

| As at 02/28/2021 | Value | 1 Month (February) | YTD | Since Launch (ITD) |
|------------------|--------|--------------------|------|--------------------|
| Share | 185.00 | 1.9% | 4.2% | 99.9% |
| NAV | 183.79 | 2.4% | 5.0% | 102.2% |

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 28.02.2021, NAV and share price returns are adjusted for dividends paid during the period (but not assuming re-investment). Full performance data is on page 5.

Note: Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed.

Welcome to our February update. Spring is here, the mornings are brighter and most of the newsflow has been incrementally positive, even if the market was there already and continues to adjust its expectations around re-opening. All of this is as we hoped.

Nonetheless, there are still a myriad of issues to contend with that warrant caution. Whilst our tone this month is notably more constructive, we will not be rushing to transition the portfolio to a more 'risk-on' strategy. One can only hope our political leaders are similarly minded and do not squander the hard-fought gains of recent months.

Monthly review

The wider market

February saw a robust return to the pro-risk, re-opening-led narrative, with the broad MSCI World Index rising 6.3% in dollars during the first half of the month, once again making all-time highs. In something of a repeat of January's dynamic, the second half of February was trickier, as the spectre of faster than expected inflation pressured bond prices. The index gave up ~1.8% of the gains over the final two weeks to close up 4.6% in dollar terms (0.7% in sterling). As Carville famously said, everyone is intimidated by the bond market.

In terms of sub-sectors, the picture was again the pro-cyclical pro-recovery stocks that led (Energy, Consumer Services, Media and Transportation), alongside those obvious interest rate beneficiaries (Banks, Diversified Financials and Insurance companies). Technology hardware was the worst performer, alongside those classical defensives with their own bond-like qualities (Pharma & Biotech, Food Retailers and Utilities).

To our minds, it does rather feel that the market is lacking an over-arching narrative now, up here in the thinner air of record valuations and an increasingly clear picture on the cadence of the consumer recovery in major markets. As Europe's resurgent pandemic case load is showing us (discussed further below), the overall earnings outlook risk seems very much to the downside for the broader market.

Healthcare

Given the reversal of the 'risk-off' narrative from January, it is no surprise that healthcare lagged February's broader market rally, declining 2.8% in dollars (4.5% in sterling). Some might be surprised that healthcare underperformed during the second-half sell-down. This is not as strange as it might seem; almost half the healthcare Index is mega-cap pharma and biotechnology. These are often owned as dividend income plays (surely we can all agree that GSK is about as uninteresting and predictable as a fixed-income security) and tend to do badly when the market is upwardly re-pricing the yield curve.

The healthcare sub-sector performance is summarised in Figure 1 below. As noted above, the Mega-Cap pharma and Biotechnology companies (within our Diversified Therapeutics and Conglomerates categorisations) were the primary drag on the index performance and frankly there were few bright spots, save for Dental where we again saw beats across the sector as consumers continued to tweak their Zoom smiles.

In case the prior comment has prompted you to wonder about Botox sales, then the answer is yes; like Dental, Abbvie's management noted its surprise at a rather v-shaped recovery in this product line over H2 2020. For all those media articles about how the pandemic will prompt introspection, allowing

Summary

BB Healthcare Trust Ltd is a high conviction, unconstrained, long-only vehicle invested in global healthcare equities with a max of 35 stocks. The target annual dividend is 3.5% of NAV and the fund offers an annual redemption option. BB Healthcare is managed by the healthcare investment trust team at Bellevue Asset Management (UK) Ltd.

humanity to eschew the material and re-focus on what truly matters, it seems we are indeed vain creatures at heart.

There may be other factors at play as well though; one of our conversations with a UK Dental practice last month revealed a material increase in hygienist appointments in recent weeks amongst the elderly; the dentist being one of the few places still open for "a trip out". These are strange times indeed.

