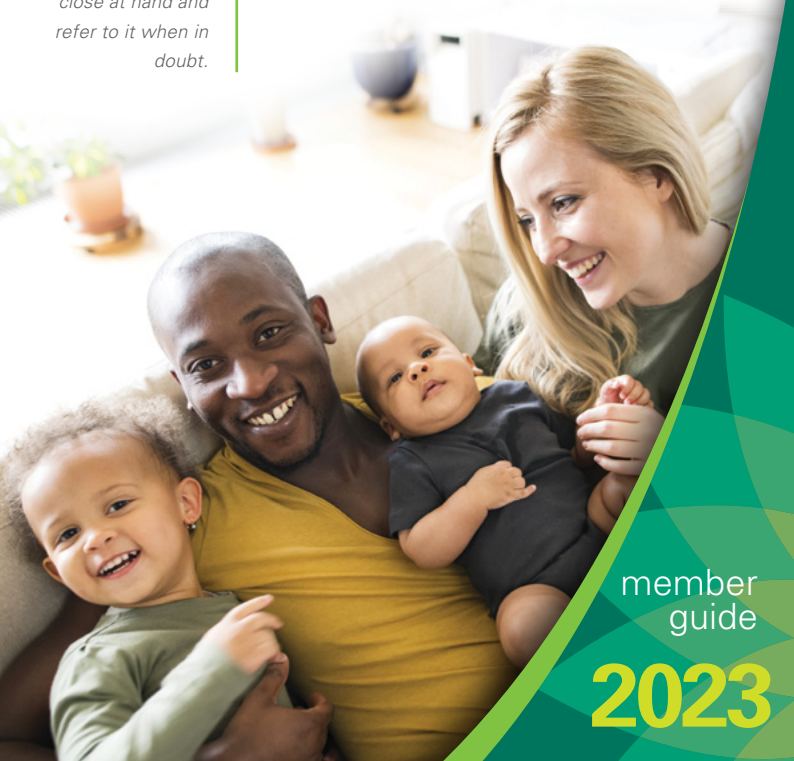
*This booklet will help you familiarise yourself with the benefits and rules of the Society – take a few moments to go through it. Keep it close at hand and refer to it when in doubt.*

# medical aid society

*there when you need us.*

bp



member guide

2023

# BP Medical Aid Society

YOUR MEDICAL AID SOCIETY

## Why medical aid?

You never know when you or one of your family members may need medical care, which could cost a substantial amount. The Fund provides medical cover to you and your dependants for a wide range of medical services, prescribed medicine and medical events, such as hospitalisation and surgery.

Health is unpredictable and the costs of quality healthcare in South Africa are rising all the time.

Health is unpredictable and the costs of quality healthcare in South Africa are rising all the time. Even if you take good care of yourself and your health, you don't want to be caught out by an accident, an unforeseen illness or even the high costs of a pregnancy, appendectomy or X-ray.

## About the Society and its management

The Society is registered as a medical scheme in terms of the Medical Schemes Act, 131 of 1998. A Board of Trustees is responsible for managing the Society and its assets. Four of the seven Trustees on the Board are elected by members. The Society has a Principal Officer who is responsible for the day-to-day functioning of the Society.

## Member guide

This booklet will help you familiarise yourself with the benefits and rules of the Society – take a few moments to go through it. Keep it close at hand and refer to it when in doubt.

## Your responsibilities as a member

- Take time to understand how your Society works.
- Inform the Society of any changes to your membership details.
- Inform the Society before you are admitted to hospital.
- Provide the necessary proof from the time your child dependants turn 18 to ensure that they enjoy cover at the appropriate rates.

- Keep your membership card in a safe place so that no one else can use it fraudulently.
- If you are an active employee, ensure that your work, home and email addresses are kept updated to receive all communication.
- If you are a pensioner, ensure that you notify the Society of your valid postal and email addresses in order to ensure that you receive your communication.

## What is the Protection of Personal Information (PoPI) Act and what impact will it have on you?

Everyone has the right to privacy. The PoPI Act, No 4 of 2013, promotes the protection of personal information and ensures that all South African institutions conduct themselves in a responsible manner when collecting, processing, storing and sharing another entity's personal information by holding them accountable should they abuse or compromise another entity's personal information in any way.

## What does this mean for your medical aid cover?

Principal members will no longer be able to access information pertaining to some of their dependants without their consent. Members should submit separate contact details for dependants who have given their consent to the Society to communicate with them directly.

***Please note:*** *The PoPI Act makes provision for the processing of a member's or dependants' information by the Society and its service providers, such as the Administrator or managed care providers, without consent, if doing so protects a legitimate interest of the individual. An example would be where the sharing of information to obtain pre-authorisation allows a member or dependant access to treatment or management of a healthcare condition.*

# MEMBERSHIP

## Who qualifies for membership of the Society?

**Active employees:** Membership of the Society is a condition of employment and is therefore compulsory for all full-time employees of BP Southern Africa (Pty) Ltd (the employer) according to your employment contract, unless you are entitled to benefits as a dependant of your spouse or partner's medical scheme.

**Continuation members:** Membership is voluntary for members and their dependants who retain their membership of the Society under the following circumstances:

- the employer has terminated your service on account of age, ill-health or disability; or
- you leave the service of the employer from the age of 50; or
- you retire from BP Southern Africa
- you take over main membership at the death of the main member if you were already a dependant on his or her membership before the death of the member.

*Please note: If you resign from the Society as a continuation member, you cannot re-apply for membership.*

## The following persons qualify as dependants:

- your spouse or partner, who is not a member or a registered dependant of a member of another medical scheme;
- your dependent child (biological or adopted), who is not a member or a registered dependant of a member of another medical scheme;

- your immediate family, i.e. your parent, brother, sister, grandchild, niece or nephew, in respect of whom you are responsible for family care and support; and
- other persons approved by the Board of Trustees as your dependants in exceptional cases and upon special motivation.

## The child rate applies to

- brothers, sisters, grandchildren and any other dependants of the member who are under the age of 21;
- dependants under the age of 25 who are dependent on the member and registered at an educational institution; and
- dependants under the age of 27 who are mentally or physically disabled.

## Joining the Society as a member

Obtain an application form from either your Human Resources Department or at www.bpmas.co.za. Complete the application form in full and submit it to your Human Resources Department with a certificate of membership (if applicable), indicating the resignation date from your medical scheme and any additional documentation or certificates, as requested on the application form.

***As it is against the law to belong to more than one medical aid scheme at a time, please make sure that you terminate your membership of your previous medical aid scheme, including membership as a dependant, before joining the Society.***

## Registering and deregistering a dependant

Please inform the Society through your Human Resources Department within 30 days of any circumstances that could affect your membership or the eligibility of your registered dependants. Examples of such changes include changes in marital status, the birth or adoption of children and the registration of a dependant on another medical scheme. The necessary record amendment form for the registration and deregistration of dependants can be obtained at www.bpmas.co.za and submitted to your Human Resources Department with the relevant supporting documents, as indicated on the form.



## Returning from assignments abroad

Members returning from assignments abroad should complete an application form via the Human Resources Department. Waiting periods will not apply to BP employees who join the Society on return to their employment in South Africa, after they have been on assignments abroad if they have had continuous coverage on an offshore health insurance policy for the duration of the assignment. The relevant proof of continuous coverage should accompany the application form.

## Retiring from BPSA

As a member, you have a right to continue your membership of the Society on retirement or termination of employment, subject to the criteria indicated under the section, 'Who qualifies for membership of the Society' on page 4.

The Society will inform members of their right to continue their membership and of the contribution payable from the date of retirement or termination of employment. Unless members inform the Board in writing of their desire to terminate their membership, qualifying members will automatically continue as members. A mandate form can be obtained from the Human Resources Department and must be submitted to the administrator to ensure that contributions are deducted from the correct banking account.



