EST 1964

BCIMA

Medical Aid

THE BUILDING AND CONSTRUCTION INDUSTRY MEDICAL AID FUND

2020

MEMBER BROCHURE

Universal Administrators

Administered by Universal Healthcare Administrators (Pty) Ltd

2020

October 2019

A Message From Your Medical Aid Fund

The past year has been exceptionally difficult for the building and construction industries, with a number of large employers in the industry having to close their doors, or reduce their operations. The Fund has felt the negative impact, with a reduction in membership, and an increase in mental health claims due to financial and relationship stressors.

The Fund has also experienced a number of high cost cases for hospital admissions, with hospital cost being 16.25% more than the previous year. There has been significant increases on all the claims categories, and the claims paid is 16% more than the previous year. As at the end of August 2019 the total amount for claims were R 85 734 931.

On an annual basis the Board of Trustees, with the help of a healthcare actuary, consider the contribution increases and benefit limits for the next year. It is important that the Fund must remain financially strong in order to provide members with benefits for years to come, yet the financial position of members need to be considered.

Contribution Increase

For 2019 the contribution increase was 7%, which was significantly less than the industry increases and salary/wage increases. Due to the significant increase in claims the Board agreed to an increase of 7.5% for 2020. Although this is higher than normal inflation, it is still much less than medical inflation and the increases the Fund experienced in claims costs.

BCIMA has an income based contribution table, and in the band where the largest number of BCIMA members are, the contribution increase calculates R 139 per month per family.

Your Employer will complete and submit the monthly wage schedule, as contributions are paid in accordance with the actual earnings of each individual. Employee Annual contributions are structured over 48 weeks/12 months. These contributions allow for cover throughout the year and cover for the 4 week holiday period.

Benefit Limits

BCIMA offers generous benefit limits to members, with an average 5.4% increase on all limits for 2020.

To highlight some of the benefits:

- Emergency Transport Service through Netcare 911. The member will not be liable for any short payments if authorised with Netcare 911, as we have an agreed tariff rate with them. When you have a medical emergency please call 082 911. Assistance and advice is just a phone call away through Netcare 911's Health-on-Line, a 24-hour Emergency Operations Centre which provides emergency as well as non-emergency telephonic medical advice to members, and dispatch an ambulance if it is clinically indicated.
- LifeSense – the HIV/aids disease management programme: Members are reminded to contact LifeSense for HIV related issues. You can call 0860 506 080 – 24hrs a day; your query will be logged and a case manager will be in touch with you as soon as possible.
- Hospital benefit R 422 000 per member family
- Annual Day to Day limit R 19 000 per family, with various sub-limits (please refer to the limits within the booklet)
- Chronic Medication benefit R11 300 per family

Personal Information Update Form

Included is the Personal Information Update Form, please complete and return to us as soon as possible. Please use this opportunity to update any information with BCIMA that might be outdated, this will ensure that you receive important information regarding your fund. Please also indicate your race and provide your Tax Reference number – this is a requirement from Government.

Fraud

In 2019 the Fund were informed of incidents where certain members and providers were allegedly involved in fraudulent activities. Please keep in mind – it is fraud to give your card to your friends or co-workers to obtain benefits such as glasses or medicine! If you as a member become aware of any fraudulent activities by a provider or a member, please contact the anonymous-secure-confidential Vuvuzela hotline on Toll Free number: 080 111 447. The case will be investigated and the appropriate action taken.

Please remember – do not take money or any other non-medical incentives from any provider! This is fraud. Providers are only allowed to provide you with medical treatment.

SMS – call back system

Remember to use the sms call back system to assist you.

Simply sms the word “CALL” followed by your membership number (e.g. CALL 1234567) to 47975 and one of our agents will call you. The sms line is open from 7h00 to 19h00 during weekdays and from 8h00 to 13h00 on Saturdays.

As we set ourselves to leap into a new year, we trust that we can only do so with you, our loyal member. 56 years on… We remain committed to offering the best quality and affordable healthcare.

Warm Regards,
BCIMA Fund

BCIMA 2020
Benefits

ANNUAL LIMITS	
LifeSense HIV Programme	Unlimited
Hospitalisation	**R 422 000** per family, per year
Annual Limit: Day-to-day expenses	**R 19 000** per family, per year
Chronic medicine Benefit paid according to RP	**R 11 300** per family, per year

