BMW
Employees
Medical Aid Society

Administered by
Discovery
Health



BMW EMPLOYEES

Medical Aid Society

BENEFIT BROCHURE 2027

A 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, we refer to BMW Employees Medical Aid Society 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

Society website | **www.bemas.co.za**

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

This does not replace the Society rules. The registered Society rules are legally binding and always take precedence.

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 > Society rules** or email **service@bemas.co.za**

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



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SUMMARY OF BENEFITS

Detailed explanations of our benefits are available on the Society's website: www.bemas.co.za. Each member has a total yearly benefit limit of R795 000. ***This amount adds up to the overall annual limit (OAL) with a maximum of R1 590 000 for a family.***

You have extended cover (gap cover) for certain procedures done during a hospital admission. We will cover services for certain procedures your healthcare professionals 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 as long as the Society has authorised your hospital 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.

Prescribed Minimum Benefits include cover for a list of 271 conditions, emergency medical 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 > Find A Document > Guides and Applications > Benefit Guides** 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** or you can contact us on **0860 002 107.**

COVER FOR MEDICAL EMERGENCIES

WHAT IS A MEDICAL EMERGENCY?

An emergency medical condition is the sudden and unexpected onset of a health condition that needs immediate medical or surgical treatment, where not providing 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 danger.

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 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 up to your day-to-day benefit limit.

EMERGENCY SERVICES

BEMAS MEMBERS HAVE ACCESS TO WORLD-CLASS EMERGENCY MEDICAL CARE

Our emergency line 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 benefit includes the following services:

- 24-hour emergency services call centre operated by Netcare 911
- Discovery 911 Alert
- Transfers between hospitals

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

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 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 are in hospital up to the Society Rate.

Limits, clinical guidelines and policies apply to some healthcare services. 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) 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 include 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 overall annual limit. 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 such as 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 about how we will pay for your hospital stay. Please refer to the section on cover for medical emergencies for more information.

  If you don't get authorisation for a planned hospital admission at least 48 hours beforehand, you may have to pay R5 700.

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 the Hospital Benefit does not pay for, 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.

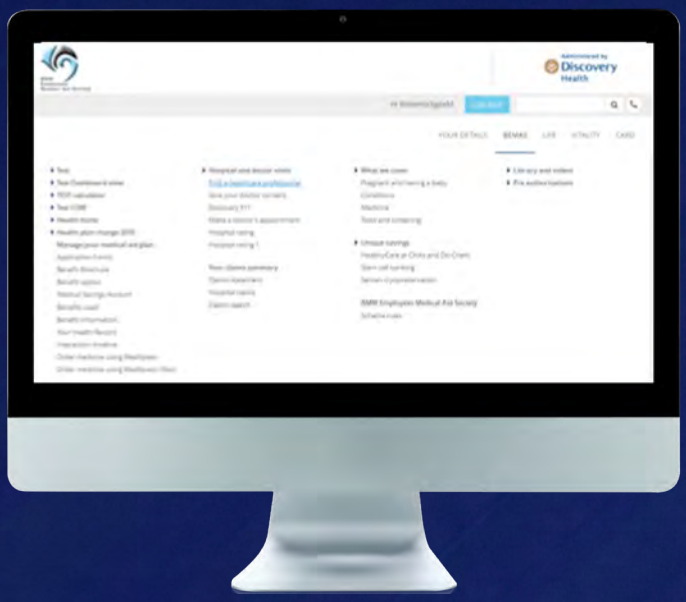
Gap cover

Gap cover (additional cover) is only applicable for in-hospital procedures. You only have additional cover for procedures done while you are admitted to hospital. We cover the services of medical and dental specialists, general and dental practitioners, physiotherapists, radiologists and pathologists up to a maximum of 150% of the Society Rate. In other words, we automatically pay an amount up to 50% above the Society Rate for these services, subject to applicable limits.

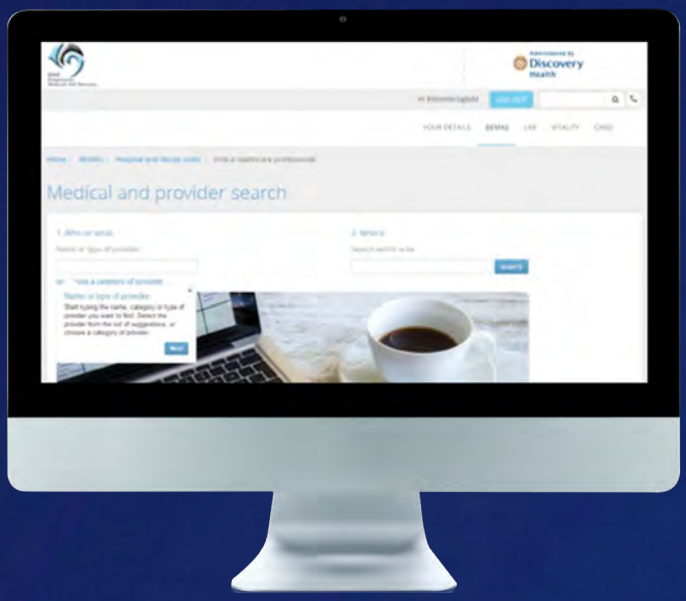
BENEFIT TIPS

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 to pay part of the cost yourself (have a co-payment) for the planned procedure.

