A very definite advantage is that the Fund was created especially for the Building, Construction and Civil Engineering Industries.
Introduction

The Building Industry Medical Aid Fund was established in 1964 under the Department of Labour legislation as part of the Gauteng Building Bargaining Council.

With the dissolution of the Gauteng Building Bargaining Council in 2002, there was an agreement that the Fund should continue serving the interests of its members. As the Fund was no longer subject to the Department of Labour legislation, it was compelled to register in terms of the Medical Schemes Act 131 of 1998 and was subsequently registered as a restricted medical aid fund, known as The Building and Construction Industry Medical Aid Fund (BCIMA).

The Fund considers itself as the preferred fund of choice for the building and construction industry in its current area of jurisdiction, as it is specifically designed for the industry.

To expand the membership and improve the risk pool, the objectives were amended to incorporate employees of the South African Federation of Civil Engineering Contractors (SAFCEC), who established the Bargaining Council for the Civil Engineering Industry (BCCEI), in terms of Section 31 of the Labour Relations Act, 1995. According to their Collective Agreement, BCIMA is the preferred Medical Aid Fund for all “Hourly Paid Employee Members”.

The Fund’s historic relationship with the building and construction industry is a definite advantage. It has an in-depth understanding of the needs of employers and their employees and is able to design appropriate contributions and benefits accordingly. The Fund is considered a low-cost fund and as such enjoys certain exemptions in terms of the provisions of the Prescribed Minimum Benefits (PMB) and Section (1)(n) of the Act, which have proved to be highly beneficial to its members.
**BCIMA 2018**

**Benefits**

<table>
<thead>
<tr>
<th>ANNUAL LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LifeSense HIV Programme</td>
</tr>
<tr>
<td>Hospitalisation</td>
</tr>
<tr>
<td>Annual Limit: Day-to-day expenses</td>
</tr>
<tr>
<td>Chronic medicine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITALISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalisation</td>
</tr>
<tr>
<td>Pre-authorisation required</td>
</tr>
</tbody>
</table>

**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**

Ambulance services

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

<table>
<thead>
<tr>
<th>Annual limit</th>
<th>Day-to-day limits apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 17 200 per family, per year</td>
<td></td>
</tr>
</tbody>
</table>

**PLEASE NOTE: ALL SUB-LIMITS ARE SUBJECT TO THE ANNUAL LIMIT**

### MEDICINE

**Acute (prescribed medication) Benefit paid according to MRP**

<table>
<thead>
<tr>
<th></th>
<th>80% of cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>R 5 550</td>
</tr>
<tr>
<td>M+ 1</td>
<td>R 6 600</td>
</tr>
<tr>
<td>M+ 2</td>
<td>R 7 100</td>
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<tr>
<td>M+ 3</td>
<td>R 8 250</td>
</tr>
<tr>
<td>M+ 4</td>
<td>R 9 150</td>
</tr>
<tr>
<td>M+ 5+</td>
<td>R 10 800</td>
</tr>
</tbody>
</table>

**Pharmacy-advised therapy (PAT) or Over-the-counter medication (OTC)**

- 100% of cost
- Single R 1 550 or Family R 2 600
- Subject to R130 per script, per beneficiary, per day

**Homeopathic remedies**

- 80% of cost

### GENERAL PRACTITIONERS/SPECIALISTS (out-of-hospital)

**Visits and consultations**

<table>
<thead>
<tr>
<th></th>
<th>100% of the BCIMA Tariff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>R 3 800</td>
</tr>
<tr>
<td>M+1</td>
<td>R 4 650</td>
</tr>
<tr>
<td>M+2</td>
<td>R 5 700</td>
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<tr>
<td>M+3</td>
<td>R 6 600</td>
</tr>
<tr>
<td>M+4</td>
<td>R 7 750</td>
</tr>
<tr>
<td>M+5+</td>
<td>R 9 000</td>
</tr>
</tbody>
</table>

**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 5 100 per family per year

### OPTICAL

**Eye tests**

- 100% of the South African Optometric Association (SAOA) Rates

**Spectacles or contact lenses**

- R 3 500 per family, per year

**Frames**

- R 600 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 3 760 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 3 760 per family, per year

**Traditional healers**

- R 1 250 per family, per year
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.
Chronic Medicine Management
The pre-authorisation of chronic medicines ensures that BCIMA’s decision to fund, limit or decline requested chronic medicine is the most appropriate and cost effective. An authorisation will also ensure that your medicines are paid from the correct benefit limit.