HOSPITALISATION	
Hospitalisation	**R 422 000** per family, per year at 100% of the agreed tariff
Pre-authorisation required	R 1 000 levy if not pre-authorised
IN-HOSPITAL AND DAY CLINICS THE FOLLOWING SERVICES ARE COVERED, INCLUDING ALL RELEVANT ACCOUNTS:	
• Ward fees - General, ICU, High Care • Theatre fees • Medication (while in hospital) • Surgical procedures • GP and specialist visits • Surgical prostheses • Oncology • MRI and CT scans • Electronic/nuclear appliances and/or prostheses, subject to prior approval by the Board of Trustees and hospital limit	• Dentistry (in-hospital procedures, subject to pre-authorisation) • Clinical technologists • Radiology • Pathology • Confinements: normal births • Caesarean sections • Home confinements - by arrangement • Blood transfusions • Renal dialyses • Psychiatric treatments - 21 days per family per year
PRIVATE NURSING	
Private nursing	100% of the agreed tariff - if pre-authorised Limited to 60 days per condition
AMBULANCE SERVICES – EMERGENCY TRANSPORT	
Netcare 911	100% of the agreed tariff - subject to hospital limit

IMPORTANT:
As BCIMA is a low-cost fund, The Registrar of Medical Schemes has granted the Fund exemption in respect of the provision of prescribed minimum benefits (PMBs). However, the Fund pays for PMB treatments at BCIMA Tariffs, subject to the annual limits.

ANNUAL LIMIT	
Annual Limit	Day-to-day limits apply R 19 000 per family, per year
PLEASE NOTE: ALL SUB-LIMITS ARE SUBJECT TO THE ANNUAL LIMIT	
MEDICINE	
Acute (prescribed medication) Benefit paid according to RP	80% of cost Member R 6 400 M+ 3 R 8 900 M+ 1 R 7 300 M+ 4 R 9 900 M+ 2 R 7 900 M+ 5+ R 11 400
Pharmacy-advised therapy (PAT) or Over-the-counter medication (OTC)	100% of cost Single R 1 750 or Family R 2 900 Subject to R150 per script, per beneficiary, per day
Homeopathic remedies	80% of cost
GENERAL PRACTITIONERS/SPECIALISTS (out-of-hospital)	
Visits and consultations	100% of the BCIMA Tariff Member R 4 300 M+3 R 7 400 M+1 R 5 200 M+4 R 8 500 M+2 R 6 300 M+5+ R 9 600
Non-surgical procedures	100% of the BCIMA Tariff - subject to annual limit
DENTISTRY	
Conservative: fillings, scaling & polishing, extractions, etc.	100% of the BCIMA tariff - subject to annual limit
Specialised: crowns, bridgework, orthodontics, periodontics, prosthodontics, plastic dentures, maxillo-facial, oral surgery, etc.	100% of the BCIMA tariff - R 5 700 per family per year
OPTICAL	
Eye tests	100% of the South African Optometric Association (SAOA) Rates
Spectacles or contact lenses	R 3 900 per family, per year
Frames	R 650 maximum (included in optical limit)
Refractive eye surgery	Subject to optical limit and the South African Optometric Association (SAOA) criteria
SURGICAL AND MEDICAL APPLIANCES	
Hearing aids, wheelchairs, crutches, glucometers, etc.	100% of the Agreed tariff - R 4 200 per family per year
OTHER SERVICES (Annual Limit for day-to-day)	
Chiropractors	100% of the BCIMA tariff; subject to day-to-day
Naturopaths and homeopaths	100% of the BCIMA tariff; subject to day-to-day
Speech, occupational therapy and audiology	100% of the BCIMA tariff; subject to day-to-day
Chiropodists (feet)	100% of the BCIMA tariff; subject to day-to-day
Pathology and X-rays	100% of the BCIMA tariff; subject to hospital limit
Physiotherapy	100% of the BCIMA tariff - 20 treatments per condition
Psychiatric treatments	R 4 200 per family, per year
Traditional healers	R 1 400 per family, per year