## Termination of membership

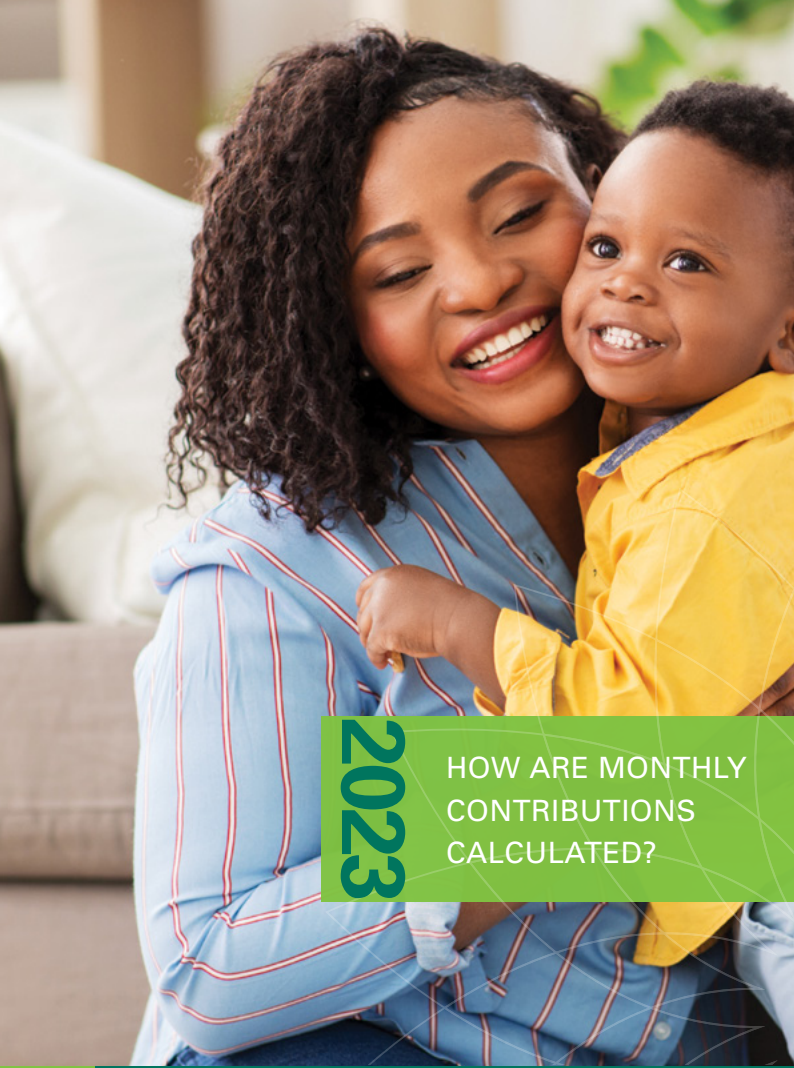
If it is a condition of employment according to your employment contract for you to belong to the Society, membership of the Society is compulsory and you may not resign from the Society unless you are registered as a dependant on your spouse or partner's medical scheme. Should you wish to resign from the Society to become a dependant on your spouse or partner's medical scheme, please notify us timeously to avoid dual membership of two medical schemes and also to ensure that we do not deduct contributions that are not due. Since it is a condition of employment for you to belong to the Society, you will be required to supply annual proof to human resources that you have joined your spouse or partner's medical scheme as a dependant.

*In the event that it is not a condition of employment for you to belong to the Society, you may terminate your membership by giving one calendar month's written notice to the Society.*

## Who do I notify in the event of a change in my personal details?

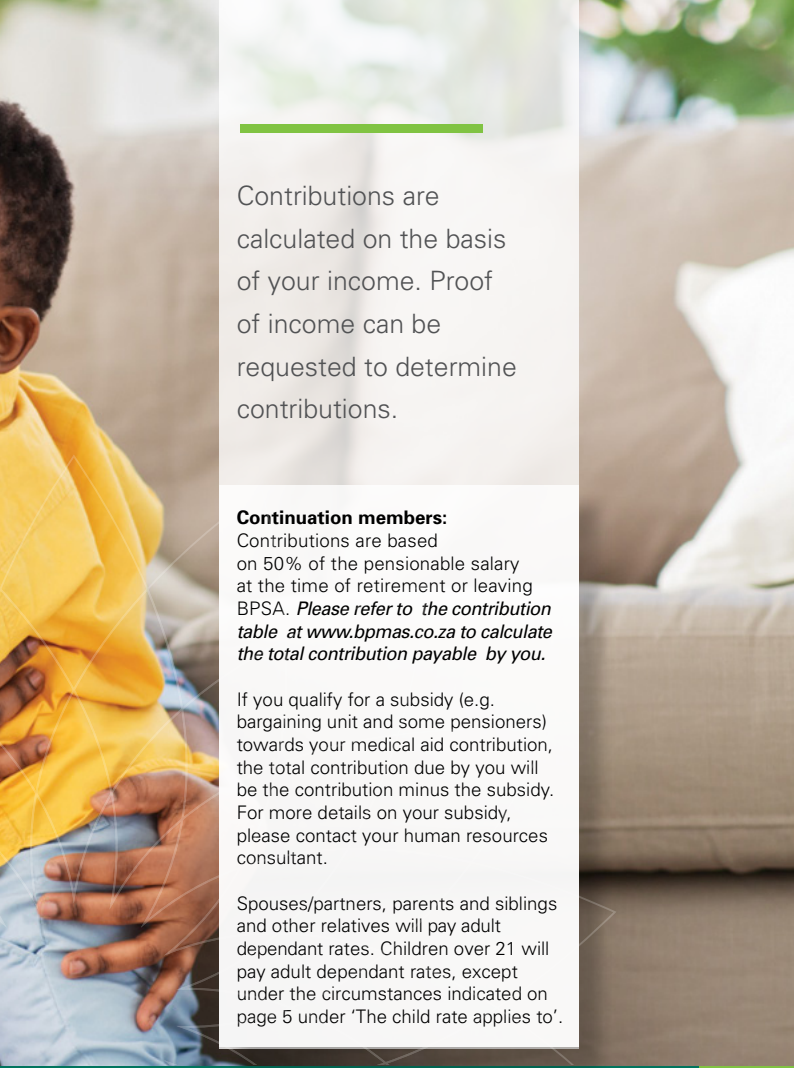
As stated, please notify both your employer's human resources department and the Society within 30 days of:

- a change in marital status; certified copies of your spouse's identity document and marriage certificate will be required;
- the birth of a child; a copy of the birth certificate will be required;
- the adoption of a child; a copy of the final legal documents should accompany your request to register the child as your dependant;
- any of your dependants who no longer qualify for dependant status;
- any change in your residential, postal or email addresses or contact numbers;
- change in your banking details;
- notice of resignation from the Society.



2023

# HOW ARE MONTHLY CONTRIBUTIONS CALCULATED?



Contributions are calculated on the basis of your income. Proof of income can be requested to determine contributions.

**Continuation members:**
Contributions are based on 50% of the pensionable salary at the time of retirement or leaving BPSA. ***Please refer to the contribution table at www.bpmas.co.za to calculate the total contribution payable by you.***

If you qualify for a subsidy (e.g. bargaining unit and some pensioners) towards your medical aid contribution, the total contribution due by you will be the contribution minus the subsidy. For more details on your subsidy, please contact your human resources consultant.

Spouses/partners, parents and siblings and other relatives will pay adult dependant rates. Children over 21 will pay adult dependant rates, except under the circumstances indicated on page 5 under 'The child rate applies to'.

## What are waiting periods and when do they apply?

The rules of the Society stipulate that general and condition-specific waiting periods may be applied to members and their registered dependants. Contributions must be paid during these waiting periods, but no insured benefits will be paid by the Society during the waiting periods, except prescribed minimum benefits (PMBs) under certain conditions.

A general waiting period is imposed for three months and a condition-specific waiting period may be imposed for a period of up to nine months for existing pregnancies and confinements and for a period of up to 12 months for any condition for which medical advice, diagnosis, care or treatment was recommended or obtained within a period of 12 months immediately prior to the date on which the application for membership of the Society was made.

General and condition-specific waiting periods do not apply:

- to a person who has been a member or a dependant of a member of a medical scheme for a continuous period of more than 24 months immediately preceding his or her application for membership and who applies within 90 days after ending his or her membership of the previous medical scheme;
- to a child dependant born during his or her parents' membership of the Society;
- to a person who was previously a member or dependant of a member of a medical scheme who applies for membership within 90 days after ending his or her membership of the previous medical scheme because of a change in employment or if the employer changes medical schemes;
- in respect of PMBs, except where a person has not been a member or a dependant of a member of a medical scheme for at least 90 days immediately preceding his or her application; and
- to a member who has been registered as a participant on the LifeSense Disease Management HIV programme.