BENCHMARK SUB-SECTOR PERFORMANCE AND WEIGHTINGS

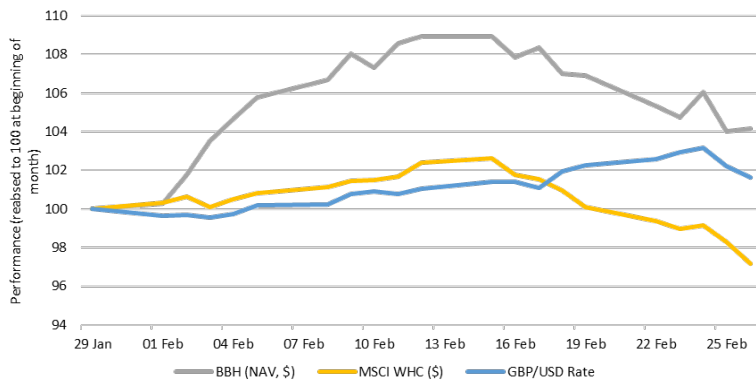
| Sub-Sector | Weighting | Perf. (USD) | Perf. (GBP) |
|--------------------------|-----------|--------------|--------------|
| Dental | 0.8% | 5.7% | 4.0% |
| Healthcare Technology | 0.8% | 3.8% | 2.1% |
| Facilities | 1.1% | 1.6% | 0.0% |
| Other HC | 1.3% | 0.8% | -0.7% |
| Med-Tech | 15.5% | -1.7% | -3.0% |
| Managed Care | 8.5% | -1.9% | -3.4% |
| Diagnostics | 2.7% | -2.5% | -4.0% |
| Services | 2.6% | -3.2% | -4.7% |
| Tools | 8.2% | -4.1% | -5.6% |
| Conglomerate | 12.5% | -4.4% | -5.9% |
| Diversified Therapeutics | 33.5% | -5.5% | -6.9% |
| Distributors | 1.2% | -5.9% | -7.4% |
| Healthcare IT | 1.9% | -9.2% | -10.6% |
| Generics | 0.6% | -12.2% | -13.6% |
| Index perf. | | -2.8% | -4.5% |

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 31-01-21. Performance to 28-02-21.

The Trust

It was another positive month for our strategy in terms of relative and absolute performance; the Trust's NAV rose 2.4% to 183.79p, outperforming the MSCI World Healthcare Index by 6.9%. The evolution of the NAV over the month is illustrated in Figure 2 page overleaf. Like the wider sector and market, we lost a significant amount of both relative and absolute performance in the market sell-off over the second half of the month.

Our NAV evolution did benefit modestly from M&A, with Jazz Pharmaceuticals proposed acquisition of GW Pharmaceuticals, which was one of our largest holdings at the time. It is difficult to disaggregate the contribution of this to our performance with any certainty, since we commenced selling down our position over the month and reinvested the money elsewhere. With that caveat being made, we estimate the positive impact at 2-300bp, so this was not the sole driver of our outperformance during the period. The continued strengthening of sterling was a meaningful headwind for the majority of the month.



Source: Bloomberg and Bellevue Asset Management (UK) Ltd.

The evolution of our sector weightings is illustrated in the table below (Figure 3). The main active allocations were to reduce Focused Therapeutics (exiting Esperion and materially selling down our holdings in GW Pharmaceuticals post the deal announcement) and adding to both Medical Technology and Services through new positions. We actively reduced our exposure to Diagnostics, but this was offset by continued strong performance.

EVOLUTION OF PORTFOLIO WEIGHTINGS

| | Subsector end Jan 21 | Subsector end Feb 21 | Change |
|--------------------------|----------------------|----------------------|-----------|
| Diagnostics | 7.6% | 7.7% | Increased |
| Diversified Therapeutics | 15.9% | 16.7% | Increased |
| Focused Therapeutics | 36.2% | 32.4% | Decreased |
| Healthcare IT | 3.6% | 5.2% | Increased |
| Managed Care | 11.5% | 11.3% | Decreased |
| Med-Tech | 15.3% | 15.9% | Increased |
| Services | 6.3% | 6.9% | Increased |
| Tools | 3.7% | 3.8% | Increased |
| | 100.0% | 100.0% | |

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 31-01-21. Performance to 28-02-21.

