from R2 162 million during the past year. This certainly is a healthy performance for the Scheme and to the benefit of members. The net healthcare result improved from R85 million the previous year to R135 million in 2017. This was largely due to a lower claims propensity and members are thanked for their disciplined claims behaviour in this regard.

While the net healthcare result at R135 million clearly represents huge values, it must be understood that an increase or reduction to the value of 1% in claims from Bestmed members, represents an amount of R40 million. If members claim 1% more benefits the cost thereof is R40 million. Investment income contributed R152 million while related expenses amounted to R48 million.

This leaves the net surplus for the year at R234 million, while the overall net situation results in a total comprehensive income of R279 million for the year.

It was indeed a healthy year for Bestmed and the BoT is thankful to be able to report this financial performance to members.

The average risk contribution increase in premiums for 2017 for all schemes amounted to 11.3% which is significantly higher than headline inflation at around 6% for the same period. For Bestmed this increase was determined at 10.9%, which was slightly lower than the industry average. The increase in contributions is certainly scheme specific and it reflects the balance between the risk profile of the Scheme, its solvency ratio, claims ratio and utilisation of benefits by members.

A significant advantage of Bestmed's strong reserve level is the stability it brings to the organisation and its increased capacity to meet members' needs.

STRATEGIC REVIEW

The Scheme's strategic framework is reviewed annually by Executive Management and the BoT, and the annual business plans are then compiled based on the revised strategic framework.

Although the strategies for the year worked well, the downward spiral in the economy brought about a slight loss of members. This necessitated a wide-ranging revision of member retention plans, as well as certain benefit structures. The medical scheme industry functions in a mature market,

characterised by no material growth in overall size of the market, fierce competition, as well as strict regulation. In this environment it is always essential to find ways to retain members. In 2017 this environment certainly presented significantly more challenges than before.

As is commonly known, poor economic conditions lead to job losses, and insurance-related products of any kind are among the first items to be trimmed or abandoned when families are struggling, as they have been this past year. Fortunately, our response to the loss of members enabled us to recruit new members with a reduced average age. Not only did this counteract the loss of members who could no longer afford medical insurance, it also reinforced our ability to sustain a robust membership pool.

The core focus of Bestmed's strategic management is the wellness of members and their dependants. When the external environment requires it, we develop and implement supporting strategies to enhance the business plans in order to achieve our ultimate goal of enhancing beneficiaries' wellness.

I am pleased to report that Bestmed's BoT are satisfied that the Scheme's current strategies are effective in fulfilling the needs of members and keeping the Scheme operating successfully.

GOVERNANCE

Before turning to governance issues per se, I wish to report on a few changes on the BoT that have taken place during this period.

One of the newly appointed trustees, Mr Johannes Lachmann, resigned early in 2017. The BoT decided not to fill the vacancy for 2017 as an election of Board members would in any case be required going into the 2018 financial year.

I reported at the previous Annual General Meeting that the King IV Report on Corporate Governance was released on 1 November 2016 and it replaced King III in its entirety. Whereas the King III guidelines were based on an underlying principle of "apply ***or*** explain", the guiding principle of King IV is for organisations to "apply ***and*** explain". This seemingly insignificant change of one small word actually represents a major shift in philosophy, so much so that the new guidelines could not, in our view, all be implemented at once.

I am pleased to be able to report that during the past year, Executive Management and the BoT completed a material amount of work to align the Scheme's policies to the new approach, with immediate implementation once approval was granted for the changes.

The BoT has over the past year discussed and scrutinised the control and governance of the business and it remains one of our priorities to ensure the Scheme is managed in accordance with the highest standards of governance to the advantage of members and participating employers.

I am satisfied that the BoT collectively possesses the desired qualifications, experience and resolve to govern the Scheme successfully in the closely regulated environment in which Bestmed operates.

As is common practice by now, the BoT again formally assessed its performance over the past year. The results of this assessment, while satisfactory, will be utilised in the process of planning the objectives to be achieved during the year ahead. It will also serve as a starting point to improve the functioning of the BoT in fulfilling the required role going forward.

COUNCIL FOR MEDICAL SCHEMES

We reported in 2016 that the CMS had informed the Board in 2015 of possible transgressions by Bestmed of the Medical Schemes Act. The BoT appointed KPMG to investigate the allegations and report back.

KPMG submitted their report setting out the findings of their forensic investigation to the BoT in early 2016, and the Board forwarded a copy of the report to the CMS. The Chairperson made a detailed presentation of the findings presented in the KPMG report and the resultant recommendations to members at the AGM in 2016, at which a representative of the CMS's Compliance Department was present.

The CMS had, however, informed the BoT just prior to the 2016 AGM that they had ordered their own investigation of the allegations as provided for in Section 44 of the Act. This investigation again focuses on the same allegations already scrutinised by KPMG.

The CMS anticipated that their investigation would be finalised during 2017 and advised that a draft report would then be provided to the Bestmed Board for comment. At that time the BoT took the decision to put on hold any further work and action required flowing from the KPMG investigation.

This decision was taken because the CMS investigation would cover exactly the same ground with the same allegations levelled at Bestmed in 2015. The Board also took the decision to fully cooperate with the investigation to be done by the CMS.

The CMS investigation was indeed completed during 2017. The CMS provided a draft report from the investigation team to the Board right at the end of the year. The Board responded in writing to the draft report from the appointed investigator and submitted this response to the CMS early in 2018. At the time this report was drafted, no further feedback had been received from the CMS.

It must be noted that the CMS clearly has the right to further this process which could be concluded by issuing directives on particular matters to Bestmed. As this process unfolds further, members will be kept informed of progress made.

THE COMPETITION COMMISSION INQUIRY INTO THE COST OF PRIVATE HEALTHCARE

While Bestmed participated in this public debate in 2015, 2016 and 2017 the process has not concluded yet and the final report is still to be delivered. The Inquiry's objective is to identify the drivers of cost in private healthcare. For the average member it is of the utmost importance that, once this has been done, the Inquiry should also recommend remedial actions in this regard. Bestmed remains committed to offering affordable private healthcare to members and we will do everything in our power to continue doing so.

KEY CHANGES OF 2017

I already reported to members at the 2017 AGM that the previous Chief Executive Officer, Mr La Grange, left the employment of Bestmed at the end of March 2017 by mutual consent and that the Board approved the payment of a severance package to Mr La Grange after a term of service spanning 28 years, of which 21 years was as the Principal Officer. You will find the expenditure in this regard reported in the financial statements of 2017 and it was also disclosed as a post-balance sheet event in the financial statements of 2016 that were approved by members at the 2017 AGM.