Authorisations
An authorisation can be requested telephonically (preferred method), via fax or email. Mediscor ChroniLine may require additional information from your doctor or pharmacist. Based on this information your chronic condition will be registered and the appropriate medicines will be authorised. You will also be informed if you are liable to pay any co-payment/s, or if the medicines are not covered on your medical fund.

Formularies
One of the measures used to manage financial risk is medicine formularies. A formulary is a list of cost effective and accessible medicines that the fund is prepared to make available to members for the treatment of a specific condition. A number of alternatives will be available, from which your doctor can select one or more to treat your condition.

Generic medication
A generic medicine contains the same active ingredients, has the same dosage strength, is safe, is equally effective and is therefore interchangeable with an original brand name product.

To encourage the use of generic medicines, thereby making the fund more affordable, BCIMA applies a generic reference price to medicines for which there are generic alternatives available. A reference price is the maximum amount that BCIMA will pay for each medicine that you are prescribed. The reference price will be high enough to offer you a choice of a number of generic alternatives to the medicine that your doctor prescribed for you.

How to avoid co-payments on chronic medicine and minimise the co-payment on acute medicine
It’s really simple. Make sure that you and your doctor know which medicines are listed on the formulary. Also ask your pharmacist to dispense a generic medicine that costs as much or less than the reference price for the prescribed formulary medicine.

CONTACT US
If you have any questions about the medicine formularies, or if you want to know if your chronic medicine qualifies for payment from the chronic benefit, you can contact Mediscor on:

<table>
<thead>
<tr>
<th>Mediscor Authorisation</th>
<th>0860 119 553</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Centre</td>
<td><a href="mailto:preauth@mediscor.co.za">preauth@mediscor.co.za</a></td>
</tr>
<tr>
<td>Mediscor General</td>
<td>0860 113 238</td>
</tr>
<tr>
<td>Contact Centre</td>
<td><a href="mailto:info@mediscor.co.za">info@mediscor.co.za</a></td>
</tr>
</tbody>
</table>
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 salpingostomy (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.


1.15. 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-palatopharyngioplasty (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. Site employees:
• Contributions are structured according to the hourly rate of pay
• Contributions are due weekly, in arrears and payable not later than the second working day of the following week.

3.2. Employer, Administration staff and 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

<table>
<thead>
<tr>
<th>Agreed Tariff/BCIMA Tariff</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSP</td>
<td>Designated service provider</td>
</tr>
<tr>
<td>OTC</td>
<td>Over-the-counter medication</td>
</tr>
<tr>
<td>PAT</td>
<td>Pharmacy-advised therapy</td>
</tr>
<tr>
<td>PMB</td>
<td>Prescribed minimum benefits</td>
</tr>
<tr>
<td>SAOA</td>
<td>South African Optometric Association</td>
</tr>
<tr>
<td>MRP</td>
<td>Mediscor Reference Pricing</td>
</tr>
</tbody>
</table>

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.
Site employees
Weekly and monthly contribution schedule
Contributions payable per family, applicable as from January 2018.

“Site employees” means employees whose remuneration is calculated on an hourly basis not withstanding the frequency of the payment thereof, and who is not a ‘salaried employee’.

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

<table>
<thead>
<tr>
<th>WEEKLY CONTRIBUTION SCHEDULE</th>
<th></th>
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<tbody>
<tr>
<td><strong>INCOME BAND</strong></td>
<td><strong>HOURLY WAGE BAND</strong></td>
</tr>
<tr>
<td>01-As</td>
<td>R 1 - R 11.99</td>
</tr>
<tr>
<td>02-Bs</td>
<td>R 12 - R 13.99</td>
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<tr>
<td>03-Cs</td>
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<td>04-Ds</td>
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<td>05-Es</td>
<td>R 18 - R 19.99</td>
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<td>06-Fs</td>
<td>R 20 - R 21.99</td>
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<tr>
<td>07-Gs</td>
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<td>08-Hs</td>
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<td>09-Ie</td>
<td>R 26 - R 27.99</td>
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<td>10-Js</td>
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<td>11-Ks</td>
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<td>12-Ls</td>
<td>R 57 - R 71.99</td>
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<td>13-Ms</td>
<td>R 72 - R 85.99</td>
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<td>14-Ns</td>
<td>R 86+</td>
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<thead>
<tr>
<th>MONTHLY CONTRIBUTION SCHEDULE</th>
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<tbody>
<tr>
<td><strong>INCOME BAND</strong></td>
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<td>01-Aa</td>
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<td>03-Ca</td>
<td>R 2 425 - R 2 772</td>
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<td>R 2 773 - R 3 118</td>
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<td>06-Fa</td>
<td>R 3 466 - R 3 812</td>
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<td>07-Ga</td>
<td>R 3 813 - R 4 158</td>
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<td>08-Ha</td>
<td>R 4 159 - R 4 505</td>
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<td>09-Ia</td>
<td>R 4 506 - R 4 852</td>
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<td>10-Ja</td>
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</tr>
<tr>
<td>11-Ka</td>
<td>R 7 500 - R 9 999</td>
</tr>
<tr>
<td>12-La</td>
<td>R 10 000 - R 12 499</td>
</tr>
<tr>
<td>13-Ma</td>
<td>R 12 500 - R 14 999</td>
</tr>
<tr>
<td>14-Na</td>
<td>R 15 000+</td>
</tr>
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Employers, Administrative Staff and Continuation Members

