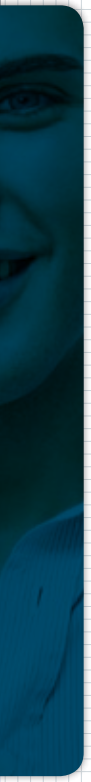
Bestmed Conference and Annual General Meeting 2013

bestMed

Better living. Better life.

Vision Statement

Bestmed shall be trusted as the medical scheme of first choice to access value-for-money lifestyle and preventative care benefits, and a healthcare offering that is unique in the market we serve.



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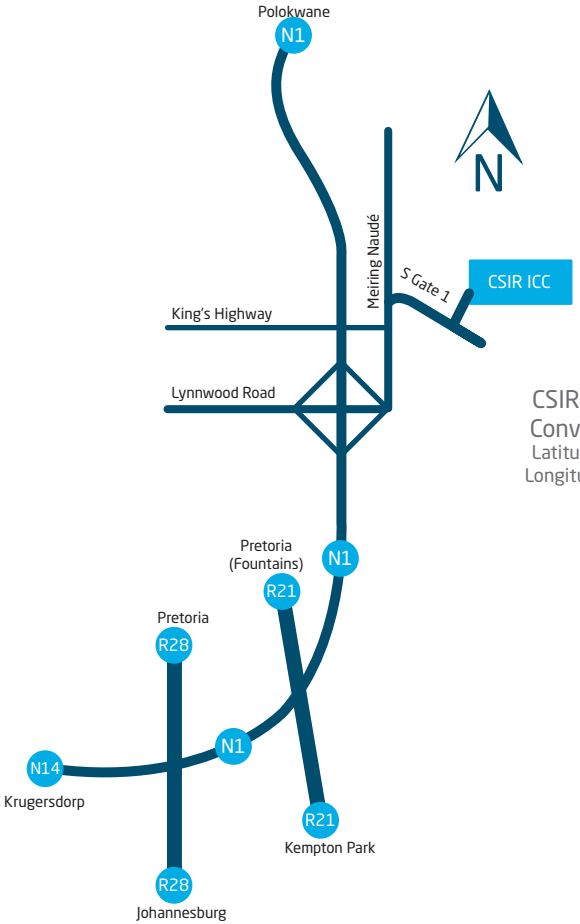
Programme

Programme for the 49th Conference & Annual General Meeting

08:00 - 08:30	Registration
08:30 - 10:30	Conference
10:30 - 10:45	Refreshment Break
10:45 - 11:30	Conference Resumes
11:30 - 11:50	Overview of 2012 and 2013
11:50 - 12:00	Comfort Break
12:00 - 13:00	Annual General Meeting
13:00	Lunch

Directions



CSIR International
Convention Centre
Latitude: S 25° 45.191'
Longitude: E 28° 16.649'

Agenda

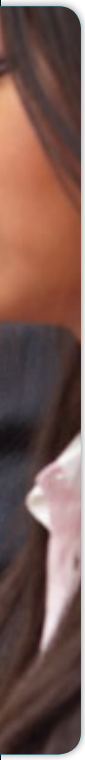
Agenda of the Forty-ninth Annual General Meeting

Notice is hereby given that the forty-ninth Annual General Meeting of members of Bestmed Medical Scheme will be held at 12:00 on Friday, 31 May 2013 at the CSIR International Convention Centre, Meiring Naude Road, Brummeria, Pretoria.

1. Opening by Chairperson
2. Finalisation of Agenda
3. Report of the Chairperson
4. Minutes of the previous Annual General Meeting held on 25 May 2012
5. Matters arising from previous Annual General Meeting
6. Financial statements and Auditor's Report
7. Appointment of Auditors for 2012/2013
8. Motions received in terms of Rule 26.1.5
9. Proposed amendments to the Rules of Bestmed
10. Other matters dealt with at an Annual General Meeting
11. Closure

Documents are printed in the language in which they were presented and submitted to the Registrar of Medical Schemes.

Minutes



Minutes of the forty-eighth Annual General Meeting of representatives of employers, employees and members held at 12:00 on Friday, 25 May 2012 at Sorex Estate, Centurion, Gauteng

1. Opening by Chairperson

1.1 Present

- 81 members
- 13 members of the Board of Trustees
- 2 special guests
- 2 representatives from Bestmed's auditors, PricewaterhouseCoopers

1.2 Apologies

Apologies had been received from Mr Willem Myburgh, Prof SA Strauss and Prof S Vil-Nkomo.

1.3 Opening by Chairperson

Adv JJ Labuschagne, 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 26.1.2 and more than 25 members being present to constitute a quorum.

He expressed his satisfaction that so many members had taken the trouble to attend the AGM. This was the occasion on which the Board of Trustees reported back publicly to members and other stakeholders on what had been attempted and accomplished the previous year, and the interest shown by those present was deeply appreciated.