Mr Van Zyl was appointed as Acting Chief Executive Officer and Principal Officer of Bestmed and he has played a key role with the Executive Management team in stabilising the performance of Bestmed.

In May 2017 Bestmed took the bold step to implement a new integrated administration IT system, known as BiT, to replace the old technology Medware system that was used for an extended period. This brought huge challenges to the staff members employed by Bestmed, as virtually all workflows and processes were changed.

I must compliment all staff members for the way in which they worked extremely long hours to implement the new system with very few problems in a way that it delivered an almost seamless changeover experience to members of the Scheme. Thank you very much ladies and gentlemen, you made us proud in the way you took on this challenge and made it work for Bestmed.

> The Board would like to thank the providers of the previously used Medware system as well as those that supplied and added enhancements to the new BiT system for their loyal support to make this change run smoothly for the Scheme and its members.

The only material problem experienced with the changeover to the new system was the incorrect deduction of debit orders on the wrong day in October. Fortunately, the problem was detected early and we were able to take the necessary corrective action virtually immediately.

The net effect of the incorrect date on which the debit orders were processed cost Bestmed R344 308 in rejection fees, interest and similar expenses that had to be reimbursed to members. While this may be a reasonably large amount, the cost is actually small if the whole change to a completely new administration process and system is considered.

Flowing from the previous inspection report of the CMS it was established that the contracts concluded with some service providers may have been questionable. While the allegation was made that Bestmed pays brokers more than the legally allowed maximum commission, no such payments in excess of the legally prescribed maximum could be found in the investigations. The actual commission paid to brokers is thus in full compliance with the Act.

The contracts concluded from 2012 with a number of service providers to assist the process of generating leads for the recruitment of new members where certain payments may have been seen to be questionable, were all terminated on instruction of the Board at the end of 2016. The result is a clear reduction in the rate of recruitment of new members to the Scheme.

Towards the end of 2017 the service of the Marketing Executive was suspended and a disciplinary process instituted. This process is not completed yet and hence the matter is sub judice.

THE FUTURE

It is envisaged that the intended move to universal health cover (or National Health Insurance as it may also be called) will continue and the South African Government could be expected to drive a process to increase the rate at which this declared policy objective is implemented.

Risk pooling is traditionally viewed as an insurance instrument where the financial risk associated with expenditure on a healthcare service for which the need and utilisation trends are unknown, is equitably shared within the covered population. In health insurance systems large risk pools tend to take advantage of economies of scale where a large number of low-risk members often cross-subsidise high-risk members. This form of pooling in a community-rated environment allows equalisation of risk and contributions across all members of the pool.

It is known that the CMS is developing a framework for benefit option classification and standardisation. This will most definitely lead to a reduced number of benefit options available in the market. We could thus expect the CMS to require a reduction in the number of healthcare options being made available by any scheme.

It will also result in the benefits available within different schemes becoming more and more of the same. In such circumstances it is clear that the larger the risk pool in a scheme, the better the possibility of utilising economies of scale and also the better the possibility of long-term survival of the scheme.

We should also understand that as the products of different schemes become the same, the only differentiating factors between schemes will be their size that would lead to the economy of scale, the extent to which the brand is known and liked amongst members, and the level of service rendered to members.

Against this background, the BoT is of the opinion that the focus for Bestmed in the next year should be on two areas. Firstly, maintaining and improving the known and extremely good levels of service rendered to members after the implementation of the new administration system is not negotiable.

Secondly, we believe a considered strategy of amalgamation of schemes should be pursued. This could result in a bigger scheme with more members and a bigger risk pool. Both of these factors will be crucially important to secure the long-term survival of our Scheme. Despite the intention to grow the size of the Scheme we should not allow any reduction of service levels in the long run.