Managed Care Programmes and Services
Chronic Medicine Management

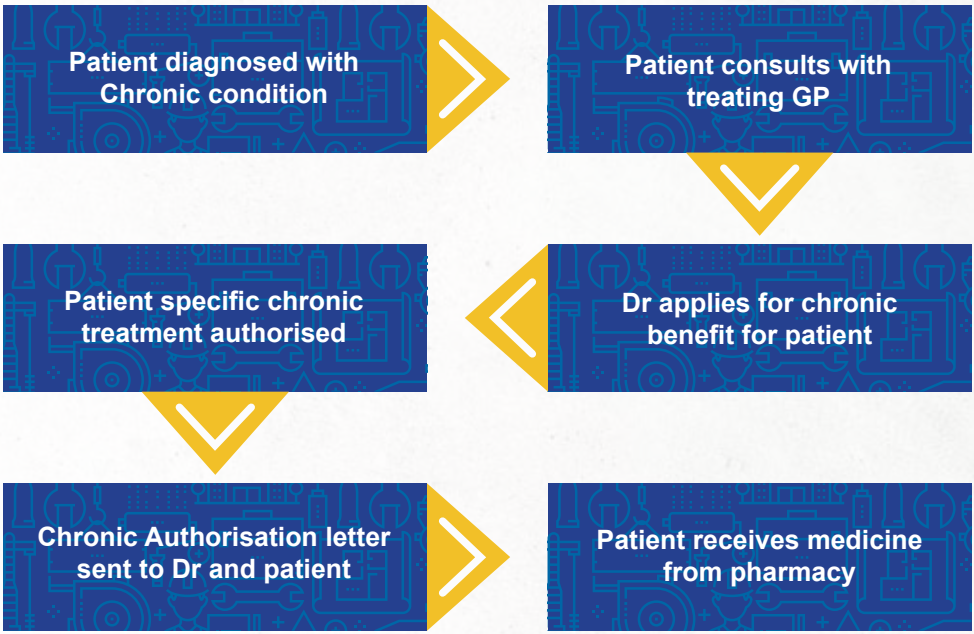
To apply, register and update chronic conditions and chronic medicines for the chronic medicine benefit.
Telephone: **011 208 1005** follow the voice prompts for chronic medicine
Fax: **086 210 8743**
Email:chronicmedicine@universal.co.za

What is the Chronic medicine benefit?
BCIMA offers a chronic medicine benefit to fund medicines used for the treatment of chronic conditions.

What is a chronic condition?
A chronic condition is a condition that requires medical treatment on-going or long term for example Asthma, High Blood Pressure, High Cholesterol, Diabetes Mellitus etc. Medicines used to treat these chronic conditions are paid from the chronic medicine benefit.

How do I apply for chronic benefits?
* If your doctor has diagnosed you with a chronic condition, you doctor can apply for chronic benefits for you.
- The doctor will complete a chronic medicine application form with you.
- The completed application form and/or a copy of your recent prescription may be faxed or emailed to the Chronic medicine programme.
- Alternatively your doctor or your pharmacist may telephone the Chronic medicine programme directly to register your chronic condition.
- Your doctor should provide information on your clinical examination information and test results e.g. Blood pressure readings, lipogram test results, HbA1c or glucose results etc.
- The request for chronic medicine benefit will be reviewed by the Chronic medicine programme.
- The chronic programme will confirm whether the medicine your doctor has prescribed is on the formulary to treat your chronic condition. Medicines that are on the formulary for your chronic condition will be covered by the Fund, subject to your chronic medicine benefit limit.
- The outcome of your application will be communicated to you. If your chronic medicine is approved you will be sent an Authorisation letter that lists the medicines that will be funded as chronic.
- You may obtain your approved chronic medicines from your local pharmacy when your chronic medicines have been approved.
- Please ensure that you take a valid repeatable prescription with you when you go to collect your medication.

Chronic Medicine Process



What is a formulary?

A Formulary is a list of affordable medicines that your doctor prescribes for the management of your chronic condition.

How do I update my chronic medicine?

If your doctor changes your medication your doctor may call the Chronic medicine programme to update the chronic medicines or you may send a copy of the latest prescription by email or fax to the Chronic programme.

Where do I get my chronic medicines?

You may obtain your chronic medicines from your local pharmacy e.g. Clicks, DisChem, FirstCare PicknPay, MediRite, ScriptSavers, Medipost etc.

Do I pay a co-payment on my chronic medicine?

A co-payment may apply if you choose a medicine that has a cheaper generic equivalent. A generic medicine is one that contains the same ingredient, works the same way, has the same strength of ingredient and is equally effective as the original branded medicine. MMAP is the maximum medical aid price that a scheme pays for medicines that have a generic medicine. So please ask your doctor to prescribe generic medicines and ask your pharmacy to supply you with generic medicine that will be covered by the Fund.

You can avoid co-payments by the following:

* Using formulary medicines
* Using generic medicines within MMAP

Managed Care Programmes and Services
Oncology Management Programme

For patients who have been diagnosed with cancer to access the oncology benefits
Telephone: **011 208 1005** follow the voice prompts for oncology
Fax: **086 295 7307**
Email:oncology@universal.co.za

What is the Oncology Management Programme?

At BCIMA we understand that battling with cancer is a difficult and emotional experience. Our Oncology Management Programme offers members, diagnosed with cancer, information, education and support they need to manage their condition. With the incredible advancements that have been made and the current treatments available, cancer can often be beaten.