Excluding the Alder ADR, the investment portfolio increased from 29 stocks to 30, as described above. Our Med-Tech focus continues to be at the acute end of the acuity spectrum, especially on interventional cardiology. We have also diversified geographically, with one of our new positions being another Chinese company. We continue to actively seek exposure to this dynamic and fast-growing market, but will not compromise on our valuation and due diligence framework in order to achieve this.

We again deployed a significant amount of capital over the month, but a combination of fund inflows, the sell-down in the GW stake and the reduction in the value of the invested assets over the second half of the month as the market sold off somewhat blunted the optics around these efforts; cash declined from 8.9% of total assets at the end of January to 6.6% at the end of February.

We continue to plan for a gradual work-down of the cash pile over the coming months, the cadence being set by the variables described in the next section of the factsheet. We issued 8.4m shares via the tapping programme during February.

Managers' Musings

"It is a capital mistake to theorise before one has data"

Once more, the meanderings of the pandemic continued to be both the dominant narrative for markets and the primary focus of our conversations with investors. It is again that delicate balance of potential salvation and consequent normality driven by the impressive celerity of vaccination

programmes in some regions (the US, UK, Israel and several Middle Eastern countries) versus the struggles in others (chiefly the EU) and the inevitable and inexorable onward march of variants (more on this anon).

Sentiment-wise, our glass continues to re-fill from its previous half-empty starting point at the turn of the year. Whilst we grow ever more optimistic on a relative basis, we are still more chary than complacent, since the pervasive narrative continues to be one of faultless execution. Let us hope this is the case, for nothing would bring us greater joy than to be proven unduly cautious and similarly, to have the confidence to view the pantheon of healthcare investment opportunities with approbation rather than abeyance.

As noted last month, we will continue to be guided by the availability of data, and by this we mean robust, peer-reviewed data presented in credible journals, not the soundbites of politicians or the media, who (to continue the Sherlock Holmes quote in the title above) seem to have a tendency to twist facts to suit theories, instead of theories to suit facts. Let us begin with a brief canter through the key developments this month, to aid understanding of our evolving position.

"Education never ends... it is a series of lessons, with the greatest for the last"

Let us begin with vaccines and start with the good news. The year began with some testy spats over vaccine availability, with the EU having to admit that centralised procurement had not gone smoothly, causing delays to vaccine deliveries in the EU. The lack of deliveries to less developed nations via the COVAX initiative was feeling increasingly morally uncomfortable, but at least offered President Macron some grandstanding opportunities ahead of the upcoming G7 meeting in the UK to distract from his domestic depredations.

But a few weeks on, we are in a situation where another vaccine is approved in the US (J&J's single shot) and another likely by May (Novavax). As a consequence, the US is likely to have more vaccines than it needs by mid-year.

As of month end, around 78 million doses have been administered in the US, and there are another 50 million doses in the system (i.e. already delivered by manufacturers and ready to be given to patients). 52 million have received their first dose and 26 million of those have also received their second dose. Another 200m+ are potentially available for delivery and could be distributed by June. In total, this amounts to enough vaccine for 200m people to complete the programme (recall that the J&J shot is only one dose).

There are 209 million people over 18 in the US, only 54 million over 65s and 116m over 50s. Even with the risk of delays, the US is now looking in a very strong position in terms of vaccine availability, prompting President Biden to promise that every American who wants a vaccination can have one by July 2021.

The Global Alliance for Vaccine's COVAX programme for developing nations has pledged for c1.3bn doses (out of a total GAVI programme of 2bn). The first shipment was delivered in February (0.5m doses of the Oxford/Astra vaccine that were manufactured in India) and the first dose from this batch was administered in Ghana this week. It is expected that ~250 million doses will have been shipped to recipient countries by May and the over-supply situation in the US and likely too the UK by that point could result in a material acceleration in deliveries as we move into the summer. The more people are vaccinated, the quicker the pandemic is likely to be brought under control.

