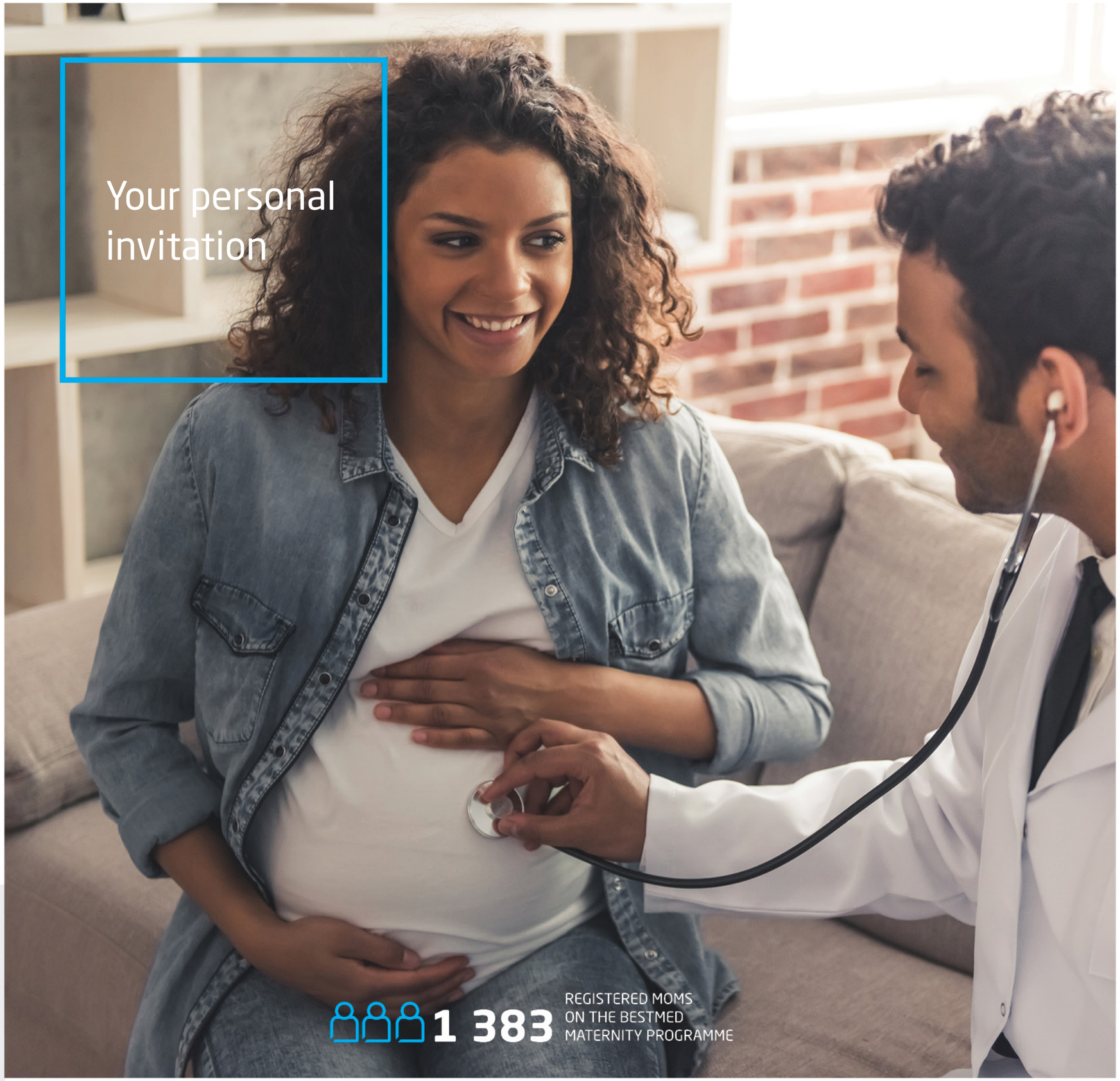
Every care counts

Highlights of the Annual Financial Statements **2018**

bestMed

personally yours



You are invited to attend Bestmed's 55th Annual General Meeting

We find ourselves more than half a century down the line since Bestmed was registered as a medical scheme, previously known as SOMS. Whilst our name and brand promise may have changed during this time, our overall mission, vision and values have remained the same. The essence of "by members, for members" remains as strong as ever and we continue our commitment to providing our members with exceptional personal service and high-quality healthcare. We believe that our *personally yours* philosophy leads the way in this industry and that every care counts, no matter how large or small.

Date:	Wednesday, 12 June 2019
Time:	Registration - 08:00 AGM - 08:45 - 11:30
Venue:	The Capital Hotel 194 Bancor Avenue Menlyn Maine Pretoria
RSVP:	Refilwe Moloisane on or before 29 May 2019
E-mail:	bestmed-agm@bestmed.co.za

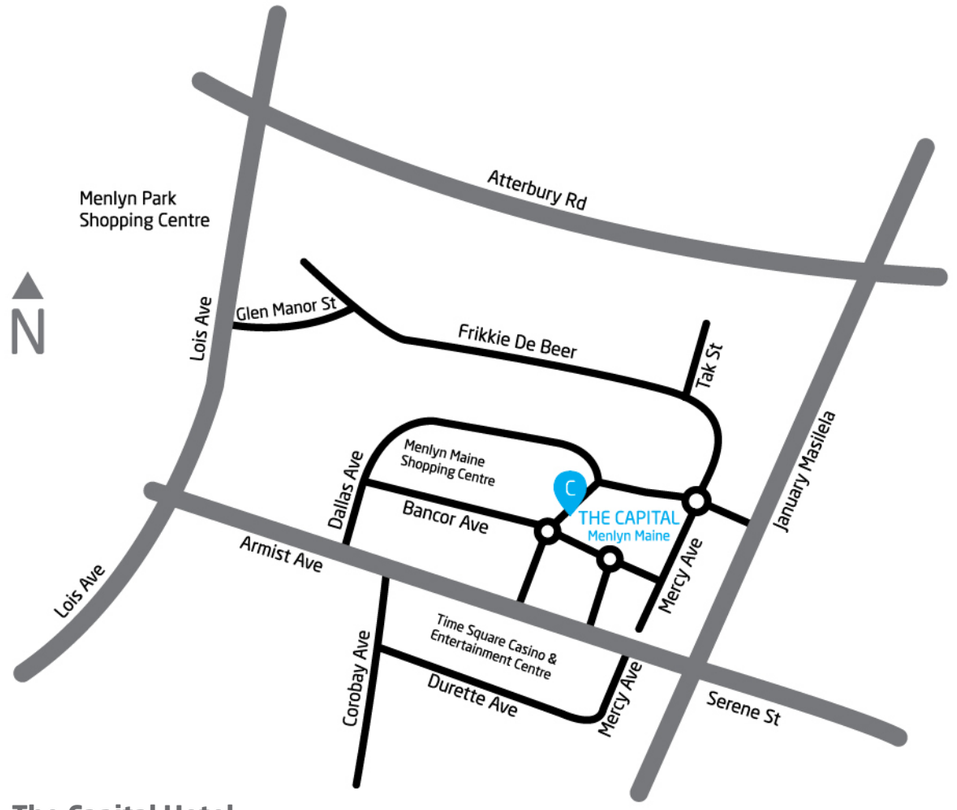
Should you wish to submit a motion for the AGM, kindly e-mail bestmed-agm@bestmed.co.za by no later than 5 June 2019.

Programme

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

Contents

Directions



The Capital Hotel

194 Bancor Avenue
Menlyn Maine
Pretoria

GPS Coordinates:

S - 25.786436 / E - 26.281669

Agenda

Opening by Chairperson

Finalisation of agenda

Minutes of the Annual General Meeting held on 15 June 2018

Matters arising from the 2018 Annual General Meeting:

- Net surplus 2018
- Expenditure on brand development
- Requirements for vetting process for Trustee elections

Report of the Chairperson

Financial statements and auditor's report

Appointment of auditors 2019/2020

Motions received in terms of Rule 26.1.4

Approval of amended trustee remuneration

Closure

55th Annual General Meeting

Notice is hereby given that the 55th Annual General Meeting of the members of Bestmed Medical Scheme will be held at 08:45 on Wednesday, 12 June 2019 at The Capital Menlyn Maine Hotel, 194 Bancor Avenue, Menlyn Maine, Pretoria.

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, please send an e-mail to: bestmed-agm@bestmed.co.za

Minutes of the 54th Annual General Meeting of representatives of employers, employees and members held at the Capital Menlyn Maine Hotel, Pretoria on Friday, 15 June 2018 at 08:45.

1. OPENING BY CHAIRPERSON

1.1 Present

1.1.1 103 active voting members
1.1.2 7 members of the Board of Trustees
1.1.3 1 guest from the Council for Medical Schemes (CMS)
1.1.4 22 delegates from employer groups

Apologies

Apologies had been received from Mr Colin Mowatt, one of Bestmed's Board members, Mr Louis Heyl, newly elected Board member, as well as the Reverend Windell, a former Board member. No further apologies were noted.

1.2 Opening by Chairperson

Mr Fred Camphor, Chairperson of the Board of Trustees, declared the meeting properly constituted, members and employers having been given adequate notice of the meeting in terms of Rule 26.1.1 and more than 25 members being present to constitute a quorum. He welcomed, in addition to the Scheme's members, representatives of the corporate employers affiliated to Bestmed, the members of the Board of Trustees, Management and staff of Bestmed. He also welcomed Adv. Lappies Labuschagne, previous Chairperson of the Board, Dr Daan Luyt, former Board member and Mr Gordon Nzalo, the independent Chairperson of the Audit Committee. Next, the Chairperson extended a word of welcome to an esteemed guest, Ms Avril Jacobs, representative of the Council for Medical Schemes (CMS). He expressed his appreciation towards Ms Jacobs for attending Bestmed's Annual General Meeting (AGM). Finally, he welcomed Mr Johannes Grové and Mrs Alke Biggs, the representatives of the Scheme's auditors, PricewaterhouseCoopers (PwC).

The Chairperson then requested the attendees to observe a moment of silent contemplation to seek guidance and strength prior to proceeding with the meeting. Next, all the relevant administrative matters, including the issuing of ballot papers prior to the AGM, were finalised.

2. FINALISATION OF AGENDA

The meeting proceeded with the finalisation of the agenda. It was requested that the process followed for the nomination and election of Board members be explained. The Chairperson replied that the matter would be attended to during the discussion of agenda item 9, dealing with the newly elected and appointed Board members.

After finalising the agenda, the Chairperson indicated that he deliberately wanted to give feedback on a number of general matters, prior to proceeding with the discussion of the agenda items:

Information on the activities of all medical schemes was provided in the detailed Annual Report of the CMS. As reflected in the most recently published Annual Report of the CMS, Bestmed's AGM expenditure was the third highest in the medical schemes industry. Since this was a matter of concern, the Board had decided to adopt a different format for the AGM in 2018 as a measure to reduce the cost substantially. As a result of the amended format of the AGM, no conference had been presented prior to the AGM. In addition, the majority of the communication material, for example the Annual Report, had been sent in an abridged format to members, while the catering requirements had been reviewed. Furthermore, in view of the amended format of the AGM, only the items listed on the agenda would be attended to at the meeting. Any enquiries on personal matters and difficulties experienced with service delivery or claims would not be addressed at the meeting. After the conclusion of the AGM, Management and certain key operational staff members would be available to assist members with personal enquiries and difficulties experienced with service delivery. In this regard, the Chairperson informed the attendees that member engagement sessions had been hosted in the various provinces in the course of the year to assist members with solving enquiries regarding benefits. Positive feedback on the success of these sessions had been received from members. Therefore, the AGM would be managed strictly according to the agenda provided for the AGM.

Finally, the Chairperson informed the Board members that, after conclusion of the AGM, a brief Board meeting would be held in the dedicated venue for the purpose of constituting the Board and electing members to the various Board committees in instances where vacancies had arisen. After the Board meeting, the Chairperson would return to the foyer to attend to personal enquiries not addressed by Management.

The meeting then proceeded with the approval of the minutes of the previous AGM held on 2 June 2017.

3. MINUTES OF PREVIOUS ANNUAL GENERAL MEETING HELD ON 2 JUNE 2017

The minutes of the 53rd Annual General Meeting were unanimously approved as a fair and accurate record of the proceedings and signed by the Chairperson.

Proposed: Prof. P Delport
(membership number: 248029);

Seconded: Prof. JCW van Rooyen
(membership number: 98396)

The Chairperson indicated that the minutes would be published and made available to the CMS.

4. MATTERS ARISING FROM THE PREVIOUS ANNUAL GENERAL MEETING

The Chairperson indicated that, in the Board's opinion, all the matters dealt with in the minutes had been attended to appropriately. No matters for further attention were identified from the minutes and the meeting proceeded with the discussion of the Chairperson's report.