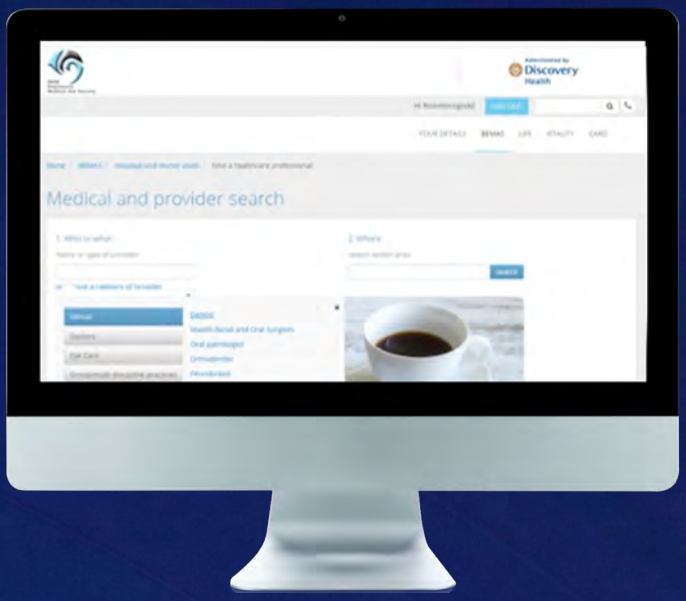
FIND A HEALTHCARE PROFESSIONAL



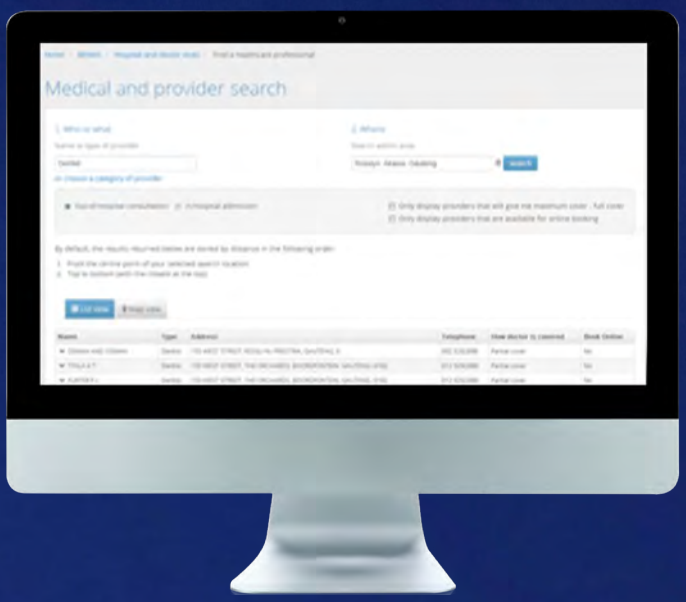
1 Go to **www.bemas.co.za** and log in with your username and password.



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



3 The page will open our **Medical and provider search** tool.



4

There are two sections:

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

The **Who or what** section gives you two options. You have to type in the name of the healthcare professional or 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 doctor you need, for example, **Psychiatrist**.
Next to **Who or what** is the location field for location (province, city or suburb). After filling in all your requirements, for example: **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 THAT COVER FAR MORE THAN THE PRESCRIBED MINIMUM BENEFITS.

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

- Your medical condition must be on the list of Prescribed Minimum Benefits and qualify for cover (meet the clinical entry criteria).
- Your treatment has to be the same as the treatment covered as a Prescribed Minimum Benefit.
- For full cover for Prescribed Minimum Benefits, you have to use our designated service providers. This does not apply in a medical emergency (see page 6).

  However, even in a medical emergency, if appropriate and according to the rules of the Society, you may be transferred to a designated service provider, otherwise you may have to pay part of the cost yourself. We pay up to the Society Rate and you have to pay the rest.