## PLEASE NOTE

*If you elect not to register your eligible dependants with the Society on the commencement of employment with the employer, your dependants' membership will, upon future application for membership, be subject to general and condition-specific waiting periods unless conditions apply under which the waiting periods can be waived.*

## Late joiner penalties

The law provides that a late joiner penalty may be imposed on the membership of a member or his or her adult dependants who are 35 years of age or older at the date of application and who:

- did not belong to a registered medical scheme on 1 April 2001; or
- belonged to a registered medical scheme on 1 April 2001, but had a break in cover of three or more consecutive months since 1 April 2001.

The Society will not impose a late joiner penalty on a new member who meets the definition of a late joiner if he or she joins the Society from the date of employment. This concession applies strictly to a member and his or her spouse, partner or child. It does not include special dependants, such as parents or siblings for whom the member is liable for family care and support.

A late joiner penalty is provided for in legislation and is calculated according to the number of years the applicant did not have medical scheme cover. The penalty is determined as follows:

*Age upon application, minus 35 years, minus number of years of previous medical aid cover = total years without cover.*

The penalty to be applied depends on the number of years without cover and is calculated as a percentage of the monthly contribution that is payable by the late joiner.

## MEMBERSHIP (CONTINUED)

| YEARS WITHOUT COVER | PERCENTAGE OF CONTRIBUTION |
|---|---|
| 1 – 4 years | 0.05 x contribution |
| 5 – 14 years | 0.25 x contribution |
| 15 – 24 years | 0.50 x contribution |
| 25+ years | 0.75 x contribution |

*Example*

- *You are 50 years old.*
- *You are not joining the Society from the first date that you are eligible to do so.*
- *You are applying for membership in January 2020.*
- *The last time you were on a medical scheme was in August 2019.*
- *You were previously on a medical scheme (or schemes) for a combined, total period of four years.*
- *Calculation of penalty:*
  *[Age upon application, minus 35 years, minus number of years of previous medical aid cover = total years without cover]*
  *50 – 35 – 4 = 11 years without cover*
  *According to the table above, you fall into the 2nd category and 0.25 of your contribution will be added as a penalty to your monthly contribution.*

## IMPORTANT

It is important that you provide proof of membership of all previous medical aid schemes when you apply to join the Society, as this can affect the calculation of the late joiner penalty. The greater the period of cover you can prove, the lower the penalty will be if a penalty applies.

## PLEASE NOTE

*To ensure that the correct contribution and penalty is charged, we require the following:*

- *your application form to be completed in full; and*
- *certificates of membership of all previous medical schemes.*

*The penalty is calculated as a percentage and will therefore increase or decrease:*

- *as and when the Society announces an overall contribution increase or decrease; and*
- *if a salary adjustment results in a change in salary category for the principal member.*

*The percentage that is added to the contribution is not a once-off fee and will apply for the duration of the late joiner's membership.*

## When will my membership be terminated?

**Active members:** As your membership of the Society is a condition of employment, you are not permitted to terminate your membership while employed by BPSA, unless you are entitled to benefits as a dependant on your spouse or partner's medical scheme or you are a TCOE employee who opted to resign from BPMAS and moved to a registered, open market medical aid scheme of your choice. Membership of the Society will automatically cease upon termination of employment with BPSA, unless one of the conditions for eligibility that is applicable to continuation of membership applies.

**Termination of membership of dependants:** You may cancel the membership of any of your dependants upon submission of one calendar month's written notice. Please note that in order for child dependants to remain registered after the age of 21, the Society requires supporting documentation from a recognised tertiary institution and an affidavit from the main member confirming that the child is a student. If no supporting documentation is received, your dependants' membership will automatically be cancelled. A doctor's report is required for children who are physically or mentally disabled. Termination of the principal member's membership will automatically end the membership of any dependants.

**Continuation members:** As your membership of the Society is voluntary, you may terminate your membership upon submission of one calendar month's written notice.

*Please note: If you resign from the Society as a continuation member, you cannot re-apply for membership.*

**Death of a member:** The deceased member's membership ceases at the end of the month following the date of death. With effect from the first day of the following month, the surviving spouse or partner becomes the principal member. If there is no spouse or partner, the eldest child assumes the principal membership.

**Death of a dependant:** The dependant's membership ceases on the date of his or her death.

**Failure to make payment:**

**Contributions:** The Society will have right to suspend all benefit payments in respect of clams which arose during the period of default. Written notice of debt will be given to the member/employer, failing which membership may be terminated in terms of the rules of the Society.

**Fraud:** It is fraudulent for anyone other than yourself and your registered dependants to use your membership card. The Board of Trustees may exclude benefits from or terminate the membership of any member or registered dependant found guilty of:

- abusing the benefits and privileges of the Society by presenting false claims;
- making a material misrepresentation; or
- the non-disclosure of factual information.

In the cases above, the member may be required by the Board of Trustees to refund any amounts that were paid on his or her behalf.

*Please note: Contributions are still due in the month of termination. No refund or any portion of a contribution shall be due to any member or other persons where such member's membership or the registration of any of his dependants terminates during the course of a month. Benefits will also accrue to the end of the month of termination of membership.*

# BENEFITS AND RULES GOVERNING BENEFITS

## Important points to understand about your benefits

- The Society's benefit year runs from 1 January to 31 December.
- Benefits are not transferable from one benefit year to the next.
- If you join the Society during the year, some of your benefits will be adjusted in proportion to your period of membership for the year. You will be able to identify the benefits that are not adjusted in this way as you read through this guide.

# PRESCRIBED MINIMUM BENEFITS (PMBs)

The PMBs that are referred to in the schedule of benefits are the minimum benefits that the Society must provide to its members for the diagnosis and treatment of approximately 270 illnesses stipulated in the Medical Schemes Act and the diagnosis, medical management and medication for the 26 chronic diseases listed further on.

**Important information regarding PMBs: Please read carefully**

Notwithstanding any provisions to the contrary in this guide, the Society will cover:

- 100% of the diagnosis, treatment and care costs of the statutory PMBs, subject to PMB regulations, if those services are obtained from a designated service provider (DSP); or
- the relevant Society rate for the diagnosis, treatment and care costs of the statutory PMBs if a beneficiary voluntarily accesses PMBs via a non-DSP when provision has been made for a DSP; or
- 100% of cost for the involuntary use of a non-DSP, subject to PMB regulations.

Please visit **www.bpmas.co.za** for a full list of the Society's DSPs.

# PRESCRIBED MINIMUM BENEFITS (PMBs)

(CONTINUED)

## Explanation of PMB conditions

PMBs cover the diagnosis, treatment and care costs for relevant healthcare services rendered at DSPs in full for PMB chronic disease list (CDL) conditions. There are no limits on these services if they are provided for in the patient's treatment plan and obtained from a DSP, subject to Appendix 1 of the Society's rules ***(visit www.bpmas.co.za)***.

## PMB CDL conditions:

1. Addison's disease
2. Asthma
3. Bipolar mood disorder
4. Bronchiectasis
5. Cardiac failure
6. Cardiomyopathy
7. Chronic obstructive pulmonary disease
8. Chronic renal disease
9. Coronary artery disease
10. Crohn's disease
11. Diabetes insipidus
12. Diabetes mellitus, types 1 and 2
13. Dysrhythmias
14. Epilepsy
15. Glaucoma
16. Haemophilia
17. HIV infection
18. Hyperlipidaemia
19. Hypertension
20. Hypothyroidism
21. Multiple sclerosis
22. Parkinson's disease
23. Rheumatoid arthritis
24. Schizophrenia
25. Systemic lupus erythematosus
26. Ulcerative colitis

# SCHEDULE OF BENEFITS

MEMBERS AND THEIR REGISTERED DEPENDANTS ARE ENTITLED TO THE FOLLOWING BENEFITS, SUBJECT TO THE PROVISIONS OF THE SOCIETY'S RULES, ANNEXURE B:

Visit **www.bpmas.co.za** for a full set of the Society's rules.

| SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|
| STATUTORY PRESCRIBED MINIMUM BENEFITS (PMBs), AS PER APPENDIX 1 OF THE SOCIETY'S RULES | 100% of cost | No limit, subject to use of relevant DSPs | Services to be rendered by designated service providers (DSPs)<br><br>For PMBs the DSPs are Mediclinic, Life Healthcare and State or public hospitals, the Independent Clinical Oncology Network (ICON), the Momentum Health Solutions general practitioner network, the Momentum Health Solutions associated specialist network, Netcare 911, Iso Leso Optical Network and Medipost for oncology medicine |
| ALL MEDICAL BENEFITS | | Overall annual limit: R2 639 000 per family per annum | The overall annual limit is not adjusted in proportion to the number of months of membership if a member joins during the course of the financial year, but sub-limits may be adjusted<br><br>Once the overall annual limit and sub-limits are reached, only costs for the diagnosis, treatment and care of PMB conditions will be paid in full |

# SCHEDULE OF BENEFITS (CONTINUED)

## 1. HOSPITALISATION AND RELATED BENEFITS

All hospitalisation requires pre-authorisation from the Society's designated agent or hospital DSP.