Regular readers will be aware that we have been sceptical around the casual presumption that SARS-CoV-2 vaccines will have a material impact on transmission, arguing that the available clinical data met the burden of proof only in respect of them protecting the recipient of the jab. We maintain the view that robust quantitative evidence on reduced transmission is still wanting, but the totality of qualitative evidence that some benefit exists is becoming unarguable.

The effect may be small (or it may be significant; we think it too early to get down from that particular fence), but any effect is clearly positive in helping to reduce the overall infection rate. However, one must remember that the primary driver of the overall (i.e. population level) and now-slowing reduction in infections here in the UK is the lockdown, not the vaccination programme and it was inevitable that cases would stabilise at a certain point and then rise as restrictions ease.

As this happens, the important metric is morbidity, not cases, but it is probably wishful thinking that the UK media might apply such a common sense approach to reporting on “the great re-opening”; the next few days will be very telling in that regard.

Now for the less positive news. As we cast an eye across the channel to our friends in Europe, it's a mess. There is no room here for Brexiteer schadenfreude if that is one's endemic disposition: we are too closely linked to the EU to not be worried about the region as a residual pool of infection and variant development. Last week, the total number of reported cases rose in the majority of the EU (Spain being the notable exception), and the tendency has been for restrictions to be extended rather than eased. In addition, vaccine hesitancy seems to have grown, as evidenced by an alarming disparity in doses shipped to countries versus given to citizens.

Perhaps worse, the supra-national co-ordinated effort is fracturing, with various countries choosing to ‘go it alone’ and procure vaccines directly. This may include more countries opting for the Russian and Chinese vaccines not approved at an EU level (Hungary is using the Russian vaccine). In a borderless zone, continued co-ordination of the response is critical.

As we have noted before, you cannot “unscare” people and those in positions of power and influence need to be very careful with their words. Negative comments from the President of France on the Oxford/Astra jab and lukewarm endorsements from Angela Merkel were very widely reported and now there is a perception that this is an inferior jab, even as real-world data on its material protective effect from a single dose pours out of the UK on a weekly basis. Instead of forcefully addressing this issue, the bloc seems hell-bent on developing vaccine passports/certificates to allow us all to get our dose of Mediterranean sunshine. The mind boggles.

As noted above, the data on transmission reduction is still unclear. The vaccinated may well be desirous of a week in Benalmadena but they could still import new strains of SARS-CoV-2 as the global diaspora once again intermingle, which might squander the gains made from successful vaccination programmes like our own. Having been through the interminable pain of this third lockdown, we do not understand why the UK borders are not closed for the remainder of 2021. We want to go back to normal as well, but rushing this process before we have answers to significant questions around the variants is foolish.

“No man burdens his mind with small matters unless he has some very good reason”

The first quarter is always a busy time for us on the administrative side of the Trust. We tend to do a number of investor meetings and we must prepare our contributions for various annual reports. Inasmuch as we enjoy these interactions, we have been rather downbeat versus other commentators in recent weeks and it is rarely a pleasurable experience to be either the recipient of, or conduit for, disappointing news. A common refrain has been along the lines of “surely now you can say the worst is behind us”. However, Bojo boosterism is not in our job description and we will continue to call it how we see it; planning for the worst and hoping for the best.

What trivial travails ail us? After all, we have vaccines aplenty and cases are falling. This is indisputably good. However, it was not more than three months ago that the NHS became overwhelmed and this will surely happen again at Christmas; it almost always does. We see no confidence as yet amongst the NHS leadership to reinstate the 20,000-odd beds taken out of the system to allow spatially distanced care, so we will again be less well positioned to cope with winter demand than, say, 2019.

If the burden is COVID cases rather than flu or just a harsh winter, then we may see another lockdown. If social distancing measures are largely eased, we will see a resurgence of flu. This was notably absent during the 20/21 winter season and will add to the burden on the NHS, as will its ever lengthening waiting lists. At some point, untreated minor ailments can become serious enough to drive up emergency admissions, further compounding the pressures on the system.

