BMW
Employees
Medical Aid Society

Administered by
Discovery
Health

BMW EMPLOYEES' MEDICAL AID SOCIETY

BENEFIT BROCHURE

2019

Message
from the Society

The Society provides you with all the tools you need to make the most of your cover.

Thank you for giving us the opportunity to look after your healthcare cover needs. In this Benefit Brochure, the BMW Employees Medical Aid Society will be referred to as the Society. You can have peace of mind knowing the Society places members first with a focus on comprehensive benefits, value for money, and services to improve the quality of care available to our members.

We have designed this Benefit Brochure to provide you with a summary of information on how to get the most out of the Society's benefits. You'll find online tools that help you choose full cover options for healthcare professionals, chronic medicine and GP consultations. We are here to help and guide you in making the best choices when it comes to your healthcare.

Our Society rules are available by logging in to the

Scheme website | www.bemas.co.za

This Benefit Brochure is a summary of the benefits and features of the BMW Employees Medical Aid Society.

The rules of the Society apply to your benefits. If you want to refer to the full set of rules, please log in to our website **www.bemas.co.za** > **Scheme rules** or email **bmwquery@discovery.co.za**

The rules and benefits explained in this guide apply to the main member and the dependants registered on their membership.

This brochure gives you a brief outline of the Benefits and Limits BMW Employees Medical Aid Society offers.

This does not replace the Scheme rules. The Registered Scheme rules are legally binding and always take precedence.

Contents

The benefits explained in this brochure are provided by BMW Employees Medical Aid Society, registration number 1526, administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

Summary of **benefits**

Detailed explanations of our benefits are available on the Society's website: www.bemas.co.za

Each beneficiary receives a total of R550 000 as an annual benefit limit. This amount accumulates towards the overall annual limit (OAL) with a maximum of R1 100 000 for a family.

Gap cover applies to in-hospital procedures. We will cover services your healthcare providers perform while in hospital up to a maximum of 150% of the Society Rate.

The Hospital Benefit covers you if you are admitted to hospital where the Society has preauthorised admission and treatment before you are admitted.

You have extensive cover for a list of certain chronic conditions and cover for cancer, HIV and AIDS.

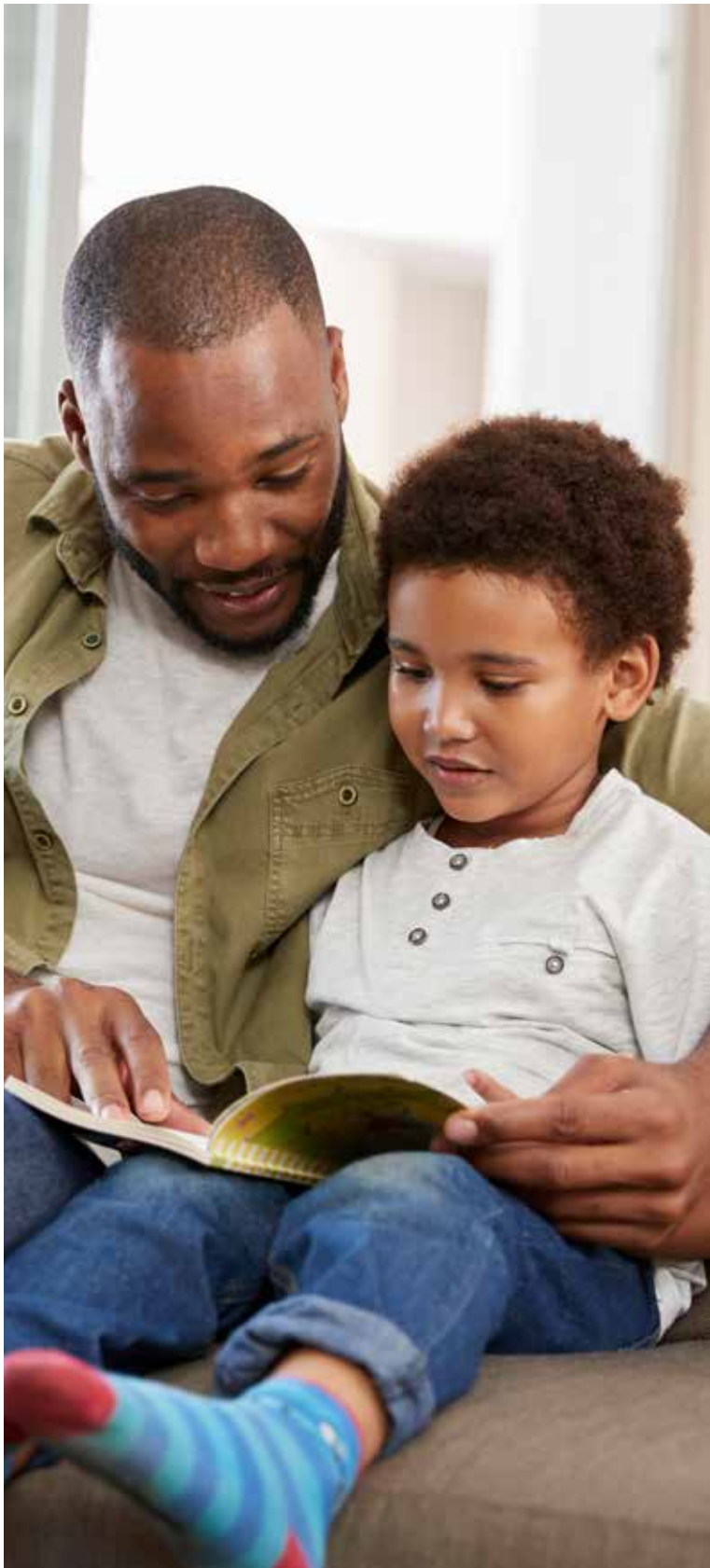
We pay your day-to-day expenses from the pooled day-to-day benefit limits. According to the Prescribed Minimum Benefits, you have the right to a guaranteed level of cover for a list of medical conditions and treatments even if your health plan benefits have run out.

These benefits include cover for a list of 270 conditions, emergency conditions and 27 chronic conditions, including HIV and AIDS.

Medical schemes must provide cover for the diagnosis, treatment and cost of ongoing care for these conditions according to the Medical Schemes Act guidelines.

To find out how you can access your Prescribed Minimum Benefits, go to www.bemas.co.za > Benefits and cover > Prescribed Minimum Benefits or contact us for more information on 0860 002 107.

Detailed explanations of our benefits are available on the Society's website at www.bemas.co.za > Benefits and cover or you can contact us on 0860 002 107.



Cover for **medical emergencies**

WHAT IS A MEDICAL EMERGENCY?

A medical emergency is the sudden and unexpected onset of a health condition that needs immediate medical or surgical treatment, where failure to provide this treatment would result in:

- Serious impairment to bodily functions, or
- Serious dysfunction of a bodily organ or part, or
- Would place the person's life in serious jeopardy.