He welcomed, in addition to the Scheme's members, representatives of the corporate employers affiliated to Bestmed, of the Council for Medical Schemes and of PricewaterhouseCoopers, the Scheme's auditors; the Chairperson of the Scheme's Audit Committee; and members of the Board of Trustees.

The year under review had been one of "the best of times", but it had also, for several weeks at the end of the year, been one of "the worst of times" (to quote Charles Dickens). However, the challenges had been overcome and a full report of the year would now be provided.

2. Finalisation of Agenda

No further items were added to the agenda.

3. Report of the Chairperson

The Chairperson stated that the Scheme's merger with TeleMed had proved highly successful. Further amalgamations would be pursued, provided they met the Board's criteria, in particular the non-negotiable requirement that members' interests were never jeopardised.

The Board had resolved that, in terms of governance, it would adhere to the King III report insofar as it applies to the operations of a mutual association such as Bestmed. Numerous steps, including downsizing the Board of Trustees from 20 to 12 members, had been taken to ensure that the Scheme's corporate governance was in line not only with King III, but also with best practice in the industry.

Bestmed had performed well within an uncertain economic environment, with reserves above 30%, membership up by over 7% and option contribution increases that compared favourably with industry averages. In addition, the Scheme's new brand identity had been very well received. Service delivery had, apart from the last three months of the year, been in line with Bestmed's usual high standards. These problems had been vigorously addressed and the required levels of service reinstated.

The Chairperson thanked his fellow Board members for their energy and wisdom in a year that had been, at times, challenging, and complimented the Principal Officer, his management team and the staff of both the Scheme and its administrator for their dedication and fortitude. He also thanked the Scheme's members for their loyalty and support.

The report of the Chairperson was accepted.
Proposed: Dr J Moncrieff
Seconded: Mr F Hurter

4. Minutes of Previous Annual General Meeting Held on 27 May 2011

The minutes of the forty-seventh Annual General Meeting were accepted as a true record of the proceedings and signed by the Chairperson.

5. Matters arising from Previous Annual General Meeting

There were no outstanding matters.

6. Financial Statements and Auditor's Report Highlights from the Statement of Comprehensive Income

Members' attention was drawn to the full set of financial statements provided in the Annual Report and the accompanying comprehensive notes.

Highlights from the statement of comprehensive income

The results for the year were, by and large, in line with the plan for 2011. Gross contribution income had increased by 14% compared with 2010. Benefit expenditure had also gone up by almost 13% and non-healthcare costs had increased by some 15%. The net healthcare result before adding investment income had decreased by 12%, although this still compares well with the 2009 deficit of some R30 000.

Investment income was considerably lower (60%) than in the previous year, mainly due to the

restructuring of the Scheme's investment portfolio in 2010, as a result of which there had been a sizeable inflow of realised gains.

Expressed on a "per member per month" basis, the monthly contribution and other income per member amounted to R2681, most of which (R2225 per month) was expended on benefits. Another way of expressing this is that 83% of every rand of the Scheme's income went back to members in the form of benefits.

Non-healthcare costs had increased by 15% due to increases in marketing expenditure, the development and piloting of the Scheme's wellness programmes and the cost of the IT recovery project.

Highlights from the statement of financial position

Two notable features of the statement of financial position were the increase in trade and other receivables (i.e. debtors) and the increase in short-term cash. Both of these were consequences of the administrator's shift to a different IT platform. On the liabilities side, the increase in savings account balances, in trade and other payables and in the claims incurred but not reported (IBNR), also reflected the shortcomings of the IT resources during the last quarter of the year.

In summary, members' funds (the equivalent in a listed company of shareholders' capital) amounted to R815 million.

Solvency

The solvency ratio at 31 December 2011 was 30%, compared with the statutory requirement of 25%.

Investments

The Scheme's investment strategy had been implemented 72 months ago with the aim of achieving a real return of 3% per annum above CPI over any rolling five year period. Although performance was somewhat weak during the 2011 financial year, with a real return of only 1.6% above CPI, the investments had delivered a return of 4,4% above CPI over the 72 months since inception of the portfolio.

Auditors' report

The auditors advised that they had no further comments to make to members on the financial statements, other than that some options had recorded a loss for the year, which was not in accordance with the Medical Schemes Act, 131 of 1998.

The meeting accepted the financial statements of the 2011 financial year.

7. Appointment of Auditors for 2012/2011

Committee to consider the appointment of auditors for the Scheme for the 2012/2013 financial year, and the Committee had again recommended that PricewaterhouseCoopers

be appointed. The Board of Trustees had unanimously accepted this recommendation.

A motion was made that PricewaterhouseCoopers be appointed as the Scheme's auditors for the 2012/2013 financial year. No objections were raised and the motion was accepted.