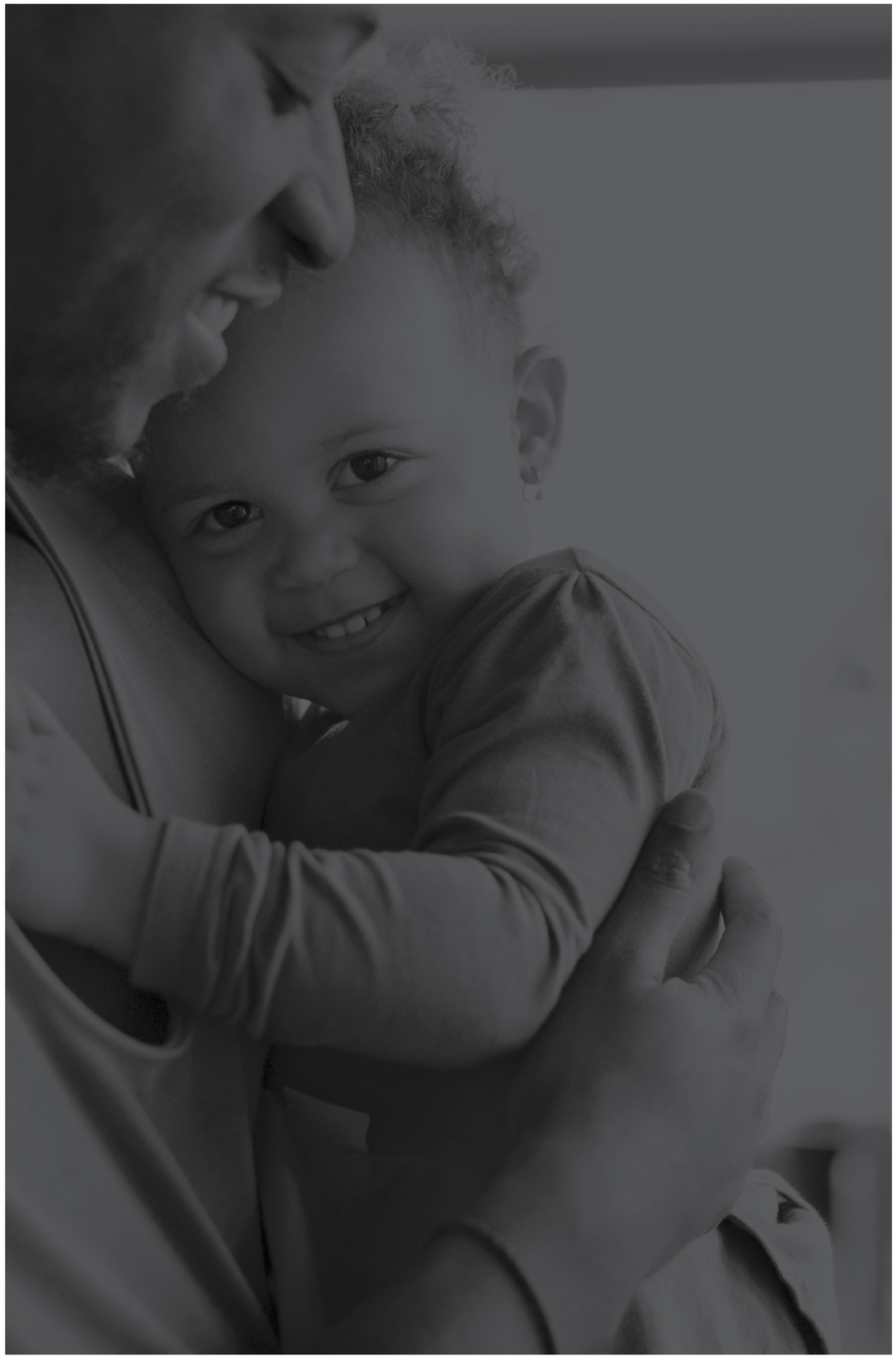
APPRECIATION

I wish to convey my most sincere appreciation to my colleagues as trustees on Bestmed's Board for their cooperation and support during another difficult year. Without your commitment, drive and support, Bestmed would not have been in the position it is now. I thank each one of you for your continued support and dedication to what often is an extremely complex task at hand.

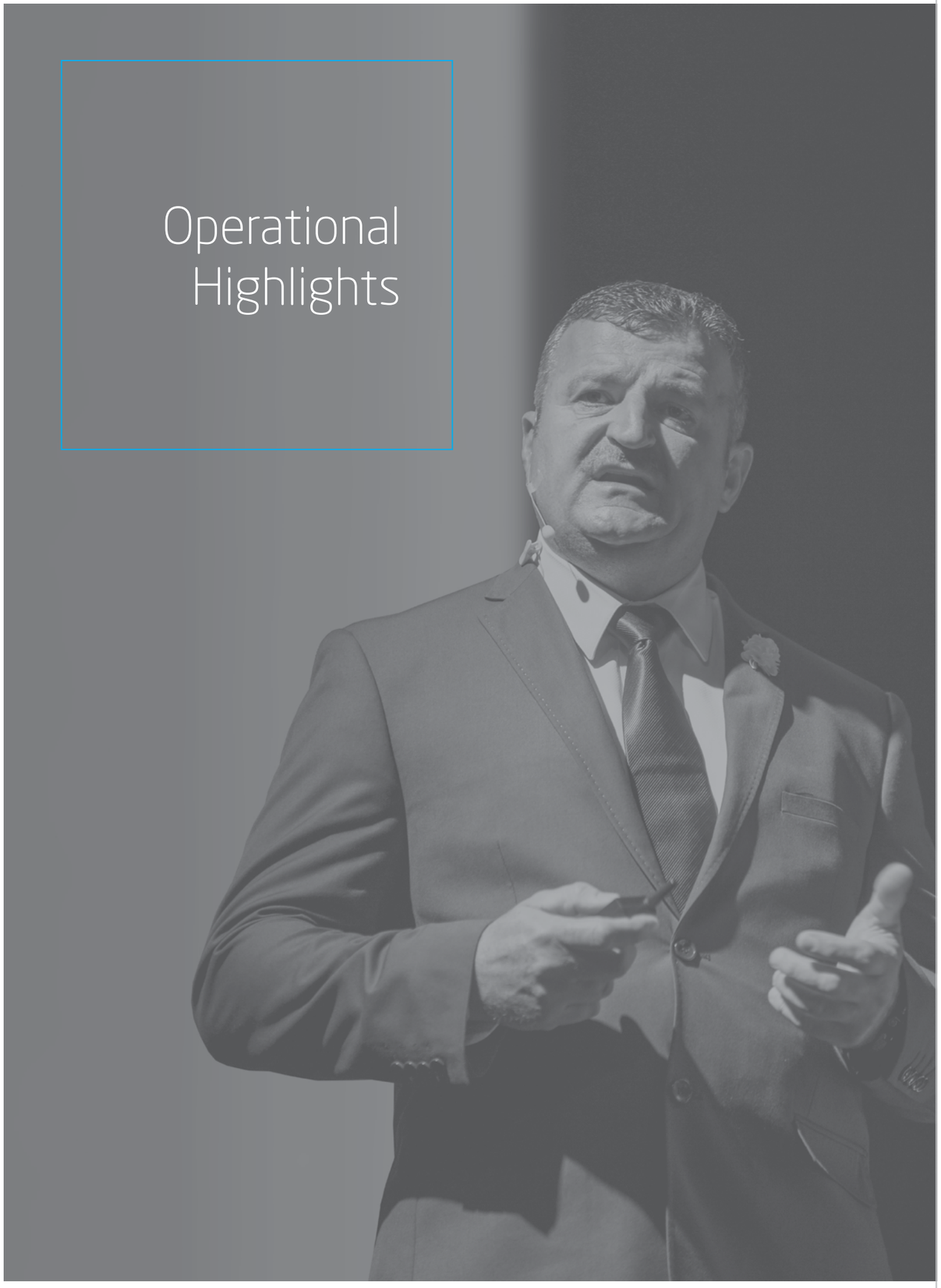
I also wish to express my heartfelt gratitude to Bestmed's Management and employees for their loyalty and dedicated hard work. You are indeed delivering on the Scheme's promise of Personally Yours. I am confident that your hard work and dedication is appreciated by all members. The Board has full confidence in your ability to keep Bestmed at the forefront of developments in the healthcare industry and your ability to continue rendering exceptional service to members.

Last but not least, I would like to express my personal gratitude by thanking the loyal members of Bestmed for your continued support. The mere fact that you remain members of the Scheme illustrates that you believe you get good value and personal service from Bestmed. This is highly appreciated.

RF Camphor (Mr)
Chairperson
Bestmed Board of Trustees



Operational Highlights



REPORT FROM THE ACTING CEO

The 2017 financial year was earmarked by internal and external change for Bestmed and despite these challenges, I am proud to report that the Scheme again managed to achieve good financial results and maintained its position as the fourth largest open scheme in the industry.

South Africa is moving towards the introduction of Universal Health Coverage (UHC) and the medical scheme industry is positioning itself to participate and play a role in this new environment that will impact members and the larger population. The current state of public healthcare, the funding mechanisms and envisaged transformation of healthcare delivery models are indeed worrying. Having said that, the National Department of Health will push forward with its vision to provide for UHC and the Minister of Health, Dr A Motsoaledi, only recently reiterated that this vision is in line with the National Development Plan (NDP) adopted by Parliament.