COVER FOR MEDICAL EMERGENCIES IN SOUTH AFRICA

Cover for going to hospital

In an emergency, go straight to hospital. If you need medically equipped transport, call 0860 999 911. This line is managed by highly qualified emergency personnel who will send air or road emergency evacuation transport to you, depending on which is most appropriate. It is important that you, a loved one or the hospital let us know about your admission as soon as possible, so we can advise you on how we will cover you for the treatment you receive.

Cover for HIV medicine – post exposure prophylaxis (PEP)

If you need HIV medicine to prevent HIV infection from occupational or traumatic exposure to HIV or sexual assault, call us immediately on 0860 002 107. Treatment must start as soon as possible.

Cover for going to casualty

If you are admitted to hospital from casualty, we will cover the costs of the casualty visit from your overall annual limit (OAL), as long as we preauthorise your hospital admission. If you go to a casualty or emergency room and you are not admitted to hospital, we will pay the costs from funds available in your day-to-day benefit limit.

Cover under the Prescribed Minimum Benefits

In an emergency, we will cover you in full at any provider until your condition is stable. You may need to pay a co-payment once your condition is stable and you receive treatment from a non-designated service provider who charges more than the Society Rate. Please remember that even though you or your doctor may consider this to be an emergency, it may not be classified as an emergency under the Prescribed Minimum Benefits.

Discovery 911

Discovery Health has made an emergency medical service available to BEMAS members to ensure that the Society's members receive world-class emergency medical care.

This service is called Discovery 911 and is operated by highly qualified Netcare 911 emergency personnel. Netcare 911 is a nationwide emergency system that brings together facilities, services and expertise of a national network of private and state hospitals, including medical personnel and doctors.

WHEN YOU HAVE AN EMERGENCY:

- Call 0860 999 911, 24 hours a day, seven days a week. This number is printed on the BEMAS car stickers.
- You will be connected with highly qualified Netcare 911 emergency personnel, who have access to the Society's database with state-of-the-art backup.
- The most appropriate emergency medical service within your geographical area will be dispatched.

NOTE: This service is only available within the borders of the Republic of South Africa

The Discovery 911 benefit includes the following services:

- 24-hour emergency services call centre operated by Netcare 911
- Discovery 911 Alert
- Medical Advice Line (previously known as Smart Health Choices)
- Inter-hospital transfers
- Discovery Trauma Support

Netcare 911 is responsible for all operational assets of the Discovery 911 rapid emergency response service. This includes handling emergency calls and sending emergency medical services, managing inter-hospital transfers, providing medical advice and offering cellphone based location services in a medical emergency.

Discovery 911 Alert

Members have an option to activate this cellphone based, voice-free panic alert system. This allows a cellphone user to send his or her location to the Discovery 911 call centres by simply pressing the programmed speed dial on the cellphone. Once this alert has been sent, the call centre will immediately call the member to find out about their emergency. If the member does not answer, a vehicle will be dispatched.

- This option can be activated using the Society's website at www.bemas.co.za
- This service is for medical emergencies only.
- The service is available to both prepaid and contract subscribers of Vodacom and MTN who have Caller Line Identity (CLI).
- This service is not available on other service providers
- This is a free service.

Medical Advice Line

- The Medical Advice Line is operated by nurses
- This service is available 24-hours a day.
- These services include the telephonic and email queries.

The telephone number for the medical information line is 0860 999 911 (select the Smart Health Choices Medical Advice Line option).

Call Discovery Trauma Support on 0860 999 911

Discovery Trauma Support is available to assist 24-hours a day, seven days a week. Mobile, face-to-face counselling by trained counsellors is made possible by our fleet of dedicated Discovery Trauma Support vehicles.

Benefit tips

- Call 0860 999 911 in an emergency.
- Let us know about your admission as soon as possible.

Hospital **benefit**

You can go to any private hospital for emergency and planned admissions

IMPORTANT INFORMATION ABOUT YOUR HOSPITAL COVER

We cover:

- The hospital cost.
- All other accounts, like accounts from your admitting doctor, anaesthetist or any approved healthcare expenses, while you were in hospital are covered up to the Society Rate.

Limits, clinical guidelines and policies apply to some healthcare services and procedures in hospital are covered up to the Society Rate.

How we pay the hospital account

We pay the hospital account (the ward and theatre fees) in full at the rate agreed with the hospital. You have cover for a general ward, not a private ward.

Accounts from your doctor and other healthcare services

Your doctor or treating healthcare professional's accounts are separate from the hospital account and are called related accounts. Examples of related accounts includes accounts from the doctor, anaesthetist and any approved healthcare expenses, (for example, radiology or pathology), that you are billed for during your hospital stay. We fund these expenses and it contributes toward the OAL. Please contact us to preauthorise your benefits before you receive treatment or extend your hospital stay.

Before you go to hospital for any planned procedure, you must:

- See your doctor who will decide if it is necessary for you to be admitted.
- Make sure you know how the account from your admitting doctor will be covered.
- Choose which hospital you want to be admitted to.
- Find out how we cover other healthcare professionals. For example, your anaesthetist.
- Call us on 0860 002 107 to preauthorise your hospital admission at least 48 hours before you go in. We will give you information that is relevant to how we will pay for your hospital stay. Please refer to the cover for medical emergencies for more information.

Cover is subject to the Society rules

We pay medically appropriate claims. Your cover is subject to our Society rules, funding guidelines and clinical rules. There are some expenses that you may be billed for while you are in hospital that your hospital benefit does not cover, for example, private ward costs and costs where a specialist charges more than the Society Rate. Please be aware that certain procedures, medicines or new technologies need separate approval while you are in hospital. Please discuss this with your doctor or the hospital.

Gap cover

Gap cover (additional cover) is only applicable for in-hospital procedures. The services of medical and dental specialists, general and dental practitioners, physiotherapists, radiologists and pathologists are covered up to a maximum of 150% of the Society Rate. In other words, an amount up to 50% over and above the Society Rate will automatically be paid for these services.

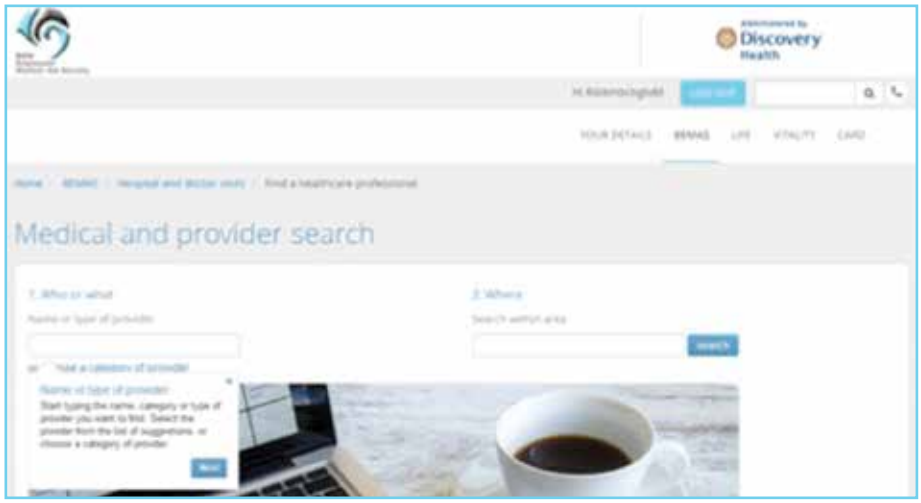
Benefit tips

If your health professional does not participate in one of the Society's networks, make sure that you submit quotes when obtaining preauthorisation to understand whether you may have a co-payment (make a payment yourself) for the planned procedure.

