EST 1964
BCIMA
Medical Aid

THE BUILDING & CONSTRUCTION INDUSTRY MEDICAL AID FUND

BASIC OPTION

MEMBER BROCHURE

2023

Administered by Universal Healthcare Administrators (Pty) Ltd

Universal™

BCIMA Basic Option Benefits 2023

ANNUAL LIMITS	
LifeSense HIV Programme	Unlimited
COVID Admissions and Related Treatment	Unlimited PMB, subject to Pre-authorisation
Preventative Care Benefit	Unlimited, subject to Pre-authorisation
Hospital Limit	**R 1 000 000** per family, per year
Annual Limit: Day-to-day expenses	**R 22 200** per family, per year
Chronic Medicine Limit Benefit paid according to Reference Pricing (RP)	**R 13 300** per family, per year

PREVENTATIVE CARE BENEFIT	
Conservative Dentistry for beneficiaries under 6 years of age	100% of the BCIMA Tariff
Mental Health Benefit	1 Clinical Psychologist Consultation per beneficiary, per year.
Health-on-Line Assistance	Call 082 911 - 24h-hour Emergency/Non-Emergency Telephonic Medical Advice and Information

HOSPITAL LIMIT	
Hospitalisation	**R 1 000 000** 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 • Alcohol and Drug Abuse/Addiction - 21 days per beneficiary per year	• 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 excluding Frail Care, mother and child postpartum	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 22 200** per family, per year
PLEASE NOTE: ALL SUB-LIMITS ARE SUBJECT TO THE ANNUAL LIMIT	
MEDICINE	
Acute (prescribed medication) Benefit paid according to Reference Pricing (RP)	80% of cost Member **R 7 500** M+ 3 **R 10 400** M+ 1 **R 8 400** M+ 4 **R 11 400** M+ 2 **R 9 400** M+ 5+ **R 12 600**
Pharmacy-advised therapy (PAT) or Over-the-counter medication (OTC)	100% of cost Single **R 2 100** or Family **R 3 400** Subject to **R 245** 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 4 900** M+3 **R 8 500** M+1 **R 6 100** M+4 **R 9 700** M+2 **R 7 300** M+5+ **R 11 000**
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 6 700** per family per year
OPTICAL	
Eye tests	100% of the South African Optometric Association (SAOA) Rates
Spectacles or contact lenses	**R 4 600** per family, per year
Frames	**R 780** 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 5 000** per family per year
OTHER SERVICES – Subject to Annual Limit (Day-to-Day)	
Chiropractors	100% of the BCIMA tariff
Naturopaths and homeopaths	100% of the BCIMA tariff
Speech, occupational therapy and audiology	100% of the BCIMA tariff
Chiropodists (feet)	100% of the BCIMA tariff
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 4 900** per family, per year
Traditional healers	**R 1 700** per family, per year

Managed Care Programmes and Services
Chronic Medicine Management

To apply, register and update chronic conditions and chronic medicines for the chronicmedicine 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 Medicine Management department directly to register your chronic condition.
- Your doctor should provide information on your clinical examination 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 Medicine Management department.
- The Medicine Management department 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 Medicine Management department will be in contact with your doctor if the medicine prescribed is not on the formulary.
- 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 collectyour medication.

Chronic Medicine Process

What is a formulary?

A Formulary is a list of affordable medicines that your doctor can prescribe 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 Medicine Management department 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, Dis-Chem, FirstCare, Pick 'n Pay, 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. To avoid a co-payment, please ask your doctor to prescribe generic medicines and ask your pharmacy to supply you with the cheapest generic medicine.

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.

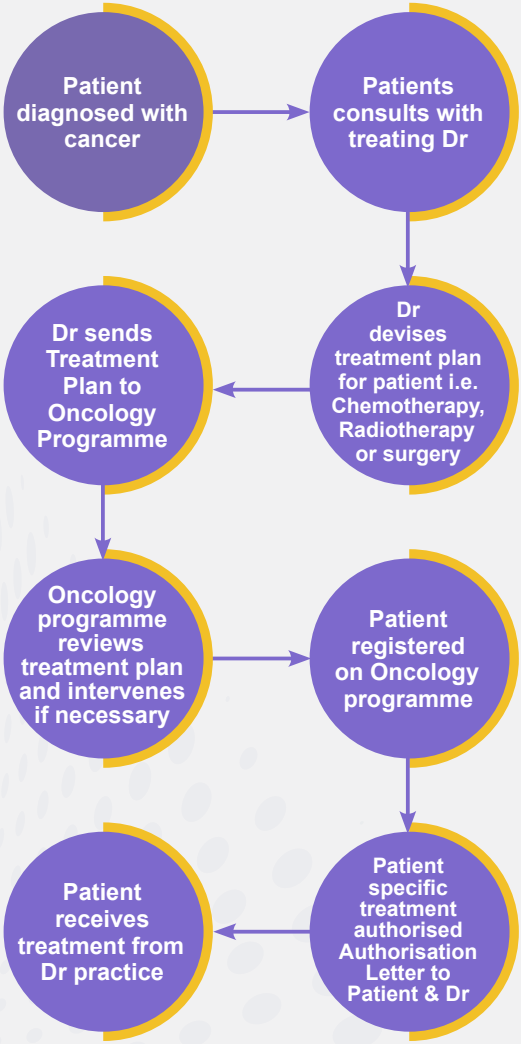
If you have been diagnosed with cancer, you must register on the Oncology Programme. By registering on the Oncology Programme, you will be able to access the Oncology benefits. Your oncology treatments will be reviewed by a medical professional and preauthorised from the oncology benefit.