The reasonable discussion is not whether or not there will be a fourth wave of infections to this pandemic; that seems a certainty. The important questions are 1) when? and 2) how symptomatic will it be? The answer to both of these questions is tied up in the circulation of so-called “variants of concern”.

Before we delve further into this topic, it bears repeating that such variants are not necessarily more harmful in terms of morbidity and mortality and puerile phrases such as “mutant COVID” are unhelpful to say the least. We will also take as read the comments on variants from last month's factsheet around the different strains and the impact of them on vaccine effectiveness. Suffice to say that it is negative. The other important question is: 3) what can be done about this?

Not the ‘flu

When it comes to the emergence of variants, the optimist may take solace from the annual influenza vaccination programme: ‘we have a new vaccine every year, tailored to the current strains and they don't need any clinical trials’ they might say. As elementary as this may seem, coronaviruses and influenza viruses are not the same and there is much that we need to understand about SARS-CoV-2 and the immune response to it in order to manage a variant vaccination programme.

We know the ‘flu virus pretty well at this point, in terms of where strains emerge and when they might become prevalent from a human disease burden perspective. The ‘flu vaccine usually contains three or four strains of inactivated virus, selected based on data from year-round influenza virus gene sequencing in more than 100 countries and co-ordinated by the World Health Organisation.

The flu virus comes in many different sub-forms within four main families (A to D) and it mutates quickly through poor replication (it has no “proof-reading” step in its replication process) and sub-unit swaps that occur during co-infection (this is known as re-assortment). As such, these different strains can have material differences in physical structure, which is why people can end up being susceptible to these new strains and why we need to continuously update the vaccination: the immune system recognises three dimensional shapes.

It is also worth pointing out that the ‘flu vaccine does not have fantastic efficacy. In a good year, it is estimated to be around 65% protective and, despite mass vaccinations, society has accepted that influenza will kill around 500,000 people globally in an average year. Influenza pandemics arise every 30-50 years, usually when we see a new Influenza B sub-unit re-assortment and deaths can be much higher if this is not spotted early enough to allow the new virus to be included in the vaccination.

Why does flu still kill so many, despite excellent pathogen surveillance and generally good vaccine development? The answer to this question lies in the functional ability of the immune systems in the very young and the very old (they work less well) and in the reality that the strains may be sufficiently different to allow the virus to avoid the most potent immune response, but not so different as to prompt the creation of a new one.

Let us try to explain the latter point using our previous analogy of the US military's DEFCON system. The initial military response is proportionate, so a low level threat gets a low level response. Only when we move up to a higher level of alert do the big guns and special forces get deployed. If the viral pathogen is similar enough looking to a previous one that has been successfully repelled, then the same tried and tested response will be activated.

However, if the virus has changed just enough that the antibodies produced against it are no longer able to disable replication, the attack will continue to some degree. In this way, we end up with a much lower level of protection. Only if the pathogen is viewed as completely new will the threat level increase to the point where new antibodies are created. This partial blindness of the immune system is known as the Hoskins Effect or colloquially as “original antigenic sin” (which sounds much cooler, we agree).

Now let's bring this back to SARS-CoV-2. This virus evolves slowly, much more slowly than 'flu. In large part, this is because it has an error correcting proof-reading step in its replication machinery. The mutation of the virus is a random process that could generate both positive and negative effects on the virus' ability to infect other cells and reproduce. Environmental factors will thus decide which mutations persist and become prevalent. This is known as natural selection.

Sometimes though, the environment changes in such a way as to drive natural selection in a particular direction. For example, genes that help a plant cope with drought will propagate through the population during a drought, through disproportionate survival versus other genotypes.

If we think about the pandemic, it began with the strain that emerged in China, known as Wuhan-1 or W1. In the first wave of SARS-CoV-2, the virus was new to us all and thus it could spread easily since it takes a few days for the immune system to ramp up its response. The mutations that propagated during the initial waves were those that helped the virus spread more easily (so called virulence traits). The first of these to be widely discussed in the media was called “D614G” (which is a code for the substitution of the amino acid Aspartate ('D') for Glycine ('G') as the 614th amino acid in the spike protein of the virus).

