Summary of benefits

SERVICE	BENEFIT (subject to the annual limit of R1 800 000 per family per annum)	ANNUAL LIMITS	CONDITIONS/REMARKS
PRIVATE AND PUBLIC (STATE) HOSPITALS, REGISTERED, UNATTACHED OPERATING THEATRES AND DAY CLINICS		Subject to overall annual limit	Subject to pre-authorisation by the Society's DSP See overleaf for further details on the pre-authorisation process and co-payments
Accommodation in a general ward, high-care ward and intensive care unit; theatre fees	100% of agreed tariff at DSP or 90% of agreed tariff at other providers		
Medicines, materials and hospital equipment	100% of cost (TTO limited to seven days) at DSP or 90% of agreed tariff at other providers		
Visits by medical practitioners	100% of cost up to a maximum of two times the Scheme rate		
Nursing services and all other non-psychiatric, in-hospital services; confinement and midwives	100% of agreed tariff at DSP or 90% of agreed tariff at other providers		
SURGICAL PROCEDURES All in-hospital services, namely operations, procedures and consultations	100% of cost, up to a maximum of two times the Scheme rate	Subject to overall annual limit	Subject to pre-authorisation Excludes dental implants unless indicated as an essential part of another pre-authorised dental procedure Includes elective orthognatic surgery and maxillo-facial surgery
IN-HOSPITAL PSYCHIATRIC TREATMENT			
Accommodation	100% of cost or 100% of Scheme rate	Limited to 21 days pbpa	Includes treatment for substance abuse Includes treatment on a day patient basis, in lieu of hospitalisation; subject to pre-authorisation See overleaf for details on how to apply for additional benefits
Medicines, materials and hospital equipment	100% of cost (TTO limited to seven days)		
Visits by medical practitioners	100% of Scheme rate		
IN-HOSPITAL PHYSIOTHERAPY AND AUXILIARY SERVICES (including audiology, occupational therapy and speech therapy)	**PMB:** 100% of cost **Non-PMB:** 100% of Scheme rate	Subject to overall annual limit	Subject to pre-authorisation
SUB-ACUTE FACILITIES/ ALTERNATIVES IN LIEU OF HOSPITALISATION			
Step-down nursing facilities	100% of Scheme rate or agreed tariff at DSP		Excludes frail care facilities Subject to pre-authorisation Post hospitalisation benefit must be in accordance with an authorised treatment plan; the Society's DSP will arrange and manage the appropriate alternatives to hospitalisation on discharge, in accordance with the beneficiary's clinical motivation from doctors and case managers
Private nursing (in lieu of hospitalisation)	100% of Scheme rate	R17 900 pfpa	
Hospice	100% of Scheme rate		
Post-hospitalisation benefit	100% of Scheme rate, or cost where no Scheme rate exists	90 days per diagnosis	
REHABILITATION		Subject to overall annual limit	Subject to pre-authorisation Includes extended physiotherapy, occupational therapy, speech therapy and biokinetics of a rehabilitative nature that is preceded by hospitalisation Such treatment must be connected to an approved rehabilitative treatment plan and must commence within two weeks of discharge from hospital The cardiac rehabilitation benefit provides for an initial three-month, intensive rehabilitation benefit, followed by a three-month continuing care benefit
Following a hospital event (post discharge)	100% of Scheme rate		
Maintenance therapy	100% of Scheme rate	Limited to R9 250 pfpa	
Cardiac rehabilitation benefit (post discharge from hospital)	100% of Scheme rate at accredited providers		
RADIOLOGY	**PMB:** 100% of cost		Excludes **PET** scans, unless authorised as part of the Oncology Programme, or if deemed clinically appropriate and medically necessary by the Society's DSP In respect of **PMB** conditions, radiology must be detailed in the care plan, to be paid at 100% of cost See overleaf for details on how to apply for additional benefits
Basic • All X-rays	**Non-PMB:** 100% of agreed tariff out of hospital 100% of agreed tariff in hospital	R990 pbpa Subject to overall annual limit	
Ultrasounds	**Non-PMB:** 100% of Scheme rate, both in and out of hospital	Subject to overall annual limit	
Advanced • MRI and CT scans • Scopes (diagnostics) • Angiography • Nuclear medicine studies	**Non-PMB:** 100% of Scheme rate, both in and out of hospital	Subject to pre-authorisation	
PATHOLOGY	**PMB:** 100% of cost **Non-PMB:** 80% of agreed tariff out of hospital 100% of agreed tariff in hospital		In respect of PMB conditions, pathology must be detailed in the care plan for the treatment of the PMB condition to be paid at 100% of cost