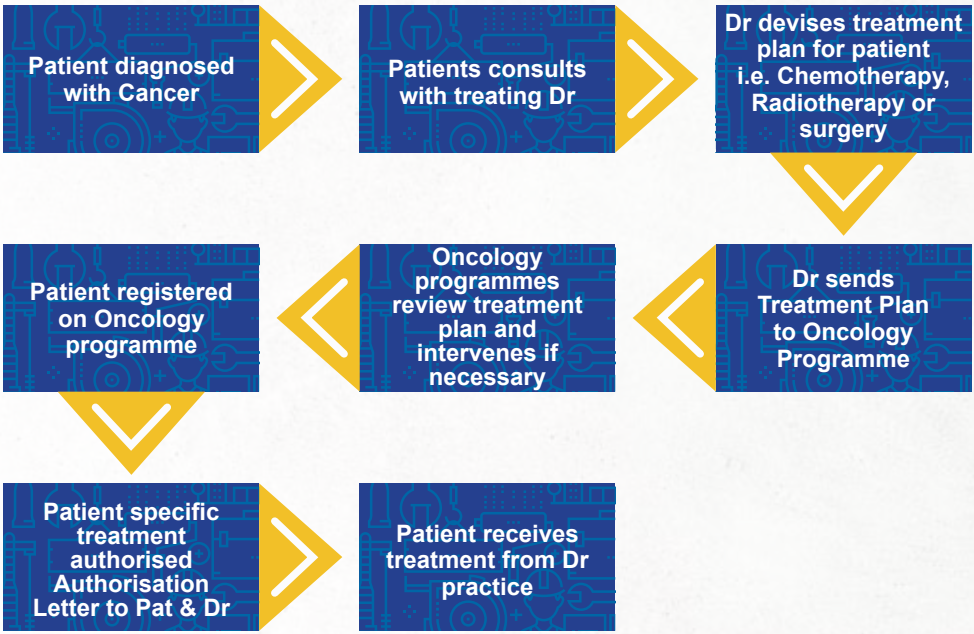
If you have been diagnosed with cancer, you must register on the Oncology Programme. By registering on the Oncology Programme, you will be able to access the Oncology benefits. Your oncology treatments will be reviewed by a medical professional and preauthorised from the oncology benefit.

You may also contact the Oncology programme for advice, support and education relating to your cancer and treatment.

How do I apply for Oncology benefits?

- It is important that your treating doctor contacts the Oncology programme as soon as you are diagnosed with cancer and that he/she registers you on the BCIMA Oncology Management Programme.
- Your doctor will devise a proposed treatment plan to treat your condition, which should be sent to the Oncology programme before treatment starts.
- The treatment plan should provide information such as the date of diagnosis, ICD-10 code, the area to be treated, any prior surgery or treatment plus history, new treatment requested, as well as results of any pathology, radiology or special investigations done. The treatment must also include the costs of the proposed treatment.
- The Oncology programme medical professional will review the treatment plan according to accepted treatment guidelines and protocols. If necessary, your doctor will be contacted to discuss more appropriate or less expensive treatments.
- Once the treatment plan has been approved, treatment can commence.
- An Authorisation letter will be sent to your treating doctor and to you. The Authorisation letter lists the treatment that will be funded from the oncology benefit.
- Most oncology treatment takes place on an outpatient basis either at the oncology or radiation practice.
- If your treatment changes, your treating doctor must submit a revised treatment plan to the Oncology programme for review and preauthorisation.

Oncology Process



What does the Oncology Benefit cover?

The Oncology benefit covers the following treatment relating to the cancer:

* Chemotherapy
* Radiotherapy
* Radiology such as X rays, MRIs, CT and PET scans relating to the cancer
* Pathology tests relating to the cancer
* Medicines related to cancer treatment
* Consultations with service providers relating to your cancer e.g oncologist, radiation oncologist. Any approved treatments will be funded from your overall hospital limit, subjects to the benefits available.

LifeSense
Disease Management Programme

Know your HIV status
Antiretroviral (ARV) medicines have been shown to be highly effective in the management of HIV (the Human Immunodeficiency Virus) and they have been made readily available in recent years. Studies show that HIV-positive individuals can live normal, productive lives with standard life expectancy, as long as their condition is appropriately medically managed. It is therefore recommended that all sexually active individuals go for an HIV test to determine their status. The HIV test is a simple blood test called the ELIZA test and it can tell whether you have been infected with HIV or not.

If you are HIV positive
If your HIV test is positive, it means you have been infected with HIV and you will need to have further tests to determine whether you require ARV treatment or not. These tests will inform you and your doctor of your CD4 cell count, which provides an indication of the state of your immune system and viral load, the amount of virus in your body.

It is recommended that those with CD4 cell counts below 350 should be started on ARVs. The aim of ARV therapy is to reduce the viral “burden” on the immune system. With successful, uninterrupted ARV therapy the viral replication should cease and the viral load become undetectable.

If HIV-positive individuals are started on ARVs before their CD4 count drops beneath 350 and their viral load remains undetectable, they may expect to live completely normal lives of average life expectancy.