5. REPORT OF THE CHAIRPERSON

The report of the Chairperson was noted. The Chairperson thanked the Board members and Bestmed's employees for their dedication and exceptional service delivery over the past year. The following matters were highlighted from the Chairperson's report:

Bestmed had indeed experienced an eventful year in 2017, characterised by a number of remarkable achievements. On 1 May 2017, Bestmed had implemented a new administration system, referred to as the BIT system (Beat-inspired technology) by staff members, to replace the outdated technology which had been used for several years. However, the switchover to a new administration system had presented unique challenges, since Bestmed's staff members had been required to adjust practically all workflows and processes. Although a number of teething problems had been experienced, as anticipated, these had been dealt with promptly and effectively. In 2011, Bestmed had made a similar, but unsuccessful, attempt to implement a new IT system. The Chairperson expressed his appreciation to all the staff members for their willingness to work exceptionally long hours. He complimented them on the manner in which they had taken on this challenge to ensure the virtually seamless switchover to the new administration system.

The Chairperson proceeded by indicating that a number of investigations had been conducted the previous year on matters reported to the CMS. In addition, as reported at the previous AGM, Mr Dries La Grange, Bestmed's former PO and CEO, had left the Scheme's employ on 31 March 2017 as reported at the previous AGM. Furthermore, a number of contracts with service providers had been terminated in the course of 2017.

South Africa had experienced a turbulent year in 2017, with a still highly volatile economic climate, to which political turmoil had added even more uncertainty. However, the first responses to changes experienced in both the political and economic arena at the end of the year were promising with respect to both political stability and an improvement in the economic climate. Protests at academic institutions probably resulting from the promised free tertiary education for the underprivileged, may remain a significant symptom of 2018, and could impact Bestmed, with a meaningful portion of its members employed at academic institutions.

Towards the end of 2017, the situation had improved and Bestmed had achieved unexpectedly good financial results. Bestmed's balance sheet had strengthened from R2 162 million to R2 562 million during the past year. The net healthcare result had improved from R85 million in 2016 to R135 million in 2017. This had mainly resulted from a lower claims propensity and the Chairperson thanked the members for their disciplined claims behaviour. In addition to the Scheme's sound financial performance, Bestmed's solvency ratio had improved to 29.37% at 31 December 2017, exceeding the statutory required solvency level of 25%. In addition, the Scheme had earned investment returns amounting to R152 million on its reserve funds. The Scheme had concluded the 2017 financial year with a R234 million net surplus and a Total Comprehensive Income of R279 million, after taking into consideration other comprehensive income of R45 million.

Although the net healthcare result of R135 million clearly represented significant values, it was emphasised that an increase or reduction in claims from Bestmed members to the value of 1% equalled approximately R40 million.

5.1 Governance

With regard to governance, the Chairperson reported that Mr Johannes Lachmann had resigned from the Board of Trustees due to emigration. At that stage, the Board had decided not to fill the vacancy.

In addition, the King IV Report on Corporate Governance had been released on 1 November 2016, which provided guidance on governance to organisations, including medical schemes. A number of matters had already been attended to and a significant amount of work had been done in this regard.

The Chairperson explained that the King IV Report on Corporate Governance stipulated an 'apply and explain' regime, as opposed to the 'apply or explain' regime in the King III Report. In terms of the King IV Report on Corporate Governance, institutions were required to apply the principles of good corporate governance and to explain how this was done.

Organisations deviating from these principles were required to provide well-substantiated reasons for non-compliance with the stipulations of the King IV Report. The Chairperson assured the attendees that the Board regarded compliance with the highest standards a priority.

Relationship with the CMS and 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 had been reported to the Board in 2015, resulting in the KPMG forensic investigation conducted in 2015/2016. At the 2016 AGM, the Chairperson had 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, soon after the AGM in 2016, the CMS had informed the Scheme that it had ordered its own routine inspection on the same allegations investigated by KPMG in 2015. The Chairperson had informed the members accordingly at the AGM in 2017.

The Board had taken the decision to give its full cooperation to the investigator appointed by the CMS and had provided all the required information to the investigator. The investigation had been finalised in 2017. After finalisation, a draft report had been provided to Bestmed and its Board for comment in November 2017. In terms of the stipulations of the Medical Schemes Act, 1998, a response to the draft report was required within 30 days. In view of the approaching December holidays, an extension had been granted following the Scheme's request in this regard. A written Board report in response to the findings in the forensic report had been submitted to the CMS in February 2018. To date, no further feedback had been received from the CMS. The Chairperson indicated that it would be inappropriate for the Board to anticipate the steps to be taken by the CMS next, although it was possible that a final report could be issued to which Bestmed would be required to respond. The CMS may then issue directives and Bestmed would be required to comply with these. The Chairperson, however, confirmed the Board's intention to cooperate with the CMS in the process, irrespective of the final report or directives.

As already indicated, the switchover to the new administration system had proceeded smoothly. In the process following the switchover in May 2017, only one material problem had been experienced, involving the deduction of debit orders on the incorrect date in October. Since this administrative oversight had been detected early, the necessary corrective action could be taken almost immediately. The net effect of the incorrect debit order deductions had amounted to R344 308 in rejection fees, interest and similar expenses which had to be reimbursed to members. The bank costs paid were reflected in the financial statements. Although this may appear to be a reasonably large amount, the financial implication was less significant if considered in relation to the magnitude of the switchover to a completely new administration process and system.

Next, the Chairperson informed the meeting that it was anticipated that the South African Government would proceed with the intended implementation of National Health Insurance, and that Government could be expected to drive a process to increase the rate at which this declared policy objective was implemented. The Chairperson explained that, in the case of health insurance systems, large risk pools would normally benefit from economies of scale in instances where high-risk members were often cross-subsidised by a large number of low-risk members. This form of pooling in a community-rated environment allowed equalisation of risk and contributions across all members of the pool.

As members might be aware, the CMS was developing a framework for benefit option classification and standardisation. It was anticipated that, once implemented, the CMS would require medical schemes to reduce the number of benefit options offered to members. In addition, implementation of the framework would result in more uniform product offerings in the medical schemes industry. As a result, the only factor differentiating a scheme from its competitors would be the size of the scheme, resulting in the economy of scale, the popularity of the brand amongst members, and the level and quality of service rendered to members. If this information was considered, it was evident that the larger the risk pool in a scheme, the better the possibility of utilising economies of scale, which, in turn, would enhance the long-term survival of the scheme.

Bestmed was currently the fourth-largest medical scheme and in order to retain its position as a leading medical scheme, the Board regarded it in the Scheme's best interest to investigate possible amalgamations.

The Chairperson explained that, against this background, the Board of Trustees was of the opinion that Bestmed should focus on two areas over the next year. The first area of focus should involve maintaining and improving the exceptionally high level of service delivery which members had become accustomed to after the implementation of the new administration system. An equally important focus area involved pursuing a well-considered amalgamation strategy in order to enhance the Scheme's risk pool. These two focus areas were regarded as vitally important factors in securing the viability of the Scheme. It was, however, cautioned that, although amalgamation

would result in an increased membership base, care should be taken to ensure it would not affect the service levels negatively. In addition, it was anticipated that over time, the number of benefit options would be reduced, and the composition of the options would be aligned to those of other medical schemes.

5.2 Acknowledgements

The Chairperson continued by conveying his sincere appreciation towards his colleagues on the Board for their cooperation and support during the year. He also expressed his heartfelt gratitude to Bestmed's Management and employees for their loyalty and dedication to increase the membership base. They were indeed delivering on the Scheme's Personally Yours brand promise. He expressed the Board's confidence in their ability to keep Bestmed at the forefront of developments in the medical schemes industry and to render exceptional client service. In addition, he thanked the members of Bestmed for their continued support over the past year.

As a final remark, the Chairperson informed the meeting that, after the 1% VAT increase in March 2018, Bestmed had taken the lead by being the first scheme to announce that it would not impose an interim increase in subscription fees to absorb the difference in cost resulting from the VAT increase. This decision was a reflection of the Scheme's endeavour to act in members' best interests and in line with the recommendation of the CMS in this regard.

After dealing with the Chairperson's report, the attendees were afforded the opportunity to ask questions.

Mr Dries La Grange (membership number 360384) raised two questions, dealing with the implementation of the King IV Code on Corporate Governance and the report on the findings of the forensic investigation conducted by the CMS respectively. In the first instance, Mr La Grange enquired about the date when the Scheme had implemented the King IV Code on Corporate Governance, in view of the significant amount of work done in this regard, as indicated by the Chairperson. The Chairperson responded by explaining that the implementation of the King IV Code dealt with establishing good corporate governance in the Scheme. In the interest of good corporate governance, a number of Bestmed policies had been amended during the year in order to align these policies with the stipulations of the King IV Code. A range of processes had been identified and a number of measures had been implemented during the year in order to enhance the Scheme's corporate governance. The process had commenced in March 2018 and would continue until finalisation.

In the second instance, Mr La Grange enquired about the payment made in respect of the report issued on the findings of the CMS forensic investigation conducted in terms of section 44(4) of the Medical Schemes Act, 1998. Mr La Grange requested the Chairperson to disclose the amount paid to the CMS upon receipt of the report. Furthermore, he requested the Chairperson to explain why the payment had been made after receiving a draft report from the CMS. In his opinion, a draft report was open for discussion and further comments, and, as a result, payment should only be made upon receipt of a final report. The Chairperson responded by explaining that the account for the forensic investigator's services appointed by the CMS had been submitted with the draft report to the Scheme. In addition, the CMS had submitted a letter to the Scheme, demanding payment within 30 days from the date of the letter. The Scheme had paid the amount of R2.1 million in order to comply with the stipulations of the Medical Schemes Act, 1998, requiring the medical scheme under investigation to settle the account.

Mrs Tersia Venter (membership number 328944) enquired whether the KPMG forensic audit had revealed instances of significant fraud and corruption in Bestmed, which had consequently resulted in this inquiry. The Chairperson explained that a number of allegations against Bestmed had been submitted anonymously to the CMS in 2015. Nine key issues had been identified and the KPMG forensic audit had dealt with those identified issues. He indicated that, although certain of these nine key issues were debatable, according to his knowledge, no explicit matters of fraud had been identified. The identified matters had been attended to and the Scheme had reported the corrective measures taken to the CMS, as reported at the 2016 AGM. One of these allegations involved the use of Bestmed offices for conducting personal business. Corrective measures had been implemented and the relevant policies had been amended. The stipulations of the amended policies were applicable to all levels of employees, inclusive of Board members. A second allegation dealt with payments to brokers exceeding the statutory commission of 3% to which they were entitled in terms of the Medical Schemes Act, 1998. The results of the KPMG forensic audit had revealed no instances of commission payment exceeding the statutory prescribed level of 3%. As a result, it appeared that certain of these allegations were invalid. In addition, the Scheme was required to report any deviations from legislation applicable to medical schemes in its financial statements. One of these deviations included payments to brokers exceeding the statutory amount as stipulated in the Medical Schemes Act, 1998, or payments made to a person who was not an accredited broker. Although instances had occurred where payments had been made to brokers whose accreditation with the CMS had since expired, measures had been implemented to address these and the relevant brokers had been requested to repay the amounts. These corrective measures had been taken to exert control and to ensure the necessary checks and balances were in place to prevent a similar event in future.

Following this explanation from the Chairperson, Dr Daan Luyt (membership number 788627) requested that further clarity on this matter be provided, stating that a number of allegations against Bestmed had been submitted to the CMS. In response to these allegations, KPMG had been appointed to conduct a forensic audit at an estimated cost of R2 million, in order to determine the validity of the allegations. The report on the findings of the forensic audit had been presented to the CMS. Although no instances of explicit fraud in Bestmed had been identified, the CMS had proceeded with its own investigation in terms of section 44(4) of the Medical Schemes Act, 1998. Bestmed was liable for paying R2.1 million for the preliminary report on the findings of the forensic investigation. He indicated that, according to him, this was highly questionable business practice. It appeared the CMS would continue with this practice until they were satisfied with the findings of the forensic investigation. He was of the opinion that, since the cost associated with the forensic investigation had been funded from member contributions, it was the responsibility of the Board to take a firm stand on the matter. The Chairperson replied by explaining that the CMS was entitled to order an investigation in terms of section 44(4) of the Medical Schemes Act, 1998, should it be of the opinion that an inspection would provide evidence of any irregularity or of non-compliance with this Act by any person or for the purposes of monitoring a medical scheme's compliance with the stipulations of this Act. A medical scheme was liable for settling the account upon submission of the report. The Board had been involved in this process since the end of 2014. The cost of the forensic audit conducted by KPMG had amounted to R560 000. The KPMG report explaining the findings of the forensic audit had been submitted to the CMS and, since they were not satisfied with the contents of the report, they had ordered an inspection on these matters. Although the account had been paid from member contributions, the CMS was entitled to require payment of the account in terms of the stipulations of the Medical Schemes Act, 1998.

Mr Rudolph Olivier (membership number 5000982) raised the opinion that it appeared the Chairperson was a proponent of the King IV Code on Corporate Governance, in view of the reference made to this document in the Chairperson's report. In terms of principle 10 of the King IV Code, an organisation was required to appoint a CEO. He enquired about the reasons why a permanent PO and CEO had not yet been appointed after Mr La Grange's early retirement at the end of March 2017. Furthermore, he pointed out that principle 14 of the Code dealt with a remuneration report which should include an implementation report of all remuneration paid to staff members and Executive Management. In addition, remuneration of Executive Management should be fair and organisations were required to disclose the manner in which this was being addressed in order to narrow the gap between the remuneration of Executive Management and those employees on the lower end of the pay scale. He asked the Chairperson to explain how principle 14 was addressed in the Scheme's process of implementing the King IV Code.