Effective 1 January 2015

Unless excluded as provided for in Annexure C (for a detailed benefit schedule, please visit www.bpmas.co.za.)

SERVICE	BENEFIT (subject to the annual limit of R1 800 000 per family per annum)	ANNUAL LIMITS	CONDITIONS/REMARKS
ORGAN TRANSPLANTS (includes harvesting of organs)	**PMB:** 100% of cost **Non-PMB:** 100% of agreed tariff at DSP	R150 000 pfpa	Subject to pre-authorisation Recipient must be a member of the Society; if only the donor is a member of the Society, the Society will not cover the cost of harvesting the organ from the donor Including anti-rejection medication, but excluding hospitalisation and related costs, which are covered under the hospitalisation benefit detailed above
KIDNEY DIALYSIS	100% of cost		Subject to pre-authorisation
BLOOD TRANSFUSIONS	100% of cost		Includes cost of blood, blood equivalents, blood products and transport of blood Subject to pre-authorisation
PROSTHESES (internal and external)	100% of agreed tariff	R18 750 pbpa per prosthesis, excluding PMBs and certain prostheses for which individual limits have been set; see overleaf for details of these individual prostheses limits Multiple external and internal prostheses are subject to a joint overall limit of R67 950 pbpa	**External:** Eyes and limbs, e.g. legs and arms **Internal:** Appliances placed in the body to replace body parts during an operation; excluding dental implants Subject to pre-authorisation by the Society's DSP See overleaf for details on how to apply for additional benefits, and the limits applicable for prostheses
ACUTE AND SELF MEDICATION Medication used to treat a temporary condition or illness, including homeopathic medication	100% of cost up to R1 110 per beneficiary; thereafter 80% of cost	Limits: M R4 090 M + 1 R6 390 M + 2 R7 240 M + 3 + R7 950	Prescribed by a person legally entitled to prescribe Subject to MetRef Self-medication is limited to R180 per ailment and will be paid according to the available acute medication benefits; see overleaf for details of the self-medication benefit Benefit is pro rated if member joins during the year
CHRONIC MEDICATION (excluding specialised medication) Medication for certain specified conditions that are often life threatening and require medication for a period of more than three to six months	**DSP:** 100% of agreed tariff **Non-DSP:** Single Exit Price (SEP) plus the lower of the dispensing fee, as set out in the medicine pricing regulations or the fee that has been agreed upon with the DSP	Limit: R27 800 pbpa (subject to rules governing PMBs) Details on these guidelines are available on www.bpmas.co.za or from the Client Service Department	Includes daily, continuous use of oxygen for a chronic ailment, excluding the cylinder, which is provided for under appliances and consumables relating to chronic disease and/or medical conditions further on Subject to: pre-authorisation from the MRM programme; TRP; your care plan; formulary (where appropriate); and must be prescribed by a person legally entitled to prescribe Member will be liable for a co-payment of 25% if he/she knowingly declines the formulary medicine Once limit is reached, only medication in respect of PMB conditions will be paid Benefit is pro rated if member joins during the year
SPECIALISED MEDICATION	**DSP:** 100% of agreed tariff **Non-DSP:** Single Exit Price (SEP) plus the lower of the dispensing fee, as set out in the medicine pricing regulations or the fee that has been agreed upon with the DSP	Limit: R120 000 pbpa	Only medication on the Society's specialised medicine list will be covered Subject to pre-authorisation and clinical entry criteria Once the limit is reached, only medication in respect of PMB chronic conditions will be paid in full Benefit is pro rated if member joins during the year
OUT-OF-HOSPITAL PREVENTATIVE CARE BENEFITS			
Cardiovascular screenings: Blood pressure Blood glucose Cholesterol Body mass index (BMI)	100% of Scheme rate		These screening tests are to be undertaken by the Society's designated service providers and subject to Society protocols Part of the Multiply programme
Cancer screenings: Mammograms Pap smears Prostate-specific antigen (PSA) Faecal occult blood	100% of agreed tariff and subject to overall annual limit	One pbpa	Subject to Society's protocols List of which is available on www.bpmas.co.za
Vaccinations: Child and infant Human Papillomavirus (HPV) Pneumococcal Flu	100% of agreed tariff and subject to overall annual limit	 Maximum of two per female beneficiary One pbpa One pbpa	A list of approved vaccinations is available on www.bpmas.co.za Female beneficiaries between the ages of 9 and 18
Male Circumcisions	100% of agreed tariffs	Limit: R1 000 if performed in a doctor's rooms	
HIV Screening: Elisa test	100% of cost	One pbpa	
Bone Density Tests	100% of agreed tariff	One pbpa	
Contraceptives		Limit: R1200 pbpa and subject to normal acute medication limit	
Dental consultation (in addition to dental benefit below)	100% of Scheme rate	One pbpa	
Eye test (Acuity, pressure and other tests)	100% of agreed tariff	One pb per two year cycle at PPN (2015/2016)	
Dietician consultation	100% of Scheme rate	One pbpa	