8. Motions Received in Terms of Rule 26.1.5

Rule 26.1.5 stipulated that a motion required the signature of the member concerned and the signatures of two supporting members. Four motions had been received, but they had all been signed only by the member making the motion. They had therefore been treated as enquiries, but in the interest of transparency the Principal Officer would provide feedback on these matters to the Annual General Meeting.

1. Mr CDN Hertzog (Membership No 4121031) requested that more dentists be added to the Prime Cure network. A course of action had been agreed upon and taken up with Prime Cure.
2. Mr MJ Thwala (Membership No 034519370) was to have presented a hospital account that he believed had not been paid, but he had not done so and it was assumed that the matter had been resolved.
3. Mr JA Louw (Membership No 1365487) had raised the issue of increases in medical schemes' subscriptions. A useful and comprehensive discussion had ensued prior to the AGM and the enquiry had been withdrawn.
4. Mr T Schmidt (Membership No 6118727) had asked the Scheme to review its PMB process. This was under way and Mr Schmidt's enquiry would be answered as soon as the required information was at hand.

It was observed that the Scheme's preference was to devote as much time as necessary to members' enquiries. Administrative issues such as these could not be dealt with adequately within the confines of an Annual General Meeting, and were best dealt with through the normal administrative channels.

9. Proposed amendments to the Rules of Bestmed

A number of amendments to the Rules, of a mostly cosmetic or routine nature, had been submitted in terms of the Medical Schemes Act to the Registrar, and all of these had been approved. Details of these were available on the Scheme's website.

10. Other Matters Dealt with at an Annual General Meeting

It was announced that the following persons had been appointed or elected to the Board of Trustees:

1. Individual members' representative. Only one nomination had been received, for Adv GW Alberts SC, and he had been declared duly elected for the period 2012 to 2016.
2. Employee representatives. Mrs Suzette Harmse had been re-elected and Mr Willem Myburgh had been newly elected. Their terms of office would be from 2012 to 2016.
3. Appointed members. Following the reduction in the number of Board members, six Trustees had been appointed by the Board:

From 2012 to 2016: Messrs B Albrechts, DJ Fredericks and AI Minnaar.

From 2012 to 2014: Dr BR Slabbert, Prof MJ van der Merwe and Prof S Vil-Nkomo.

The three remaining elected members, whose terms expired in 2014, were Adv JJ Labuschagne and Messrs AF Marais and P de V Swart.

Six members of the Board of Trustees had come to the end of their terms of office: Mr BA Bets, the Vice-chairperson of the Board for the past year, Mr GF Dempsey, Mrs A Hartzenberg, Mr CF Marais, Dr J Moncrieff and Prof SA Strauss, who had given Bestmed's Board sterling service for some 23 years. They were warmly thanked for their service to the Scheme and would be sorely missed.

11. Closure

The Chairperson thanked all those present for attending the meeting and for their interest in the affairs of the Scheme. He was confident that the year ahead would lift Bestmed to greater heights than ever before.

The proceedings concluded at 13:00.

Signed in Pretoria on this _____day of

_____ 2013.

Advocate JJ Labuschagne
Chairperson
Bestmed Board of Trustees

Report from the Chairperson

Report from the Chairperson

The General Healthcare Landscape

South Africa has always been a land of stark contrasts. The local healthcare landscape readily reminds one of this phenomenon, with nothing being more obvious than the existing chasm between the private and public healthcare sectors across all comparable areas of operation.

Our Government has decided, for better or worse, that the future lies in the creation of a system of National Health Insurance (NHI). Current thinking has it that private healthcare will coexist alongside the public healthcare sector which will be responsible for NHI. Economic realities certainly dictate that the present system of private healthcare should remain with us for a long time and that full implementation of the proposed NHI system might take up to 25 years or even longer.

The challenge of providing sustainable healthcare to the nation on an equitable basis in future will undoubtedly have to be shared by both the public and private healthcare sectors. To this end, increasing and effective co-operation and collaboration between the two are called for in an endeavour to bridge and close the present divide in the interests of national welfare.

The Medical Scheme Industry

For a number of years the industry has been experiencing a phase of consolidation, mostly characterised by amalgamations between schemes. This trend, which is more evident amongst open schemes, has seen the total number of schemes (open and restricted) in the industry diminish by approximately 20% over the last five or six years.

Although medical schemes are constantly striving towards optimising economies of scale, we believe that the consolidation being experienced in the industry has, to a significant extent, been driven by particular factors, amongst others:

- The applicable legislative framework governing the industry, which is restrictive of the ability of schemes to properly manage the risks they are obliged to assume. In this regard one is particularly mindful of statutorily entrenched features such as open enrolment, community rating, a burgeoning list of prescribed minimum benefits and the prohibition of risk underwriting;
- The complexity and cost of administering various benefit options whilst seeking to

remain sustainable as a third party funder of claims; and

- The relatively low number of lives covered, seen as a percentage of the population, and the small measure of annual growth in the number of lives covered.