This change was found to enhance both infectivity and the stability of the virus inside the human environment and soon became the dominant form of SARS-CoV-2 globally. As we have commented before, there are thousands of variants, but most amino acid substitutions do not convey any benefit to the virus and are thus ignored by scientists (and thus politicians and the media).

One year on, we have 15%+ of the population that have natural immunity from prior exposure and a growing proportion who have been vaccinated against the W1/D614G virus strains. It logically follows that the selection pressure/drive will be now in favour of those mutations that allow the virus to evade the antibodies created by vaccination or prior exposure as well as any new virulence traits.

Natural selection being what it is, these variants will evolve spontaneously all around the world. Closing borders may thus slow their march to global dominance (and buying time to evaluate new vaccine strategies is important), but it will not stop them. They are inevitable, as we describe below.

For now, there are three particular changes that make for variants of concern: N501Y, E484K, K417N (or K417T). N501Y is a mutation that conveys increased transmissibility and is a feature of the “Kent” (B.1.1.7) and “South Africa” (B.1.3.5.1) variants of which you have heard so much about and appears to have arisen spontaneously in both regions (in case you were wondering, these two strains are not considered the same because the Kent strain also has an amino acid deletion at another location, but that is inconsequential).

The South Africa variant is also widely associated with the E484K mutation, which reduces the effectiveness of antibody binding. E484K has also spontaneously arisen within the B.1.1.7 lineage here in the UK, and has been referred to as both the “Liverpool” and “Manchester” variant. Finally, we have the K417 mutation ('N' or 'T'), which further reduces the effectiveness of antibodies made against the W1/D614G viral strains. As a consequence, the co-occurrence of mutations at both the 501 and 417 positions can reduce vaccine efficacy by more than half.

“How small we feel with our petty ambitions and strivings in the presence of the great elemental forces of Nature”

What is to be done? Logically, one should select a strain that includes all three mutations (so P.1 from Brazil, or some of the lineages of B.1.3.5.1 from South Africa) and use this to create a variant vaccine. And this is exactly what Pfizer/BioNTech, Oxford/Astra and Moderna have been doing. Pfizer and Astra have said they expect to be in the clinic with their variant boosters in the “spring” and Moderna announced in late February that it was ready to start testing its modified formulation. The game is afoot, as Holmes would say.

Because they are prevalent in less developed countries who are further behind with vaccinations, we do not yet have enough data to know if infection with the P.1. and B.1.3.5.1 strains in those who have been vaccinated with the current offerings can result in serious morbidity, so variant boosters may not even be necessary - let us hope this is the case. However, even in the more recent trials that have taken place in South Africa (e.g. Novavax), the number of participants who had prior COVID-19 is too small to draw meaningful conclusions as yet, so we must await the next round of data.

Assuming that variant boosters might be needed after all, the forthcoming clinical trials should be able to tell us by Summer what the best strategy for the future will be – a separate booster shot, a change to the current vaccines or a mix of the old and new sequences together. Once we have this data, an approval for emergency use should come quickly, as vaccine safety is already well established.

On the positive side, we could know the answer sufficiently quickly to allow distribution of new shots in time for the 2021/22 winter respiratory disease season. On the negative side, one cannot rule out that the Hoskins effect will come into play and the body will not make new antibodies if it has previously been exposed to W1/D614G strains either naturally or via prior immunisation.

Coming back to the next wave of the virus: if it occurs in the winter and we are sufficiently ready then no matter. Similarly, if it occurs earlier and does not feature a high prevalence of the 501 and 417 mutations, then it may be a largely silent wave, thankfully bereft of a spike in hospitalisations and deaths.

If it comes sooner and is driven by these variants, then it may be more serious but again we do not have enough data yet on the protection offered by prior exposure to know for sure. How do we delay this as long as possible? Continued social distancing and significant limits on international travel spring to mind, hence our caution on a rapid return to what we all fondly remember as normality.