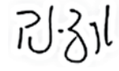
Closer to the hearts of our participating members, employers, brokers and service providers, Bestmed made the bold move to change over to the BiT (Beat Inspired Technology) administration platform as from 1 May 2017. One immediately thinks back to 2011 when the administrator unsuccessfully attempted to change from the Medware to the iMed IT platform, resulting in the Scheme returning to self-administration. I need to thank the Bestmed employees for their commitment and resilience to successfully orchestrate the preparation, go-live and stabilisation phases of this changeover project. The work will continue as we incrementally implement enhancements to benefit members and business alike. The BiT system is workflow-driven and it requires a new way of thinking with regard to the distribution of resources. With the exception of a few obstacles that had to be dealt with, the inherent controls, quality assurance system functions, checks and balances and technological possibilities, the new system paves the way for better, quicker and more client-centric service delivery with enhanced client service experiences.

The other all-important focus of the Scheme in 2017 was to establish much greater efficiencies in the areas of governance, compliance and adherence to King III – and now King IV –principles and guidelines. We revisited contract management in total and one by one dealt with problematic areas and the rectification of these. We will continue to focus on proper and justifiable contract management, meaning we are committed to and will comply with statutory and legal requirements. Management recognises and understands what is required, the Board has in no uncertain terms voiced their expectations on non-negotiable reporting and approval requirements providing for the necessary "belts and braces". The scope of work and involvement of our Internal Audit Department has progressed immensely in the past year with audit outcomes being promising and reason enough to be proud of. We have increased the resources, capacity and functions of both the Internal Audit and Legal & Governance Departments, resulting in significant progress and alignment with policies and procedures.

We have to a large extent in 2017 started to fulfil a more cooperative and participative role in the medical scheme industry which is very important to the Council for Medical Schemes. We now partake in the Principal Officers Forum at the CMS to stay abreast of industry and regulatory developments.

Bestmed joined the Health Funders Association (HFA) as of September 2017, which is a non-profit organisation representing stakeholders involved in the funding of private healthcare, such as Medical Schemes, Administrators and Managed Healthcare Organisations.

The Scheme remains committed to bringing Personally Yours to life and to giving new meaning to this brand promise. Our members are the only reason for our existence and sustainability and we will continue on this journey of personal engagement and superior service experiences. I sincerely believe that the Scheme differentiates itself from its competitors in the manner in which members, corporate clients, brokers and, importantly, service providers have access to our staff and management in a self-administration environment where we are able to create an extraordinary amount of organisational energy behind change initiatives.



Pieter van Zyl
Acting Chief Executive Officer

LEGAL AND CORPORATE GOVERNANCE REPORT

During the year under review, we centralised the manner in which litigation is managed. We also established a panel of attorneys. The manner in which litigation is managed has resulted in a significant decline in the number of matters and the costs associated thereto.

Contract management has been drastically improved, such that we virtually have a fully-fledged contract management system.

The labour-related issues which we assist the Human Resources (HR) Department with, has also taken shape, in that there is a clear demarcation of responsibilities between ourselves and HR.

Following on the progress made during the previous financial year, Risk Management has matured within Bestmed, such that we have a fully functional Risk Management Committee. This way, we are able to proactively identify and manage risks. This will also ensure business continuity.

As a result of the risk management capability within Bestmed, Internal Audit is directly taking leads from the risks we identify on an ongoing basis. Fraud detection and prevention has also been at the forefront. This includes both internal and external fraud.

Governance is an area of critical importance for Bestmed. Over the past financial year, we have seen a big focus and drive to comply with the King Report on Corporate Governance. We have taken more of the principles encapsulated therein and applied them in the manner in which we operate as Bestmed. We have also focused on the efficiency and effectiveness of the BoT, together with its structures.

The assessment and evaluation of the effectiveness of the Board is but an example of how the Board has embraced the principles as recorded in the Code. The approach adopted by the Board in relation to the Code has been filtered down to an operational level.

The year under review has also seen the development of a combined assurance framework, which is intended to provide the necessary assurance as it relates to the effectiveness of the various controls that the Scheme has put in place.

FINANCIAL ADVISORY AND INTERMEDIARY SERVICES COMPLIANCE REPORT

Bestmed, as an authorised financial services provider complies with the Financial Advisory and Intermediary Services Act, 37 of 2002, Code of Conduct and Fit and Proper requirements. During the past year we continued to remain compliant.

During the year under review, plans were put in place to develop and implement the Twin Peaks model of regulation. It will be implemented in the first quarter of 2018 and will establish two financial sector regulatory authorities: The Prudential Authority (PA) and the Financial Sector Conduct Authority (FSCA).

Twin Peaks aims to create a safer financial sector that works effectively in the interests of all South Africans. The FSCA will focus on customer protection and driving better customer outcomes. The PA, a new entity within the Reserve Bank, will be responsible for the safety and soundness of financial institutions, e.g. banks, insurers, etc. Together, the FSCA, PA, the SA Reserve Bank and the National Credit Regulator work together to form a financial sector tribunal.

HUMAN RESOURCES REPORT

The most critical projects during 2017 were change management related to the BiT project, as well as training staff on the new system. A total of 1 380 training interventions were scheduled. Currently 62% of Bestmed's 412 staff component are made up of previously disadvantaged individuals. Our resignation rate decreased from 8.9% in 2016 to 5.10% in 2017.

OPERATIONAL REPORT

Efficient membership administration and quick processing turnaround represent one of the most important business differentiators and we understand that feedback is important to our stakeholders. One of the new functionalities of the BiT system is to distribute automated communication once the quality control process has been finalised.

Reconciliation management is dealt with effectively without exposing the Scheme and its members to unnecessary risk or compromising the employer-scheme relationship.

The claims performance indicators confirm that we have consistently processed electronic and paper claims on a same-day basis. Weekly claim payment runs are now executed on Wednesdays and we consistently achieved this set target in 2017.

Measurement across all the operational spaces was done in increments of 24 hours, which equals one working day of eight hours. Our 2017 general claims processing turnaround time was 27 hours.

CLIENT RELATIONS REPORT

During the year under review, the number of member interactions have almost doubled compared to 2016 (988 391 versus 1 770 618 respectively). The reason for this exponential increase in member interactions, was the migration to the new BiT system in May 2017.

The migration to the new system also had an impact on Bestmed's Ask Afrika Orange Index Satisfaction Survey score. The annual Ask Afrika survey is the most widely-referenced service benchmark in South Africa, comparing service performance across 32 industries and ranking 164 companies.

Bestmed was ranked third in the open medical scheme industry regarding member and client satisfaction. Members rated our resolution of first contact and e-mail queries slightly lower than that in 2016. Comprehensive plans will be put in place to address these issues in 2018.