The tide has inexorably been pushing towards the establishment of an increasingly socialistic private health dispensation. This approach is fraught with danger, especially in view of the lengthy time frame in which the NHI, realistically speaking, could be expected to become a fully functional reality. In our view Government shoulders the heavy responsibility of creating a legislative framework capable of ensuring an environment in which the sustainability and effectiveness of medical schemes are secured. The existing framework will probably not stand the test of time – for example, our economy is too small to support the comprehensive list of Prescribed Minimum Benefits (PMB's) which medical schemes are exposed to at ever increasing levels of cost.

Another factor is the sophistication of treatment. Put differently, the impact of PMB's on medical schemes under the present dispensation will ultimately render the baseline cost of healthcare cover too expensive to sustain.

In our view, medical schemes should be free to operate in an environment where risks are assumed and managed within a legislative framework which adequately recognises:

- Member behaviours and attitudes (rewards and penalties);
- Benefit offerings which are determined by operation of market forces rather than regulation;
- The right of third party funders to seek the best quality and cost-effective treatment on behalf of their members.

The Past Year

The financial period under review (2012) was an exceptional year in the life of Bestmed Medical Scheme. It was a year of change, consolidation and rejuvenation. This flowed naturally from the fact that the Scheme returned to self-administration and implemented an integrated distribution strategy.

I am also pleased to report that the Scheme was managed in accordance with an approved strategic plan and all necessary actions were taken to ensure the competitiveness and growth of the Scheme. The cost was managed downwards compared to the previous year and it will further reduce in the 2013 financial year.

The Board of Trustees adopted a new strategic framework, underpinned by nine strategic pillars, which we believe creates a solid springboard capable of propelling the Scheme upwards into the highest echelons of the industry over the medium term.

During the year, the Board also completed the bulk of its revision of governance structures and policies in order to ensure that the Scheme not only properly complies with all statutory and regulatory requirements, but also functions smoothly in line with King III and best practices where applicable.

It is pleasing to note that past business strategies have continued to strengthen the position of the Scheme in the market. During the past five years the Scheme membership has almost doubled in a relatively stagnant market whilst the reserve level has, on average, been retained well above the required 25% statutory threshold.

It is exciting to report that the 2011 introduction of the new Bestmed brand has been exceptionally well received by the market and has already succeeded in positively altering staid perceptions of Bestmed. The constant upward progression in terms of brand equity is now being reflected in new member registrations and enquiries for amalgamations and is ably supported by our sponsorship, corporate social investment and customer relations strategies, as well as our lifestyle and preventative care philosophy. Bestmed will continue with the concerted effort of establishing its new corporate identity as an aspirational brand.

Our brand values reflected in the market have also re-energised the employees of the Scheme and have become the focal point in driving and encouraging high performance, customer intimacy and living the Bestmed Touch. Our commitment to providing excellent service, redefining the Bestmed way of doing business and driving our vision of delivering affordable access to quality healthcare is unwavering and constitutes Bestmed's brand promise to the healthcare industry.

Other Contributors to our Success

Bestmed's strengthening brand has been considerably bolstered by the following additional considerations:

- The general experience of our members that our service has remained excellent, despite the operational hurdles and challenges faced during the year. Our corporate service programme and effective market communication are paying dividends and the Scheme's strategy of customer intimacy is embedding our position in the market as a solutions-driven organisation;
- The implementation of the Scheme's integrated distribution strategy is starting to deliver according to expectations. However, this strategic pillar will have to be considerably strengthened to extend our distribution footprint beyond traditional

broker networks in order to effectively meet future challenges;

- The Scheme's organic growth strategy has admirably succeeded in systematically reducing our exposure to the loss of Government employees as members to an acceptable level of less than 5%;
- Our service provider strategy is rapidly coming of age and we envisage that our expanded and improved relationships with service providers will effectively contribute to our vision of accessing quality healthcare for our members;
- Bestmed's conservative, yet highly effective, investment strategy remains a key factor in the ability of the Scheme to accommodate high cash coverage costs;
- We have outperformed the industry normative profile in terms of service delivery costs, and this remains a key focus area for the future in our quest to drive down non-healthcare costs.

A Smaller Board

A new Board structure was approved and implemented during 2012. The size of the Board was reduced from 20 to 12 members. The smaller Board is more streamlined and has facilitated speedier decision-making. We fully intend implementing further steps to enhance the effectiveness of the Board.