With regard to the appointment of a permanent PO and CEO, the Chairperson responded that, as indicated in the Chairperson's Report, the Board was considering possible amalgamations. The Board had decided to appoint Mr Pieter Van Zyl as the acting PO and CEO, until a decision on amalgamation had been taken, in order to prevent possible retrenchment of the PO and CEO due to redundancy after amalgamation. As a result, a decision on the appointment of a PO and CEO in a permanent capacity would most likely be considered after amalgamation.

The Chairperson then responded to the second enquiry dealing with the requirements on the disclosure of staff remuneration stipulated in principle 14 in the King IV Code. He explained that, in terms of the Medical Schemes Act, 1998, only the remuneration of the PO and CEO should be disclosed in the annual financial statements. The Chairperson referred Mr Olivier to page 45 of the annual financial statements, reflecting the information on salaries, bonus payments as well as the payment of all benefits to other staff members, including the remuneration of the PO and CEO. Although principle 14 of the King IV Code required that information on all staff members' remuneration be disclosed, the Medical Schemes Act, 1998, only stipulated the disclosure of the PO and CEO's remuneration in the annual financial statements.

Mr Walter Maaba (membership number 10303303) added to Mr Olivier's enquiry by raising the concern that appointing a PO and CEO in a temporary capacity for an indefinite period could create grounds for a legal dispute. Should an employee act in a position for an extended period of time, it could create the expectation that the incumbent would be automatically appointed to that position on a permanent basis. Mr Maaba enquired why it had not been considered to make a fixed-term appointment

instead. Secondly, the member enquired whether the loss resulting from the 1% VAT increase carried by the Scheme would be reported as a loss or whether it would be defined differently in the annual financial statements. Finally, the member stated that the poor attendance of the AGM was a matter of concern, taking into consideration the expenses incurred for hosting the AGM. He enquired whether any specific challenges had been experienced in marketing the AGM this year.

The Chairperson first responded to the question regarding the possibility of legal liability resulting from the long-term acting appointment of the PO and CEO. He indicated that the conditions of the appointment had been clearly explained to the acting PO and CEO, including the fact that the Board would review the acting appointment from time to time. The acting PO and CEO would have no expectation to be appointed to this position in a permanent capacity. Should the acting PO and CEO be discontent with his appointment, he would discuss the matter with the Board. The Board was satisfied that there was no risk involved in the acting appointment and that appropriate remuneration was linked to the acting position as stipulated in the relevant policy.

With regard to the member's second question, the Chairperson indicated that the difference resulting from the 1% VAT increase would not necessarily be reflected as a loss in the annual financial statements. Instead, the difference would imply that the net healthcare result recorded by Bestmed would vary marginally as a result of the VAT effect. Consequently, member contributions would not be increased in order to cover the additional cost paid by the Scheme. It was anticipated that the Scheme would most probably conclude the 2018 financial year with income exceeding expenditure by R10 million, compared to the budget, although this figure would depend on the number of claims received in the course of the year.

With regard to the member's enquiry regarding the poor attendance of the AGM and the associated cost implication, the Chairperson explained that, as indicated, Bestmed's AGM costs were the third-highest in the industry the previous year, according to the information provided in the CMS report. The overall costs of the previous year's AGM had amounted to approximately R1 million. As already explained to members, measures had been implemented to reduce the costs to approximately R600 000, effecting a saving of approximately R400 000.

Mr David Murray (membership number 196070916) reverted to the matter of governance. He indicated that a portion of the remuneration reflected in the annual financial statements included consultation fees paid to two Board members. He requested the Chairperson to explain the process followed in the case of contracting Board members for consultation services, including the process followed to obtain competitive quotations from different service providers.

The Chairperson replied that he assumed Mr Murray was referring to the consultation fees paid to him and Mr Kennedy, as disclosed in the annual financial statements. He then explained that a process was normally followed requiring Board approval for contracting the services of a Board member. In view of Mr Kennedy's specialised knowledge of IT systems, a specific assignment had been allocated to him to be done on behalf of the Board, prior to the implementation of the new administration platform. He had been instructed in his capacity as a Board member to ensure the necessary controls had been applied for the implementation of the new IT system. Since the Board had allocated this particular assignment to Mr Kennedy, they had passed the resolution at a Board meeting that he should be remunerated at a defined rate, based on the time spent to complete the assignment.

Similarly, the Board had allocated an assignment to him in his capacity as the Chairperson of the Board at the time of Mr La Grange's early retirement and the rest of Executive Management taking over the reins of the Scheme. The Board had approved the payment of remuneration to the Chairperson of the Board for this assignment. However, he had agreed on a significant lower payment, compared to his remuneration as Chairperson of the Board, as stipulated in the Trustee Remuneration Policy approved at the AGM. The invoices submitted by these two Board members had been audited prior to the payment of the approved remuneration.

Mr Murray then specifically enquired to what extent this process could be regarded an independent process in view of the fact that these two persons were Board members. In addition, he enquired whether quotations had been obtained and whether competitive remuneration had been paid. In response to these enquiries, the Chairperson explained that Board members were individually legally liable for the affairs of the Scheme. As a result, the Board had required that certain matters be attended to appropriately in order to ensure the implementation of the necessary checks and balances. The two Board members concerned had been contracted to do specific assignments and the contracted Board members had been required to keep record of the time spent on the work and to submit an invoice for services rendered to Bestmed. As a result, no competitive quotations had been obtained. The Chairperson added that, although the member was of the opinion that the process followed was not completely transparent, the resolutions passed in this regard at a Board meeting had been duly recorded and the invoices had been audited. The auditors were satisfied with the process followed. He encouraged the member to suggest a process to be followed, which would be considered by the Board.

Prof. Gert Louw (membership number 322571) addressed the Chairperson in Afrikaans and raised his concern about amalgamations and the financial impact thereof on the Scheme, especially with regard to a declining reserve level. After repeating his statement in English, the Chairperson replied that one of the aspects that would be taken into account when considering possible amalgamation was the impact of such a transaction on Bestmed as well as the impact of the scheme considered for amalgamation on Bestmed's reserve level. In addition, in terms of the Bestmed Rules, any intended amalgamation with a scheme comprising more than 15 000 members should be pre-approved by members of Bestmed.

The acting PO and CEO added to the Chairperson's response, indicating that Mr Murray was referring to a decline in the reserve level from 43% after amalgamation with Telemed in 2010.

Mr Ronnie Nemaston (membership number 1713957) referred to the nine allegations investigated by KPMG in 2015, as reported on at the AGM in 2016. He indicated that when the allegations had been discussed at the 2016 AGM, the members present had mandated the Board to deal with these allegations as they deemed fit. However, it appeared members were now dissatisfied by the fact that the Board had indeed taken action to deal with the allegations. He concluded by stating that when considering the Scheme's financial performance, it was clear that the Scheme was in good standing.

Dr Daan Luyt (membership number 788627) responded by indicating that he strongly disagreed with the unfounded assumption made that the Scheme was in good standing and well managed. He expressed his concern that there were certain abnormalities which were not attended to appropriately, depending on the person involved. He then addressed the Chairperson and indicated that he had opened his presentation by stating the financial position of Bestmed. Although Bestmed was the fourth-largest medical scheme, the Scheme's membership had declined in 2017, which would result in a higher reserve level. For this reason, he was not totally convinced the Scheme was in good hands.

The meeting then proceeded with the discussion of the annual financial statements and the auditor's report.

6. FINANCIAL STATEMENTS AND AUDITOR'S REPORT

Members' attention was drawn to the full set of financial statements provided in the Annual Report and the accompanying comprehensive notes. The Finance Executive Manager expressed his appreciation for the dedication and hard work of his staff in preparing the documentation relating to the AGM. He thanked the auditors for their professional work, and the Chairperson of the Audit Committee and his team for their expert guidance.

6.1 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 2017, and 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 (Act No 131 of 1998), as amended, section 33(2).

6.2 Highlights from the statement of comprehensive income

The financial statements reflected a total risk contribution income of R4 256 million for 2017. The Scheme had recorded a net surplus of R233.6 million for the year. The total comprehensive income for the year after accounting for fair value adjustments was R279 million. The gross healthcare result had increased from R470 million in 2016 to R544 million in 2017, representing an increase of 15.8%. The total comprehensive income for the year after accounting for fair value adjustments was R279.0 million, compared to R182.5 million in 2016. In absolute terms, the Scheme had recorded 8.62% more income and had paid 7.64% more benefits in 2017 than in 2016, with a total non-healthcare cost increase of 6.17%.

Other income and expenses had increased from R76.3 million in 2016 to R98.2 million in 2017, constituting an increase of 28.7%. "Other income" referred to largely investment income, while "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' savings account funds, on which they received interest, and which were used to pay for their day-to-day benefits.

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.

6.3 Highlights from the statement of financial position

Available-for-sale investments had increased from R1 354 million in 2016 to R1 651 million in 2017, while total assets had increased slightly from R2 162 million in 2016 to R2 562 million in 2017.

The Scheme's liabilities included R66 million in respect of the personal medical savings accounts of members.

6.3 Solvency

The solvency ratio at 31 December 2017 was 29.37%, compared to the statutory requirement of 25%. The solvency ratio equalled the total accumulated funds of R1 478 million to the gross contributions of R5 033 million. This was a clear message that the Scheme was financially strong and well able to pay its dues on behalf of its members.

6.4 Investments

The Scheme's net investment returns were 10.1% per annum measured over the last 12 months. The real return per annum since inception of the portfolio (144 months), was 3.5% ahead of inflation.

A comparative analysis of the Scheme's performance in relation to its competitors was then given. According to the analysis, Bestmed had recorded an average principal member growth of 0.25%, compared to an average principal member growth of 2% achieved by both Discovery and Medihelp medical schemes.

With regard to the claims ratio percentage, which constituted the portion of risk benefits paid to risk contribution income, Bestmed had recorded an average claims ratio percentage of 87.02%, very close to Discovery at 86%, whilst Fedhealth and Medihelp had recorded average claims ratio percentages of 83.4% and 90.7% respectively.

The Scheme's non-healthcare costs as a percentage of risk contribution was 9.6%, 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 R135 million, compared to R968 million recorded by Discovery. However, calculated based on the number of principal members enrolled – 95 000 and 1.2 million in the case of Bestmed and Discovery respectively – the Scheme had recorded an exceptional net healthcare result in 2017. In addition, Bestmed's solvency level stood at 29.37%, compared to 27.44% recorded by Discovery, which was a significantly larger scheme than Bestmed. These results were indicative of the Scheme's sound financial performance.

6.5 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 Ronnie Nemaston (membership number: 1713957);

Seconded: Mrs Annelise Hartzenberg (membership number: 337536)

Mr Ayanda Simelane (membership number 11961673) enquired why no cash flow statement had been provided in the financial statements included in the presentation delivered to members. The Chief Financial Officer explained that the cash flow statement and the annual financial statements had been published on the Scheme's website. Since the member indicated that he would like to ask a question on the information provided in the cash flow statement, the Chief Financial Officer obtained a hard copy of the document. The member then requested the Chief Financial Officer to explain the reason for the increase in the personal savings, current liabilities from R44 million in 2016 to R77 million in 2017. The Chief Financial Officer responded by explaining that the benefit option structure comprised a risk component and a savings account contribution. As explained in the presentation delivered on the annual financial statements, the Scheme had recorded a lower claims ratio in 2017, resulting in an increase in the funds available in the members' personal medical savings account. These funds belonged to the members, and not the Scheme. The member then indicated that the matter would be discussed with the Chief Financial Officer after the AGM.

Mr Petrus du Plessis (membership number 18722925) enquired from the Chief Financial Officer what assurance could be given that the Scheme would maintain its policy with regard to reserving the funds in the members' personal medical savings account for the sole purpose of paying qualifying medical expenses, should the Scheme not have sufficient funds to meet its financial liabilities. This concern was raised, since there was no legislation preventing the Scheme from deciding otherwise. Secondly, the Scheme's declining membership was a matter of concern, since this trend might threaten the continued viability of a medical scheme. The Chief Financial Officer assured the member that there was a level of discipline maintained when managing members' funds. Furthermore, he indicated that the Scheme would only be required to use the funds in the members' personal medical savings account to meet its financial liabilities if the Scheme would fail to manage members' funds in a responsible and sensible manner. In terms of the Bestmed Rules, the Scheme was not entitled to use the funds in the members' savings account to meet its financial liabilities. Should the Scheme decide otherwise, a rule amendment would be required, in which instance the Scheme would first have to obtain approval from the CMS.

With regard to the slight decrease in membership over the past year, the Chairperson explained that the Board had taken the decision to increase the Scheme's internal capacity for the recruitment of members. In addition, a process had been implemented to engage brokers in order to increase new enrolments. Since approximately 2006, the number of members enrolled with medical schemes had increased marginally. Therefore, membership growth was normally effected by amalgamations or acquisitions, or interchange between medical schemes. This implied that an increase in certain schemes' membership in any given year, would necessarily result in a decline in other schemes' membership during that year.