CORPORATE SERVICES REPORT

Bestmed's service strategy is based on a customer intimacy model, managed by our highly trained Key Accounts consultants. During 2017, the focus of our Key Accounts consultants was on addressing any concerns arising from the migration to the new BiT system.

The consultants' performance was measured and monitored in terms of four key areas; namely:

- **ENQUIRY RESOLUTION:** The Key Accounts unit, in cooperation with Corporate Membership and broker consultants, established a dedicated team to provide personalised services to corporate clients during the BiT migration period. About 700 queries were received and attended to by the team, most of which arose during the period 1 June to 1 August. Due to the nature of these queries, they were all treated as escalations. Corporate clients rated the service a 7.5 out of a possible 10.
- **RELATIONSHIP STRENGTHENING (PERSONALLY YOURS):** With assistance from the Marketing Department, two events were aimed at strengthening their relationships with key participating employer groups. Eleven teams took part in the inter-corporate soccer tournament, held on 25 August at the Council for Scientific and Industrial Research's grounds in Tshwane. A total of 51 women, representing employer groups, as well as brokers/intermediaries attended the women's lunch held on 31 August.
- **GROWTH:** Primary assistance to brokers with induction sessions for newly appointed employees.
- **IMPLEMENTATION OF THE WORKPLACE WELLNESS PROGRAMME:** Bestmed's comprehensive Wellness Programme is offered to all our employer groups free of charge. In 2017, 54 employer groups incorporated Bestmed's Workplace Wellness Programme.

SERVICE PROVIDER, CONTRACTING AND RESEARCH REPORT

The establishment of healthcare service provider, product supplier and service networks were at the forefront of the Scheme's service agenda for the past six years. These networks ensure that members have access to a high-quality, suitable quantity (availability) and cost-effective healthcare service, which is sustainable (cost containment) and does not discomfort members.

Over the past six years, Bestmed has established 33 provider networks. During the year under review we incorporated the in-house administration of the specialist designated service provider (DSP) network.

The utilisation of the networks increased rapidly over the past six years, showing that, on average, 76% of healthcare provider spend is within the Bestmed DSP or Preferred Provider Networks.

MANAGED HEALTHCARE REPORT

The average claims ratio for 2017 was 81.37%. This is 5.15% better than the average claims ratio of 85.79% in 2016 and 10.38% better than a ratio of 89.82% in 2014. The decrease in the claims ratio is due to an increase of 9.15% in the average risk contribution income received, whilst the average benefits paid per beneficiary only increased by 8.37%.

The benefit cost for hospitalisation increased by 6.9% from R1 571 million in 2016 to R1 679 million in 2017. The total medicine cost for the year under review amounted to R474.2 million which equates to an increase of 8.2% in cost after adjusting for changes in the Pulse1 and Pulse2 option benefit structure during the 2017 financial year.

The results of the most prominent disease programmes, namely HIV/Aids and oncology, indicate ever-increasing prevalence rates. The prevalence of oncology cases increased by 16.15% year on year, with HIV remaining stable.

The total benefit expenditure relating to the treatment of HIV/Aids and cancer amounted to R37.2 million and R101.6 million respectively. For 2016 the total spend was R35.5 million and R104.6 million respectively. The introduction of and effective use of DSP arrangements is clearly shown in the decrease in the cost of treating cancer patients.

Bestmed annually makes provision for members and their beneficiaries to receive flu vaccinations. The data indicates that the flu vaccinations are most effective for the age group five to 80, as the percentage of lives that contracted flu following vaccination was far lower than the average. Over the last three years only 2% of those that received the vaccination were hospitalised for flu-related conditions.

The Scheme has also provided a vaccination programme in accordance with an internationally accepted guideline developed to prevent the occurrence of pneumonia. The results of the 2015 pneumonia vaccination programme indicate that it is most effective for the age group 65 to 84. Over the last three years only 4% of those that received the vaccination were hospitalised for pneumonia. As part of our infant care initiative the flu vaccination programme was also promoted for infants.

MARKETING REPORT

In 2017 the Department was restructured into two main teams: Brand Marketing (external focus/lead generation) and Corporate Marketing (internal focus/retention). The decision was made to construct the two separate teams within one department to manage the flow of marketing and communication activities more effectively.

Bestmed's marketing strategy is aimed at membership growth. To achieve that, we provide a range of support services to the various business units within the Scheme. One of our main focus areas is member communication. The underlying principle of member communication is to educate our members in order to create a greater understanding of Bestmed's structures and processes.

To do that, we are always looking for more effective ways and channels to keep our members up to date on all the latest developments at the Scheme. The channels that we currently use to communicate with members include postal and electronic mail, text messages, our new and improved Bestmed App, our website and various social media platforms including Facebook and LinkedIn. The Bestmed website traffic is doing well and it is exciting that 73.8% of the visitors are new.

In terms of public relations, the total advertising value equivalent increased by 14.9% in 2017. Bestmed annually takes part in the Partners for Possibility project. This year's beneficiary was Bula Dikgoro Primary School, based in Mamelodi, east of Pretoria. We also hosted the Annual Bestmed Golf at Woodhill Golf and Country Estate in aid of the Cancer Association of South Africa.

During the year under review, our Department hosted 31 events, ranging from sport events to broker launches. Our annual broker launches are aimed at introducing product changes and increases to brokers. The events were held in eight major centres across the country. More than 800 brokers attended these launches hosted from 6 – 20 October. Some of our major sporting events included the Bestmed TuksRace, the Bestmed Tour of Good Hope and the Bestmed Street Mile Series. More than 25 000 participants took part in the various sporting events hosted by Bestmed.

DISTRIBUTION AND SALES REPORT

The broker network increased by 12% during 2017. As a result, the Distribution team increased from 11 to 14 broker consultants. We firmly believe our differentiator in the market remains our personal touch and ability to adapt to what the needs of the specific broker/age are.

Furthermore, the Distribution team is instrumental in ensuring that the desired risk profile is attracted to the Scheme, which is evident in the fact that Bestmed's average age has not increased over the last number of years. We continue to attract an average age profile of younger than 25 years old.

Bestmed showed a marginal decline in membership during 2017 (a decline of 130 principal members, or 0.14%).

INFORMATION AND COMMUNICATION TECHNOLOGY REPORT

Our strategic objective is to continually upgrade Bestmed's information and communication technology (ICT) infrastructure and systems to establish a platform that ensures that the Scheme has a competitive advantage. ICT is increasingly a critical enabler of business transformation and growth, and needs to play a fundamentally different role as it partners with business units. IT-enabled business advances service delivery and innovation and fosters customer-led growth.

During 2017, following the re-assessment to insource some of the ICT capabilities in 2016, one of the largest ICT projects in the history of Bestmed, namely BiT, was implemented with all set milestones achieved by the end of December 2017.

