

## 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 the Medi-Clinic Group as its primary **DSP** 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.

The 10% co-payment will also not apply in respect of hospital accommodation at **Contracted Providers**. The Society contracted with Gatesville Medical Centre, Mitchell’s Plain Medical Centre and Bellville Medical Centre. Members are able to use these hospitals without being liable for a co-payment.

It is important to note that should a member fail to obtain pre-authorisation for making use of a non-DSP provider or non-contracted 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.

## 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

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- 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 technologist
- 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 & AIDS 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 on **061 230 505** 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
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic renal disease
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Crohn’s disease
- Diabetes insipidus
- Diabetes mellitus, types 1 and 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson’s disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis
- HIV infection

## Prostheses benefit limits

The following limits apply to the prostheses listed below:

- Bilateral total hip replacement R40 000
- Total hip replacement R22 700
- Partial hip replacement R12 650
- Revision hip replacement R43 300
- Knee replacement, without patella R25 200
- Knee replacement, with patella R28 500
- Bilateral knee replacement R50 500
- Revision knee replacement R43 800
- Total shoulder replacement R30 200
- Bilateral shoulder replacement R38 300
- Level one spinal fusion, without cage R13 800
- Level one spinal fusion, with cage R26 100
- Level two spinal fusion, without cage R18 350
- Level two spinal fusion, with cage R29 200
- Level two spinal fusion, with two cages R42 800
- Artificial limbs, below the knee R13 200
- Artificial limbs, above the knee R22 000
- Artificial eyes R13 200
- Finger joint prosthesis R3 250
- Pacemakers, with leads R27 400
- Biventricular pacemaker R44 900
- Intra-cardiac device R150 100
- Cardiac valves R20 700 (each)
- Cardiac stents with delivery system (maximum of three per annum) R14 900 (each)
- Drug eluting stents (maximum of three per annum) R18 600 (each)
- Aortic aneurysm repair grafts R87 800
- Cochlear implant R137 200

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
- Hearing aids
- 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 R130, 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 QMP, 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
- Sunglasses
- 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 Qualsa, 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.

- Contracted Provider**

This is a service provider, other than a DSP, with whom the Society has negotiated a preferential rate for the provision of specific services to members. As of 1 January 2006, the Society has contracted Gatesville Medical Centre, Mitchell’s Plain Medical Centre and Bellville Medical Centre for the provision of hospital accommodation.

- DSP**

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

- Hospitalisation – **Medi-Clinic Group and public (State) hospitals**
- Emergency services – **ER24**
- Optical care – **Preferred Provider Negotiators (PPN)**
- Chronic medication – **Chronicare**
- Managed care – **Qualsa** manages the following areas:
  - Hospital Risk Management (for hospital pre-authorisation)
  - Medicine Risk Management (MRM)
  - Prescribed Minimum Benefits (PMBs)
  - Oncology Programme
  - HIV & AIDS Programme.

- 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 medicines for the treatment of the 26 PMB (CDL) 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

- MRM**

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

- Pb/pa**

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

- Pf/pa**

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)



## Summary of benefits – effective 1 January 2010

Unless excluded as provided for in Annexure C (For a detailed benefit schedule please visit the Society's website.)