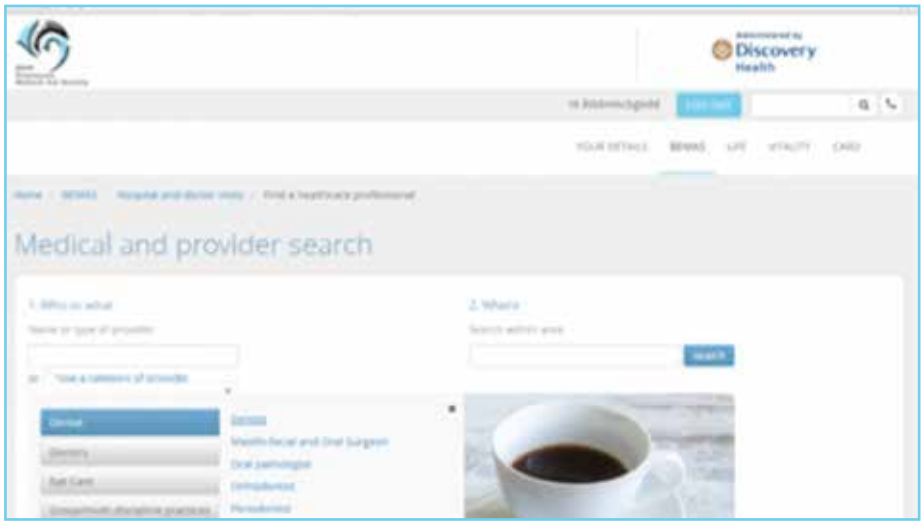
Find a **healthcare professional**

Go to www.bemas.co.za and log in with your username and password.

If you are looking for the nearest doctor or hospital, click on BEMAS tab. Look under hospital and doctor visits and click on find a healthcare professional.



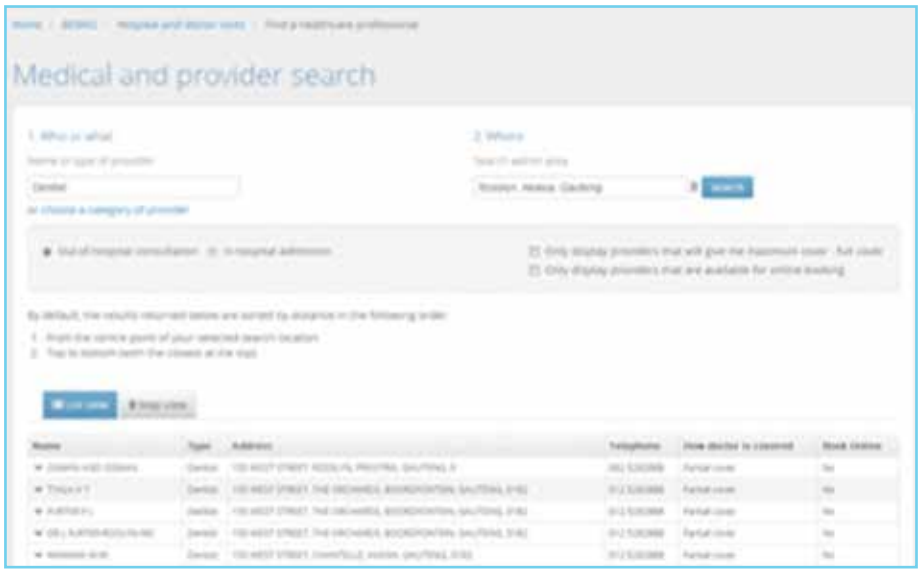
The page will open in the Medical and Provider Search (MaPS) functionality.



There are two sections:

- Provider (Who or What)
- Location (Where)

The “Provider” section gives you two options. You have to select the category of provider you are looking for. This can be “Doctors”, “Private Hospitals” or “Provincial Hospitals”. If you are looking for a doctor, you will have to indicate what type of healthcare provider (doctor) you need, for example, “Psychiatrist”.



Next to “Provider” is the location field for location, (province, city or suburb). After filling in all your requirements, for example: **Provider > Psychiatrist > Rosslyn** and then clicking on “Search”, you will be able to see a list of all the available network psychiatrists in your area. The doctor’s details will include the practice name, practice number, physical address and even GPS coordinates.

Prescribed **Minimum Benefits**

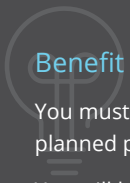
In most cases, the Society offers benefits which cover far more than the Prescribed Minimum Benefits.

To access Prescribed Minimum Benefits, there are rules that apply:

- Your medical condition must qualify for cover and be part of the list of defined Prescribed Minimum Benefits conditions.
- The treatment needed must match the treatments offered in the defined benefits.
- For payment in full, you must use designated service providers in the network. This does not apply in life-threatening emergencies.

However, even in these cases, where appropriate and according to the rules of the Society, you may be transferred to a designated service provider, otherwise you may have to cover some expenses yourself. You will be responsible for the difference between what we pay and the actual cost of your treatment.

The associated treatment (Diagnostic Treatment Pairs) links the Prescribed Minimum Benefit condition to the standard practice and protocols that apply and are aligned with the level of care in the public sector. The cost effective treatment may include medicine, consultations and investigations.



Benefit tips

You must call us at least 48 hours before any planned procedure.

You will be covered in full if you use doctors who are on our network.

Some treatments you receive while in hospital may need separate approval or benefit confirmation.

Your health plan at your fingertips

The Discovery smartphone app puts you fully in touch with your health plan no matter where you are. If your mobile device is with you, so is your plan.

Electronic membership card

View your electronic membership card with your membership number and tap on the emergency medical numbers on your card to call for emergency assistance.

Submit and track your claims

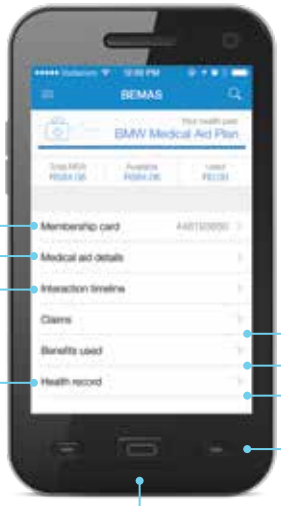
Submit claims by taking a photo of your claim using your smartphone camera and submit. You can also view a detailed history of your claims.