Share your status
Opening up about your HIV status with your loved ones and appropriate healthcare professionals, will help you to begin normalising HIV, reduce stress and anxiety, and better ensure your ability to maintain uninterrupted adherence to your ARV treatment programme. In addition, it will allow you to seek the necessary support, information and acceptance from those around you and to better understand the condition.

BICMA members who have questions regarding HIV, should not hesitate to contact a professional Case Manager at LifeSense Disease Management. These case managers have years of experience and training to help you better understand HIV from both a medical and social viewpoint.

Confidentiality
LifeSense Disease Management maintains 100% confidentiality regarding your HIV status. Anything you share with us will be handled with the utmost confidentiality and will never be passed on to your employer, colleagues or family members without your consent. Your confidentiality is protected by both the South African Constitution and the Labour Relations Act (No 66 of 1995 chapter 5 section 91). In addition, chapter 8 section 185 of the Labour Relations Act protects your right to fair labour practice and from unfair dismissal.

What is the LifeSense HIV programme?
The LifeSense HIV programme has been developed by qualified doctors and medical professionals who specialise in the treatment and management of people living with HIV. The purpose of the programme is to assist you to maintain your adherence to your ARV treatment programme, overcome any barriers that may prevent adherence, coordinate and centralise your treatment and ensure that you are able to maintain a healthy, productive lifestyle.

What can I expect from the LifeSense programme?

- Counselling from experienced case managers.
- Advice on lifestyle management.
- Referral to healthcare providers who are specialists and experienced in HIV.

What medical benefits am I covered for when joining the LifeSense programme?

- Blood tests related to HIV doctor consultations.
- Antiretroviral medication and delivery to an address of your choice.
- Treatment of expectant mothers and mother and child.
- Post exposure prophylaxis (PEP) medication to prevent HIV infection if you are exposed to blood or body fluids.
- Management of TB (tuberculosis) for those who require it (as per scheme rules).
- Treatment may be altered on recommendation of our physician and treating doctor where patients are not responding, despite adhering to their treatment programme.

How to register on the LifeSense programme

- Contact LifeSense to verify if you qualify for HIV benefits.
- Once qualified you can go to any doctor of your choice with the LifeSense application form for the initial examination.
- You can either contact LifeSense to request the application form or you can download it from **www.lifesensedm.co.za.**
- Your doctor will complete the application form with you and fax or email it back to LifeSense.
- Based on the completed application form and blood results a drug treatment plan will be approved by our physician. Your medication will be delivered to your preferred address.

Contacting LifeSense

- Send an **SMS** to **37096** and LifeSense will call you back.
- Email your query and contact details to **enquiry@lifesense.co.za** and LifeSense will call you back.
- Call **0860 506 080**, 24 hours a day, seven days a week. Your query will be logged and a case manager will get in touch with you as soon as possible.

Netcare 911 - Emergency Services

Netcare 911 is a leading private emergency medical service provider in South Africa with an extensive footprint across all nine provinces and that serves patients with quality service. Netcare 911 is focused on sustainable service excellence, especially patient outcomes.

Recognising that technology is playing an increasingly important role in all aspects of emergency medicine, Netcare 911 is harnessing cutting-edge technologies, embracing international standards and best practice, as well as academically rooted methodologies. Netcare 911's helicopter and fixed wing aeroplanes can be dispatched, should it be required.

By dialling **082 911** from any landline or cellular phone, you and your dependants have access to excellent emergency medical care.

Points to remember when calling Netcare 911:

- Dial 082 911 if there is a medical emergency.
- Give your name and the telephone number you are calling from.
- Give a brief description of what the medical emergency is.
- Give the address or location of the incident as well as the nearest cross streets or other landmarks to assist paramedics to reach the scene as quickly as possible.
- Please, if possible, tell the Call Taker which medical scheme you belong to.
- Do not put the phone down until the controller as disconnected.

Health-on-Line – emergency telephonic medical advice and information

Assistance and advice is just a phone call away through Netcare 911's Health-on-Line, which provides emergency as well as non-emergency telephonic medical advice to members by qualified nursing sisters via the Netcare 911 24-hour Emergency Operations Centre and in accordance with current clinical best practice.

Emergency medical response by road or air from scene of medical emergency

Immediate response, using the most appropriate and closest road or air medical resource, staffed by doctors, nurses and paramedics administering instant, life-saving treatment, resuscitation and stabilisation.

Ambulance authorisation procedure

In all instances, where possible, call Netcare 911. In the case of an inter-hospital transfer, when you are admitted to hospital, please inform the admitting hospital that you are a Netcare 911 member and that any transfers must be done through **082 911**.

Report without delay!