This guide does not replace the rules of the Society. In the case of a dispute the registered rules will apply.
Go to **www.bpmas.co.za** to log on to the BP Medical Aid Society website, or contact the Client Service Department on **0800 001 607** for more detailed information on the rules of the Society and your benefits for 2015.

SERVICE	**BENEFIT** (subject to the annual limit of R1 800 000 per family per annum)	ANNUAL LIMITS	CONDITIONS/REMARKS
SPECIALIST AND GENERAL PRACTITIONER SERVICES Consultations and visits (out of hospital), as well as all other services, unless stated in the benefit schedule Specialist services General practitioner services	 **PMB:** 100% of cost **Non-PMB:** 100% of Scheme rate for the first two consultations pbpa, thereafter 80% of Scheme rate **PMB:** 100% of cost at a network provider **Non-PMB:** 100% of agreed tariff at DSP or 80% of Scheme rate at other providers	Combined limit for specialist and general practitioner services: **PMB:** unlimited **Non-PMB** limits: M R5 470 M + 1 R7 310 M + 2 R9 130 M + 3 + R10 980	Consultations in respect of a PMB condition are subject to the care plan and Appendix 1 of the Society's rules Includes consultations out of hospital (including, but not limited to, chiropractors, homeopaths, biokineticists, ante-natal visits and midwifery, osteopaths, naturopaths, dieticians, podiatrists, chiropodists, ayurvedics and traditional healers, therapeutic massage therapists and outpatient facilities; subject to registration with the HPCSA and AHPCSA) See overleaf for details on how to apply for additonal benefits Benefit is pro rated if member joins during the year
MATERNITY	100% of Scheme rate	Subject to overall annual limit and subject to Society protocols	Subject to pre-authorisation and Society protocols Care plan includes the following: ten obstetric consultations, ten antenatal visits, two ultrasound scans (limited to 2D) and basic pathology tests; additional services, such a tococardiography, external cephalic version, lecithin-sphingomyelin and amniocentesis may be granted where clinically appropriate and medically necessary
AMBULANCE SERVICES (road and air) **Preferred providers** ER24: 084 124 E-med: 081 924 (for Namibian members)	100% of cost at preferred provider, except in case of emergency		Transport to be certified by a medical practitioner as essential Subject to pre-authorisation by the Society's preferred providers for emergency services, failing which the member will be liable for all costs incurred
OUT-OF-HOSPITAL AUXILIARY SERVICES (audiology, audiometry, occupational and speech therapy and orthoptic services)	80% of Scheme rate	R5 660 pfpa	Only treatment/procedures paid from this benefit; consultations paid from specialist and general practitioner services benefit category See overleaf for details on how to apply for additional benefits Benefit is pro rated if member joins during the year
APPLIANCES AND CONSUMABLES RELATED TO CHRONIC DISEASES AND/OR MEDICAL CONDITIONS Wheelchairs, crutches, braces, walking frames and similar equipment Appliances related to chronic diseases and/or medical conditions, e.g. oxygen cylinders and nebulisers (hire or purchase) Consumables related to chronic disease and/or medical conditions, e.g. colostomy kits and other incontinence materials/equipment Diabetic consumables and appliances, including needles, strips and glucometers	 100% of cost 100% of cost 100% of cost 100% of cost	 R9 120 pbpa R9 120 pbpa R17 890 pbpa R3 590 pbpa	 For appliances that are required for a period of more than three to six months Excludes daily use of oxygen, which is included under the chronic medication benefit, and hearing aids, which are provided for in a separate category See overleaf for details on how to apply for additional benefits Subject to pre-authorisation, except for nebulisers Benefit is pro rated if a member joins during the year
ACUTE MEDICAL AND SURGICAL APPLIANCES	80% of cost	R6 150 pfpa	For appliances of an acute nature, prescribed by a person legally entitled to prescribe Includes, but not limited to, braces, slings, splints and corsets, cervical collars, thermo-moulded shoes and post-operative sandals, including bunionectomy, Arco-pedico shoes, air casts, pressure garments, compression hose, cushions, mastectomy breast prostheses, TED compression stockings, the hiring of sleep apnoea monitors for infants and the hiring of wheelchairs, walking frames, crutches, traction equipment, toilet and bath raisers, and bath swivel stools
HEARING AIDS Includes repairs to hearing aids	100% of cost	R16 000 pb per two-year cycle	(Two-year cycle: 2015/2016)
OUT OF HOSPITAL PSYCHOLOGICAL AND PSYCHIATRIC TREATMENT	**PMB:** 100% of cost **Non-PMB:** 80% of Scheme rate	R6 150 pfpa	Consultations in respect of PMB conditions are subject to a care plan and Appendix 1 of the Society's rules Once benefit is exhausted, only consultations and services in respect of PMB conditions will be paid in full Benefit is pro rated if member joins during the year