Track your day-to-day medical spend and benefits

Access important benefit information about your specific plan. You can also keep track of your available benefits.

Access your health records

View a full medical record of all doctor visits, health metrics, past medicines, hospital visits and dates of X-rays or blood tests. It is all stored in an organised timeline that is easy and convenient to use.



Find a healthcare provider

Find your closest healthcare providers who we have a payment arrangement with such as pharmacies and hospitals, specialists or GPs and be covered in full.

Request a document

Need a copy of your membership certificate, latest tax certificate or other important medical scheme documents? Request it on the app and it will be emailed directly to you.

Access the procedure library

View information of hospital procedures in our comprehensive series of medical procedure guides. You can also view a list of your approved planned hospital admissions.

Update your emergency details

Update your blood type, allergies and emergency contact information.

Give consent to your doctor accessing your medical records

Give consent to your doctor to get access to your medical records on HealthID. This information will help your doctor understand your medical history and assist you during a consultation.

Managing your health plan online is now more convenient than ever. Simply checking your benefits is now even easier than picking up the phone.

A website that responds to your device

Our website has been designed to work on a variety of different digital devices – your computer, your tablet and your cellphone. No matter what size the screen, the information will always be customised to your particular device making it easy to read.

Keeping track of your benefits

You can keep track of your available benefits online. You can access all important benefit information about your plan.

Finding a healthcare professional

You can use our Medical and Provider Search (MaPS) tool to find a healthcare professional. You can also find one who we cover in full so that you don't have a co-payment on your consultation. You can even filter your search by speciality and area and the results will be tailored to your requirements.

Keep track of your claims

We have securely stored information about your claims. You can submit your claim online, view your claims statement, do a claims search if you are looking for a specific claim, see a summary of your hospital claims and even view your claims transaction history.

Accessing important documents

We have securely stored documents so that they are available when you need them most. If you are looking for your tax certificate, membership certificate or simply looking for an application form. We have them all stored on our website.

www.bemas.co.za

Cover for **healthcare professionals**

FULL COVER FOR SPECIALISTS WHO ARE IN OUR NETWORK

You can benefit by using healthcare professionals who are in our network, as we will cover procedures in full after approval.

COVER FOR NON-NETWORK SPECIALISTS

We cover you up to 100% of the Society Rate in hospital. You may have to cover some expenses if your specialist charges above these rates. We pay out-of-hospital specialist consultations at 100% of the Society Rate if you use a network specialist and up to 80% of the Society Rate if you use a non-network specialist. These consultations will add up to the consultations and visits limit for General Practitioners (GPs) and specialists. Please refer to your Benefit Schedule for more information.

OTHER HEALTHCARE PROFESSIONALS

We cover GPs who are on our network in full, subject to your available benefit and annual limits. Non-network GP consultations performed in hospital are covered at 100% of the Society Rate. Out-of-hospital GP consultations add toward the consultations and visits limit. Please refer to your Benefit Schedule for more information.

COVER FOR RADIOLOGY AND PATHOLOGY

For radiology and pathology, we cover in-hospital claims at 100% of the Society Rate from the OAL. We cover out-of-hospital claims at 100% of the Society Rate from the radiology and pathology benefit.

YOUR COVER FOR INVESTIGATIONS

Scopes (gastroscopy, colonoscopy, proctoscopy and sigmoidoscopy)

We cover scopes at 100% of the Society Rate for procedures in providers' rooms. Preauthorisation is necessary and your procedure will be covered subject to your overall annual limit. Anaesthetic costs, if applicable, are only covered for local or regional anaesthetic or, at most, conscious sedation. General anaesthetic costs are not covered for procedures performed in a doctor's rooms except in respect of Prescribed Minimum Benefits.

MRI and CT scans

If your MRI or CT scan is done as part of an authorised admission, we pay it from your Hospital Benefit at 100% of the Society Rate.

Benefit tips

More details are available on **www.bemas.co.za > Benefits and cover > Healthcare professionals** or you can contact us on **0860 002 107.**

Cover for **chronic conditions**

You have extensive cover for chronic conditions, HIV, AIDS and cancer.

COVER FOR CHRONIC MEDICINE

The Chronic Illness Benefit covers approved medicine for the 27 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions. We will pay your approved chronic medicine in full up to the Society Rate for medicine if it is on the BMW Employees Medical Aid Society medicine list (formulary). If your approved chronic medicine is not on the medicine list, we will pay your chronic medicine up to a set monthly amount (Chronic Drug Amount) for each medicine category.

If you use a combination of medicine in the same medicine category, where one medicine is on the medicine list and the other is not, we will pay for the medicine up to the one monthly Chronic Drug Amount for that medicine category.

You must apply for chronic cover by completing a chronic application form with your doctor and submitting it for review. For a condition to be covered from the Chronic Illness Benefit, there are certain criteria that the member needs to meet.

If your condition is approved by the Chronic Illness Benefit, the Chronic Illness Benefit will cover certain procedures, tests and consultations for the diagnosis and ongoing management of the 27 Chronic Disease List conditions in line with Prescribed Minimum Benefits.

Here is the list of 27 Chronic Disease List conditions that we cover under the Chronic Illness Benefit.

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disease
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus type 1
- Diabetes mellitus type 2
- Dysrhythmia
- Epilepsy
- Glaucoma
- Haemophilia
- HIV and AIDS
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

Benefit tips

Discuss alternatives with your doctor to avoid co-payments.

There are further Additional Disease List conditions we cover. There is no medicine list (formulary) for these conditions. We pay approved medicine for these conditions up to the monthly Chronic Drug Amount.

- Ankylosing spondylitis
- Behcet's disease
- Chronic rhinitis
- Cystic fibrosis
- Delusional disorder
- Dermatopolymyositis
- Gastro-oesophageal reflux disease
- Generalised anxiety disorder
- Huntington's disease
- Isolated growth hormone deficiency in children less than 18 years old
- Major depression
- Motor neurone disease
- Muscular dystrophy and other inherited myopathies
- Myasthenia gravis
- Obsessive compulsive disorder
- Osteoporosis
- Paget's disease
- Panic disorder
- Polyarteritis nodosa
- Post traumatic stress disorder
- Psoriatic arthritis
- Pulmonary interstitial fibrosis
- Sjogren's syndrome
- Systemic sclerosis
- Wegener's granulomatosis

Claims for all chronic medicine add up to an annual limit. We will only fund medicine for Chronic Disease List conditions once you have reached the annual limit.

THE SPECIALISED MEDICINE BENEFIT

This benefit covers a specific list of new and advanced medicines. This is a limited benefit and you need authorisation to qualify for this benefit.

PROGRAMME TO MANAGE ONCOLOGY

The Oncology Programme follows the South African Oncology Consortium guidelines to ensure you have access to the most appropriate level of treatment for the particular stage of your disease. Call 0860 002 107 to register on this programme.