1. Authorisation must be obtained from the Society's designated agent or hospital DSP before a beneficiary is admitted to a hospital or day clinic (except in the case of an emergency), failing which the member will be liable for a co-payment of 20% of the cost of the hospital account, up to a maximum of R1 000, except for PMB treatment. This is in addition to any co-payment in terms of note 4 below.
2. In the event of an emergency, the Society needs to be notified of the admission within one working day after admission to hospital.
3. Accommodation in a private ward is subject to motivation by the attending practitioner that it is essential for the recovery of the patient.
4. Unless the beneficiary is deemed to have involuntarily obtained a service from a provider other than a DSP, the member 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. A beneficiary will be deemed to have involuntarily obtained a service from a non-DSP provider:
   4.1 if the service was not available from the DSP or could not be provided without unreasonable delay;
   4.2 if there was no DSP within 25 kilometres of the beneficiary's ordinary place of residence; or
   4.3 in the case of an emergency, as defined in the Medical Schemes Act.
   Except in the case of note 4.3, pre-authorisation must be obtained by a member prior to obtaining a service from a non-DSP provider in terms of this rule, to enable the Society to confirm that the circumstances above are applicable. Where a beneficiary has been admitted to hospital due to an emergency and where there is a DSP within 25 kilometres of his or her residence, the patient must be transferred to a DSP hospital, provided the DSP has the appropriate facilities, as soon as the patient's condition has been stabilised. Should this transfer not take place, a co-payment will be applied, as stated in 4 above.
5. If the choice of a provider or a change of provider would result in reduced quality of care or an overall increase in the cost of care, special authorisation may be sought at the time pre-authorisation is obtained for treatment at a non-DSP, without a co-payment.