The specific treatment for a Prescribed Minimum Benefit condition is set out in the Diagnosis and Treatment Pairs. This aligns with the level of care in the public sector. The cost-effective treatment can include medicine, consultations and medical 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

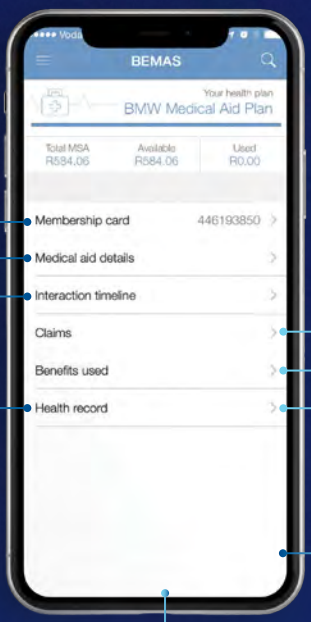
Submit claims by taking a photo of your claim using your smartphone camera and submitting it. You can also view a detailed history of your claims.

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

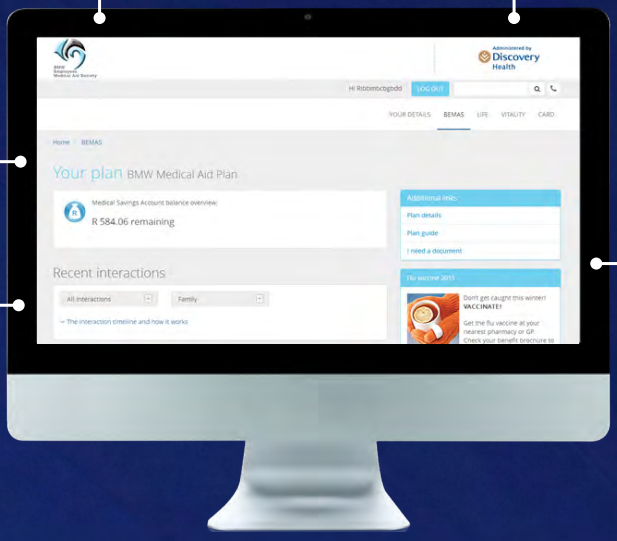
Our website has been designed to work on a variety of different digital devices – your computer, your tablet and your cellphone. No matter what size the screen, the information will always be customised to your particular device, making it easy to read.

KEEPING TRACK OF YOUR BENEFITS

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

FINDING A HEALTHCARE PROFESSIONAL

You can use our Medical and Provider Search 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. Whether you are looking for your tax certificate, membership certificate or simply looking for an application form, we have them all stored on our website.

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, as long as we've approved them subject to applicable limits.

COVER FOR NON-NETWORK SPECIALISTS

We cover you up to 100% of the Society Rate in hospital. You may have to pay part of the cost yourself if your specialist charges more than the Society Rate. We pay out-of-hospital specialist consultations at 100% of the Society Rate. These consultations count towards 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 you up to 100% of the Society Rate in hospital. You may have to pay part of the cost yourself if your GP charges more than the Society Rate. We pay out-of-hospital GP consultations at 100% of the Society Rate if you use a network or a non-network GP. These consultations will add up to the consultations and visits limit for GPs and specialists. 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 overall annual limit. 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 up to your overall annual limit. We only pay for local or regional anaesthetics or, at most, for conscious sedation for scopes. We do not pay for general anaesthetic for procedures performed in a doctor's rooms unless it is a Prescribed Minimum Benefit.

MRI and CT scans

If your MRI or CT scan is done as part of an authorised admission, we pay it from the overall annual limit 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, including HIV/AIDS. 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 Chronic Drug Amount (CDA) 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 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 Illness Benefit application form* with your doctor and submitting it for review. You can get the latest application form on **www.bemas.co.za > Find a document**. For a condition to be covered from the Chronic Illness Benefit, there are certain benefit entry criteria that the member's condition needs to meet.

If we approve funding for your condition from the Chronic Illness Benefit, the Chronic Illness Benefit covers certain procedures, tests and consultations for the diagnosis and ongoing management of the 27 Chronic Disease List conditions in line with Prescribed Minimum Benefits.

To make sure that we pay your claims from the correct benefit, we need the claims from your healthcare professionals to be submitted with the relevant ICD-10 diagnosis code(s). Please ask your doctor to include your ICD-10 diagnosis code(s) on the claims they submit and on the form that they complete when they refer you to pathologists and radiologists for tests. This will allow pathologists and radiologists to include the relevant ICD-10 diagnosis code(s) on the claims they submit to ensure that we pay your claims from the correct benefit.

YOU NEED TO LET US KNOW WHEN YOUR TREATMENT PLAN CHANGES

You do not have to complete a new Chronic Illness Benefit application form when your treating doctor changes your medicine during the management of your registered chronic condition. However, you do need to let us know when your doctor changes your treatment so that we can update your chronic authorisation. You can email the prescription for changes to your treatment plan for a registered chronic condition to **CIB_APP_FORMS@bemas.co.za**. Otherwise, your doctor can let us know of the change using HealthID as long as you have given your consent for them to do so. If you do not let us know about changes to your treatment plan, we may not pay your claims from the correct benefit.