Mr Du Plessis replied by indicating that the Chairperson had failed to explain the Scheme's strategy to counteract this tendency. The Chairperson indicated that the Board regarded broker engagement as well as annual product enhancements in consultation with the actuaries as important elements of the strategy. As already explained, certain measures had been implemented in an attempt to reverse the past year's trend of more or less stabilisation of the number of members to membership growth. These measures included enhancing the Scheme's internal capacity for the recruitment of members as well as a renewed focus on engagement with different broker groups.

The acting PO and CEO added to the Chairperson's response by indicating that care should be taken when interpreting membership figures and a decline in membership. He explained that, at the end of 2016, the Scheme's membership had totalled 94 941, compared to 94 705 members enrolled with the Scheme at the end of 2017. The difference of approximately 200 members constituted a very low percentage difference. In addition, it was pointed out that these membership terminations should not necessarily be regarded a negative trend, in view of these members' poor health profile and the resultant effect on the Scheme's claims profile. From a strategic point of view, the Scheme was considering organic growth versus acquisition to grow. With regard to the direct sales internal capacity, this was one of the elements which would be developed over time.

Mr Walter Maaba (membership number 10303303) enquired about the Scheme's investment growth in 2017. From the information provided in the annual financial statements, it appeared that the Scheme's investments had yielded a positive return of 3.3%. He requested confirmation whether this information was correct. The Chairperson indicated that the Scheme's investment returns had exceeded inflation by 3.3%. In this regard, the Chief Financial Officer explained that the Investment Committee was required to achieve a return exceeding inflation by 3% on average. In 2017, the Scheme had achieved an average return of 10.1%, exceeding the inflation of 6.8% by 3.3%. Mr Maaba thanked the Chief Financial Officer for the explanation and congratulated the Scheme on the good investment performance achieved the previous year.

Mr La Grange (membership number 360384) enquired what net surplus the Scheme had recorded at the end of May 2018. The Chief Financial Officer indicated that these numbers had not been finalised yet. However, he confirmed that the Scheme had recorded a net surplus at the end of the first quarter in 2018. The Chairperson added that the 2018 results were not available yet, as the financial results under review dealt with the Scheme's performance in 2017. In response to this information, Mr La Grange indicated that, while he accepted the fact that these figures were not part of the 2017 annual financial statements, he was of the opinion that the Scheme's solvency level was overstated. The funds in members' personal medical savings accounts should not be taken into consideration when calculating the Scheme's solvency level. He continued by stating that the Scheme had recorded a solvency level of 29.3% in 2017, compared to the statutory required level of 25%. He indicated that in view of these results as well as the current difficult economic climate, the subscription increases would be expected to be significantly lower. He raised the concern that members were being overcharged and that amalgamations might impact negatively on the Scheme's reserve funds. In this regard, he requested the Board to ensure the annual subscription increases were completely justifiable and not used to fund high staff performance bonuses. In addition, he requested that the Scheme's solvency level should be taken into consideration when calculating the annual subscription increases.

The Chairperson thanked Mr La Grange for his comment and assured him that the Board would attend to this matter. He added that subscription increases for a given financial year were determined in September each year. At the point in time when the annual subscription increases were determined, the Scheme's financial performance, including the claims ratio at that time, should be taken into consideration.

With regard to Mr La Grange's comment on the payment of performance bonuses, the Chairperson indicated that Mr La Grange would most probably have better insight into the incentive scheme, since it had been implemented during his term of office as the PO and CEO of Bestmed. He continued by explaining that the amount paid in respect of staff's performance bonuses was based on a contractual agreement between the employee and the Scheme in respect of certain deliverables and the extent to which these were achieved. As a result, bonus payments were based on the performance of an employee in a particular year, and not on the Scheme's solvency level. He indicated that the Scheme's solvency level would be taken into consideration when determining the increase in the subscription fees and the benefit structure for the next financial year. As explained in the Chairperson's report, the Scheme's favourable solvency level was also one of the reasons why the Board had decided not to impose an interim subscription increase in response to the 1% VAT increase.

Mr David Murray (membership number 196070916) indicated that he would like to add to the concern raised about the Scheme's declining membership. He indicated that, over the past 17 years, the Scheme's membership had been growing year on year. However, in 2017, the membership had declined. Should this negative trend continue in future, it could have a negative impact on the Scheme's financial performance. In addition, he enquired about the Scheme's position in the market and remarked that the Scheme's value proposition should attract members from the perceived expensive funds, given the difficult economic climate. He expressed the opinion that these circumstances created the ideal opportunity for growing the Scheme's membership. Furthermore, he indicated that, as reflected in the detailed financial statements, the Scheme's marketing expenditure had amounted to approximately R29 million in 2017. He enquired what portion of this amount had been spent on brand building specifically, instead of enhancing internal sales competency.

The Chairperson responded by indicating that, with regard to membership and growth, it was important to take into consideration the average age of the Scheme's membership base. As a result, a medical scheme should preferably focus on growing its membership with younger, healthier members in order to ensure its continued viability. Should amalgamations be considered to increase the Scheme's membership, a number of factors should be taken into account in order to make an informed decision in this regard. Factors such as the reserve funds of the relevant scheme and the average age of its members could affect the claims propensity of that particular group of members and, therefore, were important aspects for consideration. He assured the members that all the relevant information would be carefully considered when taking a decision in this regard.

The Chairperson then requested the Chief Financial Officer to comment on the member's question pertaining to the marketing expenditure. The Chief Financial Officer indicated that a large portion of the marketing expenditure had been paid in respect of retainer fees and advertising agencies in order to ensure the continued sustainability of the Scheme. Additional marketing initiatives included sponsorships as well as a wellness programme, aimed at encouraging members to adopt a healthy lifestyle. A number of cycling events were hosted across the country, aimed at creating brand awareness. Furthermore, a brand-building company and advertising agency, Promise Brand Specialists (Pty) Ltd, had been recently appointed to help develop and grow the brand in accordance with the strategy of the Board and Executive Management. In view of the scope of the contract, the implementation of brand-building initiatives was a comprehensive process. However, he assured the member that the Scheme would attend to his concerns.

In response to an enquiry made by a member on which firm had audited the annual financial statements, the Chief Financial Officer replied that PwC had been appointed as the Scheme's external auditors. The member then indicated that page 29 of the detailed financial statements reflected an amount of R2.419 million in respect of cash received from members and providers other than loans and receivables. Reference to this amount was made in note 31 on page 64 as well as in note 7 on page 45 of the annual financial statements. However, a different amount was stipulated in note 7. The member indicated that the annual financial statements could not be approved without clarification of this inconsistency. A second member supported this viewpoint, indicating that it would be unethical to approve the annual financial statements without obtaining a satisfactory explanation. One of PwC's representatives responded to this enquiry by referring the attendees to note 7 on page 45 of the annual financial statements. He explained that an amount of R17.4 million was reflected in note 7, compared to R19,8 million in 2016, totalling a difference of R2,4 million, resulting from a cash inflow reduction in debtors. The Chairperson thanked him for the clarification, and he confirmed that a disclosure would be added in future to explain the calculation.

Mrs Clarette Lombard (membership number 11641288) thanked the PwC representative for clarifying the inconsistency and proposed that the annual financial statements for 2017 be approved.

Proposed: Mrs C Lombard (membership number: 11641288);

Seconded: Prof. PJ Becker (membership number: 496316).

The annual financial statements for 2017 were then unanimously approved.

7. APPOINTMENT OF AUDITORS FOR 2018/2019

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 2017. The Board of Trustees and the Audit Committee had recommended that PwC be reappointed as auditors for the Scheme for the financial year ending 31 December 2018.

A motion was tabled that PwC be retained as the Scheme's external auditors for the financial year ending 31 December 2018. No objections were raised and the motion was unanimously accepted.

Proposed: Adv. JJ (Lappies) Labuschagne (membership number: 52140);

Seconded: Mr PA du Plessis (membership number: 18722925)

8. MOTIONS RECEIVED IN TERMS OF RULE 26.1.5

The Chairperson indicated that three proposals had been received from two members for the AGM. He explained that, in terms of the Bestmed Rules, a motion should be proposed by a member and seconded by two members. None of the three proposals submitted to the Scheme had been seconded by two members. The two members who had submitted the proposals had been contacted and the process for submitting motions as stipulated in the Bestmed Rules had been explained to them. However, since they had failed to comply with the Rules in this regard, the proposals could not be regarded as motions. As a result, it would be inappropriate to put these to the vote, since the motions had not been appropriately submitted as stipulated in the Rules of the Scheme.

The first proposal received from the first member dealt with the composition of the Board of Trustees, requesting that at least 50% of the Board members should be elected by members of the Scheme. The Chairperson made the attendees aware that the Scheme was indeed complying with this requirement, since 50% of the Bestmed Board were elected by the members, as stipulated in the Medical Schemes Act, 1998, as well as the Bestmed Rules.

The second proposal received from this member dealt with reducing the Scheme's printing costs by using a different quality of paper for printing external communication material. The Chairperson explained that, although print communication was still used to a limited extent, the majority of correspondence was sent electronically to the Scheme's client base these days. He assured the members that Bestmed consistently considered less expensive alternatives to all non-healthcare expenditure, which included printing costs and the quality of paper used.

The third proposal received from the second member dealt with dissatisfaction with Bestmed's service delivery and certain treatment protocols. Since this was regarded a complaint, instead of a proposal, the Chairperson indicated that this matter would be referred to Management for resolution.

Both members who had submitted proposals had been duly informed that they were required to comply with the Bestmed Rules, stipulating that a motion should be proposed by a member and seconded by two members. The Chairperson indicated that, apart from the three proposals received, no motions had been submitted for the AGM.

The meeting then proceeded with the discussion of the trustee remuneration for 2018-2019.

9. APPROVAL OF AMENDED TRUSTEE REMUNERATION FOR 2018-2019

The Chairperson informed the attendees that Management had submitted a proposal on amending

the trustee remuneration for 2018–2019. He indicated that, in terms of the Trustee Remuneration Policy, an increase in trustee remuneration should be approved by members at an AGM. As a result, members would be required to vote on the matter. Since the Board of Trustees did not want to make a recommendation on the trustee remuneration to members, he requested the acting PO and CEO to deliver a presentation on the matter.

Prior to the presentation, the Chairperson informed the meeting that, should fewer than 10 members present at the AGM prefer to vote by ballot paper, voting would be done by show of hands, otherwise the ballot papers issued to the members upon registration would be used for this purpose. Members would be requested to indicate their preference prior to the commencement of the voting process. Furthermore, as stipulated in the Bestmed Rules, should voting be done by means of ballot papers, the Chairperson was required to nominate three volunteering members to assist with collecting, checking and counting the votes. Finally, the Chairperson indicated that he deliberately wanted to inform the members prior to the commencement of the presentation on the trustee remuneration that, in terms of the Bestmed Rules, as the Chairperson of the Board, he would, in addition to a deliberative vote, also have a casting vote.

The acting PO and CEO proceeded with delivering a presentation on the proposed amendment to the trustee remuneration for 2018–2019. He indicated that Management had recommended that a 10% increase in trustee remuneration be approved at the AGM in 2017, as the Board had indicated that the increase should not exceed 10%. The 10% increase for Board and committee members had been approved with immediate effect from 2 June 2017 in accordance with the Trustee Remuneration Policy. In addition, it had been approved that the trustee remuneration be reviewed annually to ensure alignment with the trustee remuneration of the comparative group. Furthermore, it had been explained at the AGM in 2017 that, 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. As a result, Management recommended that a 10% increase in trustee remuneration be approved with immediate effect from 15 June 2018.

Mr Walter Maaba (membership number 10303303) referred to the minutes of the 2017 AGM included in the annual financial statements. He pointed out that, as recorded on page 24, paragraph 2 of the left-hand column, he had requested that the proposed 10% increase in trustee remuneration be justified. He argued that serving on the Board of Trustees was voluntary and, furthermore, advised that the proposed increase of 10% should be considered against the background of the Scheme's declining membership. The member further enquired about the reasons for proposing a 10% increase in trustee remuneration which exceeded the annual percentage increase of staff remuneration. The Chairperson responded by explaining that, in terms of the stipulations of the Bestmed Remuneration Policy, as approved by the Board of Trustees, staff members were remunerated at the median, which was the 50th percentile of the remuneration payable in the market, relative to the level of the position. As from January 2018, the remuneration of staff members had been increased by 6.2%, to ensure alignment with the remuneration paid in the market for similar jobs. For this reason, Management proposed that Board members be remunerated at the median, as indicated in the presentation delivered by the acting PO and CEO. However, although Bestmed's Board members were remunerated materially lower than the median, compared to the market-related trustee remuneration, the Board had instructed that the increase in trustee remuneration proposed at the AGM be limited to 10%. Therefore, should the trustee remuneration be increased by 6.2% similar to the staff remuneration increase applicable from 2018, the trustee remuneration would remain low compared to the market. Furthermore, attendees were made aware of the fact that Bestmed had not been identified as one of the 10 highest remunerating schemes in terms of trustee remuneration in the CMS Annual Report.

Mr Ronnie Nemaston (membership number 1713957) 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. In response to the Chairperson's question, more than 10 members indicated that they would prefer to vote by ballot paper. After giving members the opportunity to cast their vote, all ballot papers were collected. The Chairperson then nominated three volunteering members to assist the Internal Audit Department with counting the ballots to ensure impartiality.