PROGRAMME TO MANAGE HIV AND AIDS

The HIV*Care* Programme provides comprehensive disease management for members living with HIV and AIDS. They will have access to antiretroviral treatment, subject to the medicine list and Chronic Drug Amounts. Members who do not register will have their claims for HIV and AIDS treatment paid at 100% of the Society Rate, subject to day-to-day benefits and the overall annual limit.

To register on this programme, please call 0860 002 107.

Benefit tips

You can find a healthcare professional on www.bemas.co.za > Find a healthcare professional. You can then search for a healthcare professional who we have a network agreement with and is in our network.

Day-to-day cover

Day-to-day claims are expenses that you gather without being admitted to hospital. We cover these claims through the day-to-day pooled benefits and limits. Examples of day-to-day expenses are consultations at healthcare professionals (for example, GPs, specialists and physiotherapists), prescribed medicine, radiology, pathology performed out of hospital, and conservative dentistry.

Please refer to the Benefit Schedule for the details on how these benefits are covered and the sub-limits that are applied. All day-to-day benefits will be subject to a 20% co-payment. Co-payments do not apply when you make use of network GPs and specialists, but it will apply to GPs and specialists not on the network. The co-payment will also not apply to acute medicine.

The Society will fund generic and brand medicine on the Society medicine list at 100% of the Society Rate for medicine.

The following benefit categories are funded from this day-to-day benefit limit:

- Acute medicine
- Alternative healthcare practitioners
- Basic dentistry
- Out-of-hospital non-surgical procedures
- Additional medical services
- Out-of-hospital physiotherapy, biokinetics and chiropractics.

THE DAY-TO-DAY LIMITS (THE BENEFIT LIMIT FOR EACH BENEFICIARY IS LIMITED TO R7 000 A YEAR).	
Member	R 7 000
Member + 1 dependant	R10 350
Member + 2 dependants	R12 375
Member + 3 dependants	R14 500
Member + 4 or more dependants	R16 525

COVER FOR ACUTE MEDICINE

A Preferred Medicine List for acute medicine

Cover for acute medicine will be extended to certain cost-effective branded medicine through the Preferred Medicine List. The Preferred Medicine List will consist of branded and generic medicine.

We cover these medicine in full when you use a pharmacy in our network. Medicine not on our Preferred Medicine List, both branded and generic, is covered up to 75% of the Society Rate.

Use our online Medical and Provider Search (MaPS) tool on www.bemas.co.za > Find a healthcare professional or contact us on 0860 002 107 to find a network pharmacy.

For more information, please refer to your Benefit Schedule.

Benefit tips

Discuss alternatives with your pharmacist or doctor to avoid co-payments.

Benefit platform

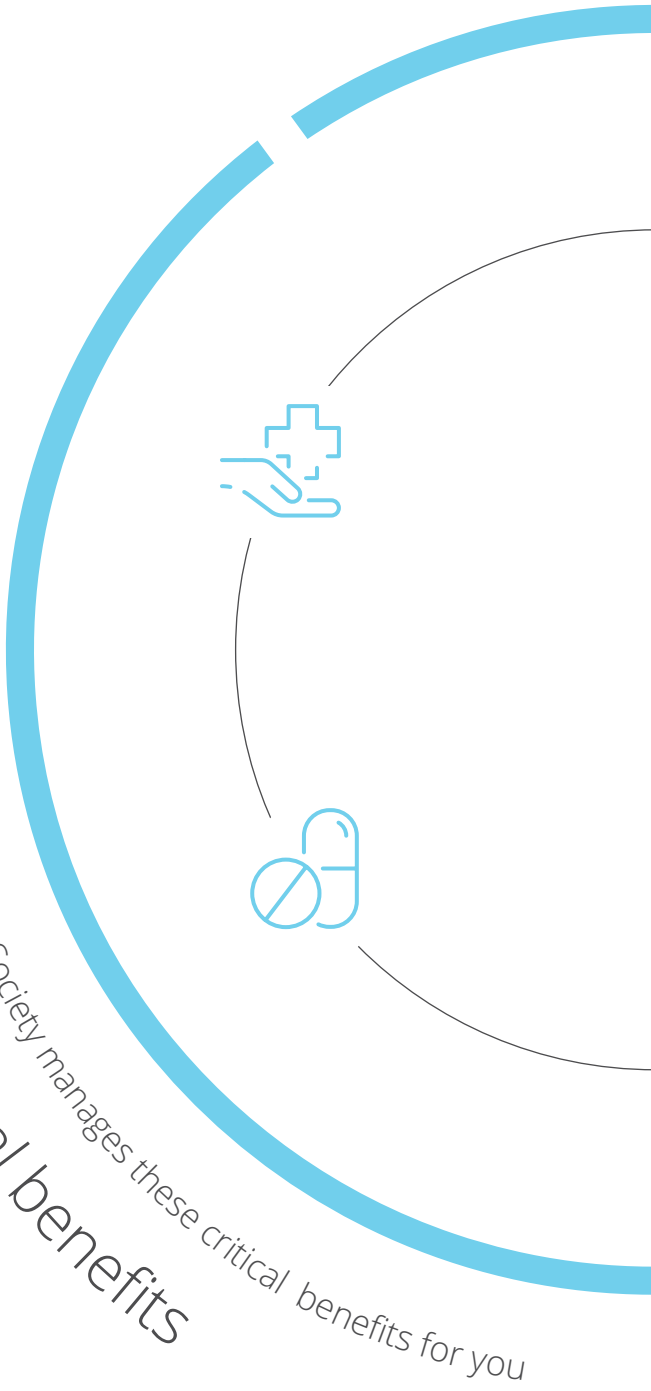
Your benefits:

Screening Benefit

- Screening test consisting of:
  - Blood glucose
  - Blood pressure
  - Cholesterol
  - Body mass index
- Must use a Discovery Wellness Network provider