Our real-time claim switching with pharmacies has seen a drastic improvement by an average of 0.2 seconds per transactions. Workflows enable us to monitor service levels and assist in consistently providing acceptable levels of interaction with our stakeholders.

The new digital customers are tech-savvy and expect exceptional experiences in transacting with service providers – at their convenience, and using intuitive apps and technologies. It is therefore imperative to improve BiT even further during 2018.

Financial Statements

STATEMENT OF FINANCIAL POSITION AT 31 DECEMBER 2017

	2017	2016
	R	R
ASSETS		
Non-current assets	**1 336 416 948**	**1 092 162 000**
Property and equipment	30 984 754	19 825 250
Investment property	1 600 000	1 600 000
Intangible assets	6 568 764	2 279 886
Available-for-sale investments	1 297 263 431	1 068 456 864
Current assets	**1 225 328 542**	**1 069 541 074**
Available-for-sale investments	834 472 321	728 228 738
Scheme	353 683 193	285 214 835
Personal medical savings account trust monies invested	480 789 128	443 013 903
Trade and other receivables	70 262 212	87 422 006
Cash and cash equivalents	320 594 010	253 890 330
Scheme	160 446 441	130 581 559
Personal medical savings account trust monies invested	160 147 569	123 308 771
Total assets	**2 561 745 490**	**2 161 703 074**
FUNDS AND LIABILITIES		
Members' funds	**1 612 170 602**	**1 333 117 471**
Accumulated funds	1 477 874 327	1 244 243 611
Available-for-sale fair value reserve	134 296 275	88 873 860
Non-current liabilities	**12 215 765**	**13 333 401**
Retirement benefit obligations	12 215 765	13 333 401
Current liabilities	**937 359 122**	**815 252 202**
Personal medical savings account trust liability	660 990 469	583 457 231
Outstanding claims provision	155 649 426	109 154 663
Trade and other payables	120 719 227	122 640 308
Total funds and liabilities	**2 561 745 490**	**2 161 703 074**

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 2017

	2017	2016
	R	R
Risk contribution income	**4 256 038 032**	**3 918 440 700**
Relevant healthcare expenditure	**(3 712 106 868)**	**(3 448 712 203)**
Net claims incurred	(3 727 508 212)	(3 465 526 570)
Risk claims incurred	(3 628 769 610)	(3 373 294 099)
Third party claims recoveries	7 283 907	7 936 003
Accredited managed healthcare services	(106 022 510)	(100 168 473)
Net income/(expense) on risk transfer arrangements	15 401 344	16 814 367
Risk transfer arrangement premiums paid	(84 190 590)	(118 042 778)
Recoveries from risk transfer arrangements	99 591 934	134 857 146
Gross healthcare result	**543 931 164**	**469 728 498**
Broker service fees and other distribution fees	(70 458 474)	(74 915 428)
Administration and other operative expenses	(328 981 752)	(306 915 065)
Net impairment losses on healthcare receivables	(9 033 687)	(2 899 348)
Net healthcare result	**135 457 250**	**84 998 657**
Other income	**154 001 238**	**125 389 491**
Investment income	152 315 255	122 291 164
Scheme	110 684 964	86 770 481
Personal medical savings account trust monies invested	41 630 290	35 520 683
Sundry income	1 685 984	3 098 327
Other expenditure	**(55 827 772)**	**(49 106 352)**
Interest paid on personal medical savings trust accounts	(41 630 290)	(35 520 683)
Interest paid	-	(87 566)
Asset management fees	(6 678 621)	(6 184 931)
Own facility net expenditure	(7 497 681)	(7 244 956)
Other losses	(21 180)	(68 215)
NET SURPLUS FOR THE YEAR	**233 630 717**	**161 281 796**
Other comprehensive income	**45 422 414**	**21 204 524**
Fair value adjustment on available-for-sale investments	57 091 454	25 436 976
Reclassification adjustment on realised gains	(11 669 040)	(2 735 157)
Impairment recognised against revaluation reserve	-	(1 497 295)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**279 053 131**	**182 486 320**

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES FOR THE YEAR ENDED 31 DECEMBER 2017

	Accumulated funds	Revaluation reserve	Available-for-sale fair value reserve	Total members' funds
	R	R	R	R
Balance as at 31 December 2015	**1 082 961 815**	**1 497 295**	**66 172 041**	**1 150 631 151**
Net surplus for the year	161 281 796	-	-	161 281 796
Impairment recognised against revaluation reserve	-	(1 497 295)	-	(1 497 295)
Other comprehensive income	-	-	22 701 819	22 701 819
Fair value adjustment on available-for-sale investments	-	-	25 436 976	25 436 976
Realised gains on available-for-sale investments	-	-	(2 735 157)	(2 735 157)
Balance as at 31 December 2016	**1 244 243 611**	**-**	**88 873 860**	**1 333 117 471**
Net surplus for the year	233 630 717	-	-	233 630 717
Other comprehensive income	-	-	45 422 415	45 422 415
Fair value adjustment on available-for-sale investments	-	-	57 091 454	57 091 454
Realised gains on available-for-sale investments	-	-	(11 669 040)	(11 669 040)
Balance as at 31 December 2017	**1 477 874 327**	**-**	**134 296 275**	**1 612 170 602**

SOLVENCY RATIO

The solvency ratio is calculated on the following basis:

	2017	2016
	R'000	R'000
Total members' funds per statement of financial position	1 612 171	1 333 117
Cumulative losses on remeasurement to fair value of financial instruments and property and equipment included in accumulated funds	500	500
Balance at beginning of year	500	600
Unrealised gain on revaluation of investment property in the statement of comprehensive income	-	(100)
Available-for-sale fair value reserve	(134 296)	(88 874)
Accumulated funds as per Regulation 29	1 478 374	1 244 744
Gross contributions	5 033 075	4 630 884
Solvency ratio	**29,37%**	**26,88%**