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 associated with chemotherapy e.g. anti-nausea, pain
- 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

Building and Construction Industry Medical Aid fund | BCIMA is contracted to LifeSense Disease Management to manage all BCIMA members that are living with HIV.

What is HIV?

HIV is the Human Immunodeficiency Virus that is contracted via direct contact with body fluids from a person living with HIV that has a detectable viral load. These bodily fluids include Blood, Semen, Rectal and Vaginal fluids, and breast milk and use of an infected persons needles / syringes.

How do I know if I have HIV?

Being tested for HIV is simple and easy. A RAPID test is available at clinics and pharmacies. This is a simple “finger prick” test that will indicate if you are HIV positive or negative. If your RAPID test result is positive, this needs to be confirmed with a follow up test called an ELISA test. This is a blood test that can be done at any pathology laboratory, or your doctor can draw blood and send it to the pathology laboratory to be tested.

What if my result is HIV Positive?

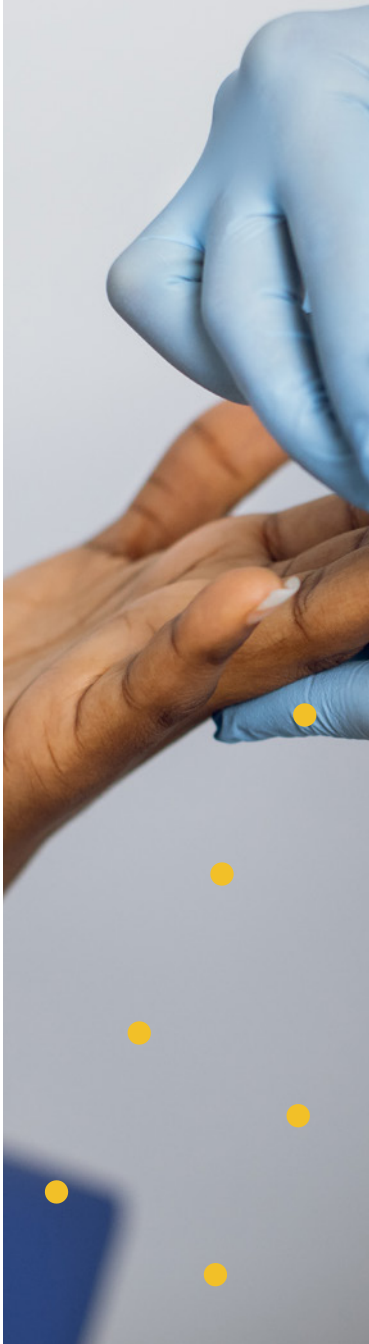
If your ELIZA test is positive, it means that you have been infected with / have contracted HIV. The “Test-and-Treat” Guidelines indicate that as soon as you know your status you must start on HIV (anti-retroviral -ARV) treatment as soon as possible. The new treatments that are available today are single tablet treatments that are taken once daily every day. The sooner you start treatment, the better your long-term outcomes are as ARV treatment stops the virus from replicating / multiplying in your body and prevents the virus from destroying your immune system (CD4 Cells).

If left untreated, the HIV virus will attack your immune system (CD4 Cells) and your CD4 Cell count will drop making you susceptible to opportunistic infections such as pneumonia and TB.

Starting ARV treatment!

When you are diagnosed with HIV your viral load (amount of HIV virus in your blood) will be high. This is know as a “detectable” viral load. Taking ARV treatment stops the virus from replicating and therefor the level of virus in your blood becomes “undetectable” i.e., it cannot be “detected” or picked up on a blood test. If your viral load is undetectable, you will not transmit HIV to your partner or other individuals. This is known as U=U: Undetectable = Untransmissible.

People living with HIV that have an undetectable viral load can safely conceive a baby, and provided that the pregnant mother maintains an undetectable viral load, she will not pass the HIV onto her unborn child.