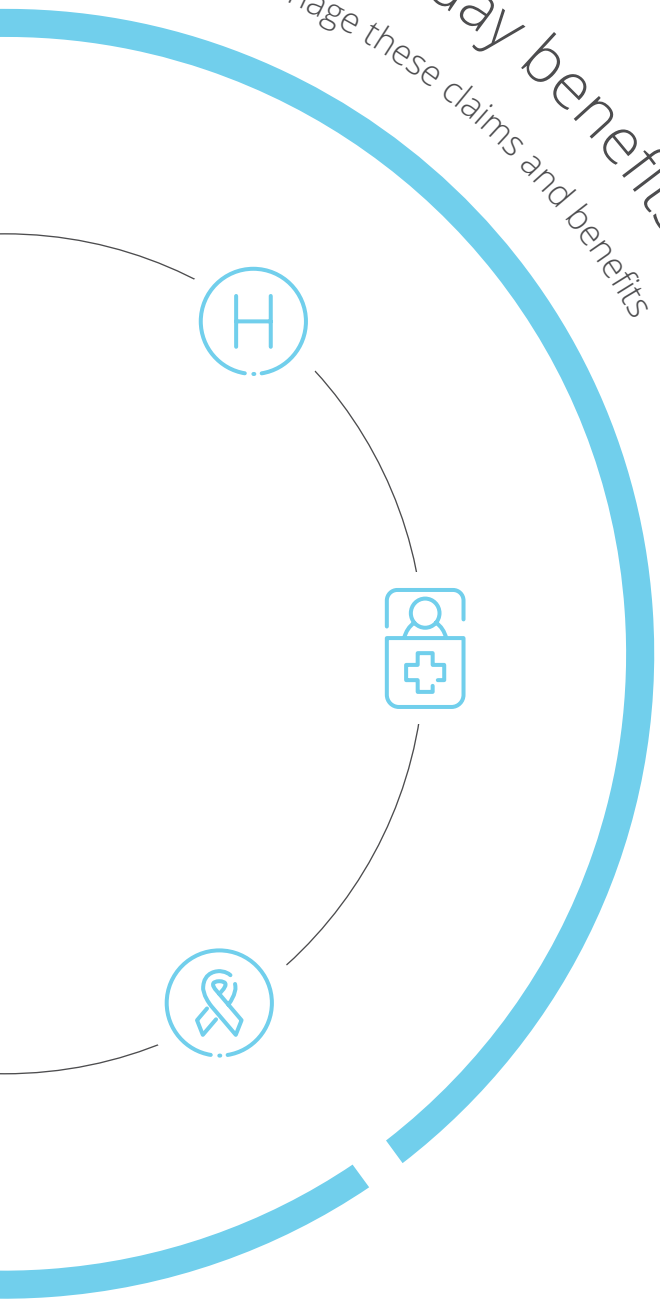
Specialised Medicine Benefit

- Cover for a defined list of latest treatments
- Includes biologics
- Up to R139 900 for each person each year
- A co-payment of up to 20% may apply



Day-to-day benefits

You manage these claims and benefits



Hospitalisation

- Extensive private hospital cover is available at any hospital in South Africa.
- You must preauthorise for hospitalisation, except in an emergency. Members have 48 hours after an emergency admission to obtain an authorisation.
- If you do not have your admission for a planned procedure authorised, you will not receive any cover.
- Preauthorise at least 48 hours in advance.

Oncology Benefit

- Extensive oncology cover.
- Access to the latest technology and treatment.
- Coverage of radiotherapy and chemotherapy.
- Coverage of scans and related treatment.
- Supportive therapy included.

Chronic Illness Benefit

- Provides cover for medicine for conditions where ongoing medicine is required.
- Includes a list of 26 conditions known as the Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL).
- You have to apply by sending us an application form.
- Your doctor needs to complete the form.
- We will tell you whether we have approved your cover.
- If approved, you can claim from this benefit

General **exclusions**

The Society has certain exclusions. We will not pay for healthcare services related to the following, except where detailed as part of a defined benefit or under the Prescribed Minimum Benefits

- Examinations, consultations and treatment relating to obesity or for cosmetic purposes
- Attempted suicide, willfully inflicted injuries, or sickness conditions arising due to body piercing or their complications outside of PMB requirements
- Costs in respect of drug abuse, unless treatment is received in state facilities, SANCA or Ramot, covered as PMB only
- Costs in respect of infertility unless treatment is received in a DSP facility or as a PMB
- Purchase or hire of medical or surgical appliances such as special beds, chairs, cushions, commodes, sheepskins, waterproof sheets, bedpans, special toilet seats, adjustment or repair of sick rooms or convalescing equipment (with the exception of hire of oxygen cylinders), unless clinically appropriate
- Unregistered providers
- Sunscreen and tanning agents
- Soaps, shampoos and other topical applications
- Household remedies
- Slimming preparations, appetite suppressors, food supplements and patent foods including baby food
- Growth hormones
- Tonics, nutritional supplements, multi-vitamins, vitamin combinations- except prenatal, lactation and paediatricuse – unless authorised as part of a Disease Management Programme
- Anti-smoking preparations
- Aphrodisiacs
- Anabolic steroids
- Treatment for erectile dysfunction
- Mouth protectors and gold dentures
- Examinations for insurance, school camps and visas
- Stimulant laxatives
- Anti-diarrheal micro-organisms replacement therapy for natural gut flora
- Travelling costs
- Accommodation in old age homes
- Accommodation and treatment in spas and resorts
- Holidays for recuperation
- Appointments not kept
- Telephone consultations with medical practitioners
- Ante-natal and post-natal exercise classes as well as breast feeding instruction
- Sunglasses and spectacle cases
- Replacement batteries for hearing aids
- Contact lens solution, kits and consultation for fitting and adjustments
- Costs associated with vocational, child and marriage guidance, school therapy or attendance at remedial education facilities
- Bleaching of teeth that have not had root canal treatment, metal inlays in dentures and front teeth
- Injuries during professional, hazardous sports and activities unless such injuries constitute a PMB condition
- Accommodation and treatment in headache and stress-relief clinics
- Payment for ambulance transportation and air lifting outside South Africa (including PMBs).

We also do not cover the complications or the direct or indirect expenses that arise from any of the exclusions listed above, except where stipulated as part of a defined benefit or under the Prescribed Minimum Benefits.

The benefits outlined in this guide are a summary of those registered in the Society's Rules. These benefits are reviewed annually and amended in line with the requirements of the Medical Schemes Act and also take into account the requirements of the Consumer Protection Act where it relates to the business of a medical scheme. Please access the full set of our Society's rules by logging in to www.bemas.co.za > Scheme rules.

Your benefits for 2019

When you reach a benefit limit, we only pay for approved treatment that relates to the Prescribed Minimum Benefits.