Fraud is not new, but it is an ever changing problem in society that we need to address. In its continuous commitment of zero tolerance towards fraud, corruption and unethical behaviour, we have implemented a totally anonymous reporting facility, the Vuvuzela Hotline.

We are asking you to join the fight against fraud today by reporting:

- Illegal or fraudulent acts
- Corruption
- Unethical behaviour
- Misuse of funds
- Bribery
- Maladministration

The reporting options are:

Toll-free number:	**080 111 4447**	Callback No:	**072 595 9139**
E-mail:	**universal@thehotline.co.za**	(Please call me's)	
Website:	**www.thehotline.co.za**	Fax:	086 672 1681
WebApp:	**www.thehotlineapp.co.za**		

This anonymous and independently managed facility provides for a safe alternative to silence.

Vuvuzela HOTLINE
It's your call
anonymous - secure - confidential

Exclusions

IMPORTANT:
As BCIMA is a low-cost fund, The Registrar of Medical Schemes has granted the Fund exemption in respect of the provision of prescribed minimum benefits (PMBs). However, the Fund pays for PMB treatments at BCIMA Tariffs, subject to the annual limits.

1.1. Treatment arising out of an injury sustained by a member or dependant and for which any other party is liable. The member shall be entitled to such benefits for the service rendered, as would have applied under normal conditions, irrespective of the lapse of time. Where a member has recourse in terms of a third party claims, the member must refund the Fund for payments received from third parties in lieu of claims paid by the Fund for the injury/event. Where the member refuses to refund the Fund it constitutes unlawful enrichment and the Fund will reverse claim payments made in respect of the injury/event.

1.2. Treatment of an illness or injury sustained by a member or a dependant of a member, where in the opinion of the Board such illness or injury is directly attributable to failure to carry out the instructions of a medical practitioner.

1.3. Claims and expenses incurred by a member or dependant of a member in the case of or arising out of willful self-inflicted injury, will not be paid.

1.4. Claims and expenses incurred by a member or dependant of a member in the case of or arising out of professional sport, speed contests and speed trials will be paid, subject to annual limits only.

1.5. Medical examinations or inoculations initiated by employers or required by a member or a dependant of a member for statutory, employment or social purposes, including consultations, visits, examinations and tests for insurance, school camps, visas, employment or similar purposes.

1.6. Cosmetic and Treatment for Obesity:
- All costs for operations, medicines, treatment and procedures for cosmetic purposes and obesity, eg Bariatric Surgery, gastric bypass, slimming preparations and appetite suppressants; including tonics, slimming products and drugs as advertised to the public.
- Consultations and treatments as provided by General Practitioners and Dieticians as part of a conservative lifestyle based protocol will be paid subject to the Annual Limit.
- Keloid and scar revisions
- Sclerotherapy
- Operations or surgical procedures relating to jaw, ear, eyelids or any other cosmetic procedures

1.7. Dental:
- Bone Augmentations
- Bone and tissue regeneration procedures
- Crowns and bridges for cosmetic reasons and associated laboratory costs
- Enamel micro abrasion
- Fillings: the cost of gold, precious metal, semi precious metal and platinum foil
- Laboratory delivery fees
- Othognatic surgery
- Sinus lift
- Gum guards or mouth protectors

1.8. Holidays for recuperative purposes, accommodation and/or treatment in headache and stress relieve clinics, spas and resorts for health, slimming recuperative or similar purposes.

1.9. Treatment of infertility and impotence:
Investigations, operations and/or treatment whether advised for psychiatric or similar reasons in respect of artificial insemination and treatment for infertility. Including but not limited to: Assisted Reproductive Technology, In-vitro fertilization, Gamete Intrafallopian Tube Transfer, vasovasostomy (reversal of vasectomy) and salpingectomy (reversal of tubal ligation).

1.10. Medicine
- Medicines not registered with the Medicines Control Council and proprietary preparations;
- Applications, toiletries and beauty preparations;
- Homemade remedies;
- Alternative medicines;
- Bandages, cotton wool and similar aids; unless prescribed by a General Practitioner or Specialist.
- Patented foods including baby foods;
- Contraceptives and slimming preparations;
- Tonics as advertised to the public;
- Household biochemical;
- Vitamins, mineral supplements and herbal remedies;
- The purchase of medicine prescribed by a person not legally entitled to prescribe medicine;
- Purchase of chemist supplies not included in the prescription from a medical practitioner or any other person who is legally entitled to prescribe medicine. Provided that this excludes benefits payable under Pharmacy Advisory Therapy;
- Aphrodisiacs and/or any products to induce, enhance, maintain and promote penile erection or to address erectile dysfunction such as erectile appliances and drugs, including but not limited to Viagra.
- Anabolic steroids such as, but not limited to Deca Durabolin;
- Non-scheduled soaps, shampoos and other topical applications;
- Stop smoking products, such as but not limited to Nicorette, Nicoblock.
- Sun screens and tanning agents;

1.11. Mental Health:
- Sleep therapy and hypnotherapy

1.12. Optical:
- Sunglasses (lenses with a tint greater than 35%)
- Coloured contact lenses
- Corneal cross linking
- Phakic implants

1.13. Radiology and Radiography
- PET scans; unless pre-authorised by oncology management for the appropriate diagnosis, staging, the monitoring of response to treatment and investigation of residual tumour or suspected recurrence (restaging). Metastatic breast cancer.
- CT Colonoscopy.