If you are diagnosed with a **new chronic condition**, you and your doctor need to complete and submit a new Chronic Illness Benefit application form.

Here is the list of 27 Chronic Disease List conditions that we cover from the Chronic Illness Benefit:

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disease (COPD)
- 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

*Managed through the HIVCare Programme

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.

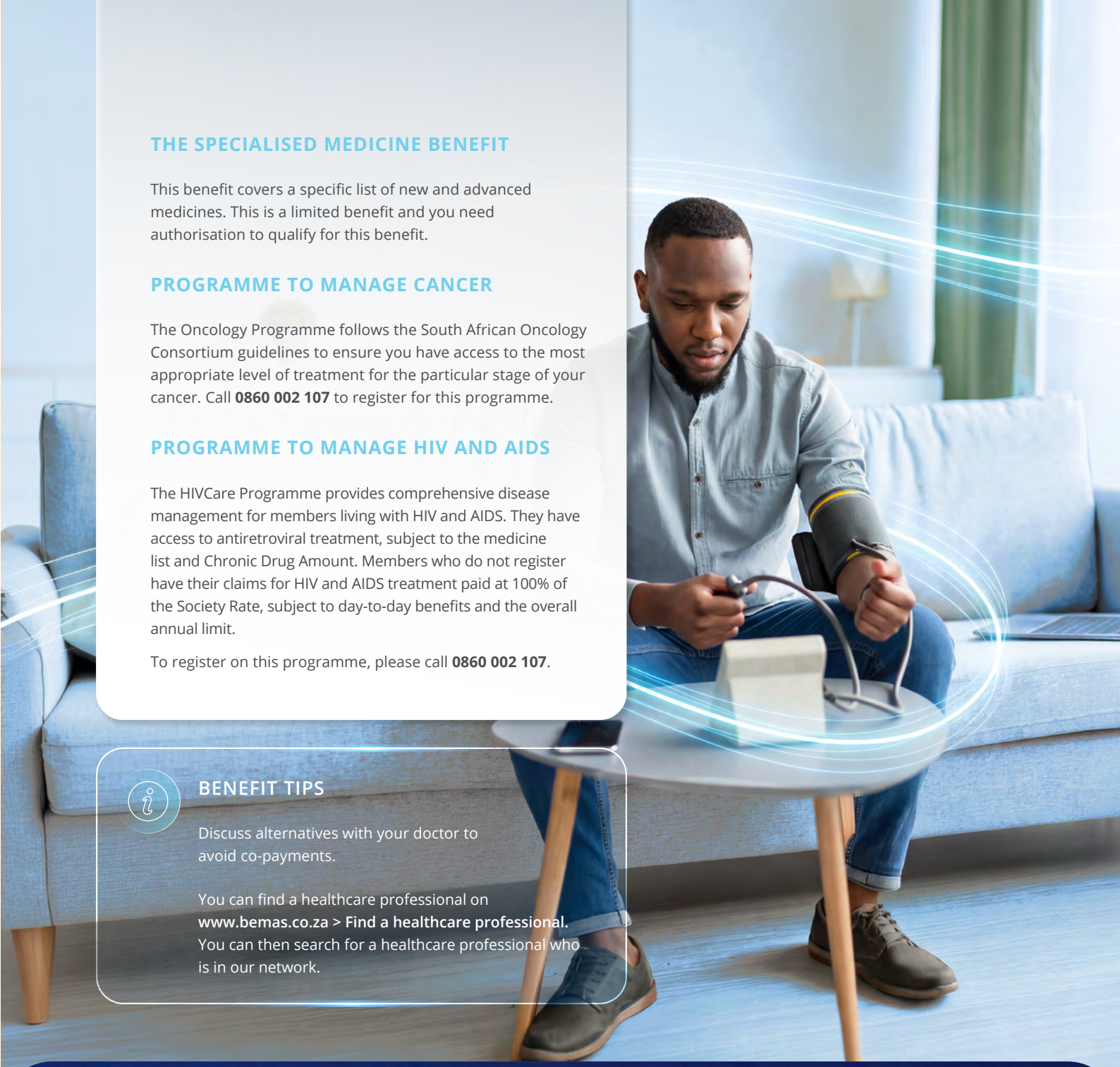
PROGRAMME TO MANAGE CANCER

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 cancer. Call **0860 002 107** to register for this programme.

PROGRAMME TO MANAGE HIV AND AIDS

The HIVCare Programme provides comprehensive disease management for members living with HIV and AIDS. They have access to antiretroviral treatment, subject to the medicine list and Chronic Drug Amount. Members who do not register 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

Discuss alternatives with your doctor to avoid co-payments.