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| 1.1 | PRIVATE AND STATE/ PUBLIC HOSPITALS AND REGISTERED, UNATTACHED OPERATING THEATRES AND DAY CLINICS | | Subject to the overall annual limit | Subject to pre-authorisation by the Society's designated agent or hospital DSP<br><br>Benefit is not adjusted in proportion to the number of months of membership if a member joins during benefit year<br><br>In-hospital consultations are subject to the overall annual limit<br><br>Excludes dental implants, unless indicated as an essential part of another pre-authorised dental procedure<br><br>Includes elective orthognathic surgery and maxillofacial surgery |
| | 1. Accommodation in a general ward, high care ward and intensive care unit | 100% of agreed tariff at DSP or 90% of agreed tariff at other providers | | |
| | 2. Theatre fees | 100% of agreed tariff at DSP or 90% of agreed tariff at other providers | | |
| | 3. Medicines, materials and hospital equipment | 100% of cost (TTO medication limited to seven days' supply) at DSP or 90% of agreed tariff at other providers | | |
| | 4. Specialist consultations and procedures | **Network**<br>PMBs: 100% of agreed tariff<br>Non-PMBs: 100% of agreed tariff<br><br>**Non-Network**<br>PMBs: 100% of agreed tariff<br>Non-PMBs: 80% of Society rate | | |
| | 5. General practitioner consultations and procedures | **Network**<br>PMBs: 100% of agreed tariff<br>Non-PMBs: 100% of agreed tariff<br><br>**Non-Network**<br>PMBs: 100% of agreed tariff<br>Non-PMBs: 80% of agreed tariff | | |
| | 6. Nursing services and all other non-psychiatric, in-hospital services | 100% of agreed tariff at DSP or 90% of agreed tariff at other providers | | |
| | 7. Confinement and midwives | 100% of agreed tariff at DSP or 90% of agreed tariff at other providers | | |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| 1.2 | IN-HOSPITAL PSYCHIATRIC TREATMENT<br>1. Accommodation<br><br>2. Medicines, materials and hospital equipment<br><br>3. Consultations at medical practitioners | PMB: 100% of cost<br>Non-PMB: 100% of Society rate<br><br>100% of cost (TTO medication limited to seven days' supply)<br><br>100% of Society rate | Limited to 21 days per beneficiary per annum | Includes treatment for substance abuse<br><br>Benefit is not adjusted in proportion to the number of months of membership if member joins during benefit year<br><br>Includes treatment on a day-patient basis instead of hospitalisation, subject to pre-authorisation<br><br>Where the treatment is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered<br><br>The benefits in respect of PMBs will be limited, as per Annexure A of the Regulations of the Medical Schemes Act |
| 1.3 | IN-HOSPITAL PHYSIOTHERAPY AND AUXILIARY SERVICES (INCLUDING AUDIOLOGY AND OCCUPATIONAL AND SPEECH THERAPY) | PMB: 100% of cost<br><br>Non-PMB: 100% of Society rate | Subject to overall annual limit | Subject to pre-authorisation |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| 1.4 | SUB-ACUTE FACILITIES/ ALTERNATIVES TO HOSPITALISATION | | | Subject to overall annual limit<br><br>Excludes frail care facilities |
| | Step-down nursing facilities | 100% of Society rate or agreed tariff at DSP, whichever is applicable | | Subject to pre-authorisation by the Society's designated agent |
| | Private nursing (instead of hospitalisation) | 100% of Society rate | Limit: R34 210 per family per annum | |
| | Hospice | PMB: 100% of cost<br><br>Non-PMB: 100% of Society rate | | |
| | Benefits after hospitalisation (instead of hospitalisation) | 100% of Society rate | 90 days per diagnosis | Post-hospitalisation and cardiac rehabilitation benefit must be in accordance with an authorised treatment plan |
| | Hospital prevention | 100% of Society rate or cost where no Society rate exists | Subject to overall annual limit and pre-authorisation; managed care protocols apply | The Society's designated agent will liaise with the case manager of the hospital and the treating doctor to assess the appropriateness of transferring certain beneficiaries to step-down facilities<br><br>The Society's designated agent will arrange for and manage the appropriate alternatives to hospitalisation upon discharge from hospital, such as to join the cardiac rehabilitation programme at an accredited provider, to visit rehabilitation or sub-acute facilities or receive home nursing in accordance with a clinical motivation from doctors and case managers<br><br>Once the sub-limits are reached, only the diagnosis, treatment and care costs for PMB conditions will be paid in full |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| 1.5 | **REHABILITATION**<br>Following a hospital event (after discharge) | 100% of Society rate | Subject to overall annual limit | Subject to pre-authorisation<br><br>Includes extended physiotherapy and occupational and speech therapy and biokinetics of a rehabilitative nature that is preceded by hospitalisation |
| | Maintenance therapy | 100% of Society rate | Limit: R13 920 per family per annum | |
| | Cardiac rehabilitation benefit (after discharge) | 100% of Society rate at accredited providers | Limited to six months per cardiac event | Such treatment must be connected to an approved rehabilitative treatment plan and must commence within two weeks of discharge from hospital<br><br>The cardiac rehabilitation benefit provides for an initial three-month, intensive rehabilitation benefit followed by a three-month continuing care benefit |
| 1.6 | **RADIOLOGY** | PMBs: 100% of cost | | The Society's designated agent must authorise MRI and CT scans, scopes and angiographies, except in emergencies<br><br>In the event of an emergency, the Society's designated agent must be notified on the first working day following the procedure<br><br>In respect of PMB conditions, radiology must be detailed in the treatment plan; treatment to be paid at 100% of cost |
| | Basic<br>All X-rays | Non-PMBs:<br>100% of agreed tariff out of hospital<br>100% of agreed tariff in hospital | Limit: R1 490 per beneficiary per annum | |
| | Ultrasounds | Non-PMBs:<br>100% of Society rate both in and out of hospital | Subject to overall annual limit | |
| | Advanced<br>MRI and CT scans<br>Scopes (diagnostics)<br>Angiography<br>Nuclear medicine studies | Non-PMBs:<br>100% of Society rate both in and out of hospital | Subject to pre-authorisation | |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| 1.6 | RADIOLOGY (continued) | | | Excludes PET scans, unless authorised as part of a member's oncology treatment or where it is deemed to be clinically appropriate and medically necessary by the Society's designated agent<br><br>Where the service is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered |
| 1.7 | PATHOLOGY | PMBs:<br>100% of cost<br><br>Non-PMBs:<br>80% of agreed tariff out of hospital<br>100% of agreed tariff in hospital | | In respect of PMB conditions, pathology must be detailed in the treatment plan; treatment to be paid at 100% of cost |
| 1.8 | ORGAN TRANSPLANTS | PMBs:<br>100% of cost<br><br>Non-PMBs:<br>100% of agreed tariff at DSP | Limit: R229 540 per family per annum | The Society will pay for the cost of harvesting the organ from the donor and to transplant it to the recipient if both the donor and the recipient are members of the Society<br><br>Where the donor is a member of the Society and the recipient is not, the costs of harvesting the organ from the donor will not be covered by the Society |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| 1.8 | ORGAN TRANSPLANTS (continued) | | | If the recipient is a member of the Society, the harvesting costs will be covered<br><br>Subject to pre-authorisation<br><br>Benefit includes anti-rejection medication, but excludes hospitalisation and related costs, which are covered under the hospitalisation benefit in 1.1 on page 19<br><br>Benefit is not adjusted in proportion to the number of months of membership if member joins during benefit year<br><br>Once the limit is reached, only medication in respect of PMB chronic conditions will be paid in full according to the treatment plan, formulary and generic and therapeutic reference pricing |
| 1.9 | RENAL DIALYSIS | 100% of cost | | Subject to pre-authorisation |
| 1.10 | BLOOD TRANSFUSIONS | 100% of cost | | Includes the cost of blood, blood equivalents, blood products and the transportation of blood<br><br>Subject to pre-authorisation |
| 1.11 | AMBULANCE SERVICES (road and air) | 100% of cost at DSP (Netcare 911), except in emergencies | | Such transport is to be certified by a medical practitioner as being essential<br><br>Subject to authorisation from the Society's DSP (Netcare 911) within 72 hours of the incident<br><br>Failure to obtain authorisation is subject to a 30% co-payment |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| 1.12 | PROSTHESES<br>External and internal | 100% of agreed tariff | R28 340 per beneficiary per annum, except for PMB conditions and the following prostheses limits:<br>Hip replacements:<br>- Bilateral total R82 280<br>- Total hip R47 440<br>- Partial hip R26 400<br>- Revision hip R90 320<br>Knee replacements:<br>- Without patella R52 440<br>- With patella R59 400<br>- Bilateral knee R105 330<br>- Revision knee R91 480<br>Shoulder replacements:<br>- Total shoulder R62 840<br>- Bilateral shoulder: R80 080<br>Spinal fusion:<br>- Level 1 (without cage) R28 570<br>- Level 1 (with cage) R54 450<br>- Level 2 (without cage) R38 180<br>- Level 2 (with 1 cage) R60 890<br>- Level 2 (with 2 cages) R89 180<br>Artificial limbs:<br>- Below the knee R27 360<br>- Above the knee R45 940<br>Artificial eyes: R27 360<br>Finger joint prosthesis: R6 780<br>Pacemakers:<br>- With leads: R57 090<br>- Biventricular: R93 600<br>Intracardiac device: R313 240<br>Cardiac valves, each: R42 830<br>Cardiac stents with delivery system, each (maximum of three per annum): R30 930<br>Drug eluting stents, each (maximum of three per annum): R38 810<br>Aortic aneurism repair grafts: R183 070<br>Cochlear implant: R286 390<br><br>Multiple external and internal prostheses are subject to a joint overall limit of R102 570 per beneficiary per annum | External: Eyes and limbs, e.g. legs and arms<br><br>Internal: Appliances placed in the body to replace body parts during an operation, with the exception of dental implants<br><br>Subject to pre-authorisation by the Society's designated agent or hospital DSP<br><br>Benefit is not adjusted in proportion to the number of months of membership if a member joins during benefit year<br><br>Where the prosthesis is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the procedure |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **2.** | **PRESCRIBED MEDICINE AND INJECTION MATERIAL** | | | |
| 2.1 | SELF-MEDICATION | 100% of cost or 80% of cost, as per the acute medication benefit | R280 per ailment, subject to the acute medication limits | See Annexure D to the Society's rules for details of the self-medication benefit |