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:

Votes in favour of the proposed increase in trustee remuneration:	53
Votes against the proposed increase in trustee remuneration:	28
Abstain:	7
Spoilt ballot papers:	1
Total votes cast:	**89**

Mr La Grange (membership number 360384) requested that an independent organisation be contracted in future to deliver a presentation on trustee remuneration in order to give members the opportunity to take an informed decision in this regard.

10. PROGRESS WITH THE CMS ROUTINE INSPECTION DURING 2011

A number of directives, following from the CMS investigation conducted in 2011, had been issued to Bestmed. During 2016, the CMS had 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 had concluded the process that had started with the investigation in 2011 and the directives that had been issued following the process.

The meeting then proceeded with the discussion of results of the trustee election and appointment.

11. RESULTS OF THE TRUSTEE ELECTION AND APPOINTMENT

The Chairperson indicated that the trustee election had been announced in accordance with the stipulations of the relevant Bestmed Rules. Members had been informed in writing to nominate candidates for election to the Board of Trustees. The Board had appointed PwC as Independent Electoral Body to manage the process on behalf of Bestmed. All nominated candidates had been subjected to a vetting process to ensure compliance with the requirements of "fit and proper" as stipulated in the Act. Furthermore, the following requirements set for the vetting of candidates had been complied with:

- Tax clearance with the South African Revenue Service (SARS)
- Credit risk check
- Confirmation of qualifications
- Criminal record check
- Compliance with the King IV Code of Corporate Governance

The following members had been duly elected by Bestmed members in the different categories:

- Mr Martin Joubert from Vaal Technical University (Employee Member)
- Mr Louis Heyl (Individual Member – unopposed and declared validly elected)
- Mrs Annelise Hartzenberg (Continuation Member)

In terms of the Bestmed Rules, 50% of trustees should be appointed by the Board. The following members had been appointed at a special Board meeting held on 7 June 2018:

- Mrs Suzanne Stevens
- Dr Tumi Legobye
- Mr Steyn du Plessis

The complete Board of Trustees after the election comprised the following members:

- Mr Fred Camphor (Chairperson) (2015–2020)
- Prof. Piet Delport (Vice-chairperson) (2015–2020)
- Mr Leo Dlamini (2015–2020)
- Mr Steyn Du Plessis (2018–2022)
- Mrs Annelise Hartzenberg (2018–2022)
- Mr Louis Heyl (2018–2022)
- Mr Martin Joubert (2018–2022)
- Mr Peter Kennedy (2015–2020)
- Dr BE Legobye (2018–2022)
- Mrs Elmarie Marx (2016–2020)
- Mr Colin Mowatt (2015–2020)
- Mrs Suzanne Stevens (2018–2022)

Mr Rudolph Olivier (membership number 5000982) remarked that a more transparent process with regard to the trustee election and appointment should be followed in future, in particular the vetting process prescribed by the Scheme. In this regard, it was advised that the relevant stipulations of the King IV Code of Corporate Governance be distributed to members to inform them of the requirements in order to ensure the Board would not amend the process as they deemed fit. The Chairperson responded by indicating that the requirements for the vetting process would be made available to members prior to the 2020 trustee election.

Mr La Grange (membership number 360384) enquired whether any of the nominated members had been disqualified in terms of the stipulations of the King IV Code of Corporate Governance. The Chairperson answered in the affirmative, indicating that two nominated members had been disqualified in the vetting process conducted by the Independent Electoral Body. Mr La Grange responded by stating that in terms of the stipulations of the King IV Code, a decision on the disqualification of a nominated candidate should be taken by the Board and not by an independent organisation appointed to act on the Board's behalf. The Board remained responsible for decisions taken by the independent organisation. The Chairperson replied by indicating that the Board had decided to outsource the function to PwC to ensure impartiality, since the Board would not be involved in the process.

Adv. Lappies Labuschagne (membership number 52140) thanked the Board members for making themselves available to serve the Scheme with their knowledge and time. The affairs of the Scheme were managed in a professional manner to ensure its continued financial stability and exceptional performance.

Dr Daan Luyt (membership number 788627) expressed the opinion that there appeared to be a sense of discomfort with the manner in which certain processes and procedures had been followed. He appealed to the Board members to act diligently when dealing with the affairs of the Scheme. He cautioned that 50% of the Board comprised Bestmed members and, as stipulated in the Medical Schemes Act, 1998, the members of a scheme were entitled to have Board members removed, should there appear to be

sufficient grounds to justify such an act.

Adv. George Alberts (membership number 474207) indicated that he wanted to raise one matter with regard to the disqualification of the two candidates nominated for election to the Board of Trustees. He added that he raised this matter guardedly, as it might have far-reaching consequences. The Board had approved the decision taken by the Independent Electoral Body to disqualify the two nominated candidates on grounds of former employment with the Scheme. Although this criterion was stipulated in the King IV Code, the matter was more complicated, since the disqualified members had referred the matter to the Bestmed Disputes Committee. However, it appeared Management was dealing with this matter in an arbitrary manner, which was unacceptable. Members were entitled to exercise their rights and, should this not be respected, it could result in an application to the High Court of South Africa. He cautioned that the Board was not properly constituted in that meritorious candidates had not been properly considered, which could require re-election of the Board. He enquired whether the Board of Trustees was aware of the full extent of the objections taken, due to these disqualifications.

The Chairperson replied by indicating that the Board was completely aware of the consequences and concurred with the decision taken by the Independent Electoral Body. In the Board's view, the Disputes Committee dealt with matters pertaining to membership and benefit allocation. As a result, it was advised that the disqualified members should refer the matter to the CMS, as stipulated in the Medical Schemes Act, 1998, or, alternatively, the High Court. Adv. Alberts responded by indicating that the perspective that disputes of this nature were not dealt with by the Disputes Committee was a matter of interpretation. In his opinion, referring this matter to the CMS while a less formal channel existed was not a sensible decision, as it could result in costly litigation. Adv. Alberts then concluded by indicating that he took note of the Chairperson's final answer.

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

12. CLOSURE

The proceedings concluded at 14:55.

Signed in Pretoria on this _____ day of _____ 2019.

RF Camphor (Mr)
Chairperson
Bestmed Board of Trustees

Chairperson's Report

OVERVIEW

It is my privilege to present the highlights of the activities of Bestmed Medical Scheme during the 2018 financial year to all stakeholders. The Scheme once again experienced a good year in 2018, despite various events that could have caused a different outcome.

While 2017 was described as a turbulent year for South Africa with a highly depressed economic climate, to which political turmoil added even more uncertainty, the same could, to a large extent, be said about 2018. However, some of the changes we have seen in both the political and economic arena in 2018 were promising, with regard to both political stability and a possible improvement in the economic climate.

This report was held back to be drafted just after the 2019 national elections on 8 May, as the outcome could have material impact on Bestmed, just as on all other medical schemes. I will refer to the outcome of the national elections again later in the report.

The actual financial impact of the promised free tertiary education for underprivileged students is only starting to become a reality now. This will remain a significant matter in future. Tertiary education institutions are clearly under serious financial pressure. This may have a continued impact on Bestmed, since a meaningful portion of its members are employed at academic institutions.

FINANCIAL PERFORMANCE

I am pleased to report that Bestmed achieved satisfactory financial performance in 2018, despite the challenging economic climate. The Scheme's reserve level improved once again, largely as a result of both good investment returns and a lower claims propensity in the last month of the year. Members should be satisfied that Bestmed exceeded the prescribed statutory reserve level of 25%. The Scheme's solvency ratio increased from 29.37% in 2017 to 31.94% at the end of 2018. While a material number of the other medical schemes realised operating deficits or small positive operating margins, it was a relatively good year for Bestmed.

Bestmed's balance sheet improved from R2 562 million to R2 872 million during the past year. The net healthcare result reduced from R135,4 million the previous year to R87,6 million in 2018. The Scheme's members definitely benefit from its sound financial performance.

While the net healthcare result of R87,6 million recorded in 2018 clearly represents a significant value, it must be understood that an increase or reduction to the value of 1% in claims from Bestmed members, equates to approximately R40 million. A 2% increase in the value of claims in December 2018 would have balanced out the positive net healthcare result.

Investment income contributed R156,7 million, while related expenses amounted to R49,8 million.

This leaves the net surplus for the year at R187,7 million, while the Total Comprehensive Income after adjustments amounts to

R159,1 million for the year. Although 2018 was a relatively good year for Bestmed, the financial performance achieved in 2018 was approximately R120 million worse than in 2017. A significant contributor to the surplus resulted from positive investment returns, instead of the annual increase in contributions.

The average risk contribution increase in premiums for all open schemes in 2018 amounted to 8.6%, which was still higher than headline inflation at approximately 6% for the corresponding period. This increase was determined at 8.4% for Bestmed, which was slightly lower than the average contribution increase for all open schemes. As confirmation of the fact that the Board listens to members, Bestmed's average contribution increase in 2019 was 8.94%, while the average increase for all other open schemes amounted to 9.3%.

Members are also reminded of the fact that Bestmed was the first medical scheme to decide not to recover the additional expenses resulting from the 1% increase in VAT announced in April 2018. This clearly set the trend for the industry and nearly all schemes then followed this decision. The CMS also issued a statement after 1 April 2018, requesting schemes not to recover the increased expenses paid in respect of the 1% VAT increase from members. This decision by the Board ensured that an amount of R21.8 million in respect of increased VAT was paid by the Scheme, but not recovered from members in 2018.

The Board of Trustees is thankful to be able to report this positive financial performance to members.

STRATEGIC REVIEW

Executive Management and the Board of Trustees review the Scheme's strategic framework annually. Business plans are then developed to focus on delivering the strategic objectives for the next year.

In 2018, membership reduced by 1 363 members, while the average age of beneficiaries remained more or less consistent. The Board views this period as a consolidation phase after a number of material changes were implemented in 2017.

It must be kept in mind that the medical schemes 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 essential to find ways to retain members of the required profile.

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 reviewed for less comprehensive, cheaper alternatives or discontinued when families are struggling financially. Although this tendency was once again experienced in 2018, our response to the loss of members fortunately enabled us to recruit new members with a similar 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.

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

GOVERNANCE

I wish to report on a few changes to the structure of the Board of Trustees that have taken place over the past year. The term of office of Prof. Kobus van Rooyen terminated at the AGM of 2018. Ms A Hartzenberg as well as Messrs L Heyl and MJ Joubert were elected by members to the Board of Trustees. Dr T Legobye was appointed as Board member, while Ms S Stevens and Mr GS du Plessis were reappointed as Board members. The terms of office of these newly elected and appointed Board members commenced at the AGM in 2018.

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

During the past year, Executive Management and the Board continued the process to review a number of policies in order to comply with good governance principles. These changes have been completed and the operation of Bestmed as medical scheme runs successfully in the view of the Board.

As is common practice by now, the Board again formally assessed its own performance over the past year. The results of this assessment were discussed in detail in a recent Board meeting and will contribute to the process of planning the objectives to be achieved during the year ahead. It will also serve as an entry point to improve the functioning of the Board of Trustees in fulfilling the required role going forward.

Following certain matters discussed at the AGM in 2018, a dispute was declared by a member who did not attend the AGM. In the opinion of the Board, this dispute had to be referred to the Council for Medical Schemes, which was duly done. At the date of drafting this report, no formal feedback on the matter has yet been received.

COUNCIL FOR MEDICAL SCHEMES (CMS)

While it may be common knowledge by now, the Board is of the opinion that, for the record, the matter of the investigation conducted by the CMS in terms of Section 44(4) of the Medical Schemes Act, 1998 needs to be presented in relative detail, hence this repeat of information already presented in the Annual Report of 2017.

In 2015, the CMS informed the Board in 2015 of possible transgressions by Bestmed of the Medical Schemes Act, 1998. The Board of Trustees appointed KPMG to investigate the allegations and report back to the Board.

KPMG submitted their report setting out the findings of their forensic investigation to the Board of Trustees early in 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 Board 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 focused 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 Board 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 in 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 of the AGM in 2018, no further feedback had been received from the CMS. This is still the case, as no further response had been received from the CMS on this matter.

While the Board would like to believe the matter is finalised and closed, 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. Should this process unfold further, members will be kept informed of the progress made in this regard.

MANAGEMENT OF BESTMED IN OF 2018

Mr Pieter van Zyl was appointed as Acting Chief Executive Officer and Principal Officer of Bestmed in April 2017 and he played a key role with the Executive Management team in stabilising the performance of Bestmed.

The implementation of the new integrated administration IT system, known as BIT, to replace the outdated Medware system in May 2017, was successful. The system has stabilised and a number of smaller enhancements were done to ensure efficient and effective service to members.

The focus in 2018 was on stabilising the new IT system, ensuring that service levels to members are retained and ensuring that we get best value from the new IT service platform implemented through a number of enhancements done. In addition, a large number of contractual agreements with various service providers were reviewed and revised, where necessary. This was done to ensure Bestmed is well positioned to focus on future growth without any concern about the ability to properly service such growth objectives.

Although a possible merger was considered in 2018, the Board concluded that it would most likely not be in the best interests of Bestmed and its members to pursue the specific opportunity.

THE FUTURE

It is still envisaged that the intended move to Universal Health Coverage (or National Health Insurance (NHI) 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. The principle of the rich subsidising the poor and the healthy subsidising the sick is clearly followed by the SA Government and even after this immediate past elections, we could expect to see some changes made to pursue this objective.