You can find a healthcare professional on **www.bemas.co.za > Find a healthcare professional.** You can then search for a healthcare professional who is in our network.

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

- Ankylosing spondylitis
- Behçet'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 younger than 18 years
- 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
- Sjögren's syndrome
- Systemic sclerosis

Claims for all chronic medicine add up to a yearly limit. We will only continue funding medicine for approved Chronic Disease List (CDL) conditions once you have reached the yearly limit.

DAY-TO-DAY COVER

Day-to-day claims are for healthcare services you need 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 read the Benefit Schedule to find out the details on your cover for day-to-day benefits and the limits for different benefits.

You do not have to pay part of the cost (have a co-payment) if you visit network GPs and network specialists, or get medicine you have to take for a short time (acute medicine) on the Society medicine list from a network pharmacy. We fund generic and brand-name medicine at 100% of the Society Rate for medicine.

THE DAY-TO-DAY LIMITS (THE BENEFIT LIMIT FOR EACH MEMBER IS LIMITED TO R10 200 A YEAR).

MEMBERS	COST
Member	R10 200
Member + 1 dependant	R15 100
Member + 2 dependants	R18 100
Member + 3 dependants	R21 000
Member + 4 or more dependants	R23 900



BENEFIT TIPS

Discuss the medicine you're prescribed with your pharmacist or doctor to avoid co-payments.

You have a co-payment of 20% on all other day-to-day benefits.

The following benefit categories are funded up to the 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.

COVER FOR ACUTE MEDICINE

A Preferred Medicine List for acute medicine

We call medicine that you have to take for a short time `acute medicine'. You have cover for certain cost-effective brand-name medicine that is on our Preferred Medicine List. The list has brand-name and generic medicine on it.

You have full cover for medicine on the Preferred Medicine List if you use a pharmacy in our network. We pay up to 75% of the Society Rate for all other medicine.

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.



CARE AND SUPPORT PROGRAMMES

EMERGENCY ROOM (ER)/ CASUALTY GP NETWORK

The benefit gives you access to a network of ER GPs who are able to assist you in preventing non-urgent visits to the ER, whilst continuing to support access to high quality of care emergency medicine.

HEALTH @ HOME

Health @ Home includes a number of programmes that give members access to a range of quality hospital-level healthcare services in the comfort of their home for a defined list of medical conditions. Members have to meet the clinical entry criteria and care at home has to be clinically appropriate.

POINT OF CARE TESTS

The benefit allows your treating provider to administer a defined list of tests in the doctors' rooms, without the need to visit a laboratory. The tests are conducted by means of fully integrated and approved devices that link directly to your digital health profile and provide immediate results for quicker diagnosis and treatment.

GP VIRTUAL HOUSE CALL

This service is available to members registered on the Chronic Illness Benefit. A GP will reach out through a virtual consultation if a member is identified as being at high risk of being admitted to hospital and an intervention can reasonably be expected to prevent the admission.

MINOR PROCEDURES IN DOCTOR'S ROOMS

Members are able to receive the required level of service at the appropriate time, by the appropriate healthcare professional, in the appropriate setting or place of care. This benefit is available for a defined list of procedures and subject to the Society's clinical entry criteria.

ADVANCED ILLNESS MEMBER SUPPORT PROGRAMME (AIMSP)

The advanced illness member support programme offers support before it's necessary to register on the Advanced Illness Benefit (AIB). It gives patients access to healthcare professionals who specialise in palliative (supportive) care. The programme allows members to establish relationships and create links to support and maintain their wellbeing until the time comes when they might need to use the AIB.

ADVANCED ILLNESS BENEFIT (AIB)

This programme is offered to oncology patients in the advanced stage of their illness, subject to the patients meeting clinical entry criteria. This benefit is unlimited and gives patients access to palliative care by a multidisciplinary team. The basket of care can cover medicine, oxygen, psychosocial support, nursing care, hospice, pain management, radiology, pathology and physiotherapy. The care is based on the treatment plan submitted by the doctor and approved by the Society. The costs of the programme do not have an impact on the member's day-to-day benefits.

MEMBER CARE PROGRAMME (MCP)

The Society offers a customised, voluntary outpatient programme for members who have complex medical needs and who meet the clinical entry criteria. Members receive high quality, patient-centric care and chronic condition management to improve the quality, continuity and efficiency of their care.

MENTAL HEALTH CARE PROGRAMME

The Mental Health Care Programme, together with your healthcare professional, will help you actively manage episodic depression. This Programme gives you and your healthcare professional access to tools and benefits to monitor and manage your condition to ensure you get high quality and coordinated healthcare.