Amalgamations

Amalgamations present potentially great opportunities for the growth of membership of the Scheme. With amalgamations, accumulated reserves and the claims history are transferred to the Scheme, which assists in substantially mitigating the claims risk which is assumed (as opposed to new members recruited without a claims history. Bestmed has been in serious discussion with a number of Schemes who are seeking amalgamation opportunities. In this regard our broad strategic intent is to create a more viable risk pool and the strategic element of growth serves to build a sustainable risk profile which will enable the Scheme to become a more dominant role player in the industry.

The proposed amalgamation with Sappi Medical Scheme was approved by the Board during 2012 and is scheduled for implementation at the outset of the second quarter of 2013. All indications are that Bestmed will engage with more schemes in this regard.

We Remain True to Our Vision

The Bestmed Board of Trustees is committed to the strategic imperative we set ourselves. The Vision statement as mentioned on the Index page, serves as our driving force in designing and enhancing our strategic pillars and implementing our business plans for the next three to five years. We endeavour to uphold good governance and remain true to our philosophy of being a Scheme for our members, run by our members.

Bestmed has created a new operational department which ultimately aims to:

- Cement relationships with service providers and to conclude contracts with them;
- Continuously conduct research into new protocols and treatments.

Building a Culture of Innovation for a Competitive Edge

The Bestmed philosophy of adding value for our members is supported by an information technology and process re-engineering mind-set aimed at driving a self-service environment. We believe that an empowered customer is a loyal customer and this philosophy has underpinned Bestmed's success in the healthcare industry. Much effort will be invested in this area in future.

My sincere gratitude is conveyed to:

- Adv J J (Lappies) Labuschagne, my predecessor as Chairperson of the Board of Trustees, for his astute leadership and consummate diplomacy in piloting the Bestmed ship through troubled seas to calmer waters during the past two years;
- Fellow members of the Board of Trustees, for their unselfish commitment, dedication and loyalty to our medical scheme members, service providers, intermediaries and the employees of the Scheme;
- Our CEO, Dries la Grange, his management team and the Scheme's dedicated employees, for their unsurpassed loyalty and untiring resolve, tenacity and passion in serving Bestmed and all those associated with the Scheme;
- All our corporate customers and individual members, whose loyalty has made the Scheme the first choice for many and without whom Bestmed would not exist;
- Our service providers and other stakeholders, for their invaluable contributions in caring for the wellness of our members;
- Our broker fraternity, whose relationship with us we cherish and whose loyal support we deeply appreciate, for all their hard work.

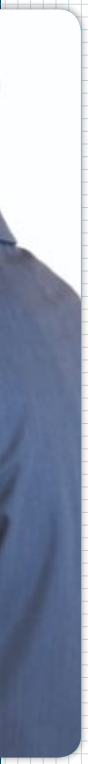
We look forward to the future with renewed confidence in the undoubted ability of Bestmed to rise to great heights, secure in the knowledge that our members will, true to the Bestmed Touch, always enjoy superior service delivered with absolute passion.

G W ALBERTS

CHAIRPERSON OF THE BOARD OF TRUSTEES

Highlights of the Financial Statements

The financial information in the Highlights document has been extracted from and is in agreement with the audited Annual Financial Statements. The full set of Annual Financial Statements will be available on the Bestmed website on 22 May 2013.



Statement of Financial Position

as at 31 December 2012

	2012 R	2011 R
ASSETS		
Non-current assets	**1,077,354,105**	966,671,528
Property and equipment	**22,169,271**	4,107,372
Investment property	**1,500,000**	1,800,000
Available-for-sale investments	**1,053,411,915**	960,393,769
Loans and receivables	**272,919**	370,387
Current assets	**320,226,167**	293,816,354
Loans and receivables	**610,785**	403,947
Trade and other receivables	**42,820,172**	43,048,868
Assets held for sale	**4,000,000**	4,000,000
Cash and cash equivalents	**272,795,210**	246,363,539
Total assets	**1,397,580,272**	1,260,487,882
FUNDS AND LIABILITIES		
Members' Funds	**882,446,059**	815,127,742
Accumulated funds	**781,336,281**	750,903,108
Revaluation reserves	**2,297,295**	2,297,295
Available-for-sale fair value reserve	**98,812,483**	61,927,339
Non-current liabilities	**17,441,080**	13,694,425
Retirement benefit obligations	**14,724,759**	13,694,425
Finance lease liability	**2,716,321**	-
Current liabilities	**497,693,133**	431,665,715
Savings plan liability	**306,418,246**	252,378,298
Outstanding claims provision	**89,475,503**	58,819,605
Trade and other payables	**101,799, 384**	120,467,812
Total funds and liabilities	**1,397,580,272**	1,260,487,882