“The question is what can you make people believe you have done”

In summary, we are in a more positive place than we were three months ago and the positive news continues to outweigh the negative. However, we are cognisant of “known unknowns” and these clearly represent downside risk scenarios so we are still somewhat cautious and will continue to monitor these developments very closely.

Consumer sentiment is both fickle and fragile and the way all of this plays out in the media will likely have a significant impact on people's willingness to re-engage with pre-COVID norms. Likely as not, headlines about variants will be dominating our news for some time to come.

We always appreciate the opportunity to interact with our investors directly and you can submit questions regarding the Trust at any time via: shareholder_questions@bbhealthcaretrust.co.uk

As ever, we will endeavour to respond in a timely fashion. We thank you for your support of BB Healthcare Trust.

Paul Major and Brett Darke

Standardised discrete performance (%)

| | 1 year Feb 20 - Feb 21 | 2 years Feb 19 - Feb 21 | 3 years Feb 18 - Feb 21 | since inception |
|---------------------------------|---------------------------|----------------------------|----------------------------|--------------------|
| 12-month total return | | | | |
| NAV return (inc. dividends) | 38.5% | 39.1% | 79.3% | 102.2% |
| Share price | 35.5% | 29.8% | 70.5% | 85.0% |
| Share price (inc. dividends) | 39.1% | 35.0% | 81.0% | 99.9% |
| MSCI WHC Total Net Return Index | 11.2% | 22.0% | 38.2% | 56.2% |

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 28.02.2021

NAV return and share price returns are adjusted for dividends paid during period where started (but not assuming reinvestment)

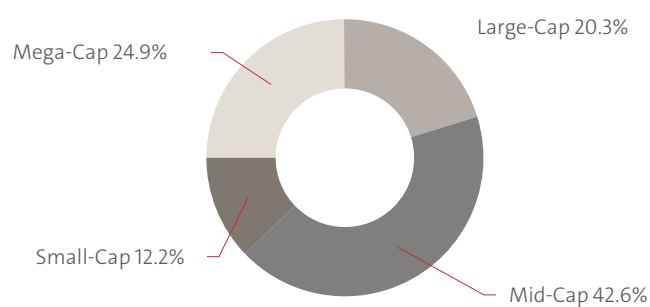
Note: Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed

TOP 10 HOLDINGS

| | |
|-------------------------|--------------|
| Bristol Myers Squibb | 7.5% |
| Vertex Pharmaceuticals | 6.5% |
| Jazz Pharmaceuticals | 6.1% |
| Insmed | 5.6% |
| Hill-Rom Holdings | 5.5% |
| Anthem | 5.0% |
| Alnylam Pharmaceuticals | 4.9% |
| Genmark Diagnostics | 4.2% |
| Bio-Rad Laboratories | 3.8% |
| Humana | 3.5% |
| Total | 52.6% |

Source: Bellevue Asset Management, 28.02.2021

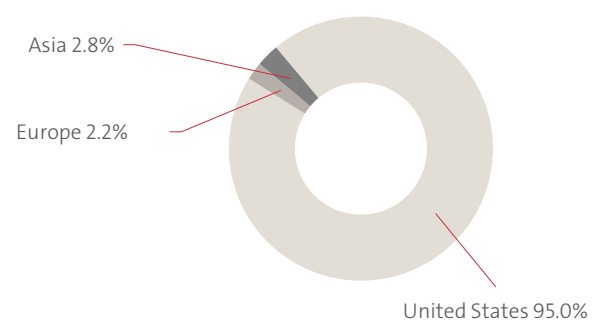
MARKET CAP BREAKDOWN



Source: Bellevue Asset Management, 28.02.2021

"Mega Cap >\$50bn, Large Cap >\$10bn, Mid-Cap \$2-10bn, Small-Cap <\$2bn."