OPERATIONAL STATISTICS PER BENEFIT OPTION

2017	Beat1	Beat2	Beat3	Beat4	Pace1	Pace2	Pace3	Pace4	Pulse1	Pulse2	Total Scheme
Members at 31 December	5 851	24 811	7 159	4 920	29 129	10 035	6 000	2 863	3 156	781	**94 705**
Average number of members for the accounting period	5 739	24 246	7 211	5 047	29 330	10 136	6 062	2 929	3 252	807	**94 758**
Dependants at 31 December	6 141	25 689	7 579	5 479	41 798	8 259	5 945	1 623	1 992	172	**104 677**
Average number of dependants for the accounting period	6 097	25 392	7 584	5 642	41 728	8 412	6 040	1 690	2 085	185	**104 854**
Average beneficiaries for the accounting period	11 837	49 638	14 795	10 689	71 058	18 548	12 102	4 618	5 337	992	**199 612**
Ratio of average dependants at 31 December	1.06	1.05	1.05	1.12	1.42	0.83	1.00	0.58	0.64	0.23	**1.11**
Average age of beneficiaries for the accounting period	35.02	29.64	36.48	43.52	33.23	52.16	51.74	61.24	42.83	77.50	**37.14**
Ratio of beneficiaries older than 65 years	8.18%	3.15%	11.72%	18.26%	7.28%	34.20%	34.26%	48.97%	20.32%	88.56%	**12.94%**
Risk contribution per average member per month	2 080	2 014	3 045	4 966	3 868	5 611	6 465	8 599	2 424	5 324	**3 743**
Risk contribution per average beneficiary per month	1 009	984	1 484	2 345	1 597	3 066	3 239	5 453	1 477	4 330	**1 777**
Healthcare expenditure per average member per month	1 682	1 608	2 712	4 091	3 064	5 518	6 160	8 582	2 550	4 883	**3 265**
Healthcare expenditure per average beneficiary per month	816	785	1 322	1 931	1 265	3 015	3 086	5 442	1 554	3 972	**1 550**
Relevant healthcare expenditure as a percentage of risk contributions	80.8%	79.8%	89.1%	82.4%	79.2%	98.3%	95.3%	99.8%	105.2%	91.7%	**87.2%**
Non-healthcare expenditure per average member per month	346	351	357	337	375	355	377	348	340	303	**359**
Non-healthcare expenditure per average beneficiary per month	168	172	174	159	155	194	189	221	207	246	**171**
Non-healthcare expenditure as a percentage of risk contributions	16.61%	17.43%	11.74%	6.78%	9.71%	6.33%	5.82%	4.05%	14.01%	5.68%	**9.60%**

2016	Beat1	Beat2	Beat3	Beat4	Pace1	Pace2	Pace3	Pace4	Pulse1	Pulse2	Total Scheme
Members at 31 December	5 703	23 579	7 186	5 574	28 577	10 403	6 238	3 221	3 588	872	**94 941**
Average number of members for the accounting period	5 647	23 108	7 170	5 617	28 802	10 533	6 278	3 296	3 732	903	**95 085**
Dependants at 31 December	6 065	24 850	7 673	6 263	40 712	9 008	6 419	1 973	2 386	222	**105 571**
Average number of dependants for the accounting period	5 962	24 359	7 526	6 312	40 767	9 232	6 527	2 070	2 514	241	**105 509**
Average beneficiaries for the accounting period	11 608	47 467	14 696	11 929	69 569	19 765	12 805	5 366	6 246	1 143	**200 595**
Ratio of average dependants at 31 December	1.06	1.05	1.05	1.12	1.42	0.88	1.04	0.63	0.67	0.27	**1.11**
Average age of beneficiaries for the accounting period	33.99	28.76	36.39	42.82	33.04	50.51	50.13	59.51	41.00	74.55	**36.97**
Ratio of beneficiaries older than 65 years	6.51%	2.88%	12.10%	17.12%	6.84%	31.74%	31.36%	45.76%	18.48%	85.28%	**12.63%**
Risk contribution per average member per month	1 898	1 844	2 766	4 326	3 488	5 079	5 861	7 810	2 190	4 874	**3 434**
Risk contribution per average beneficiary per month	923	898	1 350	2 037	1 444	2 707	2 874	4 797	1 308	3 848	**1 628**
Healthcare expenditure per average member per month	1 495	1 506	2 337	4 275	2 837	4 874	5 143	7 667	2 023	5 787	**3 022**
Healthcare expenditure per average beneficiary per month	727	733	1 140	2 013	1 175	2 598	2 522	4 709	1 209	4 568	**1 433**
Relevant healthcare expenditure as a percentage of risk contributions	78.8%	81.7%	84.5%	98.8%	81.3%	96.0%	87.7%	98.2%	92.4%	118.7%	**88.0%**
Non-healthcare expenditure per average member per month	327	332	336	315	353	330	349	320	322	284	**337**
Non-healthcare expenditure per average beneficiary per month	159	162	164	148	146	176	171	197	192	224	**160**
Non-healthcare expenditure as a percentage of risk contributions	17.22%	18.03%	12.16%	7.27%	10.13%	6.50%	5.96%	4.10%	14.69%	5.82%	**9.82%**

OPERATIONAL STATISTICS FOR THE SCHEME

	2017	2016
Average accumulated funds per average member at 31 December	15 543	13 369
Average accumulated funds per average beneficiary at 31 December	7 367	6 333
Return on investments as a percentage of investments	6.21%	5.96%
Administration and other operative expenses as a percentage of gross contributions	6.54%	6.63%

PERSONAL MEDICAL SAVINGS ACCOUNT TRUST MONIES

In accordance with the Rules of the Scheme, the personal medical savings accounts are underwritten by the Scheme.

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

The carrying amount of the personal medical savings account trust investments approximates their fair values due to the short-term nature of investments. Interest earned on all personal medical savings account funds invested as cash and cash equivalents and available-for-sale investments are allocated to members' personal medical saving account balances, and are not recognised as income for the Scheme.

The Scheme does not charge interest on debit personal medical savings plan balances and advances on personal medical savings accounts are funded by the Scheme and are included and disclosed in trade and other receivables.

Fair value as at 31 December 2017

Cash and Cash Equivalents	
Current accounts	R160 147 569
Available-for-sale Investments	
Money Market funds	R480 789 128
	R640 936 697

NON-COMPLIANCE WITH MEDICAL SCHEMES ACT 131 OF 1998, AS AMENDED

NON-COMPLIANCE WITH SECTION 26(7) OF THE MEDICAL SCHEMES ACT - CONTRIBUTIONS NOT RECEIVED WITHIN THREE DAYS OF BECOMING DUE

There were instances where the Scheme, in absence of any agreement or understanding, received contributions more than three days after due date. Contribution receivables are amounts receivable from individuals or employer groups and are collected by debit orders or cash payments. If not received within three days of due date, benefits of individuals are suspended and terminated if not received within 60 days. Employer group discrepancies are actively monitored and rectified on a monthly basis.

NON-COMPLIANCE WITH REGULATION 28(5) - PAYMENT OF COMMISSION ON RECEIPT OF CONTRIBUTION

Regulation 28(5) of the Act states that, payment by a medical scheme to a broker in terms of sub regulation (2) shall be made on a monthly basis and upon receipt by the scheme of the relevant monthly contribution in respect of that member.