Service	Benefit (subject to the annual limit of R1 300 000 per family per annum)	Annual Limits	Conditions/Remarks
<b>PRIVATE AND PUBLIC (STATE) HOSPITALS, REGISTERED, UNATTACHED OPERATING THEATRES AND DAY CLINICS</b> Accommodation in a general ward, high-care ward and intensive care unit; theatre fees	100% of Agreed Tariff at DSP or Contracted Provider, or 90% of Agreed Tariff at other providers	Subject to hospitalisation limit of R890 000 pf/pa	Subject to pre-authorization by the Scheme's DSP Hospital accommodation, theatre fees, medicines and materials in hospital and hospital equipment, are subject to the annual limit of R890 000 pf/pa See overleaf for further details on the pre-authorization process and co-payments
Medicines, materials and hospital equipment	100% of cost (TTO limited to 7 days) at DSP or Contracted Provider or 90% of Agreed Tariff at other providers	Subject to hospitalisation limit of R890 000 pf/pa	
Visits by medical practitioners	100% of cost up to a maximum of three times the RPL		
Nursing services and all other non-psychiatric, in-hospital services; confinement and midwives	100% of Agreed Tariff at DSP or Contracted Provider, or 90% of Agreed Tariff at other providers		
<b>SURGICAL PROCEDURES</b> All in-hospital services, namely operations, procedures and consultations	100% of cost, up to a maximum of three times the RPL		Subject to pre-authorization Excludes dental implants unless indicated as an essential part of another pre-authorized dental procedure Includes elective orthognatic surgery and maxillo-facial surgery
<b>IN-HOSPITAL PSYCHIATRIC TREATMENT</b> Accommodation	100% of RPL or 100% of UPFS	Limited to 21 days pb/pa	Includes treatment for substance abuse Includes treatment on a day patient basis, in lieu of hospitalisation; subject to pre-authorization See overleaf for details on how to apply for additional benefits
Medicines, materials and hospital equipment	100% of cost (TTO limited to 7 days)		
Visits by medical practitioners	100% of RPL		
<b>SUB-ACUTE FACILITIES/ALTERNATIVES IN LIEU OF HOSPITALISATION</b> Step-down nursing facilities	100% of RPL or Agreed Tariff at DSP or Contracted Provider		Excludes frail care facilities Subject to pre-authorization Post hospitalisation benefit and/or cardiac rehabilitation 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	100% of RPL	R12 960 pf/pa	
Hospice	100% of RPL		
Post hospitalisation benefit (in lieu of hospitalisation)	100% of RPL, or cost where no RPL exists	90 days per diagnosis	
Cardiac rehabilitation benefit (following hospitalisation/post discharge)	100% of RPL at Accredited Providers	6 months per cardiac event, subject to hospitalisation limit of R890 000 pf/pa	The cardiac rehabilitation benefit provides for an initial 3-month intensive rehabilitation benefit, followed by a 3-month continuing care benefit
<b>RADIOLOGY</b>	<b>PMB:</b> 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 <b>PMB</b> conditions, radiology must be detailed in the care plan, to be paid at 100% of cost
Basic - All x-rays	<b>Non-PMB:</b> 100% of RPL, both in and out of hospital	R715 pb/pa	
Ultrasounds	<b>Non-PMB:</b> 100% of RPL, both in and out of hospital		
Advanced - MRI and CT scans - Scopes (diagnostics) - Angiography	<b>Non-PMB:</b> 100% of RPL, both in and out of hospital	Subject to pre-authorization	
<b>PATHOLOGY AND MEDICAL TECHNOLOGY</b>	<b>PMB:</b> 100% of cost <b>Non-PMB:</b> 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
<b>ORGAN TRANSPLANTS</b> (includes harvesting of organs)	<b>PMB:</b> 100% of cost <b>Non-PMB:</b> 100% of Agreed Tariff at DSP	R108 000 pf/pa	Subject to pre-authorization 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
<b>KIDNEY DIALYSIS</b>	100% of RPL		Subject to pre-authorization
<b>BLOOD TRANSFUSIONS</b>	100% of cost		Includes cost of blood, blood equivalents, blood products and transport of blood Subject to pre-authorization
<b>PROSTHESES</b> (external and internal)	100% of Agreed Tariff at DSP or Contracted Provider, or 90% of cost at other providers	R13 600 pb/pa per prosthesis, excluding 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 R49 200 pb/pa	<b>External:</b> Eyes and limbs, e.g. legs and arms <b>Internal:</b> Appliances placed in the body to replace body parts during an operation; excluding dental implants Subject to pre-authorization by the Society's DSP See overleaf for details on how to apply for additional benefits, and the limits applicable for prostheses
<b>ACUTE AND SELF MEDICATION</b> Medication used to treat a temporary condition or illness, including homeopathic medication	100% of cost up to R800 per beneficiary; thereafter 80% of cost	Limits: M R2 960 M + 1 R4 630 M + 2 R5 230 M + 3 + R5 760	Prescribed by a person legally entitled to prescribe Subject to QMP Self-medication is limited to R130 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
<b>NON-PMB CHRONIC MEDICATION</b> Medication for certain specified conditions that are often life threatening and require medication for a period of more than 3 to 6 months	100% of Agreed Tariff at DSP At a non-DSP, the Single Exit Price 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	<b>Limit:</b> R20 200 pb/pa (subject to rules governing PMBs) Details on these guidelines are available on the Society's website 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-authorization from the MRM programme; QMP; 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
<b>PREVENTATIVE OUT-OF-HOSPITAL PROCEDURES</b> Blood pressure measurement, blood glucose screening, cholesterol screening and body mass index measurement	100% of cost	R100 pb/pa	Only screening tests to be paid from this benefit