SERVICE	**BENEFIT** (subject to the annual limit of R1 800 000 per family per annum)	ANNUAL LIMITS	CONDITIONS/REMARKS
CLINICAL AND TECHNICAL TECHNOLOGISTS In-hospital services Out-of-hospital services	100% of cost to a maximum of two times the Scheme rate 100% of Scheme rate		All in-hospital services are subject to pre-authorisation
DENTAL SERVICES (conservative and restorative dentistry [including plastic dentures and extractions under conscious sedation], special dentistry [including metal base dentures] and implants)	100% of Scheme rate or agreed tariff	Limits: M R8 590 M + 1 R12 830 M + 2 R15 900 M + 3 + R17 170	All orthodontic services are subject to prior approval General anaesthetic and hospitalisation for conservative dental work excluded except in the case of trauma and impacted 3rd molars. In-hospital dentistry is subject to prior approval and pre-authorisation by the Society's DSP Benefit is pro rated if member joins during the year
OUT-OF-HOSPITAL PHYSIOTHERAPY	**PMB:** 100% of cost **Non-PMB:** 80% of Scheme rate	R6 120 pfpa, limited to R2 130 pbpa	Benefits in respect of CDL-related PMB conditions are subject to a care plan and Appendix 1 of the Society's rules Once benefit is exhausted, only benefits in respect of PMB regulations will be paid in full Benefit is pro rated if member joins during the year
OPTICAL SERVICES Comprehensive consultation (inclusive of tonometry [glaucoma] screening and visual screening) PLUS: Spectacles • Lenses • Frames and/or prescription lens enhancements OR • Contact lenses in lieu of spectacles (inclusive of consultation) Refractive surgery	100% of cost if obtained from PPN 100% of cost for one pair of clear single-vision spectacle lenses, including charges for extra lenses and prismatic correction when obtained from PPN pb per cycle OR 100% of cost for one pair of clear AQUITY bifocal spectacle lenses when obtained from PPN pb per cycle 100% of cost in and out of network 100% of cost in and out of network Benefit provided under hospitalisation benefit	One pb per cycle Consultations outside network limited to a maximum cost of R310 pb per cycle One pair of clear single-vision spectacle lenses limited to R150 per lens pb per cycle when obtained outside network One pair of clear bifocal or multifocal spectacle lenses, limited to R325 per lens pb per cycle when obtained outside network Limited to R750 pb per cycle Limited to R1 225 pb per cycle	Cycle: a two-year period (2015/2016) PPN is the Society's DSP for optical care to members; all out-of-network care will be subject to a limit Refractive eye surgery is provided for under the hospitalisation benefit; subject to pre-authorisation and guidelines laid down by the Society's DSP All out-of-network care will be subject to the following maximum limits: • spectacles with single vision lenses: R750 per frame and R150 per lens • spectacles with bifocal or multifocal lenses: R750 per frame and R325 per lens • contact lenses: R1 225 • consultation: R310 Where the maximum frame entitlement of R750 is not utilised, the balance may be used for prescription lens enhancement A list of PPN-affiliated optometrists may be accessed on www.bpmas.co.za
HIV & AIDS AND RELATED ILLNESSES	 100% of Single Exit Price (SEP) plus the lower of the agreed or regulated dispensing fee at DSP 100% of agreed tariff at DSP or 90% of cost at other providers	Subject to PMBs and Appendix 1 of the Society's rules In respect of pathology, medication and consultations In respect of hospitalisation and related services	Subject to PMBs, pre-authorisation and once-off registration on the HIV YourLife Programme Use of a DSP and formulary medication is required, failing which a co-payment for the voluntary use of a non-DSP and non-formulary medication will apply Post exposure prophylactics: members covered for 28 days on triple therapy See overleaf for details on how to apply for additional benefits
ALCOHOLISM AND DRUG DEPENDENCY	Benefits payable in terms of the relevant paragraphs above	Subject to PMBs and Appendix 1 of the Society's rules	Subject to pre-authorisation See overleaf for details on how to apply for additional benefits, if needed
INFERTILITY	PMBs only		PMBs will be paid in respect of services obtained from DSP and public (State) hospitals
ONCOLOGY PROGRAMME/ CHEMOTHERAPY AND RADIOTHERAPY (in and out-of-hospital treatment)	100% of agreed tariff Medication obtained from non-DSP will be paid at Single Exit Price (SEP) plus the lower of the agreed dispensing fee at DSP	Limited to R475 000 pbpa, subject to PMBs and Appendix 1 of the Society's rules	Subject to pre-authorisation and once-off registration on the programme and use of a specialist affiliated with the Independent Clinical Oncology Network (ICON) Includes medication to treat side-effects of chemo- and radiotherapy Not subject to chronic medication limits, and includes treatment in terms of care plans; consultations are not subject to specialist and general practitioner services limits