| 2.2 | ACUTE MEDICATION<br>Acute sickness conditions | 100% of cost, up to R1 700 per beneficiary; thereafter 80% of cost | Limits:<br>M R6 290<br>M+1 R9 820<br>M+2 R11 100<br>M+3+ R12 210 | Prescribed by a person legally entitled to prescribe<br><br>Subject to generic and therapeutic reference pricing<br><br>Benefit is adjusted in proportion to the number of months of membership if member joins during benefit year<br><br>Acute medication benefit is subject to an acute medication exclusion list |
| 2.3 | CHRONIC MEDICATION (EXCLUDING SPECIALISED MEDICATION)<br>Chronic sickness conditions | 100% of agreed tariff at DSP (Clicks) for chronic medication<br><br>For non-DSPs, the single exit price, plus the lower of the dispensing fee at a non-DSP, as set out in medicine pricing regulations, or the fee that has been agreed upon with the DSP<br><br>A co-payment of 20% will apply at a non-DSP | Limit: R43 280 per beneficiary per annum, subject to Appendix 1 of the Society's rules | Includes daily, continuous use of oxygen for a chronic ailment, excluding the cylinder that is provided for in benefit 3.5 on page 32; subject to pre-authorisation<br><br>Prescribed by a person legally entitled to prescribe<br><br>Medication in respect of PMB conditions is subject to a treatment plan, formulary, generic and therapeutic reference pricing and Appendix 1 of the Society's rules |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **2.** | **PRESCRIBED MEDICINE AND INJECTION MATERIAL** | | | |
| 2.3 | CHRONIC MEDICATION- EXCLUDING SPECIALISED MEDICATION (continued)<br>Chronic sickness conditions | | | Medication in respect of a condition that is not included in the list of PMB conditions is subject to pre-authorisation by Medicine Risk Management, generic or therapeutic reference pricing and Appendix 1 of the Society's rules<br><br>Once the limit is reached, only medication in respect of PMB chronic conditions will be paid in full according to the treatment plan, formulary and generic or therapeutic reference pricing<br><br>Benefit is adjusted in proportion to the number of months of membership if the member joins during benefit year |
| 2.4 | SPECIALISED MEDICATION | 100% of agreed tariff at DSP<br><br>Single exit price, plus the lower of the dispensing fee at a non-DSP, as set out in medicine pricing regulations, or the fee that has been agreed upon with the DSP | Limit: R159 380 per beneficiary per annum | Only medication on the Society's specialised medicine list will be covered<br><br>Subject to authorisation and clinical entry criteria<br><br>Benefit is adjusted in proportion to the number of months of membership if the member joins during the year<br><br>Once the limit is reached, only medication in respect of PMB chronic conditions will be paid in full |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **3.** | **PRIMARY CARE** | | | |
| | *If you require more tests, these will be paid from the general practitioner and specialist benefit. The consultation fees for the general practitioner, specialist or nurse will be subject to the specialist and general practitioner limits as indicated in 3.2* | | | |
| 3.1 | PREVENTATIVE CARE BENEFITS - OUT OF HOSPITAL<br>Cardiovascular screenings:<br>- Blood pressure<br>- Blood glucose<br>- Cholesterol<br>- Body mass index | 100% of Society rate | One per beneficiary per annum | Benefits are subject to Society's protocols and use of the Society's DSPs |
| | Cancer screenings:<br>- Mammograms | 100% of agreed tariff | One per beneficiary per annum | Age limit: 40 years (benefits for beneficiaries younger than 40 are subject to motivation and prior approval) |
| | - Pap smears | 100% of agreed tariff | One per beneficiary per annum | |
| | - Prostate-specific antigen (PSA) | 100% of agreed tariff | One per beneficiary per annum | Age limit: 50 years and older (benefits for beneficiaries younger than 50 are subject to motivation and prior approval) |
| | - Faecal occult blood | 100% of cost | One per beneficiary per annum | Age limit: 50 years and older (benefits for beneficiaries younger than 50 are subject to motivation and prior approval) |
| | Vaccinations:<br>- Child and infant vaccinations | 100% of agreed tariff | State protocols apply | A list of approved vaccinations is available at www.bpmas.co.za |
| | - Human papillomavirus (HPV) | 100% of agreed tariff | Maximum of three per beneficiary, depending on vaccination manufacturer | Male and female beneficiaries between the ages of nine and 18 |
| | - Pneumococcal vaccination | 100% of agreed tariff | One per beneficiary per annum | |
| | - Flu vaccination | 100% of agreed tariff | One per beneficiary per annum | |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **3.** | **PRIMARY CARE** | | | |
| 3.1 | PREVENTATIVE CARE BENEFITS - OUT OF HOSPITAL (continued) | | | |
| | Male circumcision (in general practitioner's rooms) | 100% of agreed tariff | 1 per beneficiary per year Subject to a limit of R1 490 if performed in a doctor's rooms | |
| | HIV screening: Elisa test | 100% of agreed tariff | One per beneficiary per annum | |
| | Bone density test | 100% of agreed tariff | One per beneficiary per annum | Age limit: 50 years and older (benefits for beneficiaries younger than 50 are subject to motivation and prior approval) |
| | Contraceptives | 100% of agreed tariff | Limited to R1 890 per beneficiary per year and subject to overall acute medication limit | |
| | Dental consultation (in addition to dental benefit in 3.9 on page 34) | 100% of Society rate | One per beneficiary per annum | |
| | Eye test (acuity, pressure and other) | | One per beneficiary every two-year cycle at DSP | |
| | Dietician consultation | 100% of Society rate | One per beneficiary per annum | |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **3.** | **PRIMARY CARE** | | | |
| 3.2 | SPECIALIST AND GENERAL PRACTITIONER SERVICES<br>1. Consultations and visits (out of hospital)<br>2. All other services, unless stated otherwise in this benefit schedule | | PMBs: Unlimited, subject to the diagnoses, treatment and care cost of PMB conditions<br><br>Combined limit: PMB: Unlimited Non-PMB Limits:<br>M R8 040<br>M + 1 R10 780<br>M + 2 R13 430<br>M + 3 + R16 170 | Consultations in respect of a PMB condition are subject to a treatment plan and Appendix 1 of the Society's rules<br><br>Includes consultations out of hospital (including, but not limited to, chiropractors, homeopaths, antenatal consultation and midwifery, osteopaths, naturopaths, podiatrists, chiropodists, ayurvedic and traditional healers, therapeutic massage therapists and outpatient facilities; subject to registration with the HPCSA and AHPCSA)<br><br>Once the limit is reached, only consultations in respect of PMB chronic conditions will be paid in full |
| | Specialist services | **Network**<br>PMBs: 100% of agreed tariff<br>Non-PMBs: 100% of agreed tariff<br><br>**Non-Network**<br>PMBs: 100% of agreed tariff<br>Non-PMBs: 80% of Society rate | | |
| | General practitioner services | **Network**<br>PMBs: 100% of agreed tariff<br>Non-PMBs: 100% of agreed tariff<br><br>**Non-Network**<br>PMBs: 100% of agreed tariff<br>Non-PMBs: 80% of agreed tariff | Limited to combined limit for specialist and general practitioner services detailed above | Where the service is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered<br><br>Benefit is adjusted in proportion to the number of months of membership if member joins during benefit year |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **3.** | **PRIMARY CARE** | | | |
| 3.3 | MATERNITY | 100% of Society rate | Subject to overall annual limit and the Society's protocols | Subject to pre-authorisation and the Society's protocols<br><br>Treatment plan includes the following:<br>- 10 obstetric consultations<br>- 10 antenatal consultations<br>- two ultrasound scans, limited to 2D<br>- basic pathology tests<br><br>Additional services, such as tococardiography, external cephalic version, lecithin-sphingomyelin ratio tests and amniocentesis may be granted where clinically appropriate and medically necessary |
| 3.4 | OUT-OF-HOSPITAL AUXILIARY SERVICES<br>1. Audiology<br>2. Audiometry<br>3. Occupational therapy<br>4. Speech therapy<br>5. Orthoptic services<br>6. Biokinetics<br>7. Physiotherapy<br>8. Psychological treatment: Social workers and registered counsellors<br>9. Clinical and technical technologists<br>10. Dietitian services | 80% of Society rate | Limits:<br>M R7 860<br>M+1 R10 510<br>M+2 R13 100<br>M+3+ R15 770 | Only treatment or procedures to be paid from this benefit<br><br>Consultations are to be paid in accordance with benefits defined in 3.2 on page 30<br><br>Where the service is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered<br><br>Benefit is adjusted in proportion to the number of months of membership if member joins during benefit year |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **3.** | **PRIMARY CARE** | | | |
| 3.5 | APPLIANCES AND CONSUMABLES RELATING TO CHRONIC DISEASES AND OTHER MEDICAL CONDITIONS: | | | Excludes: Daily, continuous use of oxygen, which is included under the chronic medication benefit in 2.3 on page 26 |
| | 1. Wheelchairs, crutches, braces, walking frames and similar equipment | 100% of cost | Limited to R13 770 per beneficiary per annum | Hearing aids are provided for in a separate benefit under 3.7 on page 33 |
| | 2. Appliances relating to chronic diseases and other medical conditions, e.g. oxygen cylinders and nebulisers (includes either hire or purchase) | 100% of cost | Limited to R13 770 per beneficiary per annum | Benefit is adjusted in proportion to the number of months of membership if member joins during benefit year<br><br>Where the appliance or consumable is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered |
| | 3. Consumables relating to chronic diseases and other medical conditions, e.g. colostomy kits and other incontinence materials or equipment | 100% of cost | Limited to R25 880 per beneficiary per annum | |
| | 4. Diabetic consumables and appliances, including needles, strips and glucometers | 100% of cost | Limited to R5 430 per beneficiary per annum | All benefits, except for nebulisers, are subject to pre-authorisation |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **3.** | **PRIMARY CARE** | | | |
| 3.6 | MEDICAL AND SURGICAL APPLIANCES FOR ACUTE CONDITIONS | 80% of cost | Limited to R9 280 per family per annum | This benefit is for appliances for the treatment of acute conditions<br><br>Must be prescribed by a person legally entitled to prescribe<br><br>Examples of appliances for acute conditions include, but are not limited to: braces, slings, splints and corsets; cervical collars; thermo-moulded shoes and post-operative sandals, including bunionectomy Arcopedico shoes; air casts; pressure garments; compression hoses; 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 |
| 3.7 | HEARING AIDS<br>Includes repairs to hearing aids | 100% of cost | Limited to R24 160 per beneficiary per 2-year cycle | A cycle is a two-year period that at present runs from 2023 to 2024 |

