bpomas

BENEFIT GUIDE

2023/24

#1 Medical Aid Provider.

Thank you for choosing and trusting **BPOMAS** to take care of your healthcare needs. As a Scheme, we are passionate about finding new ways of delivering increased member value and access to quality healthcare services for you and your loved ones.

This guide provides more information on how to use your benefits and many services that are available to you.

WHAT TO READ

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04

WHO CAN BE A BPOMAS MEMBER?

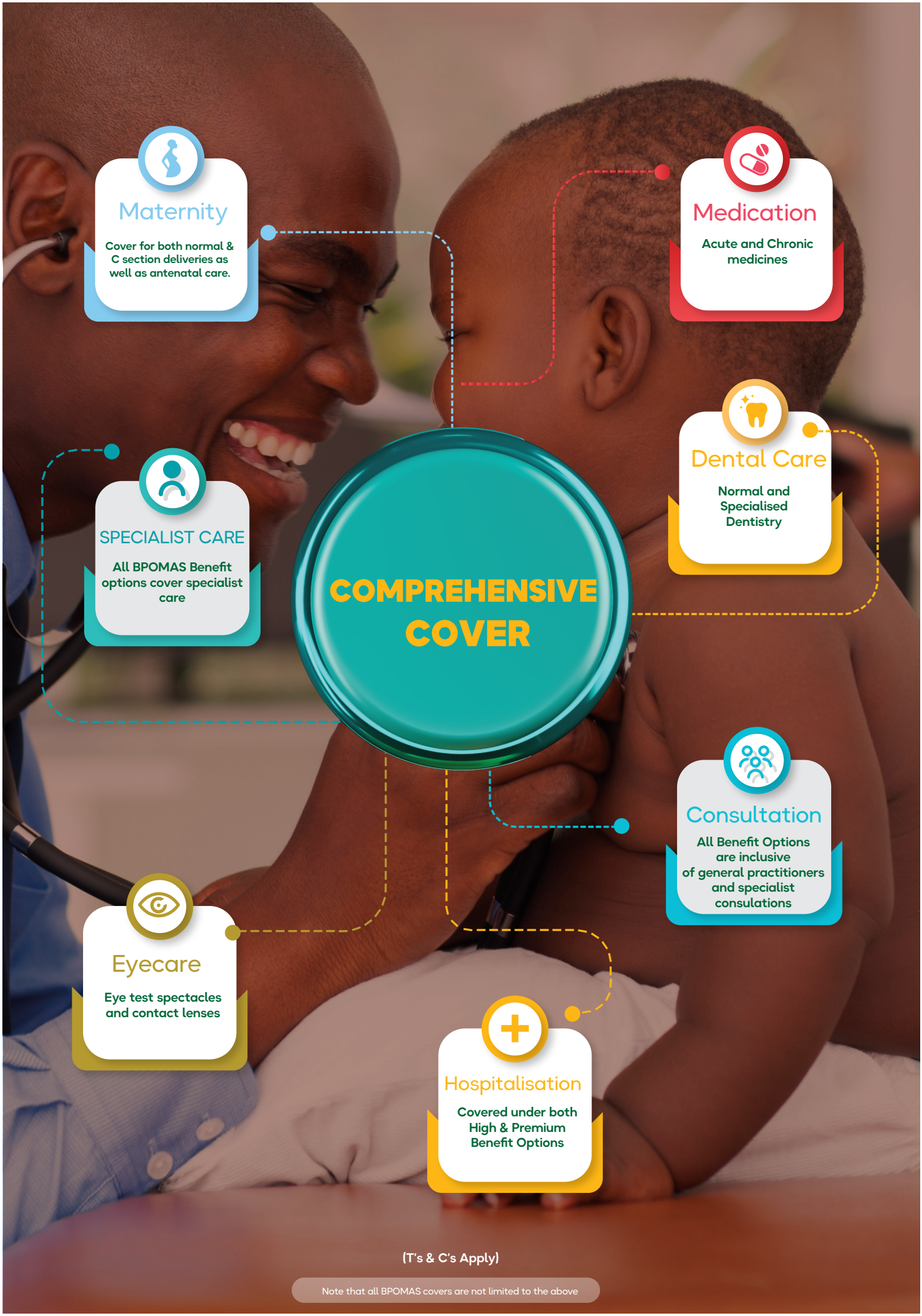
Who can be a Member of **BPOMAS?**

- Government employees
- Employees of parastatals
- Pensioners

Who can I include as **DEPENDANTS?**

- Spouse (Civil and Customary)
- Children under **21 years** (biological/ legally adopted)
- Children up to **25 years** if they are studying fulltime
- Adult Children **21 years - 35 years**
- Parents and Parents In-law
- Grandchildren