Guidelines for pre-authorisation and co-payments

Pre-authorisation, or approval prior to admission to hospital, needs to be obtained from the Society's DSP at least 24 hours prior to admission to a day clinic or hospital. The only exception to this rule is in the case of an emergency, and even in such cases authorisation must be obtained within one working day of the emergency admission.

Members who fail to obtain the required authorisation, even if they are admitted to a DSP, will be liable for a co-payment of 20% of the cost of the hospital account, up to a maximum of R1 000. However, should a member be admitted to hospital for a PMB condition, and fails to obtain authorisation, no co-payment would apply.

The Society has appointed Mediclinic and Life Healthcare as its primary **DSPs** for the provision of hospital services. As such no co-payment will be applied to members or their dependants who are admitted to these hospitals.

Should a member use any other hospital, he/she will be liable for a co-payment of 10% of the cost of the non-DSP hospital account, up to a maximum of R10 000. The co-payment will not apply under the following circumstances:

- if the service is not available from the DSP or could not be provided without unreasonable delay;
- if there is no DSP within 25 kilometres of the beneficiary's ordinary place of residence; or
- in the case of an emergency, as defined in the Medical Schemes Act.

Except in the case of an **emergency** as stipulated above, a member must obtain pre-authorisation prior to obtaining services from a non-DSP provider. This will enable the Society to confirm that the above circumstances are applicable and that the co-payment should indeed be waived. If a beneficiary has been admitted to a non-DSP hospital due to an emergency and there is a DSP within 25 kilometres of his/her residence, the patient must be transferred to a DSP hospital as soon as his/her condition has been stabilised, provided the DSP has the appropriate treatment facilities available. Should this transfer not take place, the member will be liable for a co-payment of 10% of the hospital account, up to a maximum of R10 000.

Furthermore, if the choice of a provider or a change of provider would result in a reduction of the quality of care or an overall increase in the cost of care, special pre-authorisation for treatment at a non-DSP provider may be sought and a co-payment will not apply.

IMPORTANT

It is important to note that should a member fail to obtain pre-authorisation for making use of a non-DSP provider, both the 20% co-payment for not obtaining pre-authorisation and the 10% co-payment for voluntary use of a non-DSP can be applied. In other words, a co-payment of 30% may be applied, subject to the maximum amounts above.

Pre-authorisation is also required for some other services.

2015 member guide

Benefits and services that require pre-authorisation

Pre-authorisation is required for all hospitalisation, as well as the following benefits and services:

- Any surgery or medical procedure in a normal or day hospital, including dentistry and psychiatry
- Any surgery or medical procedure performed in a doctor's rooms in lieu of hospitalisation