GEOGRAPHICAL BREAKDOWN (OPERATIONAL HQ)



Source: Bellevue Asset Management, 28.02.2021

INVESTMENT FOCUS

- The BB Healthcare Trust invests in a concentrated portfolio of listed equities in the global healthcare industry (maximum of 35 holdings)
- Managed by Bellevue group ("Bellevue"), who manage BB Biotech AG (ticker: BION SW), Europe's leading biotech investment trust
- The overall objective for the BB Healthcare Trust is to provide shareholders with capital growth and income over the long term
- The investable universe for BB Healthcare is the global healthcare industry including companies within industries such as pharmaceuticals, biotechnology, medical devices and equipment, healthcare insurers and facility operators, information technology (where the product or service supports, supplies or services the delivery of healthcare), drug retail, consumer healthcare and distribution
- There will be no restrictions on the constituents of BB Healthcare's portfolio by index benchmark, geography, market capitalisation or healthcare industry sub-sector. BB Healthcare will not seek to replicate the benchmark index in constructing its portfolio

DISCLAIMER

BB Healthcare Trust PLC (the "Company") is a UK investment trust premium listed on the London Stock Exchange and is a member of the Association of Investment Companies. As this Company may implement a gearing policy investors should be aware that the share price movement may be more volatile than movements in the price of the underlying investments. **Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed. An investor may not get back the original amount invested.** Changes in the rates of exchange between currencies may cause the value of investment to fluctuate. Fluctuation may be particularly marked in the case of a higher volatility fund and the value of an investment may fall suddenly and substantially over time. This document is for information purposes only and does not constitute an offer or invitation to purchase shares in the Company and has not been prepared in connection with any such offer or invitation. Investment trust share prices may not fully reflect underlying net asset values. There may be a difference between the prices at which you may purchase ("the offer price") or sell ("the bid price") a share on the stock market which is known as the "bid-offer" or "dealing" spread. This is set by the market markers and varies from share to share. This net asset value per share is calculated in accordance with the guidelines of the Association of Investment Companies. The net asset value is stated inclusive of income received. Any opinions on individual stocks are those of the Company's Portfolio Manager and no reliance should be given on such views. This communication has been prepared by Bellevue Asset Management (UK) Ltd., which is authorised and regulated by the Financial Conduct Authority in the United Kingdom. Any research in this document has been procured and may not have been acted upon by Bellevue Asset Management (UK) Ltd. for its own purposes. The results are being made available to you only incidentally. The views expressed herein do not constitute investment or any other advice and are subject to change. They do not necessarily reflect the view of Bellevue Asset Management (UK) Ltd. and no assurances are made as to their accuracy.

FIVE GOOD REASONS

- Healthcare has a strong, fundamental demographic-driven growth outlook
- The Fund has a global and unconstrained investment remit
- It is a concentrated high conviction portfolio
- The Trust offers a combination of high quality healthcare exposure and targets a dividend payout equal to 3.5% of the prior financial year-end NAV
- BB Healthcare has an experienced management team and strong board of directors

MANAGEMENT TEAM



Paul Major



Brett Darke

GENERAL INFORMATION

| | |
|---------------------------|--|
| Issuer | BB Healthcare Trust (LSE main Market (Premium Segment, Official List) UK Incorporated Investment Trust |
| Launch | December 2, 2016 |
| Market capitalization | GBP 938.1 million |
| ISIN | GBO0BZCNLL95 |
| Investment Manager | Bellevue Asset Management (UK) Ltd., external AIFM |
| Investment objective | Generate both capital growth and income by investing in a portfolio of global healthcare stocks |
| Benchmark | MSCI World Healthcare Index (in GBP) - BB Healthcare Trust will not follow any benchmark |
| Investment policy | Bottom up, multi-cap, best ideas approach (unconstrained w.r.t benchmark) |
| Number of ordinary shares | 507 095 455 |
| Number of holdings | Max. 35 ideas |
| Gearing policy | Max. 20% of NAV |
| Dividend policy | Target annual dividend set at 3.5% of preceding year end NAV, to be paid in two equal instalments |
| Fee structure | 0.95% flat fee on market cap (no performance fee) |
| Discount management | Annual redemption option at/close to NAV |

CONTACT

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