HOW TO JOIN THE MENTAL HEALTH CARE PROGRAMME

A Nominated PCP on the Premier Plus network or a Psychologist in the Mental Health Care Programme network can enroll you on the programme through Health ID, provided you give consent.

YOUR NETWORK GP AND PSYCHOLOGIST WILL WORK WITH YOU TO MANAGE YOUR CONDITION

The Mental Health Care Programme gives you and your healthcare professional access to tools and benefits to monitor and manage your condition and to ensure you have access to coordinated care.

Your healthcare professional can track your progress on a personalised dashboard on HealthID. This will help to identify which areas require attention so that your healthcare professional can improve the management of your condition.

The Mental Health Care Programme runs over a 6-month period but can be extended to 12-months by your enrolling provider, where clinically appropriate.

MENTAL HEALTH RELAPSE PREVENTION

The Depression Relapse Prevention Programme seeks to reduce the risk of chronicity of Major Depression and to prevent multiple admissions to hospital for depression related illnesses. A Risk Intelligence prediction tool is used to identify members who are at risk of being admitted to hospital for a depression related illness and at risk of a relapse thereafter.

PRIMARY CARE PROVIDER FOR CHRONIC CARE

Members who have registered on the Chronic Illness Benefit, Out-of-Hospital Prescribed Minimum Benefit (OHPMB) and the HIV Programme can nominate a Primary Care Provider within the GP network for full cover of their chronic consultations. The Society will pay 100% of the Society Rate for network General Practitioners. You can change your nomination three times every calendar year.

BENEFITS

- Counselling and education by registered counsellors over a 6-month period
- Access to the Relapse prevention basket of care which includes a defined number of psychiatry visits and sessions with any of the following allied healthcare professionals:
  - Psychologists
  - Occupational therapists
  - Social workers
  - Registered counsellors

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



BENEFIT PLATFORM



Your benefits:

ONCOLOGY BENEFIT

- Extensive cancer cover.
- Access to the latest technology and treatment
- Cover for radiotherapy and chemo-therapy
- Cover for scans and related treatment
- Supportive therapy included

SPECIALISED MEDICINE BENEFIT

- Cover for a defined list of latest treatments
- Includes biologics
- Up to R204 000 for each person each year
- 100% of Society Rate for medicine

HOSPITALISATION

- Extensive private hospital cover is available at hospitals in South Africa.
- You must get preauthorisation for hospitalisation, except in an emergency. Members have 48 hours after an emergency admission to get authorisation.
- Get preauthorisation for a planned hospital stay at least 48 hours beforehand.

  If you don't get preauthorisation at least 48 hours before your hospital admission, you may have to pay R5 700.

CHRONIC ILLNESS BENEFIT

- Provides cover for medicine for conditions where ongoing medicine is required.
- Cover for a list of 27 conditions called the Prescribed Minimum Benefit (PMB) Chronic Disease List conditions.
- You have to apply by sending us an application form.
- You and your doctor need to complete the form.
- We will tell you whether we have approved cover or not.
- If approved, we fund claims for your chronic condition from this benefit.

SCREENING BENEFIT

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

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, wilfully inflicted injuries, or sickness conditions arising due to body piercing or their complications outside of Prescribed Minimum Benefit (PMB) requirements
- Costs related to drug abuse, unless treatment is received in state facilities, SANCA or Ramot, covered as PMB only
- Costs related to treating 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 hiring 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, multivitamins, vitamin combinations – unless the vitamins are for pregnancy or breastfeeding – prenatal, lactation and paediatric use – or unless authorised as part of one of our disease management programmes
- Anti-smoking preparations
- Aphrodisiacs
- Anabolic steroids
- Treatment for erectile dysfunction
- Mouth protectors and gold dentures
- Examinations for insurance, school camps and visas
- Stimulant laxatives
- Antidiarrhoeal micro-organisms replacement therapy for natural gut flora
- Accommodation in old age homes
- Accommodation and treatment in spas and resorts
- Holidays for recuperation
- Appointments not kept
- 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 treatment is a PMB
- 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 in this list, except if it is 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. We review these benefits each year and update them in line with the Medical Schemes Act. We also take into account the requirements of the Consumer Protection Act where it relates to the business of a medical scheme. You can access the full set of our Society's rules by logging in to www.bemas.co.za > Society Rules.