### ■ 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 to the right, mention is made of the benefit categories that are pro rated.

### ■ QMP

**Qualsa Maximum 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 QMP and the price of the original product. The Society will cover the cost of the original product where there is no generic equivalent available.

### ■ RPL

**The Reference Price List** published by the Department of Health: If the Department of Health does not publish the RPL in a particular year, the Board may determine an appropriate rate of payment for that year. Should this occur in 2010, the RPL will be defined as the RPL determined by the Scheme for 2009 plus an inflationary increase of 8%. In respect of claims from Namibian service providers, the RPL will be the NAMAF tariff.

### ■ TTO

**To-take-out medicines:** This is medicine that is taken home subsequent to hospitalisation. This medication is subject to the QMP 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

Service	Benefit (subject to the annual limit of R1 300 000 per family per annum)	Annual Limits	Conditions/Remarks
<b>SPECIALIST AND GENERAL PRACTITIONER SERVICES</b> Consultations and visits (out of hospital), as well as all other services, unless stated otherwise in the benefit schedule	<b>PMB:</b> 100% of RPL <b>Non-PMB:</b> 100% of RPL for first four consultations pb/pa; thereafter 80% of RPL	<b>PMB:</b> Unlimited <b>Non-PMB limits:</b> M R3 960 M + 1 R5 290 M + 2 R6 610 M + 3 + R7 940	Consultations in respect of a PMB condition are subject to the care plan and Appendix 1 Includes consultations out of hospital (including, but not limited to, chiropractors, homeopaths, biokineticists, ante-natal visits and midwifery, osteopaths, naturopaths, dieticians, podiatrists, chiroprodists, 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 additional benefits Benefit is pro rated if member joins during the year
<b>AMBULANCE SERVICES</b> (road and air)	100% of cost at preferred provider (ER24), except in case of emergency		Transport to be certified by a medical practitioner as essential Subject to pre-authorization by ER24 (the Society's DSP for emergency services), failing which the member will be liable for all costs incurred
<b>AUXILIARY SERVICES</b> (audiology, audiometry, occupational and speech therapy, and orthoptic services)	80% of RPL	R4 100 pf/pa	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
<b>APPLIANCES AND CONSUMABLES RELATED TO CHRONIC DISEASES AND/OR MEDICAL CONDITIONS</b> Wheelchairs, crutches, braces, walking frames and similar equipment	100% of cost	R6 600 pb/pa	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
Appliances related to chronic diseases and/or medical conditions, e.g. oxygen cylinders and nebulisers (hire or purchase)	100% of cost	R6 600 pb/pa	Subject to pre-authorization, except for nebulisers Benefit is pro rated if a member joins during the year
Consumables related to chronic disease and/or medical conditions, e.g. colostomy kits and other incontinence materials/equipment	100% of cost	R12 950 pb/pa	
Diabetic consumables and appliances, including needles, strips and glucometers	100% of cost	R2 600 pb/pa	
<b>ACUTE MEDICAL AND SURGICAL APPLIANCES</b>	80% of cost	R4 450 pb/pa	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 prosthesis, 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
<b>HEARING AIDS</b> Includes repairs to hearing aids	100% of cost	R6 480 pb per two-year cycle	(Two-year cycle: 2009/2010) See overleaf for details on how to apply for additional benefits
<b>PSYCHOLOGICAL AND PSYCHIATRIC TREATMENT</b> Out of hospital	<b>PMB:</b> 100% of RPL <b>Non-PMB:</b> 80% of RPL	R4 450 pf/pa	Consultations in respect of PMB conditions are subject to a care plan and Appendix 1 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
<b>CLINICAL AND TECHNICAL TECHNOLOGISTS</b> In-hospital services	100% of cost to a maximum of three times the RPL		All in-hospital services are subject to pre-authorization