# 2023 member guide

SCHEDULE OF BENEFITS 2023

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **3.** | **PRIMARY CARE** | | | |
| 3.8 | MENTAL HEALTH AND DRUG AND ALCOHOL REHABILITATION | | **Combined limit:** Limited to R9 280 per family per annum | Subject to pre-authorisation and clinical protocols |
| | 1. Psychologist: Consultations and treatment | **PMB:** 100% of cost<br><br>**Non-PMB:** 80% of Society rate | | Consultations and treatment in respect of a PMB condition are subject to the care plan and Appendix 1 of the Society's rules |
| | 2. Psychiatrist: Consultations and treatment | **PMB:** 100% of agreed tariff if a network or non-network service provider is used<br><br>**Non-PMB:**<br>- 100% of agreed tariff if a network service provider is used<br>- 80% of Society rate if a non-network service provider is used | | Once the limit is reached, only consultations and treatment in respect of PMB conditions will be paid |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **3.** | **PRIMARY CARE** | | | |
| 3.9 | DENTAL SERVICES<br>• Conservative and restorative dentistry (includes plastic dentures and extractions under conscious sedation)<br>• Special dentistry (including metal-based dentures)<br>• Implants | 100% of Society rate or agreed tariff | Limits:<br>M R12 350<br>M+1 R18 440<br>M+2 R22 840<br>M+3+ R24 660 | All orthodontic services are subject to prior approval<br><br>Where the service is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered<br><br>General anaesthetic and hospitalisation for conservative dental work excluded, except in the case of trauma and impacted third molars<br><br>In-hospital dentistry subject to pre-authorisation by Society's designated agent or hospital DSP<br><br>Benefit is adjusted in proportion to the number of months of membership if a member joins during benefit year |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **3.** | **PRIMARY CARE** | | | |
| 3.10 | OPTICAL SERVICES<br>Comprehensive consultation (inclusive of tonometry [glaucoma] screening and visual screening) | 100% of cost when obtained from Iso Leso | One consultation per beneficiary per cycle<br><br>Consultations at a non-network provider will be limited to a maximum of R450 per beneficiary per cycle | A cycle is a two-year period that at present runs from 2023 to 2024<br><br>Iso Leso is the Society's DSP for optical care<br><br>A list of Iso Leso-affiliated optometrists is available at www.bpmas.co.za |
| | PLUS | | | |
| | Spectacles | 100% of cost for clear, single-vision spectacle lenses when obtained from Iso Leso per beneficiary per cycle | One pair of clear, single-vision spectacle lenses, limited to R220 per lens when obtained from non-network provider per beneficiary per cycle | |
| | Lenses | 100% of cost for one pair of clear, bifocal spectacle lenses when obtained from Iso Leso per beneficiary per cycle | One pair of clear, bifocal lenses, limited to R470 per lens when obtained from a non-network provider per beneficiary per cycle | |
| | | 100% of cost when obtained from Iso Leso Network | One pair of clear,multi-focal lenses of any prescription; limited to R1 010 per lens when obtained from non-network provider | |
| | Frames and/or prescription lens enhancements | 100% of cost if obtained from Iso Leso Network | Limited to R1 010 per beneficiary per cycle when obtained from a non-network provider | |
| | OR | | | |
| | Contact lenses instead of spectacles (alternate to spectacle benefit) | 100% of cost when obtained from Iso Leso Network | 100% of cost when obtained from a non-network provider, limited to R1 960 per beneficiary per cycle | |
| | Lens enhancements | 100% of cost available to Iso Leso members only | Lens enhancements of R650 per beneficiary per cycle when obtained from a non-network provider | |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **3.** | **PRIMARY CARE** | | | |
| 3.10 | Refractive surgery | | Benefits provided for under hospitalisation | Refractive eye surgery is provided for under the hospitalisation benefit and is subject to pre-authorisation and the guidelines of the Society's designated agent |
| **4.** | **GENERAL** | | | |
| 4.1 | HIV/AIDS AND RELATED ILLNESSES | 100% of single exit price, plus the lower of the agreed upon or regulated dispensing fee at DSP<br><br>100% of agreed tariff at DSP or 80% of cost at other providers | Medication<br><br>Pathology, consultations, hospitalisation and related services<br><br>Subject to PMBs, Appendix 1 of the Society's rules and protocols | Medicine and hospital pre-authorisation is required<br><br>Subject to PMBs, pre-authorisation and the Society's protocols<br><br>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<br><br>Subject to Appendix 1 of the Society's rules<br><br>Post-exposure prophylactics: Members will be covered for 28 days on triple therapy |
| 4.2 | 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<br><br>Where the treatment is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered |

| | SERVICE | BENEFIT *(Subject to annual limits)* | ANNUAL LIMITS | CONDITIONS OR REMARKS |
|---|---|---|---|---|
| **4.** | **GENERAL** | | | |
| 4.3 | INFERTILITY | PMBs only | | PMBs will be paid in respect of services obtained at the DSP and from State and public hospitals |
| 4.4 | ONCOLOGY PROGRAMME/ CHEMO- AND RADIOTHERAPY | 100% of agreed tariff at DSP; Medipost is the DSP for oncology medication | Limit of R676 110 per beneficiary per annum, subject to PMBs and Appendix 1 | Subject to pre-authorisation, once-off registration on the programme and use of a specialist affiliated with ICON<br><br>These benefits apply to in- and out-of-hospital chemo- and radiotherapy<br><br>Medication to treat the side-effects of chemo- and radiotherapy are to be paid from this benefit<br><br>Not subject to chronic medication limits<br><br>Includes all treatment in terms of the treatment plan<br><br>Consultations are subject to authorised treatment plans and not the limits set out in benefit 3.2 on page 30<br><br>Where the treatment is deemed to be clinically appropriate and medically necessary by the Society's designated agent, an additional benefit may be granted by the Trustees in excess of the limit, provided that application is made for the additional benefit prior to the service being rendered |

*Benefits are not transferable from one financial year to another or from one category to another.*

# DESIGNATED SERVICE PROVIDERS

The Society selects and contracts designated service providers (DSPs) and preferred providers of healthcare services to members. It has also contracted a managed healthcare provider for the provision of managed healthcare programmes. Through the DSPs and managed healthcare programmes, the Society ensures the appropriate and cost-effective diagnosis, treatment and care for members for all the PMB conditions. The Society has established DSP networks, such as hospital, pharmacy, general practitioner (GP), specialist, ambulance and optical networks. A beneficiary will be deemed to involuntarily have obtained a service from a non-DSP provider:

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

## DESIGNATED SERVICE PROVIDERS (CONTINUED)

### Managed care programmes:

- hospital management (manages pre-authorisation for hospitalisation);
- medicine risk management (manages pre-authorisation for chronic medication);
- HIV management via LifeSense Disease Management;
- integrated care programme (manages respiratory, cardiovascular, diabetic, renal (kidney) and mental health conditions);
- oncology management (manages the pre-authorisation of oncology treatment plans);
- Eldercare programme;
- maternity programme; and
- PMB programme.

*For more information or to register on the above programmes, please contact the Client Service Department on 0800 001 607.*

### DSPs:

- Clicks (for the provision of chronic and HIV medication);
- Medipost (for the provision of oncology medication);
- Mediclinic and Life Healthcare hospitals (for hospitalisation);
- The Momentum Health Solutions general practitioner network;
- The Momentum Health Solutions associated specialist network;
- Netcare 911 for emergency transportation services;
- Iso Leso Optical Network; and
- Independent Clinical Oncology Network (ICON) (for oncology treatment).

*PLEASE NOTE:*
*Members are encouraged to use DSPs to avoid out-of-pocket costs from service providers who charge much higher rates.*

In addition to contracting DSPs, establishing preferred provider networks and providing managed healthcare services, the Society seeks to manage its exposure to health risk through the establishment of treatment protocols, the use of formularies, capitation agreements and limitations on disease cover, which the Board may find appropriate for the management of the benefits detailed in the registered rules.

## Medicine risk management

**How do I apply for the chronic medication benefit?**
To use the chronic medication benefit, you must apply to Medicine Risk Management (MRM). Your doctor may:

- call 0861 888 124 (for doctors and pharmacists) to obtain immediate authorisation for your chronic medication; or
- download an MRM application form at www.bpmas.co.za and return the completed form by email to mrm@bpmas.co.za.

For further information, please contact the Client Service Department on 0800 001 607.

**What is a chronic condition?**
A chronic condition is a disease that is persistent or otherwise long-lasting in its effects. The term chronic is often applied when the course of the disease lasts for more than three months.

**Claiming for chronic medication**
Medication items to treat chronic conditions must be authorised as chronic to be covered for chronic, long-term use instead of acute, short-term use.

Medication items that are used primarily to treat chronic conditions, but may sometimes also be used to treat acute conditions, are allowed to be claimed for once from the acute medication benefit, after which these items must be registered as chronic medication in order to be covered by the Society.

If members attempt to claim for these items from the acute medication benefit a second time, it will be rejected via a message on the pharmacy claims screen and the member will be required to ask his or her pharmacist or prescribing doctor to contact the Medicine Risk Management team to register the medicine in question on the chronic medication benefit. Certain criteria may have to be met before authorisation is granted.