1.14. Travelling expenses.

1.15. All costs in respect of sickness conditions that were specifically excluded from benefits when the member joined the Fund; as per waiting periods and exclusions applied as per the Medical Schemes Act.

1.16. Private Nursing Fees in respect of both mother and child in postpartum cases.

1.17. Cost of accommodation in respect of old age homes, and other custodial care facilities.

1.18. Alcoholism and drug addiction.

1.19. Charges for appointments which a beneficiary fails to keep.

1.20. Venereal Disease.

1.21. Injuries arising from parachute jumping or hang-gliding.

1.22. Uvulo-palatopharyingioplasty {UPPP}.

1.23. All costs that are more than the annual maximum benefit to which a benefit is entitled in terms of the Fund.

1.24. Costs for services rendered by –

- Persons not registered with a recognised professional body constituted in terms of an Act of Parliament; or
- Any institution, nursing home or similar institution not registered in terms of any law except a state or provincial hospital.

1.25. No member shall be entitled to any benefits or portion thereof, payable in terms of these Rules, where such benefit or portion thereof is recoverable by such member.

- Under the Compensation for Occupational Injuries and Diseases Act; or
- Are invalidated as claims under the Compensation for Occupational Injuries and Diseases Act through failure of the member to report the accident in the manner required; or
- Would have arisen if the member had been able to, and had made use of the facilities provided by the Employer at factories to treat the results of accidents at work, or
- Are covered by any ex-gratia compensation from the Employer; or
- From third party {including an insurance company registered under Act 29 of 1942} who is liable therefore;
- Any amount recovered or recoverable by the member or dependant as aforesaid in respect of any illness or accident must be disclosed by the member of the Fund.

1.26. Prosthesis and appliances:

- Where not introduced as an integral part of a surgical operation;
- Transcatheter Aortic Valve Implantation (TAVI);
- Replacement batteries for hearing aids or other devices;

2. LIMITATION OF BENEFITS

2.1. The amount payable in any one financial year, i.e. the period from **1st January** to **31st December** inclusive, shall be limited only to the extent of the separate maxima as set out in the relevant Annexures.

2.2. For the purpose of these Rules a claim shall be considered as falling within the financial year if the liability was incurred by the member or a dependant of a member within such financial year.

2.3. Beneficiaries admitted during the course of a financial year are entitled to the benefits set out in the relevant benefit option chosen, with the maximum benefits being adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular financial year.

2.4. In cases of illness of a protracted nature, the Board shall have the right to insist upon a member or dependant of a member consulting a particular specialist the Board may nominate in consultation with the attending practitioner. In such cases, if the specialist's advice is not acted upon, no further benefits will be allowed for that particular illness.

2.5. In cases where a specialist, except an eye specialist, is consulted without the recommendation of general practitioner, the amount of assistance to be rendered by the Society may, at the discretion of the Board, be limited to the amount that would have been paid to the general practitioner for the same service.

2.6. Unless otherwise decided by the Board – hospitalisation in respect of psychiatric treatment shall be limited to a stay of not more than 21 days per family in a calendar year.

2.7. Benefits for the following medication will be allowed if prescribed by a Dermatologist: Dianne and Roaccutane.

2.8. No claim shall be payable by the Fund if, in the opinion of the Medical Adviser, the health care service in respect of which such claim is made, is not appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition at an acceptable and reasonable level of care.

2.9. Not with standing the provisions of this Rule, the Board shall be entitled, but at no stage obliged, in its role and absolute discretion, to pay the whole or part of any account which may otherwise be excluded in terms of the Rules.

2.10. Unless otherwise decided by the Board, benefits in respect of medicines obtained on a prescription are limited to one month's supply for every such prescription or repeat thereof.

3. CONTRIBUTIONS

3.1. Hourly Rate and Monthly Paid Employees:

- Contributions for hourly rate of pay employees are due weekly, in arrears and payable no later than the second working day of the following week.
- Monthly paid employees' contributions are payable in advance and no later than the second working day of the month that the contributions are due.