YOUR BENEFITS FOR 2027

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 get preauthorisation, you may have to pay R5 700 yourself. 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 preassessment.		
Hospital and hospital-related benefits	–	Subject to an overall annual limit of R1 590 000 for a family and limited to R795 000 for each member
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	R425 000 for a member. Subject to overall annual limit. This is subject to preauthorisation
Hospitalisation for substance abuse and mental health	150% of Society Rate	R61 750 for a family or 21 days for a member each year. Limited to one rehabilitation programme for each person a year
Maxillofacial 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	R80 750 for a family each year
Cochlear implants	100% of cost	R332 500 for a member each year
HIV and AIDS	100% of Society Rate for all relevant treatment and antiretrovirals 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
Cancer (including hospitalisation, chemotherapy and consultations, radiotherapy, pathology, brachytherapy, scopes and scans)	100% of Society Rate	R942 500 for a family
Cancer – specialised medicine	100% of Society Rate	R427 500 for a family
Chronic medicine	100% of Society Rate for medicine on the medicine list (formulary). Medicine not on the medicine list is funded up to the Chronic Drug Amount (CDA).	R44 900 for a person each year, then Prescribed Minimum Benefits only

YOUR BENEFITS FOR 2027

BENEFIT	RATE	LIMIT
Basic dentistry	100% of Society Rate	R2 250 for a member each year You have an upfront payment (deductible) for dental procedures done in hospital or at a day clinic. Members younger than 13 years have a hospital deductible (upfront payment) of R2 950 and a deductible of R1 450 at a day clinic Members 13 years or older will have a hospital deductible (upfront payment) of R8 000 and a deductible of R4 950 at a day clinic
Maternity	100% of Society Rate	Subject to a limit of R9 200 a pregnancy and has the following sub-limits: • Pregnancy scans: two 2D pregnancy scans for a pregnancy. We fund 3D and 4D scans up to the maximum of the cost of a 2D scan • Antenatal consultations: 12 with a specialist, GP or midwife for a pregnancy • One amniocentesis 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. You must register for the Maternity Benefit to get access to its cover. You have to get preauthorisation and meet our clinical entry criteria. These services include: • A nurse – 5 classes to use during the pregnancy or five visits up until baby's second birthday • Prenatal screening or non-invasive prenatal testing (NIPT) – 1 for each pregnancy • Blood tests – a set basket of routine pregnancy tests for each pregnancy • Dietician nutrition assessment – 1 for each delivery • Mental health consultations – 2 consultations for each delivery with either a GP, gynaecologist, or a psychologist • Consultations for infants up to 100% of the Society Rate, or agreed rate for children under the age of two • You have to pay R3 500 if you have a Caesarean section and it is not a medical emergency.
Day-to-day benefits **Consultation and visits for speech therapy, occupational therapy, dietitians, physiotherapy, audiology, chiropractics, podiatry, social workers, etc.**	80% of Society Rate. You have to pay the rest to the healthcare professional at your appointment.	Main member only R10 200 Member + 1 R15 100 Member + 2 R18 100 Member + 3 R21 000 Member + 4+ R23 900 Limited to R10 200 for each member
Comprehensive consultation, including tonometry, glaucoma and visual screening	100% of Society Rate for one comprehensive consultation for a member	Subject to overall annual limit
Frames	100% of Society Rate	Limited to R1 790 for each member every two years
Lenses	100% of Society Rate	One pair of single vision lenses for a member each year or one pair of bifocal lenses for a member each year or one pair of multifocal lenses for a member each year

YOUR BENEFITS FOR 2027

BENEFIT	RATE	LIMIT
Contact lenses	100% of Society Rate	As an alternative to frames and lenses, members may choose to have contact lenses, limited to R4 650 for each member a year
Readers	–	Subject to the frames limit and limited to R200 for a member every two years
Refractive eye surgery	100% of Society Rate	Limited to R34 100 for a member each year (regardless of place of service)
Intraocular lens implants	100% of Society Rate	Limited to R4 850 for each beneficiary each year
Radiology and pathology	100% of Society Rate	R11 900 for a family each year
Out-of-hospital consultations for substance abuse and mental health	100% of Society Rate	R8 300 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	A yearly limit of R1 200 for a member. Subject to day-to-day benefits. Once the limit of R1 200 has been reached, the Society will fund schedule 0, 1 and 2 medicine from the Acute Medicine Benefit as long as there is a prescription.
Ambulance	100% of Society Rate	Subject to overall annual limit
Medical appliances	100% of Society Rate	• Medical and surgical: R14 800 for a family. This includes medical appliances such as blood pressure monitors and nebulisers. Please note that diabetic accessories excluding glucometers must be claimed from your Chronic Illness Benefit. • CPAP machines: R26 800 for a family (combined medical and surgical appliance and CPAP limit) • Stoma products: R26 800 for a family (combined medical and surgical appliance and Stoma limit)
Hearing aid	100% of Society Rate	The hearing aid limit is R39 100 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) calculation. 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 network provider. Members must pay for these tests once they reach the benefit limit	Two tests for a member each year included in the overall annual limit.

DEFINITIONS

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. 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 above are calculated for 1 January 2027 to 31 December 2027, based on the services provided during the year. If a member joins during the year, we calculate the maximum yearly benefit based on the number of months left in a year. Benefits are not transferable from one benefit period to another or from one category to another.