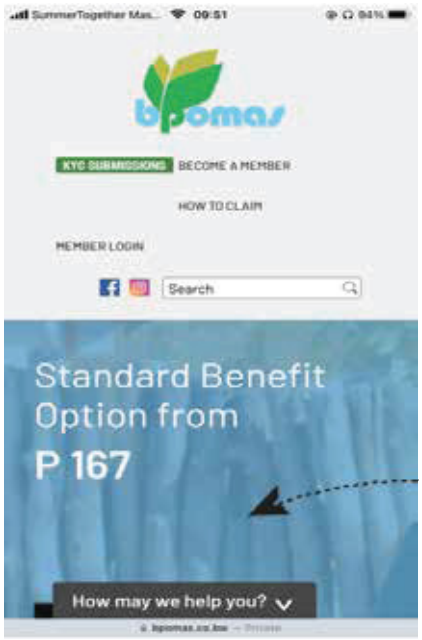
(T's & C's Apply)

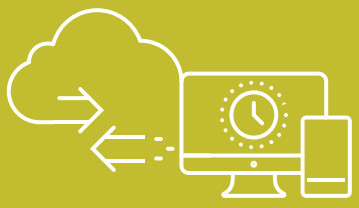


(T's & C's Apply)

Note that all BPOMAS covers are not limited to the above

HOW TO JOIN





STEP 1

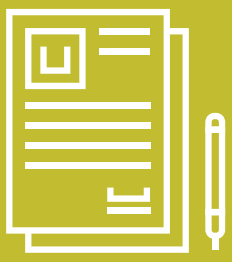
Get the New Member Application form by:
Downloading from www.bpomas.co.bw

STEP 2

- Complete the New Member Application form
- Have it signed and stamped by your employer

Attach the following documents:

- ☐ Copy of certified **ID/Omang** or **Passport** for foreign nationals
- ☐ Recent payslip (not older than 2 months)
- ☐ Spouse's certified **ID** copy and marriage certificate (if adding spouse)
- ☐ Children's certified birth certificates (if adding children)
- ☐ Certificate of membership from previous medical aid (if previouly covered)



STEP 3

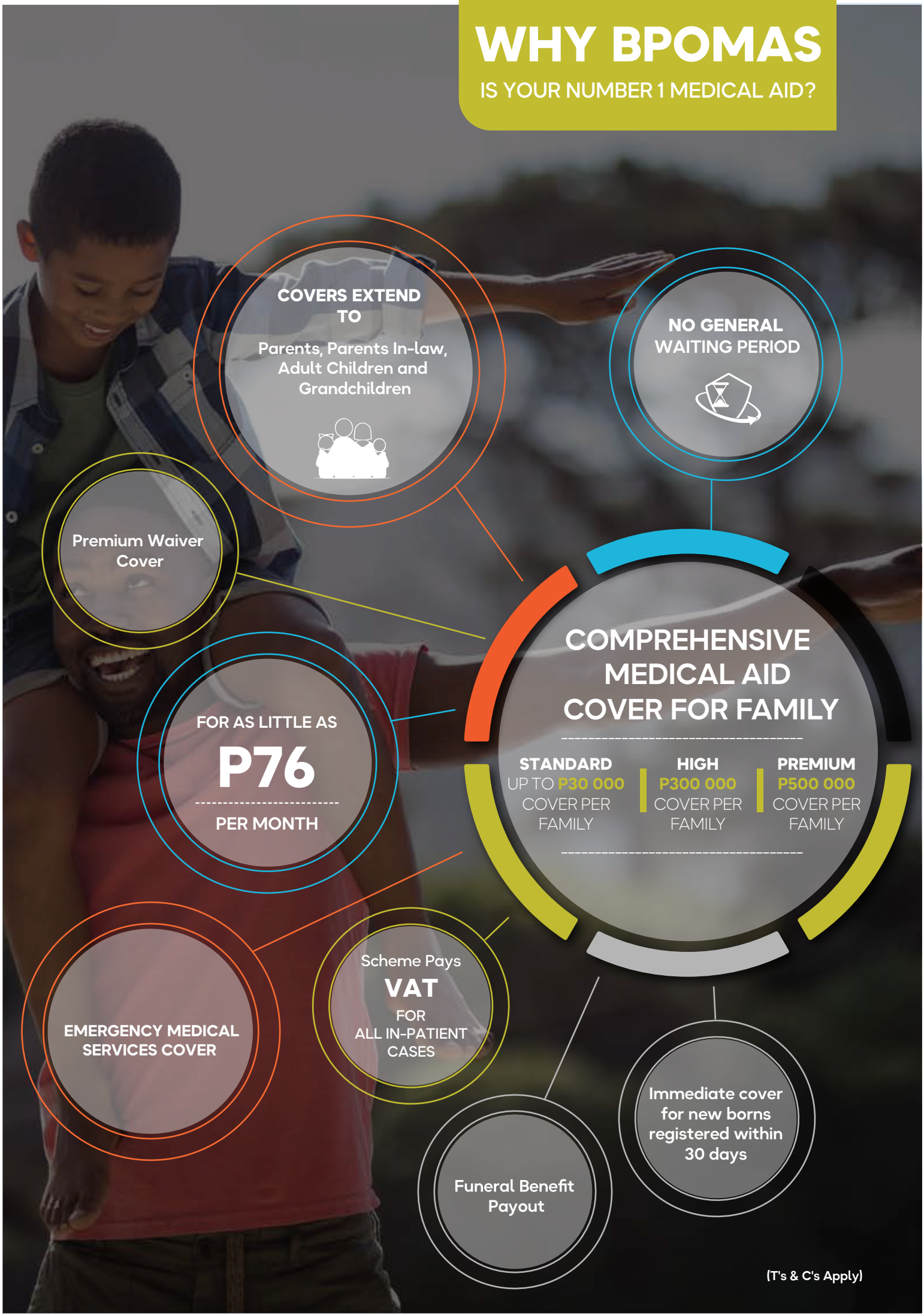
Submit the completed form and supporting documents by:

Email to: join@bpomas.co.bw or sales@bpomas.co.bw
Hand delivery to any of our offices closer to you or,
Fax to +267 316 8910 / 397 2402

visit www.bpomas.co.bw for more details

WHY BPOMAS

IS YOUR NUMBER 1 MEDICAL AID?



COVERS EXTEND TO

Parents, Parents In-law, Adult Children and Grandchildren

NO GENERAL WAITING PERIOD

Premium Waiver Cover

COMPREHENSIVE MEDICAL AID COVER FOR FAMILY

STANDARD	HIGH	PREMIUM
UP TO P30 000 COVER PER FAMILY	P300 000 COVER PER FAMILY	P500 000 COVER PER FAMILY

FOR AS LITTLE AS

P76

PER MONTH

EMERGENCY MEDICAL SERVICES COVER

Scheme Pays **VAT** FOR ALL IN-PATIENT CASES

Immediate cover for new borns registered within 30 days

Funeral Benefit Payout

(T's & C's Apply)

COMPREHENSIVE MEDICAL AID COVER FOR FAMILY

NEWLY INTRODUCED COVER

GRANDCHILD DEPENDANT COVER

A Principal Member can now add grandchildren as dependants. (T's & C's Apply)

ADULT CHILD DEPENDANT COVER

A Principal Member can now cover their adult children, who are between 21 years and 35 years of age and, are not in receipt of income not more than minimum wage paid by the Government of Botswana from time to time and have been a beneficiaries of the Scheme for a continuous period of one (1) year.

PARENT DEPENDANT COVER

- A Principal Member can now cover biological/adoptive mother or father and/or the biological/adoptive mother or father of a spouse who is not a pensioner as per the Scheme rules and who is not more than **65 years** of age at the time of entry.
- Each fully paid up Principal Member of **BPOMAS** shall be allowed to cover up to a maximum of four **(4) parents.**

NOTE

Please note that both adult child and parent dependants as defined above, who are admitted into individual dependant membership will have their own medical aid cover; as though they were principal members and have the grand child as the adult childs dependant.

However, continued membership shall be subject to the substantive principal member continuing to be a fully paid up BPOMAS member . The Principal Member shall be liable to pay 100% of the monthly contribution for adult child and parent dependants.

Grandchild
Benefit Cover

Cover your grandchild from as little as
P137.00 Per/ month

BENEFIT OPTION COMPARISON

Benefit	Annual and other limits in Pula		
	Premium Benefit Option	**High Benefit Option**	**Standard Benefit Option**
Annual Benefit Cover	**P500,000** per family	**P300,000** per family	
Annual Overall Limits	**P200,000** per family	**P150,000** per family	**P30,000** per family
1. Medical Practitioner	**Premium**	**High**	**Standard**
1.1 General Practitioners & Medical Specialists, including Psychiatrists	Up to annual overall limit per family limit	Up to annual overall per family overall	Up to annual limit per family
1.2 Maternity Benefits			
1.2.1 Normal Delivery	**P9,680** per beneficiary	**P9,680** per beneficiary	**P8,800** per beneficiaty
1.2.2 Caesarean Delivery	**P15,015** per family per annum	**P14,610** per family per annum	**P13,915** per family per annum
2. Physiotherapy	Up to annual overall limit and upon referral by a medical doctor		
3. Dentistry	**Premium**	**High**	**Standard**
3.1 Maxillofacial & Oral Surgery	Up to annual overall limit	Up to annual overall limit	Up to annual overall limit
3.2 Conservative dentistry including plastic based dentures	Up to annual overall limit	Up to annual overall limit	Up to annual overall limit
3.3 Limited Dentistry Inlays, crowns, bridgework, study models, metal base dentures and the repair, periodontics, prosthodontics and orthodontics	**P8,800** per family per annum	**P7, 260** per family per annum	**P3,630** per family per annum