Share your status!

Be open and honest with your partner and loved ones and seek professional and appropriate care and counselling to help you reduce the stress and anxiety of living with HIV. People living with HIV that have an undetectable viral load, can live as long and as healthy as someone that does not have HIV.

Where can I go for help and assistance?

LifeSense Disease Management manages all BCIMA members that are living with HIV. Contact LifeSense on **0860 506 080** and speak to one of their professional Case Managers who will assist you with registering on the LifeSense Programme. Alternatively you can e-mail **enquiry@lifesense.co.za**, or send an SMS to **31271** and LifeSense will call you back, or, you can access an application form from the LifeSense website www.lifesensedm.co.za and take this to your treating doctor to complete so that you can register for your HIV benefits offered to you by BCIMA.

What can I expect from the LifeSense programme?

- Experienced HIV counsellors and Case Managers will offer counselling and support to you and your family members.
- Advice on how and when to take your medication.
- Advise on healthy lifestyle and HIV management.
- Reminder of when you are due for follow up blood tests and scripts.
- Individualised case file review by the LifeSense Medical Officer to ensure ongoing optimal care and management of your HIV. If required, the LifeSense Medical Officer will liaise directly with your treating doctor regarding your ongoing treatment.

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

- Once registered on the LifeSense programme BCIMA will cover the cost of your doctor consultations and blood tests that are HIV related. Your choice of doctor is your decision, and once registered on the LifeSense programme your consultations with your treating doctor will be covered as per scheme rules.
- Your HIV medication (ARV treatment) will be paid for by BCIMA and delivered to your chosen address by a courier pharmacy.
- All pregnancy females will have access to treatment and care whilst pregnant as well as prophylactic treatment for baby once baby is born.
- Post Exposure Prophylaxis (PEP): This is access to emergency ARV treatment for 1 month if you are accidently exposed to HIV. Access to PEP must be done within 72 hours of exposure: Call LifeSense 24/7/365 on **0860 506 080**.
- Management of TB (tuberculosis) for those who require treatment. (This is subject to BCIMA Scheme rules).

LifeSense Disease Management
0860 506 080 | enquiry@lifesense.co.za
SMS: 31271

Netcare 911 Emergency Services

NETCARE 082 911
24HR EMERGENCY MEDICAL 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 dialing **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**.

Fraud
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

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

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

The reporting options are:

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

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, e.g. 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 Frail Care and 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. Charges for appointments which a beneficiary fails to keep.

1.19. Venereal Disease.

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

1.21. Uvulo-palatopharyingioplasty {UPPP}.

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

1.23. 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.

1.24. 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.

1.25. 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: Dianneand 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. Notwithstanding 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. An administrative fee may be imposed upon a member according to the late joiner penalties, as described in the Medical Schemes Act.

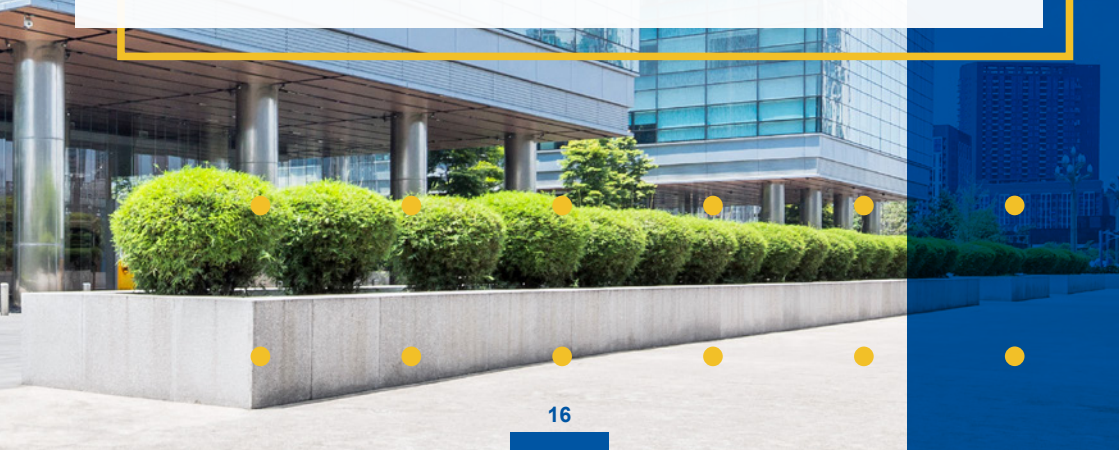
5. ABBREVIATIONS AND DEFINITIONS

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
BT	BCIMA Tariff
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 2023

Contributions structured according to the employee's hourly rate of pay.