Statement of Comprehensive Income

for the year ended 31 December 2012

	2012 R	2011 R
Risk contribution income	**2,351,196,065**	2,193,274,126
Relevant healthcare expenditure	**(2,038,111,862)**	(1,868,352,238)
Net claims incurred	**(2,032,377,113)**	(1,869,101,306)
Risk claims incurred	**(2,036,763,581)**	(1,874,034,826)
Third party claims recoveries	**4,386,468**	4,933,520
Net (expense)/income on risk transfer arrangements	**(5,734,749)**	749,068
Risk transfer arrangement premiums paid	**(84,650,899)**	(86,954,150)
Recoveries from risk transfer arrangements	**78,916,150**	87,703,218
Gross healthcare result	**313,084,203**	324,921,888
Managed care management services	**(44,193,400)**	(47,426,207)
Broker service fees	**(38,774,215)**	(33,503,231)
Administration expenses	**(249,426,429)**	(249,865,301)
Net impairment losses on healthcare receivables	**(1,738,740)**	(2,513,587)
Net healthcare result	**(21,048,581)**	(8,386,438)
Other income	**76,009,096**	64,808,920
Investment income	**72,076,528**	63,808,590
Other operating income	**3,932,568**	1,000,330
Other expenditure	**(24,527,342)**	(11,953,508)
Interest paid on savings accounts	**(12,130,487)**	(5,687,966)
Interest paid	**(246,372)**	-
Asset management fees	**(4,601,847)**	(6,165,542)
Other losses	**(7,548,636)**	(100,000)
NET SURPLUS FOR THE YEAR	**30,433,173**	44,468,974
Other comprehensive income	**36,885,144**	12,372,399
	36,885,144	17,312,399
Fair value adjustment on available-for-sale investments	**47,412,867**	24,259,091
Reclassification adjustment on realised gains	**(10,527,723)**	(6,946,692)
Land and building revaluation	**-**	(4,940,000)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**67,318,317**	56,841,373

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND RESERVES FOR THE YEAR ENDED 31 DECEMBER 2012

	ACCUMULATED FUNDS	REVALUATION RESERVE	AVAILABLE-FOR-SALE FAIR VALUE RESERVE	TOTAL MEMBERS' FUNDS
	R	R	R	R
BALANCE AS AT 31 DECEMBER 2010	706,434,134	7,237,295	44,614,940	758,286,369
Net surplus for the year	44,468,974	-	-	44,468,974
Other comprehensive income	-	(4,940,000)	17,312,399	12,372,399
Fair value adjustment on available-for-sale investments	-	-	24,259,091	24,259,091
Realised gains on available-for-sale investments	-	-	(6,946,692)	(6,946,692)
Revaluation of land and buildings	-	(4,940,000)	-	(4,940,000)
BALANCE AS AT 31 DECEMBER 2011	750,903,108	2,297,295	61,927,339	815,127,742
Net surplus for the year	**30,433,173**	-	-	**30,433,173**
Other comprehensive income	-	-	**36,885,144**	**36,885,144**
Fair value adjustment on available-for-sale investments	-	-	**47,412,867**	**47,412,867**
Realised gains on available-for-sale investments	-	-	**(10,527,723)**	**(10,527,723)**
BALANCE AS AT 31 DECEMBER 2012	**781,336,281**	**2,297,295**	**98,812,483**	**882,446,059**

SOLVENCY RATIO

	2012	2011
	R	R
Total members' funds per statement of financial position	**882,446,059**	815,127,742
Unrealised loss on revaluation of investment property in the statement of comprehensive income	**600,000**	300,000
Revaluation reserves	**(2,297,295)**	(2,297,295)
Available-for-sale fair value reserve	**(98,812,483)**	(61,927,339)
Bank guarantee as office renting deposit	**(2,465,605)**	-
Accumulated funds per Regulation 29	**779,470,676**	751,203,108
Gross contributions	**2,735,280,317**	2,486,060,428
SOLVENCY MARGIN (ACCUMULATED FUNDS/GROSS CONTRIBUTIONS * 100)	**28,50%**	30,22%

Operational Statistics per Benefit Option 2012

2012	Beat1
Members as at 31 December	3,372
Average number of members for the accounting period	3,060
Dependants as at 31 December	3,278
Average number of dependants for the accounting period	2,616
Average beneficiaries for the accounting period	5,676
Ratio of average dependants as at 31 December	0.85
Average age of beneficiaries for the accounting period	33,71
Ratio of beneficiaries older than 65 years	5.69%
Risk contribution per average member per month	1,303
Risk contribution per average beneficiary per month	702
Healthcare expenditure per average member per month	736
Healthcare expenditure per average beneficiary per month	397
Relevant healthcare expenditure as a percentage of risk contributions	56.5%
Non-healthcare expenditure per average member per month	325
Non-healthcare expenditure per average beneficiary per month	175
Non-healthcare expenditure as a percentage of risk contributions	24.98%
Net healthcare result	8,851,819
Net surplus (deficit) for the year	9,752,088