Risk pooling is certainly still viewed as an insurance instrument where financial risk associated with expenditure on 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. This trend is expected to continue and, as a result, further consolidation of medical schemes in the industry is anticipated.

As already reported in 2018, we will most likely also see a reduced number of benefit options available in the market. This trend will certainly continue and it will result in the benefits available from different schemes becoming more and more similar. Under these 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.

Against this background, the only differentiating factors between schemes will be its size that will bring along the economy of scale, the extent to which the brand is known and liked by members and potential members, and the level of service rendered to members.

These are the reasons why the Board of Trustees continues its focus with Bestmed Management on maintaining and improving the extremely good levels of service which members have become accustomed to and reinforcing its brand in the industry.

Furthermore, the Board believes a strategy of amalgamation of schemes should be pursued. If Bestmed does not drive the process towards mergers and/or amalgamations, then some other scheme will do so. 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 your Scheme, and of any scheme. If these are the imperatives, the Board believes that Bestmed should rather drive the processes in which we get involved, than allow another role player to do so. Despite the intention to grow the size of the Scheme we should not allow any reduction of service levels to members.

After the elections held on 8 May 2019, it seems to be clear that there may be bigger challenges for South Africa in various other areas than NHI. Although it is still expected that NHI will be pursued by Government, the expectation for the moment is that NHI will most likely once again be put on the back burner for the foreseeable future.

At the time of drafting this report, we do not yet know of any material changes made in the national policy, or even who the new Minister of Health may be. Rather than speculate, the Board believes that Bestmed should focus its attention on serving its members in the best way possible. The Board will address any material changes as these come along and then take the decisions deemed appropriate and necessary for Bestmed and its members.

APPRECIATION

I wish to express my personal gratitude by thanking the loyal members of Bestmed for their continued support. The mere fact that you remain members of the Scheme certainly shows that you get good value and personal service from Bestmed. This is highly appreciated and I thank you for your continued support.

I also wish to express my gratitude to Bestmed's management and employees for their loyalty and dedication. You are indeed delivering on the Scheme's promise of Personally Yours and your hard work 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.

To my colleagues as fellow Board members, I wish to convey my most sincere appreciation for your cooperation and support during the past 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 a complex and difficult task. Thank you for being prepared to take the difficult decisions we are sometimes forced to do. I really appreciate your support and dedication.

RF Camphor (Mr)
Chairperson
Bestmed Board of Trustees

Operational Highlights

Report from the Acting Chief Executive Officer

There comes a certain time of the year when the leader of an organisation will set time aside to look back over the previous year. The mind races away with the same questions of old, "Could we have done it differently?", "Could we perhaps have done it better?", "If another decision had been taken at that moment, what would the outcome have been?" This is part of the process. However, it is also wise to remember that dwelling too much on the past can make us neglect the future. We should review the lessons we have learnt and build on those.

While 2017 may have been earmarked by significant change and the dawn of a new era for Bestmed, including the changeover to the BiT IT administration platform, we were able to achieve exceptional financial results and retain our position as the fourth-largest open scheme in the industry. We are happy to report that we have continued with this trend in 2018 and our finances are looking very healthy with a 31.94% solvency ratio. Although we experienced a marginal decline in membership, our membership base is very sustainable in terms of average age and claims ratios. We are confident that we have the right people, processes and strategies in place to grow our membership going forward.

Through extensive planning in 2018, objectives and goals were set in accordance with the Scheme's strategy to ensure that our service offerings exceed the expectations of members, corporates, healthcare providers and brokers. We are reaping the benefits of implementing our new administration system and can report that this integrated system and processes have stabilised, resulting in significantly improved service delivery models. We will continue our pursuit to enhance the system by evaluating new and innovative ways to benefit our stakeholders. Digitalisation is a reality for every business and we are confident that we have built a solid foundation that will enable us to create added value and further streamline our processes to benefit our members.

Although 2018 may have been focused largely on stabilisation, integration and planning for the future, we are proud that we achieved various milestones. High-level achievements for 2018 are as follows:

FUTURE OF HR AWARDS: HR TECH SERVICE PROVIDER 2018 - WINNER

Contenders for this award are innovative service providers that create and distribute HR-specific technology solutions to stakeholders in business – for example, payroll software solutions or user-friendly digital HR platforms for employees. The intent of the award is to showcase cost-effective technology solutions that have improved or contributed to the HR function's impact and efficiency.

FUTURE OF HR AWARDS: CORPORATE WELLNESS CHAMPION 2018 – FINALIST

This is awarded to the organisation that has implemented the winning strategy for health and wellbeing in the workplace.

ASK AFRIKA ORANGE INDEX SURVEY - THIRD PLACE

Bestmed was awarded third place in the Ask Afrika Orange Index Customer Service Benchmarking Survey among open and closed schemes. The Ask Afrika Orange Index® is at the forefront of service benchmarking (since 2001) and is the broadest, most independent and widely-referenced service excellence benchmark in South Africa. Whilst it may be a tough task, our objective remains to be the number one medical scheme in service delivery.

GRANT THORNTON CAPITAL SURVEY - BEST PROVIDER

Bestmed was rated the best provider in the Hospital and Saver plan categories.

ORGANISATIONAL HEALTH FACTOR BENCHMARK (OHFB)

Bestmed annually benchmarks its organisational climate to understand the dynamics in the workplace in terms of the ability of the workforce to function at an optimum level and to react on strategic intent. The results achieved in 2018 exceeded the 2017 results and the Scheme scored the highest of all participants in corporate citizenship behaviour which measures how much employees "love their organisation" and are "going the extra mile" for clients.

NO ADDITIONAL VAT INCREASE IN 2018

Bestmed was the industry leader in being the first scheme deciding not to burden its members with the additional 1% VAT increase that came into effect on 1 April 2018.

RENEWAL OF ACCREDITATION FOR ADMINISTRATION AND MANAGED CARE FROM THE COUNCIL FOR MEDICAL SCHEMES (CMS)

The CMS last year finalised its compliance/accreditation process by which the Scheme was evaluated against the same approval standards applicable to medical scheme administrators and managed healthcare organisations. Bestmed received both the accreditation certificates for Administration and Managed Healthcare. There are a number of partial findings that require attention and the revision of certain processes and these have been planned for accordingly.

REMAINED THE FOURTH-LARGEST OPEN MEDICAL SCHEME IN THE COUNTRY

Bestmed retained the position of the fourth-largest open medical scheme in South Africa .

Although there are a number of achievements that can be celebrated, we also have to address concerns that have been raised by members to reassure them that Bestmed is committed to being transparent and maintains high levels of governance and compliance.

Concerns were raised in the latter part of 2018 after the release of the CMS Annual Report 2017/2018. In our commitment to transparency, I would like to share the findings of the CMS and provide the context and assurances going forward.

1. **The 10 schemes with the highest remuneration for Principal Officers (PO) in 2017 – Bestmed ranked first.**

   In context, Bestmed should have been in sixth place was it not for the once-off severance package paid to the previous PO and CEO of 21 years. The reported amount also included his monthly salary for the first three months of 2017 until his departure. The Scheme acknowledges that this anomaly will not recur. The Scheme acted in a transparent manner and the total compensation in respect of the former PO and CEO was disclosed in note 29 of the annual financial statements (AFS) for 2017. The severance payment was also disclosed as a post-balance sheet event in the AFS for 2016 and was approved accordingly by members at the 2017 AGM. The Scheme makes use of the Remchannel database of PwC and market-related remuneration as the basis to determine the remuneration of all employees in a responsible and defendable manner.

2. **The 10 open schemes with the highest governance-related expenditure – Bestmed ranked 10th**

   This anomaly related to legacy matters which will not recur going forward.

3. **The 10 schemes with the highest AGM costs in 2017 – Bestmed ranked 7th**

   The Executive and Board of Bestmed have noted this concern and acted accordingly. The 2018 AGM was downscaled resulting in material cost savings, while still providing members with a professional meeting. We will continue in this manner in future.

   It is also worthwhile to note **where Bestmed has not featured** in the CMS Annual Report 2017/2018 and I would like to draw your attention to this.

   - Top 10 open medical schemes with most complaints per 1 000 beneficiaries
   - The 10 open schemes with the highest administration expenditure above the industry average of R140.30 per average beneficiary per month
   - The 10 open schemes with the highest administration fees per average beneficiary per month
   - The 10 schemes with the highest trustee fees in 2017
   - Schemes with broker fees above the industry average in 2016 and 2017
   - Open schemes with high non-healthcare expenditure and a solvency ratio below average in 2017
   - The top 20 schemes with the largest net healthcare deficits in 2016 and 2017
   - Schemes with the largest net healthcare deficits and solvency levels above the industry average of 33.2% in 2017

The Scheme, with the unconditional support and guidance of the Board, has succeeded in establishing far greater efficiencies in the areas of governance and compliance. The adoption of and adherence to the King IV principles and guidelines continue to illustrate our absolute commitment to good governance. Our efforts in this regard are supported by the Internal Audit Department that forms a very important part of our assurance process.

We will continue to listen to our members and make the best decisions possible to their benefit within statutory and legal requirements. We do this in a transparent and personal manner by touching the lives and making a difference in the health and wellness of every Bestmed member and family. We have learnt important lessons over the past few years, have taken these to heart, endured, and will continue to strive to improve our services and value proposition for our members. Bestmed remains true to its brand promise, Personally Yours.

Legal and Governance Report

The Scheme, through the Board, is committed to the principles of fairness, ethical conduct, integrity, accountability and good governance in all its dealings with stakeholders. The Scheme aspires to fully comply with all aspects of good governance as espoused in the Medical Schemes Act and its regulations as amended.

In 2018, following the publication of the King IV Code on Good Governance, the Board embarked on various initiatives for the Scheme to work towards complying with the Code. The initiatives include, but are not limited to, the review of the Scheme Rules to ensure alignment to the Code and a review of trustee guidelines in as far as trustee responsibilities are concerned. Work in this regard is ongoing and further changes will in all probability be required following the review process of the Medical Schemes Act that is currently under way.

During 2018, the Board relied on its committees to oversee different aspects of the Scheme's operations. The committees do not assume the functions of management, these remain the responsibility of the Principal Officer and other members of senior management.

Operational Report

The performance of the Operations Departments in 2018 was very satisfactory. Both Administration and Managed Healthcare functions were re-accredited for a three-year period by the CMS in 2018 and the certificates have been issued to the Scheme. It is evident that our new IT platform is stable and functioning optimally and coupled with improved processes have culminated into excellent turnaround times. The service delivery models continue to function very well in Operations.

An online application process is in its final testing phase and will soon be implemented. This will further improve the turnaround times – in support of our marketing strategy – to ensure positive growth and enhanced broker and client experiences.

We are particularly proud of our achievement in reconciliation management as every discrepancy requires manual investigation and third-party involvement, which is a challenge on its own. We can report that the number of discrepancies has drastically reduced and is marginal compared to the principal member count.

In the claims processing space, the improved speed and efficiency has resulted in greatly improved turnaround times with claims consistently being processed within 24 hours.

Fraud, waste and abuse will always remain a concern, however, Scheme representatives attend regular meetings at the Healthcare Fraud Management Unit of the Board of Healthcare Funders. During 2018, the Unit developed and introduced a forensic portal enabling different schemes to share information on fraudulent incidents that are detected and reported by them. This has resulted in a cooperative effort to better mitigate risk which has benefited the Scheme.

Client Relations Report

The most prominent change we made with regard to service delivery during 2018 was the initiation of member engagement sessions that took place on a national basis. In these sessions, members had the opportunity to raise their concerns, issues and proposed changes. The issues raised related to service delivery, internal processes and benefit limits. Overall, the feedback from members confirmed that the sessions were regarded as highly successful and it also benefited the Scheme as it provided important input for decision making. Similar sessions were convened for brokers and intermediaries and these too were experienced as positive and valuable by all stakeholders. A number of revisions to processes and procedures were implemented to address the issues raised. In addition to these, processes relating to escalation and service delivery via the various regional offices were also revisited to improve the Scheme's overall service to its members, brokers and providers.

A highlight of the year was the roll-out of the Bestmed Mobile Application (App) to our members. The take-up was positive and resulted in fewer queries channelled to the contact centre – either via phone or e-mail – compared to those received in 2017. Improvements made to the App continue to reduce the queries received via other channels. At year-end, 16 903 members have downloaded the App. In 2019, we will continue with improvements to the App, linked with improvements to the website and web portals which are the primary sources of information for members, brokers and corporate clients.

Although self-help functionalities are very important, a significant portion of members still prefer to make use of the walk-in centres to liaise with representatives of the Scheme in person. Therefore, we will focus on improving the service delivery at the walk-in centres as well to ensure members have access to a professional service via the channel of their choice.

Another highlight was that Bestmed was rated 3rd in the Ask Afrika Orange Index industry satisfaction benchmark. Our objective is to achieve second place in 2020 in our quest to ultimately become the industry winners.

Corporate Services Report

Strong and mutually beneficial relationships with our employer groups remain an important priority for the Scheme and therefore we need to focus on creating different and more dynamic ways to nurture these relationships. Previously, key account consultants primarily focused on resolving queries when calling on employer groups. Corporate clients now utilise the self-help facilities, including the App, to resolve the majority of their queries. The focus of the key account consultants has shifted to the implementation of the Workplace Wellness activities and strengthen the relationship with key role-players at the corporate clients.