BENEFIT	RATE	LIMIT
You need to get preauthorisation from the Society at least 48 hours before a hospital admission or treatment. Please note if you do not preauthorise, you will be responsible for the payment of all accounts. We can advise you on the rate of payment before admission to hospital if you submit the known procedure codes from the doctor to us for pre-assessment.		
Hospital and hospital-related benefits	–	Subject to an overall annual limit of R1 100 000 for a family and limited to R550 000 for a beneficiary
Operations, procedures and surgery (GPs and Specialists)	150% of Society Rate	Subject to overall annual limit
Ward and theatre fees	150% of Society Rate	Subject to overall annual limit
X-rays	150% of Society Rate	Subject to overall annual limit
Pathology	150% of Society Rate	Subject to overall annual limit
Radiotherapy	150% of Society Rate	Subject to overall annual limit
Blood transfusion	150% of Society Rate	Subject to overall annual limit
Organ transplants	100% of Society Rate	Subject to overall annual limit
Renal dialysis	150% of Society Rate	Subject to overall annual limit
Deep brain stimulator	150% of Society Rate	R292 000 for a beneficiary. Subject to overall annual limit. This is subject to preauthorisation
Hospitalisation for substance abuse and mental health	150% of Society Rate	R42 750 for a family or 21 days for a beneficiary each year. Limited to one rehabilitation programme for each beneficiary a year
Maxillo-facial and oral surgery	150% of Society Rate	Subject to overall annual limit and preauthorisation
Internal and external prostheses: • **Total hip replacement** • **Knee replacement** • **Shoulder replacement** • **Stents** • **Pacemakers** • **Artificial limbs** • **Spinal internal prostheses** • **Stents**	100% of cost	R56 200 for a family each year
Cochlear implants	100% of cost	R230 000 for a beneficiary each year
HIV and AIDS	100% of cost for all relevant treatment and anti-retrovirals Subject to medicine list	Benefits available upon registration on the Discovery*Care* HIV*Care* Programme
Post-exposure prophylaxis	100% of Society Rate	Subject to overall annual limit
Oncology (including hospitalisation, chemotherapy and consultations, radiotherapy, pathology, brachytherapy, scopes and scans)	100% of Society Rate	R657 500 for a family
Oncology – specialised drugs	100% of Society Rate	R295 500 for a family
Chronic medicine	100% of Society Rate for medicine in the medicine list Medicine not in the medicine list subject to the Chronic Drug Amount	R30 500 for a beneficiary each year, then Prescribed Minimum Benefits only

BENEFIT	RATE	LIMIT
Specialised medicine	100% of Society Rate for medicine	R139 900 for a beneficiary Macular degeneration – R58 900 for a family
Specialised dentistry	100% of Society Rate	Member only R11 000 Family R23 800
Basic dentistry	100% of Society Rate	R1 550 for a beneficiary for a year A deductible (upfront payment) will apply for dental procedures carried out at a hospital or a day clinic. Members younger than 13 years will have a hospital deductible (upfront payment) of R2 100 and a deductible of R1 000 at a day clinic Members 13 years and older will have a hospital deductible (upfront payment) of R5 500 and a deductible of R3 500 at a day clinic
Maternity	100% of Society Rate	Subject to a limit of R6 400 for a pregnancy and the following sub-limits: ■ Pregnancy scans: two 2D pregnancy scans for a pregnancy. ■ Antenatal consultations: 12 with a specialist, general practitioner or midwife for a pregnancy. ■ One amniocentisis done by a registered practice or radiologist for a pregnancy subject to the overall annual limit. Members have access to the Maternity Benefit, which offers services related to pregnancy and delivery. These services include: ■ Postnatal visits-5 consultations or classes per pregnancy and/or delivery. ■ Prenatal screening or non-invasive prenatal testing (NIPT)-1 per pregnancy. ■ 2 pregnancy scans per pregnancy. ■ Blood tests-i set of routine basket of pregnancy tests per pregnancy. ■ 1 Post natal consultation per delivery. ■ Dietician nutrition assessment – 1 per delivery. ■ Mental health consultations – 2 consultations per delivery. ■ Consultations for infants up to 100% of the Scheme Rate, or agreed rate for children under the age of two. ■ These services will be funded from your Health Care Cover and is subject to applicable limits and also subject to pre authorisation and registration onto the benefit and the treatment meeting the Scheme's clinical entry criteria. ■ The Scheme will fund for 3D and 4D scans up to the maximum of the cost of a 2D scan.
Day-to-day benefits **Consultation and visits for speech therapy, occupational therapy, dietitians, physiotherapy, audiology, chiropractics, podiatry, social workers, etc.**	80% of Society Rate. There will be a 20% co-payment at the point of service.	Member only R 7 000 Member +1 R10 350 Member +2 R12 375 Member +3 R14 500 Member +4+ R16 525 Limited to R7 000 for each beneficiary

BENEFIT	RATE	LIMIT
General practitioners and specialist consultations	100% of Society Rate provided that members use a network service provider. If a member uses a non-network service provider, the Scheme will only cover up to 80% of the Scheme Rate and members will need to pay a 20% co-payment.	Member only 10 Member +1 15 Member +2 17 Member +3 20 Member +4+ 25
Optometry	–	–
Comprehensive consultation, inclusive of tonometry, glaucoma and visual screening	100% of Society Rate for one comprehensive consultation for a beneficiary	Subject to overall annual limit
Frames	100% of Society Rate	Limited to R1 320 for a beneficiary every two years
Lenses	100% of Society Rate	One pair of single vision lenses for a beneficiary each year or One pair of bifocal lenses for a beneficiary each year or One pair of multifocal lenses for a beneficiary each year
Contact lenses (alternative to glasses)	100% of Society Rate	Subject to a total limit of R3 225 for a beneficiary each year
Readers	–	Subject to the frames limit and limited to R135 for a beneficiary every two years
Refractive eye surgery	100% of Society Rate	Limited to R23 500 for a beneficiary each year (regardless of place of service)
Intraocular lens implants	100% of Society Rate	Limited to R3 400 for a family each year
Radiology and pathology	100% of Society Rate	R8 300 for a family
Out-of-hospital consultations for substance abuse and mental health	100% of Society Rate	R5 750 for a family each year
Acute medicine	Preferentially priced generic and brand medicine: Up to a maximum of 100% of the Society Rate for medicine, subject to day-to-day benefits. Non-preferentially priced generic and brand medicine: Up to a maximum of 75% of the Society Rate for medicine, subject to day-to-day benefits	Subject to day-to-day benefits
Over-the-counter medicine (this includes prescribed or non-prescribed schedule 0, 1 and 2 medicine)	100% of the Society Rate for medicine	An annual limit of R830 for a beneficiary. Subject to day-to-day benefits. Once the limit of R830 has been depleted, the Society will fund for schedule 0, 1 and 2 medicine from the Acute Medicine Benefit provided there is a prescription.
Ambulance	100% of Society Rate	Subject to overall annual limit
Medical appliances	100% of Society Rate	■ Medical and surgical: R10 500 for a family. This includes medical appliances such as blood pressure monitors, nebulisers etc. Please note that diabetic accessories excluding glucometers must be claimed from your Chronic Illness Benefit. ■ CPAP Machines: R18 900 for a family ■ Stoma products: R18 900 for a family

BENEFIT	RATE	LIMIT
Hearing aid	100% of Society Rate	The hearing aid limit is R28 750 for each member of a family. Subject to the overall annual limit.
Screening Benefit A - Group of tests consisting of blood glucose test, blood pressure test, cholesterol test and body mass index (BMI). Defined diabetes and cholesterol screening test.	Up to a maximum of 100% of the Society Rate for group of tests. Tests must be performed at a contracted provider. Tests in excess of annual limit for member's account.	Two tests per beneficiary per annum included in the overall annual limit.

Benefits and contribution amounts are subject to Council for Medical Schemes approval. The registered rules are binding and take precedence over the Benefit Brochure and Benefit Schedule.

PP = Preferred Provider (the Society's preferred provider for ambulance services is Netcare 911).