Beat2	Beat3	Pace1	Pace2	Pace3	Pace4	Pulse1	Pulse2	Total Scheme
12,736	6,599	20,137	11,216	7,055	4,504	5,839	1,413	**72,871**
11,154	6,610	19,895	11,223	7,328	4,782	7,640	1,489	**73,181**
12,661	6,793	28,670	10,782	8,411	3,611	4,826	596	**79,628**
10,937	6,932	28,583	10,904	8,786	4,048	6,248	654	**79,708**
22,091	13,542	48,478	22,127	16,114	8,830	13,888	2,143	**152,889**
0.98	1.05	1.44	0.97	1.20	0.85	0.82	0.44	**1.09**
28,99	35,93	33,68	47,89	44,53	51,28	32,43	69,26	**37,74**
2.66%	10.98%	5.17%	26.10%	20.57%	28.05%	7.32%	73.74%	**12.39%**
1,254	1,964	2,471	3,653	4,044	5,782	1,518	3,978	**2,677**
633	959	1,014	1,853	1,839	3,131	835	2,764	**1,282**
919	1,453	2,090	3,333	3,720	5,020	1,338	4,873	**2,321**
464	709	858	1,690	1,692	2,719	736	3,386	**1,111**
73.3%	74.0%	84.6%	91.2%	92.0%	86.8%	88.2%	122.5%	**86.68%**
332	359	406	395	421	452	325	358	**380**
167	175	167	200	191	245	179	249	**182**
26.44%	18.26%	16.43%	10.82%	10.41%	7.82%	21.40%	9.00%	**14.21%**
447,355	12,111,746	(5,919,720)	(10,067,643)	(8,535,711)	17,764,805	(13,313,630)	(22,387,602)	**(21,048,581)**
4,151,243	15,625,771	8,260,954	825,483	(446,419)	24,008,619	(10,694,516)	(21,050,050)	**30,433,173**

Operational Statistics per Benefit Option 2011

2011	Beat1	Beat2
Members as at 31 December	2,587	8,946
Average number of members for the accounting period	2,194	8,043
Dependants as at 31 December	1,341	5,400
Average number of dependants for the accounting period	1,928	7,268
Average beneficiaries for the accounting period	4,122	15,311
Ratio of average dependants as at 31 December	0.88	0.90
Average age of beneficiaries for the accounting period	33,38	29,20
Ratio of beneficiaries older than 65 years	5.53%	2.87%
Risk contribution per average member per month	1,179	1,138
Risk contribution per average beneficiary per month	627	598
Healthcare expenditure per average member per month	883	841
Healthcare expenditure per average beneficiary per month	470	442
Relevant healthcare expenditure as a percentage of risk contributions	74.9%	73.9%
Non-healthcare expenditure per average member per month	312	313
Non-healthcare expenditure per average beneficiary per month	166	164
Non-healthcare expenditure as a percentage of risk contributions	26.44%	27.46%
Net healthcare result	(425,725)	(1,490,578)
Net surplus (deficit) for the year	398,754	1,266,892

Beat3	BonusPlus	Millennium Comprehensive	Topcare	Best Platinum	BluePrint	Best Gold Select	Best Gold	Total Scheme
6,655	18,151	3,896	7,104	5,289	8,657	1,622	7,330	**70,237**
6,673	18,411	3,992	7,145	5,462	8,873	1,665	7,524	**69,982**
6,983	26,724	3,671	8,706	4,733	7,057	773	7,537	**72,925**
7,044	27,593	3,847	8,824	5,000	7,230	822	7,947	**77,503**
13,717	46,004	7,839	15,969	10,462	16,103	2,487	15,471	**147,485**
1.06	1.50	0.96	1.23	0.92	0.81	0.49	1.06	**1.11**
35,80	33,56	49,32	43,29	49,43	31,55	67,12	45,63	**37,89**
11.02%	4.99%	28.45%	18.47%	24.81%	6.33%	69.52%	22.44%	**12.46%**
1,799	2,301	3,370	3,649	5,297	1,347	3,699	4,000	**2,612**
875	921	1,716	1,633	2,766	742	2,476	1,945	**1,239**
1,379	1,895	2,887	3,412	4,588	1,155	4,684	3,174	**2,225**
671	759	1,470	1,527	2,395	636	3,136	1,544	**1,056**
76.7%	82.4%	85.7%	93.5%	86.6%	85.8%	126.6%	79.4%	**85.19%**
337	434	439	476	534	279	382	421	**397**
164	174	224	213	279	154	256	205	**188**
18.72%	18.84%	13.02%	13.05%	10.08%	20.70%	10.33%	10.52%	**15.20%**
6,607,231	(6,154,006)	2,116,073	(20,490,348)	11,493,763	(9,268,237)	(27,314,415)	36,539,804	**(8,386,438)**
10,011,316	4,806,212	5,947,469	(14,078,507)	20,753,587	(5,451,370)	(25,344,236)	46,158,860	**44,468,974**