- Sub-acute facilities and alternatives in lieu of hospitalisation, including the cardiac rehabilitation benefit
- MRI scans, CT scans, angiographs and scopes
- Organ transplants and kidney dialysis
- Blood transfusions
- Prostheses (see detailed list of sub-limits further on)
- In-hospital clinical and technical technologists
- Refractive eye surgery.

Please call **0800 007 092** for pre-authorisation for the above services.

To register on the **Oncology Programme**, or to obtain pre-authorisation, call **021 480 4073**.

Please dial **0861 888 300** to register on the confidential **HIV YourLife Programme**, or to apply for medication or hospital pre-authorisation for HIV & AIDS and related illnesses.

To apply for chronic and/or PMB cover, request your treating doctor to contact the **Online Pharmacist** on **0861 101 900** for real-time telephonic authorisation. Alternatively, you must fill in a Medicine Risk Management (MRM) application form, which can be obtained from the **Client Service Department** on **0800 001 607**, or printed from the Society's website at **www.bpmas.co.za**. Your doctor is also required to complete part of this application form.

Appliances and consumables for chronic disease and/or medical conditions (excluding nebulisers) must be pre-authorised. Please contact the **Client Service Department** on **0800 001 607** for details of the pre-authorisation process.

Remember to contact **ER24** for ambulance services on **084 124**, or **E-med** on **081 924** if you reside in Namibia.

What are Prescribed Minimum Benefits (PMBs)?

PMBs are the minimum benefits that the Society **must** provide to members for the diagnosis and treatment of approximately 270 illness conditions (as stipulated in the Medical Schemes Act), and diagnosis, medical management and medication for 26 Chronic Disease List (CDL) conditions.

There are no limits on these services, provided they are provided for in your care plan and obtained from the DSP, where applicable. Services rendered in public (State) hospitals will be covered at 100% of cost. →

THE 26 CDL CONDITIONS ARE:

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

Prostheses benefit limits

The following limits apply to the prostheses listed below:

Bilateral total hip replacement	R54 500
Total hip replacement	R31 400
Partial hip replacement	R17 500
Revision hip replacement	R59 800
Knee replacement, without patella	R34 750
Knee replacement, with patella	R39 350
Bilateral knee replacement	R69 750
Revision knee replacement	R60 550
Total shoulder replacement	R41 650
Bilateral shoulder replacement	R53 000
Level one spinal fusion, without cage	R18 950
Level one spinal fusion, with cage	R36 050
Level two spinal fusion, without cage	R25 350
Level two spinal fusion, with cage	R40 300
Level two spinal fusion, with two cages	R59 050
Artificial limbs, below the knee	R18 150
Artificial limbs, above the knee	R30 400
Artificial eyes	R18 150
Finger joint prosthesis	R4 450
Pacemakers, with leads	R37 850
Biventricular pacemaker	R62 000
Intra-cardiac device	R207 450
Cardiac valves	R28 600
Cardiac stents with delivery system (maximum of three per annum)	R20 500 (each)
Drug eluting stents (maximum of three per annum)	R25 650 (each)
Aortic aneurysm repair grafts	R121 250
Cochlear implant	R189 650