Chronic Drug Amount (CDA) = The CDA is a monthly amount we pay up to for a medicine class. This applies to medicine that is not listed on the medicine list (formulary). The Chronic Drug Amount includes VAT and the dispensing fee.

Society Rate = This is the amount of money the Society pays for a specific type of medical procedure, treatment or consultation. There are, however, certain healthcare professionals the Society has negotiated rates with. The negotiated rate replaces the Society Rate in those instances.

Maximum annual benefits referred to in the table will be calculated from 1 January 2019 to 31 December 2019, based on the services provided during the year and will be subject to pro rata (proportional) calculated amount from the joining date to the end of the benefit period. Benefits are not transferable from one benefit period to another or from one category to another.

Contributions for 2019

MEMBER ONLY		FOR EACH ADULT DEPENDANT		FOR EACH CHILD DEPENDANT	
Standard contribution	R2 304	Standard contribution	R2 304	Standard contribution	R1 155
Total monthly contribution	**R2 304**	Total monthly contribution	**R2 304**	Total monthly contribution	**R1 155**

This brochure is a summary of the benefits and features of the BMW Employees Medical Aid Society, pending formal approval from the Council for Medical Schemes.

BMW Employees Medical Aid Society. Registration number 1526. Administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

Important tips when claiming

When claiming from the Society for your medical costs, whether these are hospital, chronic or day-to-day, these steps apply:

1 | To avoid duplication, check with your healthcare professional if they have sent your claims to us.

2 | Send your claims within four months, otherwise we will consider them expired and will not pay them.

3 | When sending claims, please make sure the following details are clear:

- **3.1** | Your membership number
- **3.2** | The service date
- **3.3** | Your healthcare professional's details and practice number
- **3.4** | The amounts charged
- **3.5** | The relevant consultation, procedure or NAPPI code and diagnostic (ICD-10) codes
- **3.6** | The name and birth date of the dependant for whom the service was done
- **3.7** | If paid, attach your receipt or make sure the claim says 'paid'.

Benefit tips

Remember to always keep copies of your claims for your records.

To see the status of your claim, you can log in to **www.bemas.co.za > Claims search.**

This brochure is a summary of the benefits and features of the BMW Employees Medical Aid Society, pending approval from the Council for Medical Schemes.

Contact us

For ambulance and other emergency services
call Discovery 911 at 0860 999 911

General queries
Email: **service@discovery.co.za**
Call centre: **0860 002 107**

To send in claims
Email us at **claims@discovery.co.za** or
fax it to **0860 329 252**

Drop off your claim in any blue Discovery Health claims box, or post it to:
PO Box 652509, Benmore 2010

Other services
Oncology service centre: **0860 002 107**
HIV*Care* Programme: **0860 002 107**
Internet queries: **0860 100 696**

If you would like to let us know about suspected fraud, please call our fraud hotline on **0800 004 500** (callers will remain anonymous).

Visit our website for more information at **www.bemas.co.za**

To preauthorise admission to hospital
Email us at: **preauthorisations@discovery.co.za**
or call us from a landline at **0860 002 107**

Report Fraud
If you even slightly suspect someone of committing fraud, report all information to the Discovery fraud hotline: forensics@discovery.co.za directly

Or you may remain anonymous if you prefer:

Toll-free phone: 0800 004 500

SMS 43477 and include a description of the alleged fraud

Toll-free fax: 0800 00 77 88
Email: discovery@tip-offs.com
Post: Freepost DN298, Umhlanga Rocks 4320.

The Council **for Medical Schemes**

For you, for health, for life.

WHAT?

The Council for Medical Schemes (CMS) is a statutory body established in terms of the Medical Schemes Act 131 of 1998 to provide regulatory oversight to the medical scheme industry. The CMS' vision is to promote vibrant and affordable healthcare cover for all.

WHY?

It is our mission to regulate the medical schemes industry in a fair and transparent manner.

- We protect the public, informing them about their rights, obligations and other matters, in respect of medical schemes;
- We ensure that complaints raised by members of the public are handled appropriately and speedily;
- We ensure that all entities conducting the business of medical schemes, and other regulated entities, comply with the Medical Schemes Act;
- We ensure the improved management and governance of medical schemes;
- We advise the Minister of Health of appropriate regulatory and policy interventions that will assist in attaining national health policy objectives; and
- We collaborate with other entities in executing our regulatory mandate.

WHO?

The CMS governs the medical schemes industry and therefore your complaint should be related to your medical scheme. Any beneficiary or any person who is aggrieved with the conduct of a medical scheme can submit a complaint.

It is however very important to note that a prospective complainant should always first seek to resolve complaints through the complaints mechanisms in place at the respective medical scheme before approaching the CMS for assistance. You can contact your scheme by phone or if not satisfied with the outcome, in writing to the Principal Officer of the scheme, giving her/him full details of your complaint. If you are not satisfied with the response from your Principal Officer, you can ask the matter to be referred to the Disputes Committee of your scheme.

If you are not satisfied with the decision of the Disputes Committee, you can appeal against the decision within 3 months of the date of the decision to the CMS. The appeal should be in the form of an affidavit directed to the CMS. We are for you.

WHEN?

When you need us! The CMS protects and informs the public about their medical scheme rights and obligations, ensuring that complaints raised are handled appropriately and speedily. We are for health.

HOW?

Complaints against your medical scheme can be submitted by letter, fax, email or in person at our Offices from Mondays to Fridays (08:00-17:00).The complaint form is available from www.medicalschemes.com

Your complaints should be in writing, detailing the following: Full names, membership number, benefit option, contact details and full details of the complaint with any documents or information that substantiate the complaint.

The CMS' Customer Care Centre and Complaints Adjudication Unit also provides telephonic advice and personal consultations, when necessary.

Our aim is to provide a transparent, equitable, accessible, expeditious, as well as a reasonable and procedurally fair dispute resolution process. The CMS will send a written acknowledgement of a complaint within three working days of its receipt, providing the name, reference number and contact details of the person who will be dealing with a complaint.

In terms of Section 47 of the Medical Schemes Act 131 of 1998, a written complaint received in relation to any matter provided for in this Act will be referred to the medical scheme. The medical scheme is obliged to provide a written response to the CMS within 30 days.

The CMS shall within four days of receiving the complaint from the scheme or its administrator, analyse the complaint and refer the complaint to the relevant medical scheme for comments.

You can contact the CMS

Customer Care Centre
0861 123 267
0861 123 CMS

Reception
Tel: 012 431 0500
Fax: 012 430 7644

General enquiries
Email enquiries: information@medicalschemes.com
www.medicalschemes.com

Complaints
Fax: (086) 673 2466
Email: complaints@medicalschemes.com

Postal address
Private Bag X34
Hatfield
0028

Physical address
Block A, Eco Glades 2 Office Park
420 Witch-Hazel Avenue
Eco Park, Centurion
0157

BMW
Employees
Medical Aid Society

Administered by
Discovery
Health

Call Centre 0860 002 107 | service@discovery.co.za | www.bemas.co.za

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