Strong focus will be placed on further development of the important elements that contribute to a compelling value proposition for employer groups, including the Primary Healthcare offering, the Workplace Wellness programme, integration of HR and Finance systems and the disease management programmes offered by Scheme e.g. the HIV/Aids and Diabetes programmes.

Wellness Report

The main priorities of the Wellness department for 2018 were the implementation of family assessments and the development and implementation of a new wellness IT system which integrates into the larger operational system. In addition to these, family workshops were piloted in Gauteng during the year. The feedback was very positive and we plan to have more of these workshops across the country in 2019.

The participation in the family assessments exceeded expectations and the feedback from parents who participated in these assessments confirmed that the programme and offering is regarded as valuable and different to other offerings in the market. Unfortunately the number of adult registrations on the Wellness programme did not meet the targets. To promote higher participation in the programme, regional health days were held during the third quarter of 2018. These were successful and will continue in 2019, coupled with an official launch of the of the Wellness programme via an extensive marketing and communication plan which will be implemented during the first half of 2019.

Service Provider, Contracting and Research Report

We are very proud of the growth in our provider network as well as the increase in member utilisation of the network which exceeded the network maturity level of 75%. In 2018, Bestmed launched a project to provide Family Practitioners with easy access to network information with the aim of promoting the use of the Specialist Designated Service Provider (DSP) network for referrals. As part of the project, Family Practitioners had the opportunity to nominate Specialists whom they wanted the Scheme to approach to join the network. This initiative adds tremendous value to the network and reduces member co-payments when they need the services of a Specialist.

We continued to focus on building, maintaining and strengthening our relationships with providers during 2018. We visited the practices of 510 Specialists and 452 Family Practitioners in person to assist with queries and/or challenges that they had.

Managed Healthcare Report

Typically referred to as a collection of techniques aimed at influencing the clinical behaviours of healthcare providers and patients, managed care initiatives are vital to the ultimate sustainability and survival of medical schemes. Managed care takes into account clinical as well as financial risk whilst considering the appropriateness and cost-effectiveness of health services within the constraints of affordability.

Although the management of the cost is a major consideration, it is equally important to ensure that an appropriate and cost-effective system is in place that both considers acute cases and manages patients holistically in a combination of preventative, acute and post-acute care.

HOSPITALISATION

The hospital benefit management call centre received 211 785 calls for the year ended 31 December 2018,

an average of 18 482 per month. Hospitalisation costs increased by 8.7% in real terms totalling R1 835 million with the average cost per admission being R31 222. The Scheme experienced a significant increase in the severity of cases admitted with the severity index increasing by 5.31% year on year. After adjusting for the severity of cases, the cost per admission increased by 3.04%. From the above it is clear that, although the Scheme is able to contain cost increases, the uncertainty with regard to the level of complexity presented by cases have a major impact on the cost of hospitalisation.

MEDICINE

Risk benefits paid in respect of medicine includes medicine for chronic diseases (as defined on the chronic disease list), and additional chronic diseases as defined in the option rules of the Scheme. Furthermore, a portion of acute medicine is paid from risk benefits in options that qualify for this benefit. The total expenditure on medicine amounted to R505 million, an increase of 6.5% compared to the previous year. Of the total spend, 56% was for chronic medication whilst 8% of the spend was for the treatment of oncology patients. In 2018, a total of 7 798 731 script lines were claimed, an average of 3.77 items per claiming beneficiary.

DISEASE MANAGEMENT PROGRAMMES

Disease management is a system of coordinated healthcare interventions and communications for defined patient populations where self-care efforts can be implemented. Disease management empowers individuals, working with other healthcare providers, to manage their disease and prevent complications. For the year under review the following programmes were available to members:

- HIV
- Oncology
- Preventative Back and Neck Treatment
- Renal Care

From the beginning of 2019 a disease management programme for patients diagnosed with diabetes will also be implemented.

PREVENTATIVE BENEFIT PROGRAMMES

The Scheme makes provision for members to annually receive vaccinations for flu as well as vaccinations to prevent the occurrence of pneumonia. In 2018 only 2.2% of those members that received the flu vaccination were hospitalised for flu-related conditions. Pneumonia vaccinations are aimed at the elderly (65 years of age and older) as well as infants and children up to the age of 9 years. These vaccinations show results of significantly reduced hospitalisation in the age group 65 years and older compared to the age group 30 to 60 years of age. The latter group, which accounts for only 1% of the total vaccinations, had double the amount of hospitalised cases compared to those of 65 years and older.

Marketing

The past two years have seen a slight decline in membership growth figures following an extended period of positive growth. Consequently, a decision was made to do a national relaunch of the brand which commenced towards the end of 2018. Previously, the Scheme was primarily focused on corporate business, resulting in the majority of campaigns and marketing initiatives being focused on the workplace as well as broker channels. This dynamic has changed, necessitating increased brand awareness in the broader public. The aim of the national brand campaign is to create awareness and interest via above-the-line channels which are supplemented by various digital initiatives, public relations and targeted sponsorship activities.

CORPORATE SOCIAL INVESTMENT (CSI) AND SPONSORSHIP

Bestmed is very cognisant of the fact that it operates as part of wider communities and remains passionate about making a difference in the lives of others, not only through the provision of healthcare benefits but also by giving back to the community. Together with Partners for Possibility, the Scheme reached out to the principal and teachers of the Dr IM Monare Primary School in Mamelodi to improve their leadership skills through facilitated training and team building. Bestmed also raised funds and donated desktop PCs to the school to benefit both the children and employees. The Scheme is also involved in other initiatives such as the Bestmed Development Cycling Team and the Bestmed Cycle4CANSA championship.

During 2018, the Scheme sponsored a number of cycling and running events including the Bestmed TuksRace, Bestmed Berge en Dale Road Championship, Bestmed Tour of Good Hope, Bestmed Jock Classic, Bestmed Chokka Trail Run, Bestmed Makro Tour, Bestmed Satellite Classic and the Bestmed Eden Street Mile Series, to name a few. These sponsorships were reviewed and reduced for the 2019 year to allow for a more focused approach to sponsorships.

Distribution and Sales

The Scheme's distribution channel consists mainly of a Direct Sales team and a Broker channel that is serviced by a team of Broker Consultants. New registrations via both the Direct Sales channel as well as the Broker channel increased compared to the previous year although the majority of business via the Broker channel was acquired through a few large brokerages.

The distribution activity for 2018 was intensified through specific initiatives of which the majority focused on accreditation and training, specifically in the areas of Prescribed Minimum Benefits (PMBs), enhanced wellness offerings and underwriting. New brokers are continuously recruited and contracted with the success of these agreements being measured by how quickly new business is placed. For the 2018 year, the Broker Consultant team made 2 113 visits to brokers, facilitated 458 training sessions and travelled 93 955 kilometres.

The Financial Services Conduct Authority (FSCA) published the Board Notice 194 of 2017: Determination of Fit and Proper Requirements for Financial Services Providers in December 2017, that incorporated several changes to the previous requirements. During the course of the year, policies were revised and processes were amended and implemented to comply with the requirements. Bestmed also successfully rolled out the required Product Specific Examination to brokers to meet the 1 August 2018 deadline.

Bestmed consulted with the Council for Medical Schemes (CMS) regarding the amendment of broker agreements as published. The agreement was amended, approved by the CMS and rolled out to the broker network.

The Direct Sales team performed well, achieving 85% of their target for 2018. In comparison to the previous year this reflects an upward trajectory in terms of new member registrations. In 2019, increased efforts will be made to provide the department with sufficient, quality leads to convert. Other priorities for 2019 include the development of an online application process for individual members to improve the effectiveness of the membership application process and improvements to the existing leads management system.

Human Resources (HR) Report

The HR department, also referred to as the Talent Team, has succeeded in automating the majority of its workflows including Disclosure of Interests, Performance Management, Reward and Recognition and Recruitment and Selection. The team also finalised the development and roll-out of an E-learning platform to enhance vocational training and employee development initiatives.

We are proud to announce that Bestmed was named the 2018 Technology Champion at the fourth annual Future of HR Awards hosted by Topco Media and Careers24. This achievement came after being nominated as finalists in two categories: Technology Champion and Corporate Wellness Champion. The Talent Team went through an extensive application process to showcase how we use our technology system to the maximum benefit of our internal stakeholders.

We have revisited most of our policies and procedures, which represents an ongoing and important business imperative to ensure that good governance and best practice principles are adhered to. Attracting competent and skilled talent remains a challenge, however, Bestmed remains committed to and focused on transformation.

Of our 435 staff complement, 66% represent previously disadvantaged individuals and the 2019-2021 Employment Equity Plan, in collaboration with our Employment Equity Forum, was successfully submitted to the Department of Labour. The employee turnover in the measurement period was 6.43% which is lower than the industry average.

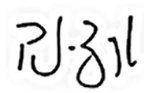
The Scheme annually utilise the Organisational Health Factor Benchmark (OHFB) workplace analytics system which is a standardised and culturally sensitive HR risk management instrument. It identifies employee and workplace functioning risks that might impede the ability of Bestmed employees to act on strategic intent. In 2018 the Scheme obtained the highest corporate citizenship score of all participants and the highest ever since introducing the initiative. The main corporate citizenship employee responses measured via the instrument are how much "I love my organisation" and that "I will walk the extra mile".

Information and Communication Technology (ICT) Report

Our strategic objective is to continually upgrade Bestmed's ICT infrastructure and systems to benefit the end-user, to remain competitive in the industry and to improve the efficiency of the Scheme. ICT continues to be 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.

The recent implementation of Bestmed's new administration system proved to be a sound business decision which is resulting in improved service delivery and effectiveness across the organisation. The system remains new and relevant in the industry and with additional enhancements completed during 2018, it has enabled the organisation to improve the member experience without incurring additional cost. The realised cost savings are a direct result of the efficiencies achieved thus far. Furthermore, we have also seen a reduction in non-healthcare cost as the Scheme becomes more efficient within the digital landscape.

Our digital transformation strategy continues to provide us with rich data to analyse and with the incorporation of machine learning models for decision making and value adds, we will continue to enhance our infrastructure during 2019 to provide an even better service to our members.



Pieter van Zyl
Acting Chief Executive Officer

OPERATIONAL HIGHLIGHTS

Highlights of the 2018 financial statements

HIGHLIGHTS OF FINANCIAL STATEMENTS

STATEMENT OF FINANCIAL POSITION AT 31 DECEMBER 2018

	2018	2017
	R	R
ASSETS		
Non-current assets	**1 510 164 279**	**1 336 416 948**
Property and equipment	24 598 586	30 984 754
Investment property	-	1 600 000
Intangible assets	9 791 025	6 568 764
Financial assets at fair value through profit or loss	1 308 339 644	-
Financial assets at fair value through other comprehensive income	167 435 024	-
Available-for-sale investments	-	1 297 263 431
Current assets	**1 361 352 162**	**1 225 328 542**
Financial assets at fair value through profit or loss	878 348 268	-
Scheme	358 313 714	-
Personal medical savings account trust monies invested	520 034 554	-
Financial assets at fair value through other comprehensive income	133 498	-
Available-for-sale investments	-	834 472 321
Scheme	-	353 683 193
Personal medical savings account trust monies invested	-	480 789 128
Trade and other receivables	265 762 863	70 262 212
Cash and cash equivalents	217 107 533	320 594 010
Scheme	16 775 115	160 446 441
Personal medical savings account trust monies invested	200 332 418	160 147 569
Total assets	**2 871 516 441**	**2 561 745 490**
FUNDS AND LIABILITIES		
Members' Funds	**1 771 305 337**	**1 612 170 602**
Accumulated funds	1 775 599 276	1 477 874 327
Revaluation reserves - Available-for-sale assets	-	134 296 275
Revaluation Reserve - Financial assets at fair value through other comprehensive income	(4 293 939)	-
Non-current assets	**11 712 158**	**12 215 765**
Retirement benefit obligations	11 712 158	12 215 765
Current liabilities	**1 088 498 946**	**937 359 122**
Personal medical savings account trust liability	736 004 819	660 990 469
Outstanding claims provision	165 676 037	155 649 426
Trade and other payables	186 818 090	120 719 227
Total funds and liabilities	**2 871 516 441**	**2 561 745 490**