Out-of-hospital services	80% of RPL		
<b>DENTAL SERVICES</b> (conservative and restorative dentistry [including plastic dentures and extractions under conscious sedation], special dentistry [including metal base dentures] and implants)	80% of RPL or Agreed Tariff	R12 520 pf/pa, limited to R6 260 pb/pa	All orthodontic services are subject to prior approval In-hospital dentistry is subject to prior approval and pre-authorization by the Society's DSP Benefit is pro rated if member joins during the year
<b>PHYSIOTHERAPY</b>	<b>PMB:</b> 100% of RPL <b>Non-PMB:</b> 80% of RPL	R4 430 pf/pa, limited to R1 540 pb/pa	Benefits in respect of CDL-related PMB conditions are subject to a care plan and Appendix 1 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
<b>TRAVELLING EXPENSES</b>	80% of cost	R650 pf/pa	Costs unavoidably incurred in the seeking of urgent or emergency medical treatment Subject to criteria set by the Board from time to time and granted at the discretion of the Board Benefit is pro rated if member joins during the year
<b>OPTICAL SERVICES</b> Comprehensive consultation (inclusive of tonometry [glaucoma] screening and visual screening) <b>PLUS:</b> Spectacles - Lenses	100% of cost for one pair of clear single-vision spectacle lenses of any prescription, 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 of any prescription when obtained from PPN pb per cycle	One pb per cycle Consultations outside network limited to a maximum cost of R400 pb per cycle  One pair of clear single-vision spectacle lenses limited to R120 per lens pb per cycle when obtained outside network	Cycle: a two-year period (2009/2010) Preferred Provider Negotiators (PPN) is the Society's DSP for providing 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-authorization 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: R840 - spectacles with bifocal or multifocal lenses: R1 100 - contact lenses: R840 - consultation: R400 Where the maximum frame entitlement of R600 is not utilised, the balance may be used for prescription lense enhancement
- Frames and/or prescription lens enhancements <b>OR</b> - Contact lenses in lieu of spectacles (inclusive of consultation)	100% of cost in and out of network  100% of cost in and out of network	Limited to R600 pb per cycle  Limited to R840 pb per cycle	
Refractive surgery	Benefit provided under hospitalisation benefit		
<b>HIV &amp; AIDS AND RELATED ILLNESSES</b>	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 Contracted Provider, or 90% of cost at other providers	In respect of pathology, medication and consultations  In respect of hospitalisation and related services	Subject to registration on the programme and pre-authorization for medication and hospitalisation Failure to comply with the programme will result in a co-payment Post exposure prophylactics: members covered for 28 days on triple therapy See overleaf for details on how to apply for additional benefits
<b>ALCOHOLISM AND DRUG DEPENDENCY</b>	Benefits payable in terms of the relevant paragraphs above	Subject to PMBs and Appendix 1 (which can be obtained from the Society's website or the Client Service Department)	Subject to pre-authorization See overleaf for details on how to apply for additional benefits, if needed
<b>INFERTILITY</b>	PMBs only		PMB benefits will be paid in respect of services obtained from DSP and public (State) hospitals
<b>ONCOLOGY PROGRAMME/CHEMO AND RADIOTHERAPY</b> (in and out-of-hospital treatment)	100% of Agreed Tariff	Limited to R350 000 pb/pa, subject to PMB and Appendix 1 (which can be found on the website or obtained from the Client Service Department)	Subject to pre-authorization and registration on the programme 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

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](http://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 2010.