WHAT'S CHANGING IN 2027

There are a few important updates to your BEMAS benefits and contributions for 2027:

Benefit limits: Benefit limits will increase by 4% from 1 January 2027.

Contributions: Contributions will increase by 4% from 1 July 2027, meaning your contribution remains unchanged for the first six months of the year.

GLP-1 medicines: From 1 January 2027, day-to-day funding for GLP-1 medicines will be available to members registered for Type 2 diabetes, subject to the applicable benefit limits. Clinically justified use for other conditions may be considered through the Scheme's exception process, supported by a medical motivation.

MAIN MEMBER ONLY		FOR EACH ADULT DEPENDANT		FOR EACH CHILD DEPENDANT	
Total monthly contribution	**R3 532**	Total monthly contribution	**R3 532**	Total monthly contribution	**R1 771**

This brochure is a summary of the benefits and features of BMW Employees Medical Aid Society, pending formal approval from the Council for Medical Schemes. The registered rules are binding and take precedence over the Benefit Brochure and Benefit Schedule.

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



TIPS TO HELP YOU AVOID CO-PAYMENTS AND OUT-OF-POCKET COSTS

A few simple choices can help you make the most of your BEMAS benefits and reduce what you may need to pay yourself:

- **Use network healthcare providers.** Where possible, choose BEMAS network GPs, specialists and other healthcare providers. This can help you avoid additional costs.
- **Check what your provider charges.** Ask whether your doctor or specialist charges the BEMAS Society Rate. If they charge more, you may need to pay the difference yourself.
- **Get preauthorisation before planned procedures.** Contact BEMAS at least 48 hours before a planned procedure and confirm how the procedure and healthcare professionals involved will be covered.
- **Ask for a quote upfront.** For planned treatment, ask your healthcare provider for a quote and check your cover with BEMAS before proceeding, particularly if the provider is not in the Society's network.
- **Use network pharmacies and preferred medicines.** For acute medicine, using a network pharmacy and medicine on the Society's Preferred Medicine List can help you get the most from your cover and avoid unnecessary co-payments.
- **Ask about medicine alternatives.** Speak to your doctor or pharmacist about generic or preferred alternatives that provide the same appropriate treatment at a lower cost.
- **Know your day-to-day cover.** Some out-of-hospital services attract a 20% co-payment, so check your Benefit Schedule and available limits before receiving non-urgent treatment.
- **Use designated service providers for PMBs.** If you are receiving treatment for a Prescribed Minimum Benefit, using the Society's designated service providers helps ensure you receive the appropriate level of cover.
- **Check before you go to casualty.** If you visit casualty and are not admitted to hospital, the cost is paid from your day-to-day benefits.
- **Before you receive treatment: Check the provider. Check the cost. Check your cover.** Use 'Find a healthcare professional' on the BEMAS website to locate network providers, or contact BEMAS on 0860 002 107 if you are unsure about your cover.

IMPORTANT TIPS WHEN CLAIMING

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

1 | Ask your healthcare professional if they send the claim directly to us. If they do, you don't have to follow the rest of this process.

2 | **Send your claims within four months from the service date, 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 who received the Healthcare service
- 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 BMW Employees Medical Aid Society, pending approval from the Council for Medical Schemes.

CONTACT US

FOR AMBULANCE AND OTHER EMERGENCY SERVICES

Call Discovery 911: **0860 999 911**

GENERAL QUESTIONS

Email: **service@bemas.co.za**
Call centre: **0860 002 107**

TO SEND CLAIMS

Email: **claims@bemas.co.za**

ONCOLOGY SERVICES

Email: **oncology@bemas.co.za**
Call centre: **0860 002 107**

OTHER SERVICES

HIV*Care* Programme: **0860 002 107**
Digital Support: **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 get preauthorisation for a hospital stay
Call us from a landline: **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 33490 and include a description of the suspected fraud

Email: **forensics@discovery.co.za**

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's 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.

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's 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.

WHO?

The CMS governs the medical schemes industry and therefore your complaint should be related to your medical scheme. Any member 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 them 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 three 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.

THE COUNCIL FOR MEDICAL SCHEMES

In terms of Section 47 of the Medical Schemes Act 131 of 1998, a written complaint received about any matter provided for in this Act will be referred to the medical scheme. The medical scheme must 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: **086 206 8260**

GENERAL QUESTIONS

Email: **information@medicalschemes.co.za**
Website: **www.medicalschemes.com**

COMPLAINTS

Fax: **086 673 2466**
Email: **complaints@medicalschemes.co.za**

POSTAL ADDRESS

Private Bag X34
Hatfield
0028

PHYSICAL ADDRESS

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





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

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

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