Contribution Schedule
Applicable as from January 2018

“Administrative staff” means employees whose remuneration is calculated on a monthly basis not withstanding the number of hours or days actually worked, who performs work generally understood to be that of a salaried employee, and who is not an ‘hourly-rated employee’

Payable monthly, in advance, per family

<table>
<thead>
<tr>
<th>INCOME BAND</th>
<th>MONTHLY INCOME BAND</th>
<th>MONTHLY CONTRIBUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-A</td>
<td>R 1 - R 2 749</td>
<td>R 1 090</td>
</tr>
<tr>
<td>02-B</td>
<td>R 2 750 - R 3 999</td>
<td>R 1 560</td>
</tr>
<tr>
<td>03-C</td>
<td>R 4 000 - R 5 999</td>
<td>R 2 040</td>
</tr>
<tr>
<td>04-D</td>
<td>R 6 000 - R 7 499</td>
<td>R 2 820</td>
</tr>
<tr>
<td>05-E</td>
<td>R 7 500 - R 9 999</td>
<td>R 3 540</td>
</tr>
<tr>
<td>06-F</td>
<td>R 10 000 - R 12 499</td>
<td>R 4 060</td>
</tr>
<tr>
<td>07-G</td>
<td>R 12 500 - R 14 999</td>
<td>R 4 570</td>
</tr>
<tr>
<td>08-H</td>
<td>R 15 000+</td>
<td>R 5 220</td>
</tr>
</tbody>
</table>
Contact Us

J C C I House
27 Owl Street
Cnr Empire Road
Milpark
Tel: 011 208 1005
E-mail: bcima@universal.co.za

P O Box 3201
Johannesburg
2000
Fax: 0867 266 633
011 208 1026

Should you have any queries, or require any further information please contact:

Claims & Administration:
Direct Tel: 011 208 1005
Direct Fax: 0865 292 757
E-mail: claims@universal.co.za

Hospital Pre-Authorisation:
Direct Tel: 011 208 1100
Direct Fax: 0862 957 355
E-mail: preauthorisation@universal.co.za

Contribution Department:
Yolande Disney
Direct Tel: 011 208 1369/1370
Direct Fax: 0865 292 738
E-mail: bcimafund@universal.co.za

Membership:
Lindi Nemulalate
Direct Tel: 011 208 1271/1404
Direct Fax: 0865 292 566
E-mail: bcimafund@universal.co.za

Operations Manager:
Sarie Lowings
Direct Tel: 011 208 1380
Direct Fax: 0865 292 580
E-mail: bcimafund@universal.co.za

Fund Manager:
Hélana Ueckermann
Direct Tel: 011 208 1228
Direct Fax: 0865 328 067
Email: helana.ueckermann@universal.co.za

Council for Medical Schemes:
General Queries and Complaints
Private Bag X34
Hatfield
0028
Share Call: 0861 123 267
E-mail: support@medicalschemes.com
complaints@medicalschemes.com

Key Account Manager:
Patrick Geqeza
Direct Tel: 011 208 1321
Mobile: 060 449 7150
E-mail: bcimafund@universal.co.za

Principal Officer:
Mr Bernard le Roux
Direct Tel: 011 208 1250
Direct Fax: 011 803 6237
E-mail: bernardleroux@iafrica.com

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
All information relating to the 2018 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.