3.2. Continuation members:

- Contributions are structured according to the gross monthly salary or pensionable earnings
- Contributions are payable in advance not later than the second working day of the month that the contributions are due.

4. WAITING PERIODS AND SPECIAL EXCLUSIONS

In terms of the criteria laid down by the Medical Schemes Amendment Act, the Fund may impose the following waiting periods:

4.1. A general waiting period of three months.

4.2. Twelve month exclusion on pre-existing medical condition/s, for that specific condition/s.

4.3. A administrative fee may be imposed upon a member according to the late joiner penalties, as described in the Medical Schemes Act.

5. ABBREVIATIONS AND DEFINITIONS

Agreed Tariff/ BCIMA Tariff	The National Health Reference Price List (NHRPL) of 2006 increased with inflation annually, or the Uniform Patient Fee Schedule (UPFS), or the contracted fee or negotiated fee, or the Universal Healthcare negotiated fee
DSP	Designated service provider
OTC	Over-the-counter medication
PAT	Pharmacy-advised therapy
PMB	Prescribed minimum benefits
SAOA	South African Optometric Association
RP	Reference Pricing
EXCLUSIONS	Claims not covered according to the rules of the Fund

6. IMPORTANT NOTICE

This is a summary of benefits that are applicable in terms of the rules of the Fund. A copy of the rules may be obtained from the administrator if so required.

The rules of the Fund will always take precedence over this summary.

Contribution Schedule for
Weekly and Monthly Paid Employees

Contributions payable per family, applicable as from January 2020.

Contributions payable per family, structured according to the employee's hourly rate of pay

WEEKLY CONTRIBUTION SCHEDULE			
CONTRIBUTION CODE	HOURLY WAGE BAND	50% OF CONTRIBUTION	WEEKLY CONTRIBUTION
01-As	R 1 - R 24.99	R 181.30	R 326.60
02-Bs	R 25 - R 26.99	R 197.15	R 394.30
03-Cs	R 27 - R 28.99	R 214.90	R 429.80
04-Ds	R 29 - R 31.99	R 231.65	R 463.30
05-Es	R 32 - R 48.99	R 249.15	R 498.30
06-Fs	R 49 - R 64.99	R 314.50	R 629.00
07-Gs	R 65 - R 81.99	R 358.30	R 716.60
08-Hs	R 82 - R 97.99	R 399.60	R 799.20
09-Is	R 98 +	R 455.85	R 911.70

Contributions payable per family, structured according to the employee's monthly salary

MONTHLY CONTRIBUTION SCHEDULE (Based on 48 weeks divided by 12 months.)			
INCOME BAND	MONTHLY INCOME BAND	50% OF CONTRIBUTION	MONTHLY CONTRIBUTION
01-Aa/Av	R 1 - R 4 332	R 725.20	R 1 450.40
02-Ba/Bv	R 4 333 - R 4 679	R 788.60	R 1 577.20
03-Ca/Cv	R 4 680 - R 5 025	R 859.60	R 1 719.20
04-Da/Dv	R 5 026 - R 5 545	R 926.60	R 1 853.20
05-Ea/Ev	R 5 546 - R 8 492	R 996.60	R 1 993.20
06-Fa/Fv	R 8 493 - R 11 265	R 1 258.00	R 2 516.00
07-Ga/Gv	R 11 266 – R 14 212	R 1 433.20	R 2 866.40
08-Ha/Hv	R 14 213 – R 16 985	R 1 598.40	R 3 196.80
09-Ia/Iv	R 16 986 +	R 1 823.40	R 3 646.80

Contribution Schedule for Continuation Members

Applicable as from January 2020

Payable monthly, in advance, per family

INCOME BAND	MONTHLY INCOME BAND	MONTHLY CONTRIBUTION
01 - Ac	R 1 - R 3 109	R 1 258
02 - Bc	R 3 110 - R 4 519	R 1 795
03 - Cc	R 4 520 - R 6 769	R 2 354
04 - Dc	R 6 770 - R 8 459	R 3 257
05 - Ec	R 8 460 - R 11 289	R 4 085
06 - Fc	R 11 290 - R 14 199	R 4 687
07 - Gc	R 14 200 - R 16 939	R 5 268
08 - Hc	R 16 940 +	R 6 020

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SMS the word ***"CALL"*** followed by your membership number (e.g. CALL 1234567) to 47975, and one of our agents will phone you within 24 hours.
07h00 - 19h00 weekdays
08h00 - 13h00 Saturdays

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Reg. No. 1974/001443/07

All information relating to the 2020 BCIMA benefits and contributions is subject to formal approval by the Council for Medical Schemes. On joining the Fund, all members will receive a detailed member brochure, as approved. The final registered Rules of the Fund will apply.

Universal Administrators

Administered by Universal Healthcare Administrators (Pty) Ltd