In certain instances where the employer and employee contributions are paid separately to the Scheme, the broker commission is paid before both employee and employer contribution has been received.

The Scheme management will ensure the necessary changes to the IT systems to ensure broker commissions are only paid once the full premium is received, irrespective of the source of payment of the premium.

NON-COMPLIANCE WITH SECTION 33(2)(B) OF THE MEDICAL SCHEMES ACT - OPTION SELF-SUFFICIENCY IN TERMS OF MEMBERSHIP AND FINANCIAL PERFORMANCE MUST BE FINANCIALLY SOUND

The Act stipulates that a benefit option shall be self-supporting in terms of membership and financial performance. During the year under review five benefit options of the Scheme, namely Beat3, Pace2, Pace3, Pace4 and Pulse1 made a net healthcare deficit.

After accounting for other income Pace2, Pace4 and Pulse1 options showed a net deficit.

The Scheme monitors the results of all options and evaluates different strategies to improve the financial outcomes of all options. The different financial results reflect the different disease burdens in each option, among many other factors.

The strategy on sustainability of options has to balance short- and long-term financial considerations, with fairness to both healthy and sick members and with continued affordability of cover for members on different levels of income and needs.

The Scheme remains committed to comply with the applicable legislation, as far as possible, but also focuses on the overall stability and financial position of the Scheme as a whole and not only on individual options.

NON-COMPLIANCE WITH SECTION 35(6)(A) OF THE MEDICAL SCHEMES ACT - BORROWINGS

Section 35(6)(a) states that "A medical scheme shall not encumber its assets."

Bestmed registered as a financial service provider with the Financial Services Board (FSB). Registration number 44058. The FSB required a guarantee of R1 million in terms of section 8(7) of the FSB Board notice 106 of 2008.

In addition, the terms of the Scheme building lease agreement required a guarantee to an amount of R2,3 million.

The Scheme's banker issued these guarantees as part of the Scheme's facilities and required no additional security.

Application for the renewal of guarantees exemption was lodged with the Council in August 2017. At the date of the report the Council has not granted the Scheme exemption for the guarantees.

NON-COMPLIANCE WITH SECTION 35(8)(A) OF THE MEDICAL SCHEMES ACT - INVESTMENTS IN EMPLOYERS, ADMINISTRATORS OR ANY ARRANGEMENT ASSOCIATED WITH THE MEDICAL SCHEME

Section 35(8) of the Act states that "A medical scheme shall not invest any of its assets in the business of or grant loans to

(a) An employer 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.

Due to some of the Scheme's employer groups being listed on the JSE, investments were made in certain of its employer groups listed on the JSE through the portfolios of the investment products the Scheme utilises. This is also applicable to JSE listed administrators.

The Council for Medical Schemes has granted the Scheme an exemption from section 35(8) of the Medical Schemes Act.

NON-COMPLIANCE WITH MEDICAL SCHEMES ACT 131 OF 1998, AS AMENDED (continued)

NON-COMPLIANCE WITH SECTION 59(2) OF THE MEDICAL SCHEMES ACT - CLAIMS NOT PAID WITHIN 30 DAYS

Section 59(2) of the Medical Schemes Act states that "claims submitted to the scheme should be paid out within 30 days after the day on which the claim was received".

There were certain claims paid after 30 days from the date that the claims were received.

Claims received at Bestmed are assessed, rejected, paid or pended within 30 days of receipt. There are various reasons that a claim will be pended where further information, assistance or motivation is required. All related claims will pend along with the authorisation and will be paid or rejected once the authorisation is finalised, pending the outcome. Pended reports are also reviewed by the claims supervisors to follow up on long outstanding pended authorisations with the relevant department.

NON-COMPLIANCE WITH SECTION 65(3) OF THE MEDICAL SCHEMES ACT - BROKER COMMISSION PAID TO AN UNACCREDITED BROKER

Section 65(3) of the Medical Schemes Act states that "No person shall be compensated for providing services relating to the introduction or admission of a member to a medical scheme in terms of subsection (1) unless the Council has, in a particular case or in general, granted accreditation to such a person".

One instance was noted where commission was paid to a broker who was not accredited. This was an administration oversight as there is a system in place to prevent payment of commission to unaccredited brokers. The Scheme does, as a courtesy, issue brokers with written notification at least 3 months before expiry of their accreditation with CMS to renew. A greater effort will be made to ensure that only accredited brokers are remunerated.

NON-COMPLIANCE WITH REGULATION 10(6) OF THE ACT – PERSONAL MEDICAL SAVINGS ACCOUNTS

Regulation 10(6) of the Act states that "The funds in a member's medical savings account shall not be used to pay for the cost of a prescribed minimum benefit."

It was noted that for certain prescribed minimum benefit "PMB" claims, where a co-payment was applicable, that the payments were made from the member's savings account. This occurred when a member utilised the Bestmed Application to fund their co-payments.

The Bestmed application has been modified to block such instances from re-occurring.

GOVERNANCE IN TERMS OF THE MEDICAL SCHEMES ACT 131 OF 1998, AS AMENDED

COUNCIL FOR MEDICAL SCHEME INVESTIGATION

During the 2016 financial period and following the forensic investigation carried out by KPMG in 2015, the Council for Medical Schemes (CMS) decided to initiate a further inspection in terms of section 44 of the Medical Schemes Act against Bestmed. The inspection addresses exactly the same subjects as the forensic investigation ordered by the Board of Trustees in 2015.

The CMS appointed an external investigator who completed his work and provided a draft report to the CMS. The CMS required Bestmed to pay the full cost of this investigation, which was duly done as instructed.

A copy of the draft report was presented to the Board of Trustees by the CMS late in 2017 with the request to comment on the content thereof. The Bestmed Board of Trustees indeed made detailed presentations on various matters identified in the content of the report, focused on both some of the findings as well as some of the recommendations made in the draft report, which were submitted in writing to the CMS early in 2018.

The Scheme now awaits the final version of the completed report together with the findings and possibly some directives from the CMS, which will be attended to as required when received.

Disclaimer: Whilst Bestmed has taken all reasonable care in compiling the Highlights of Bestmed's Financial Statements, we cannot accept liability for any errors or omissions contained herein. Please note that should a dispute arise, the audited Financial Statements in Bestmed's Annual Report 2017 which will be available on our website shall prevail. Please visit **www.bestmed.co.za** for the complete liability and responsibility disclaimer for the Bestmed Medical Scheme Annual Report as well as our terms and conditions.

Bestmed is a registered medical scheme (Reg. no. 1252) and an Authorised Financial Services Provider.
(FSP no. 44058). www.bestmed.co.za

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