Please bear in mind that in cases where the prosthesis is deemed clinically appropriate and medically necessary by the Society's Medical Advisor, an additional benefit may be granted in excess of the limit, provided that application is made for the additional benefit prior to the procedure. Please contact the **Client Service Department** on **0800 001 607** to enquire about applying for these additional benefits.

Applying for additional benefits in excess of the stipulated limits

You may apply for additional benefits in the following cases if you have exhausted the limits stipulated in the benefit schedule:

- Prostheses (as mentioned above)
- In and out-of-hospital psychiatric and psychological treatment
- Out-of-hospital specialist and general practitioner services
- Auxiliary services, such as occupational therapy
- Appliances and consumables relating to chronic disease and/or medical conditions
- HIV & AIDS and related illnesses
- Alcoholism and drug dependency
- Oncology Programme/chemotherapy and radiotherapy.

It is important to apply for these additional benefits before they are needed. The Trustees will consider applications based on whether the treatment or procedure is deemed clinically appropriate and medically necessary and may grant an additional benefit where justified and necessary. Please contact the **Client Service Department** on **0800 001 607** should you need to apply for additional benefits for one of the above categories.

How does the self-medication benefit work?

Self-medication is also known as over-the-counter (OTC) medication and is generally used when a member or dependant is able to self-diagnose his/her illness (e.g. colds, flu, etc.) and consult a pharmacist for treatment. In such cases the pharmacist will dispense OTC medication. The service is limited to a supply of medication initiated by the pharmacist for the treatment of the particular condition. If the treatment is unsuccessful, the patient must be referred to a doctor, as no ongoing treatment of this nature will be allowed.

Only one ailment will be treated at a time and the medication may not exceed R180, including VAT and the dispensing fee, where applicable. A maximum of three days' supply may be obtained unless otherwise indicated. Only medication classified as schedule 0, 1, 2 or 3 can be dispensed over the counter. Household medicines requested by the member will not be covered.

Claims submitted to the Society must be endorsed as "supplied on request of member, condition self-diagnosed", and must include the member's signature and membership number.

This benefit is subject to the acute medication benefit and MetRef, and will be suspended in the case of abuse.

The **Client Service Department** can be contacted on **0800 001 607**, should you require more information on this benefit. Alternatively, you may visit our website at **www.bpmas.co.za**.

What services are not covered by the Society?

A full list of exclusions is available from the **Client Service Department** on **0800 001 607**. Here are a number of products and services typically excluded from benefits:

- Medical costs in excess of defined limits, unless stated otherwise in the benefit schedule
- Treatment relating to cosmetic or elective surgery
- Holidays for recuperative purposes
- Treatment at any headache clinic
- Bandages and patent foods
- Fertility treatment, except as provided for in the regulations governing PMBs.

jargon busters

Various medical industry terms and abbreviations have been used in this guide. Here is a brief explanation of the most commonly used terminology:

Agreed tariff
This is the tariff that has been agreed upon between the Society and the service provider, whether a designated, contracted or preferred provider.

AHPCSA
The Allied Health Professions Council of South Africa: This is a statutory Council for allied health professions established in terms of the Allied Health Professions Act. Registration with this Council is a legislative requirement and only claims from registered providers will be paid by the Society.

Care plan
Based on the protocols and guidelines published by the Minister of Health it documents a guideline of services for special PMB CDL conditions. Managed by Metropolitan Health Risk Management, it may include general practitioner and specialist consultations, pathology and other diagnostic services, such as radiology and physiotherapy.

CDL
Chronic Disease List: This is a list of 26 chronic diseases for which the Society must provide diagnosis, medical management and medication. There are no limits on these services, provided the services are provided for in the member's care plan and that the services are obtained from the DSP, where applicable.