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 2018

	2018	2017
	R	R
RISK CONTRIBUTION INCOME	**4 479 138 426**	**4 256 038 032**
Relevant healthcare expenditure	**(3 989 323 832)**	**(3 712 106 868)**
Net claims incurred	(4 001 437 392)	(3 727 508 212)
Risk claims incurred	(3 903 152 564)	(3 628 769 610)
Third-party claims recoveries	8 603 947	7 283 907
Accredited managed healthcare services	(106 888 775)	(106 022 510)
Net income/(expense) on risk transfer arrangements	12 113 560	15 401 344
Risk transfer arrangement premiums paid	(86 467 640)	(84 190 590)
Recoveries from risk transfer arrangements	98 581 199	99 591 934
Gross healthcare result	**489 814 594**	**543 931 164**
Broker service fees and other distribution fees	(74 831 727)	(70 458 474)
Administration and other operative expenses	(321 011 058)	(328 981 752)
Net impairment losses on healthcare receivables	(6 392 567)	(9 033 687)
Net healthcare result	**87 579 243**	**135 457 250**
Other income	**158 060 867**	**154 001 238**
Investment income	156 759 887	152 315 255
Scheme	112 889 958	110 684 964
Personal medical savings account trust monies invested	43 869 929	41 630 290
Sundry income	1 300 980	1 685 984
Other expenditure	**(57 948 920)**	**(55 827 772)**
Interest paid on personal medical savings trust accounts	(43 869 929)	(41 630 290)
Asset management fees	(5 903 824)	(6 678 621)
Own facility net expenditure	(8 061 316)	(7 497 681)
Other losses	(113 852)	(21 180)
NET SURPLUS FOR THE YEAR	**187 691 190**	**233 630 717**
Other comprehensive income	**(28 556 455)**	**45 422 414**
Fair value adjustment on financial assets through other comprehensive income	(28 556 455)	-
Realised gains on financial assets at fair value through other comprehensive income	(23 317 540)	-
Fair value adjustment on available-for-sale investments	-	57 091 454
Reclassification adjustment on realised gains / (loss)	23 317 540	(11 669 040)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**159 134 735**	**279 053 131**

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES FOR THE YEAR ENDED 31 DECEMBER 2018

	Accumulated Funds	Available-for-sale Revaluation Reserve	Revaluation Reserve - OCI	Total members' funds
	R	R	R	R
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**
Change in accounting policy	86 716 219	(134 296 275)	47 580 056	-
Net surplus for the year	187 691 190	-	-	187 691 190
Other comprehensive income	23 317 540	-	(51 873 995)	(28 556 455)
Fair value adjustment on financial assets through other comprehensive income	-	-	(28 556 455)	-
Realised gains on financial assets at fair value through other comprehensive income	23 317 540	-	(23 317 540)	-
Balance as at 31 December 2018	**1 775 599 276**	-	**(4 293 939)**	**1 771 305 337**

SOLVENCY RATIO

The solvency ratio is calculated on the following basis:

	2018	2017
	R'000	R'000
Total members' funds per statement of financial position	1 771 305	1 612 171
Cumulative losses on remeasurement to fair value of financial instruments and property and equipment included in accumulated funds	-	500
Balance at beginning of year	500	500
Unrealised gain on revaluation of investment property in the statement of comprehensive income	(500)	-
Revaluation reserves	(75 774)	(134 296)
Accumulated funds as per Regulation 29	1 695 531	1 478 374
Gross contributions	5 308 251	5 033 075
SOLVENCY RATIO	**31.94%**	**29.37%**

OPERATIONAL STATISTICS PER BENEFIT OPTION

2018	Beat1	Beat2	Beat3	Beat4	Pace1	Pace2	Pace3	Pace4	Pulse1	Pulse2	Total Scheme
Members at 31 December	5 685	25 735	7 157	4 290	29 091	9 829	5 554	2 606	2 731	664	93 342
Average number of members for the accounting period	5 687	25 202	7 144	4 421	29 405	9 977	5 613	2 662	2 818	705	93 635
Dependants at 31 December	5 923	26 469	7 514	4 730	42 317	7 643	5 417	1 395	1 629	134	103 171
Average number of dependants for the accounting period	5 960	25 958	7 455	4 890	42 517	7 830	5 546	1 446	1 708	145	103 454
Average beneficiaries for the accounting period	11 646	51 160	14 599	9 311	71 922	17 807	11 159	4 108	4 526	850	197 088
Ratio of average dependants at 31 December	1,05	1,03	1,04	1,11	1,45	0,78	0,99	0,54	0,61	0,21	1,10
Average age of beneficiaries for the accounting period	35,49	29,97	36,63	44,44	33,58	53,59	52,65	62,78	44,90	77,73	37,33
Ratio of beneficiaries older than 65 years	8.62%	3.32%	12.05%	19.97%	8.00%	37.28%	35.57%	53.04%	23.58%	89.10%	13.38%
Risk contribution per average member per month	2 246	2 172	3 285	5 328	4 226	5 983	6 995	9 142	2 583	5 520	3 986
Risk contribution per average beneficiary per month	1 097	1 070	1 607	2 530	1 728	3 352	3 519	5 924	1 608	4 578	1 894
Healthcare expenditure per average member per month	1 897	1 714	3 017	4 635	3 522	5 842	6 724	9 577	2 520	5 980	3 550
Healthcare expenditure per average beneficiary per month	926	844	1 477	2 201	1 440	3 273	3 382	6 206	1 569	4 959	1 687
Relevant healthcare expenditure as a percentage of risk contributions	84.4%	78.9%	91.9%	87.0%	83.4%	97.7%	96.1%	104.8%	97.6%	108.3%	89.1%
Non-healthcare expenditure per average member per month	345	350	357	331	374	353	381	344	337	296	358
Non-healthcare expenditure per average beneficiary per month	168	172	174	157	153	198	192	223	210	245	170
Non-healthcare expenditure as a percentage of risk contributions	15.35%	16.11%	10.85%	6.21%	8.85%	5.90%	5.45%	3.77%	13.06%	5.35%	8.98%

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%

OPERATIONAL STATISTICS FOR THE SCHEME

	2018	2017
Average accumulated funds per average member at 31 December	18 738	15 543
Average accumulated funds per average beneficiary at 31 December	8 895	7 367
Return on investments as a percentage of investments	6.10%	6.21%
Administration and other operative expenses as a percentage of gross contributions	6.05%	6.54%

PERSONAL MEDICAL SAVINGS ACCOUNT TRUST MONIES

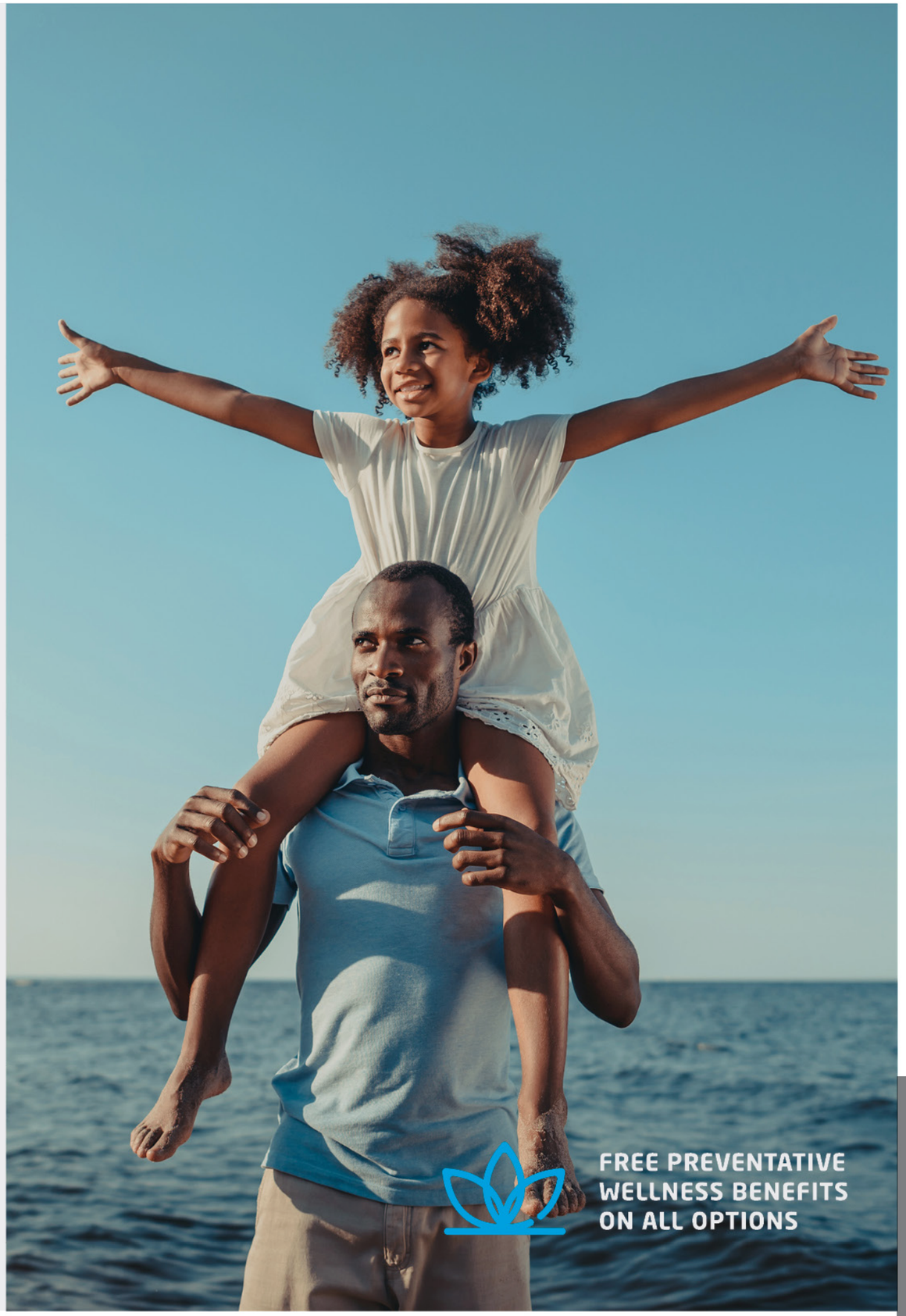
In accordance with the Rules of the Scheme, the personal medical savings accounts are underwritten by the Scheme.

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. 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 2018	
Cash and Cash Equivalents	
Current accounts	R200 332 418
Financial assests at fair value through profit or loss	
Money Market funds	R520 034 554
	R720 366 972



MATTERS OF NON-COMPLIANCE WITH THE MEDICAL SCHEMES ACT 131 OF 1998

NON-COMPLIANCE WITH SECTION 1 AND 20(2) OF THE MEDICAL SCHEME'S ACT

"No medical scheme shall purchase any insurance policy in respect of any relevant health services other than to reinsure a liability in terms of section 26(1)" This was highlighted by Circular 45 of 2018 that any such circumstances had to be rectified within 30 days of the date of the circular.

It was noted as part of Bestmed's International Travel policy with Bryte Insurance Company that some of the services under the policy does not relate to the business of a medical scheme as statement in section 1 and 20(2) or 26(1) of the Act.

An addendum to the policy was signed on 30 November 2018 in order to comply with circular 45 of 2018.

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 system enhancement only came into effect from 1 August 2018. Commission is now only payable on full receipt of the contribution received.

With regard to the "various inconsistencies in the commission data relating to the brokers and brokerage names and accreditation numbers", this anomaly only occurs with non-accredited brokers linked to accredited brokerages. The Scheme pays the commission over to the accredited brokerage only. The responsibility is that of the individual broker to obtain their accreditation from the CMS.

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

The Act stipulates that a benefit option shall be self-supporting in terms of membership and financial performance. During the year under review, six benefit options of the Scheme, namely Beat3, Pace2, Pace3, Pace4, Pulse1 and Pulse2 made a net healthcare deficit.

After accounting for other income, Beat3, Pace2, Pace4, Pulse1 and Pulse2 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 Sector Conduct Authority (FSCA). Registration number 44058. The FSCA required a guarantee of R1 million in terms of section 8(7) of the FSCA 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 were lodged with the Council in August 2017 and exemption was received on 10 April 2019, effective until 1 April 2020.

NON-COMPLIANCE WITH SECTION 35(8)(A), (C) AND (D) 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)(a), (c) and (d) of the Medical Schemes Act.

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. Pend reports are also reviewed by the claims supervisors to follow up on long outstanding pended authorisations with the relevant department.

NON-COMPLIANCE WITH REGULATION 6(1) AND SCHEME RULE 15.3 - CLAIMS TO BE SUBMITTED WITHIN 4 (FOUR) MONTHS

Regulation 6(1) of the Act states that: "A medical scheme must not in its rules or in any other manner in respect of any benefit to which a member or former member of such medical scheme or a dependent of such member is entitled, limit, exclude, retain or withhold, as the case may be, any payment to such member or supplier of service as a result of the late submission or late re-submission of an account or statement, before the end of the fourth month
a) from the last date of the service rendered as stated on the account, statement or claim; or
b) during which such account, statement or claim was returned for correction."

Furthermore Rule 15.3 of the Bestmed Rules states that: "In order to qualify for benefits, any claim must, unless otherwise arranged, be signed and certified as correct by a Member and must be submitted to the Scheme not later than the last day of the 4th (fourth) month following the month in which the relevant health service was rendered."

The Scheme continually evaluates and considers payments of stale claims. A stale claim policy is enforced, where the claims are investigated and decision made accordingly so as not to unfairly prejudice the members and service providers.

NON-COMPLIANCE WITH REGULATION 10(6) OF THE ACT - PMB PAID OUT OF 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 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 App to fund their co-payments.

The Bestmed App 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 CMS decided to initiate a further inspection in terms of section 44 of the Medical Schemes Act against Bestmed. The inspection addressed exactly the same subjects as the forensic investigation ordered by the Board of Trustees in 2015.

The Scheme still awaits the final report together with any directives from the CMS, after making a formal representation in February 2018. The final report will be attended to upon receipt.


4811
Registered
Oncology
patients receiving
treatment cover

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

bestMed

personally yours