Operational Statistics for the Scheme

	2012	2011
Average accumulated funds per average member as at 31 December	**R10,677**	R10,730
Average accumulated funds per average beneficiary as at 31 December	**R5,110**	R5,091
Return on investments as a percentage of investments	**5.43%**	5.29%
Managed care expenses as a percentage of gross contributions	**1.62%**	1.91%
Administration expenses as a percentage of gross contributions	**9.12%**	10.05%

Investments of the Scheme

MAIN CATEGORIES OF INVESTMENTS OF THE SCHEME AND THE AVERAGE RETURN PER CATEGORY

	FAIR VALUE AS AT 31 DECEMBER 2012	AVERAGE RETURN FOR THE 3 YEARS ENDED 31 DECEMBER 2012
Equity	135,679,796	13.6%
Linked Fund Policies	334,964,976	8.5%
Money Market Funds	314,254,960	6.8%
Bonds	147,502,605	11.5%
Collective Investment Schemes	67,527,330	5.5%
SA Listed Properties	26,920,595	13.6%
Foreign Bonds	26,561,653	13.6%
	1,053,411,915	**10.4%**

PERSONAL MEDICAL SAVINGS ACCOUNT TRUST MONIES

The Council for Medical Schemes granted the Scheme exemption until 31 December 2012 to comply with Circular 38 of 2011, clarified by Circular 5 of 2012 whereby members' Personal Medical Savings should be invested separately from the Scheme's investments'. The Scheme paid interest in 2012 on the balances in the Personal Medical Savings Accounts at the rate earned on cash and cash equivalents as required by the exemption granted. These Personal Medical Savings balances were transferred to Savings Trust accounts in January 2013.

Members' Personal Savings constitute trust monies and are managed by the Investment Committee of the Board of Trustees on the members' behalf in terms of the Scheme Rules. Interest earned on Trust Savings funds invested as Cash and Cash equivalents are allocated to members' Personal Medical Savings balances, and are not recognised as income for the Scheme.

Non-compliance with Medical Schemes Act

Non-compliance with Medical Schemes Act, 131 of 1998, as Amended

Profitability of benefit options – Section 33(2)(b)

The Act stipulates that a benefit option shall be self-supporting in terms of membership and financial performance. During the year under review five benefit options of the Scheme, namely Pace1, Pace2, Pace3, Pulse1 and Pulse2, made a net healthcare deficit. After accounting for other income only the Pace3, Pulse1 and Pulse2 options show a net deficit.

Contribution payments not received within three days of becoming due – Section 26(7)

In terms of Section 26(7) of the Medical Schemes Act, 131 of 1998, as amended, not all contributions were received within three days after payment thereof becoming due. The Scheme has policies and procedures in place to suspend membership if a payment is not received within three days of the due date.

Financial arrangements – Non-compliance with Section 35(6)(b) of the Act

The Scheme building (Marlands Township, Germiston) is still registered in the name of Posmed Medical Scheme. Posmed was a closed scheme under the former Department of Post and Telecommunications, and the scheme's name was changed to TeleMed in 1994. The Scheme is currently in the process of registering the building in the name of Bestmed Medical Scheme.

Financial arrangements – Non-compliance with Section 35(8) of the Act

The Scheme indirectly holds assets in administrators through its investment portfolio, which is prohibited by Section 35(8) of the Act. Subsequently the Scheme has obtained exemption during 2012 from this requirement from the Council for Medical Schemes.

Claims not paid within 30 days of receipt – Non-compliance with Section 59(2) of the Act

Instances occurred where claims were not paid within 30 days of receipt as required by the Act. This was during the implementation of a new administrator system, but subsequently the Scheme reverted to the previous system used.

Encumbered assets – Non-compliance with Section 35(6)(a) of the Act

The Scheme has a guaranteed amount of R2,397,100 in the bank account to the benefit of Hyprop Invest Ltd as an office renting deposit. An application for exemption will be submitted to the Council for Medical Schemes.

Brochures not agreeing to the Scheme rules – Non-compliance with Section 33(1)

There were differences between the option brochures for marketing purposes and the Scheme rules approved by the Registrar. The discrepancies were due to an administrative oversight and the Scheme has implemented additional controls to address this matter.

Broker fees paid before contributions are received – Non-compliance with Regulation 28(5) of the Act

Payments of commission to brokers are done monthly after receipt of the relevant monthly contribution from the member. Commissions were paid on contributions that were rejected and were "clawed back" from payments in the following month.

Commission paid to broker without written consent from member – Non-compliance with Section 65(1) of the Act

A brokerage has been compensated for a member who has no agreement with that brokerage. This was an isolated administrative oversight and systems and controls are in place to prevent a re-occurrence.

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