Conscious sedation
This is a technique used for procedures, including dental, that are performed in a practitioner's rooms instead of in a hospital. The patient is given an intravenous drug that depresses consciousness to a level where the patient is co-operative and aware of what is happening, but does not feel any pain and is able to respond to verbal commands from the doctor.

DSP
Designated Service Provider: This is the service provider that the Society has chosen as its preferred provider for specific services to members. Your DSPs are:

- Hospitalisation: **Mediclinic, Life Healthcare and public (State) hospitals**
- Oncology: **Independent Clinical Oncology Network (ICON)**
- Emergency services: **ER24**
- Optical care: **Preferred Provider Negotiators (PPN)**
- Chronic medication: **Clicks Pharmacies – direct**medicines and Retail – and **Dis-Chem**
- Managed care: **Metropolitan Health Risk Management** manages the following areas:
  - Hospital Risk Management (for hospital pre-authorisation)
  - Medicine Risk Management (MRM)
  - Prescribed Minimum Benefits (PMBs)
  - Oncology Programme
  - HIV YourLife Programme.
- General Practitioner Network: managed by **Metropolitan Health Risk Management**

Emergency medical condition
An emergency medical condition is defined as the sudden and (at the time) unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical 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, according to Section 7 of the Regulations to the Medical Schemes Act.

Formulary
This is a list of preferred medication for the treatment of chronic conditions. It includes branded and generic medicines and is administered by the Society's DSP. Should a member choose not to use formulary medicines, he/she will be liable for a co-payment of 25% of the cost of the medication.

HPCSA
The Health Professions Council of South Africa: This is a statutory body, established in terms of the Health Professions Act. Registration in terms of the Act is a prerequisite for medical practitioners and only claims from registered providers will be paid by the Society.

M
A single member with no registered dependants

M+
A member with registered dependants

MetRef
Metropolitan Health Reference Price: This is the maximum price the Society pays for medication, based on the cost of any original product. Should you prefer to use an original product, you will be responsible for paying the difference between the MetRef and the price of the original product. The Society will cover the cost of the original product where there is no generic equivalent available.

MRM
Medicine Risk Management: This programme assists members in managing their chronic conditions efficiently and effectively. Metropolitan Health Risk Management is the Society's DSP for this programme.

Pbpa
Per beneficiary per annum/year (a beneficiary of the Society is defined as a main member or any of his/her registered dependants)

Pfpa
Per family per annum/year (in terms of the Society's rules, a family is defined as the member, plus his or her registered dependants)

PMB
Prescribed Minimum Benefits: These are the minimum benefits that the Society must provide to members as stipuated in the Regulations to the Medical Schemes Act.

This list includes approximately 270 illness conditions for which the Society has to provide medical and surgical management. There are also 26 chronic diseases for which the Society has to provide diagnostic and medical management, as well as medication. Please refer to the section on PMBs elsewhere in this brochure for more detailed information.

PPN
Preferred Provider Negotiators: This is the Society's DSP for optical care to members. PPN can be contacted on **0860 103 529** for more information.

Pro rata
The Society's financial year runs from 1 January to 31 December. Certain benefit amounts accumulate over this twelve-month period. If you join the Society during the course of a financial year, some benefit amounts may be pro rated. This means that the annual benefit amount is adjusted in proportion to the number of months of actual membership. In the benefit schedule overleaf, mention is made of the benefit categories that are pro rated.

Scheme rate
The Scheme rate is the rate determined by the Society for 2014, plus a 6% inflationary increase. In respect of claims from Namibian service providers, the Scheme rate will be the NAMAF tariff.

TRP
Therapeutic reference pricing is the maximum price that the Society pays for medication for a particular chronic condition, based on a range of medications that have the same therapeutic effect and pharmacological mode of action.

TTO
To-take-out medicines: This is medicine that is taken home subsequent to hospitalisation. This medication is subject to the MetRef and is limited to a seven-day supply. Any medication in excess of seven days' supply will be paid from the acute medication benefit.

UPFS
The Uniform Patient Fee Schedule: The tariff charged by public (State) facilities.