WEEKLY CONTRIBUTION SCHEDULE SITE EMPLOYEES			
CONTRIBUTION CODE	**HOURLY WAGE BAND**	**50% OF CONTRIBUTION**	**PER FAMILY CONTRIBUTION**
A	R 1.00 - R 26.99	R 212.70	**R 425.40**
B	R 27.00 - R 29.99	R 251.40	**R 502.80**
C	R 30.00 - R 33.99	R 271.00	**R 542.00**
D	R 34.00 - R 51.99	R 291.50	**R 583.00**
E	R 52.00 - R 67.99	R 368.00	**R 736.00**
F	R 68.00 - R 85.99	R 419.20	**R 838.40**
G	R 86.00 - R 102.99	R 467.40	**R 934.80**
H	R 103.00+	R 533.20	**R 1 066.40**

Contributions structured according to the employee's monthly salary.

MONTHLY CONTRIBUTION SCHEDULE EMPLOYER, ADMINISTRATIVE STAFF AND SITE EMPLOYEES			
CONTRIBUTION CODE	**MONTHLY INCOME BAND**	**50% OF CONTRIBUTION**	**PER FAMILY CONTRIBUTION**
A	R 1.00 - R 4 679.99	R 850.00	**R 1 701.60**
B	R 4 680.00 - R 5 199.99	R 1 005.60	**R 2 011.20**
C	R 5 200.00 - R 5 892.99	R 1 084.00	**R 2 168.00**
D	R 5 893.00 - R 9 012.99	R 1 166.00	**R 2 332.00**
E	R 9 013.00 - R 11 785.99	R 1 472.00	**R 2 944.00**
F	R 11 786.00 - R 14 905.99	R 1 676.80	**R 3 353.60**
G	R 14 906.00 - R 17 852.99	R 1 869.60	**R 3 739.20**
H	R 17 853.00+	R 2 132.80	**R 4 265.60**

Contribution Schedule for Continuation Members

Applicable as from January 2023 - Payable monthly and in advance

CONTRIBUTION CODE	MONTHLY INCOME BAND	PER FAMILY CONTRIBUTION
L	R 1.00 - R 3 264.99	**R 1 470.00**
M	R 3 265.00 - R 4 745.99	**R 2 100.00**
N	R 4 746.00 - R 7 108.99	**R 2 750.00**
P	R 7 109.00 - R 8 882.99	**R 3 810.00**
Q	R 8 883.00 - R 11 854.99	**R 4 780.00**
R	R 11 855.00 - R 14 909.99	**R 5 480.00**
S	R 14 910.00 - R 17 786.99	**R 6 160.00**
T	R 17 787.00+	**R 7 040.00**

Contact Us

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Call back SMS facility:
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

Hospital Pre-Authorisation:
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Direct Fax: 0862 957 355
E-mail: preauthorisation@universal.co.za

Chronic Medication:
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Reg. No. 1974/001443/07

Processing of Personal Information

Processing of Personal information by the Scheme is justified in terms of section 11(1) of POPIA. Further the processing of Special Personal Information is authorized in terms of section 32 of Protection of Personal Information Act (POPIA). In addition to the justification and authorization expressly provided in POPIA, the operation of these Rules also serve consent between the parties to process Personal Information in terms of the binding contract that it constitutes between a member and the Scheme as provided for in section 32 of the Act.

Since the promulgation of POPIA new members have been signing application forms, incorporating consent to process their personal information as well as that of their dependants. The consent provisions included in these Rules and/or the application form includes prior consent by the principal members as a competent person, to process Personal Information of a child as provided for in section 35 of POPIA.

Personal Information is required for the processing of a member's application form, assessment of risks and underwriting, the execution of the agreement between the Scheme and the member and/or for the protection of the legitimate interests of the Scheme and the member and/or in terms of relevant legislation. The provision of the personal information is mandatory and without it the Scheme will not be able to perform its contractual and legal obligations in relating to the business of a medical scheme as defined in the Act.

Personal Information includes but is not limited to the member and dependant's health information, identity number, residential address etc. As far as reasonably possible the Scheme will collect the information directly from the member.

COMPLAINTS PROCEDURE

Protection of Personal Information Act (POPIA)

In the unlikely event of a member needing to report an incident where a personal inform data breach has occurred, the following process needs to be followed:

Please inform the Fund Immediately -
Tel no: 011 208 1005 or bcimafund@universal.co.za

Once the breach has been confirmed, please complete the incident form available on the website, and submit it to the CEO of the Fund.
phumi@bcima.co.za or POPIA@universal.co.za

If you are not satisfied with the outcome from the CEO, you can refer the matter to the Information regulator.
Information regulator: www.justice.gov.za/inforeg or inforeg@justice.gov.za

All information relating to the 2023 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.

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