## DESIGNATED SERVICE PROVIDERS (CONTINUED)

### Hospital risk management

This is the management of benefits whilst a beneficiary is in hospital.

**Pre-authorisation for hospitalisation**
Pre-authorisation is a process that is followed by the Society's managed healthcare provider that includes the application of clinical protocols to determine if a medical procedure is clinically required and if benefits are available. Please note that the granting of pre-authorisation does not guarantee full payment of your claims. Requests for pre-authorisation are very rarely declined. An example of a procedure for which pre-authorisation would be declined is surgery for cosmetic reasons. Annexure C of the Society's rules provides a comprehensive list of other procedures that are excluded from payment.

Failure to obtain pre-authorisation will result in a co-payment amounting to 20% of the cost of the hospital account, subject to a maximum of R1 000.

You will need to obtain authorisation prior to any of the following procedures:

- admission to hospital (all in-hospital services);
- kidney dialysis (in and out of hospital);


- organ transplants;
- fitment of surgical prosthesis;
- dental surgery (in hospital);
- surgical procedures (internal and external); and
- MRI and CT scans.

To ensure a smooth authorisation process, keep the following information handy:

- your Society membership number;
- full name and date of birth of patient being admitted for the procedure;
- hospital practice number;
- doctor's practice number;
- ICD-10 code (your doctor will issue you with this);
- CPT4 number or tariff code (your doctor will issue you with this);
- date of admission or procedure; and
- cost that the doctor will be charging.

Members are notified in writing when the request is authorised or declined. If declined, no benefits will be paid for that specific procedure. In the unlikely event that the managed healthcare provider does not grant you pre-authorisation, you have the right to appeal the decision.

# CLAIMS SUBMISSION

## How soon should I send in a claim?

Claims must be received within four months of the date of service.

## When are claims settled?

Claims are processed and paid twice a month to members and service providers. If you have submitted a claim for payment, you will receive a claims statement after a claims run. It is wise to thoroughly check these for correctness.

## Email notification of claims that have been processed

If you provide us with your email address, you will receive an email each time one of your claims is processed.

Email your claims to enquiries@bpmas.co.za, or post them to:
BP Medical Aid Society
PO Box 532
Cape Town
8000

# PLEASE NOTE

*Claims for services rendered outside the borders of South Africa must be paid for in cash and submitted to the Society with proof of payment. Such claims must bear a detailed description in English of each service rendered. Benefits on such claims will be paid at the Society rate as if the services had been rendered in the Republic of South Africa.*

## SUMMARY OF ANNEXURE C (RULES AND LIMITATIONS)

The full list of the exclusions and limitations can be viewed on the Society's website at www.bpmas.co.za.

The following products and services will not be covered by the Society, except in the case of prescribed minimum benefits (PMBs):

- medicines not registered with the Medicines Control Council;
- bandages and aids, dressings, cotton wool and other consumable items not supplied as part of hospital treatment;
- patent food, including baby food;
- contraceptives, unless prescribed by a medical practitioner;
- any device intended to induce, enhance, maintain and promote penile erection or to address erectile dysfunction, such as erectile appliances and auto injectors;
- domestic and herbal remedies not included in a prescription from a registered naturopath or herbalist;
- slimming preparations, appetite suppressants, food supplements, vitamins and tonics, unless prescribed and medically necessary;
- household and biochemical remedies, such as devices and material such as dental floss, toothbrushes and toothpaste, sunscreening and tanning agents, soaps, shampoos and other non-medical topical applications;
- infertility and artificial insemination;
- cosmetic procedures;
- willful injury or attempted suicide; and
- services rendered by any person not registered by a recognised professional body.

## COMPLAINTS AND DISPUTES

Should you have any queries regarding the Society, please contact the Client Service Department on 0800 001 607 or by email to enquiries@bpmas.co.za with the details of your query.

Should you feel that the Client Service Department has not resolved your query, you may request that it be referred to a team leader, followed by the Client Service Manager. If the query is still not resolved, it can be submitted to the Fund Manager at Momentum Health Solutions. Please provide all details pertaining to the claim, as well as the details of your interactions with the Client Service Department.

There is also a grievance form available at www.bpmas.co.za that can be completed and submitted directly to the Principal Officer of the Society.


Please bear in mind that the Society's registered rules and practices will take precedence at all times when we consider what action should be taken to resolve the query.

You have the right to request that your query be referred to the Board of Trustees for consideration or, should the query still not be resolved, that the Principal Officer refers your case to the Society's Disputes Committee.

Once the matter has been referred to all of the above channels and you are still not satisfied that the query has been properly resolved, you have the right to lodge a complaint with the Registrar of the Council for Medical Schemes. Remember: before doing so, you are encouraged to log your disputes with the Society for investigation, allowing the Society fair opportunity to assist you in resolving your dispute before lodging a dispute with Council for Medical Schemes.

# GLOSSARY

**Agreed tariff =** The tariff agreed upon between the Society and the service provider, whether designated or preferred

**Formulary =** A list of preferred medicines for the treatment of the 26 prescribed minimum benefit (PMB) conditions that includes original, brand-name and generic medicines and is administered by the Society's designated agent

**Generic reference pricing =** The maximum price that the Society pays for medication, based on the cost of any original product

**Single exit price =** The price determined by the manufacturer or importer of a medicine or scheduled substance, combined with the logistics fee and VAT

**Therapeutic reference pricing =** the maximum price that the Society pays for medication for a particular chronic condition, based on a range of medicines that have the same therapeutic effect and pharmacological action

**PMBs =** Prescribed minimum benefits, as stipulated in the Regulations to the Medical Schemes Act – a set of defined benefits that medical schemes must cover to ensure that all members have access to certain minimum health services

**Society rate =** The Society rate is determined by the 2022 Society rate, plus an inflationary increase; in respect of claims from Namibian service providers, the Society rate will be referred to as the NAMAF rate

**TTO =** To-take-out medicine – medicine taken home after being hospitalised

**UPFS =** Uniform patient fee schedule – the tariffs charged by State or public facilities

**Per family per annum =** A family is defined as the member plus his or her registered dependants

**MRM =** Medicine Risk Management Programme provided by the Society's designated agent

**HPCSA =** Health Professions Council of South Africa

**AHPCSA =** Allied Health Professions Council of South Africa

**M =** Single member with no dependants

**M+ =** Member with dependants

**Treatment plan =** A list of services for the specific PMB conditions, based on protocols or guidelines, as published by the Minister of Health; the services may include general practitioner and specialist consultations, as well as pathology and other diagnostic services, such as radiology and physiotherapy

**DSP =** A designated service provider is a provider that the Society has chosen as its preferred provider for specific services, such as Mediclinic and Life Healthcare hospitals for hospitalisation

# Contact details

**Please send claims to:**

BP Medical Aid Society
PO Box 5324, Cape Town 8000

**Client Service Department (including prescribed minimum benefit queries)**

South Africa: +27 21 480 4610 or 0800 001 607
Namibia: +27 21 480 4610
South Africa fax: +27 21 480 4969
Namibia fax: +27 21 480 4969
enquiries@bpmas.co.za
www.bpmas.co.za

**Netcare 911 emergency services**

South Africa: 082 911
Namibia: 082 911

**Clicks Direct Medicines**

0861 444 405 or 010 210 3500
Fax: 0861 444 414
clicks.directmedicines@dirmed.co.za

**Hospital pre-authorisation**

Namibia: +27 21 480 4762
South Africa: 0800 007 092

**LifeSense Disease (HIV programme)**

0860 506 080
Email: results@lifesense.co.za

**Oncology programme**

South Africa: +27 21 480 4073
Namibia: +27 21 480 4073

**Fraud hotline:**

South Africa: 0800 000 436
Namibia: +27 21 480 4610

**Pension queries (Momentum)**

0800 000 329

**Iso Leso (for optical care)**

South Africa: 0860 10 30 50/60
Namibia: +27 11 340 9200

**Council for Medical Schemes**

Customer Care Centre
0861 123 267 or 0861 123 CMS
information@medicalschemes.co.za

**Complaints**

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

**Postal address**

Private Bag X34, Hatfield 0028

**Medipost**

Tel: 012 426 4000 or 087 098 0426
Fax: 0866 488 446
info@medipost.co.za

# Notes

www.bpmas.co.za