4. Medicine (non-antiretroviral drugs)	Premium	High	Standard
4.1 Overall Medicines Limit	Up to **P8,600** per family	Up to **P8,015** per family	Up to **P9,420** per family
4.1.1 Pharmacy Medicines (Over the Counter medicines)	Only Up to **P2,580** per family	Up to **P2,400** per family	Up to **P2,830** per family
4.1.2 Prescription Medicines	Only Up to **P6,020** per family	Up to **P5,615** per family	Up to **P6,590** per family
4.1.3 Injection materials supplied by a medical pratitioner, Dentists or authorised health professional.	Up to overall medicines limit (i.e. Up to 4.1)	Up to overall medicines limit (i.e. Up to 4.1)	Up to overall medicines limit
5. Government and Private Hospitals (in-patients)			
5.1. Accommodation (general ward)	Up to annual overall limit per family	Up to annual overall limit per family	A total of **P350** per day for all under categories 5.1 to 5.4 per family
5.2. Intensive Care or High Care	Up to annual overall limit per family	Up to annual overall limit per family	
5.3. Recovery Room Fees	Up to annual overall limit per family	Up to annual overall limit per family	
5.4. Medicines, materials & apparatus	Up to annual overall limit per family	Up to annual overall limit per family	**P 5,830** per case
5.5. Prosthesis used in surgery	Up to **P33,000** per case per annum	Up to **P24,200** per case per annum	
6. Allied Health Service			
6.1 Audiology and/Speech Therapy	**P7,200** (For any one of or a combination of 6.1 to 6.4) per Family	**P6,300** (For any one of or a combination of 6.1 to 6.4) per Family	**P2,800** per family
6.2. Dietician (Doctor's referral required			**P1,400** per family
6.3 Clinical Psychology			**P1,400** per family
6.4. Occupational Therapy			**P1,400** per family
6.5. Ambulance (Interhospil transfer)	**P3,500** per case	**P1,115** per case	**P560** per family
6.6. Blood Transfusion	Up to annual overall limit		
6.7. Chiropody	**P1,600** per Family	**P1,400** per family	**P1,400** per family
6.8. Medical Assistive Device	**P7,500** per Family	**P5,300** per family	**P4,500** per family
6.9. Medical and Surgical Appliances	Up to **P1,320** per family	Up to **P1,320** per family	Up to **P1,370** per family
6.10 Consulting Nurse (Family Nurse)	At a consultation tariff equivalent to half that for a general medical practitioner		
6.11. Step-down Facility	At agreed tariff maximum 21 Days in any one finacial year per family	At agreed tariff maximum 21 Days in any one finacial year per family	Not available
6.12 Home Based Nursing	Up to **P3,500** per family	Up to **P875** per family	Not available
6.13 Wheel Chair	Up to **P3,850** per beneficiary once every three (3) finacial years	Up to **P3,520** per beneficiary once every three (3) finacial years	Up to **P3,520** per beneficiary once every three (3) finacial years

7. Optical	Premium	High	Standard
7.1 Eye test by Optometrist	At agreed tarrif	At agreed tarrif	At agreed tarrif
7.2 Orthoptistry	**P670** per beneficiary per two (2) financial years	**P670** per beneficiary per two (2) financial years	Up to **P840** per two (2) financial years
7.3 Spectacles and Contact lenses solutions	**P2,200** per beneficiary per two (2) financial years	**P1,980** per beneficiary per two (2) financial years	**P1,045** per beneficiary per two (2) financial years
8. Associated Health Services			
8.1 Chiropractic	Up to **P1,200** per family	Up to **P700** per family	**P495** per person per annum
8.2 Homeopathic/ Naturopathy	Up to **P1,200** per family	Up to **P700** per family	**P495** per person family
9. Acupuncture			
	P1,500 per family	Up to **P1,230** per family	**P950** per family
10. Safe Male Circumcision (HIV prevention only)			
	Up to a maximum of **P1,200** per case	Up to a maximum of **P1,200** per case	N/A
11. Surgical Contraception (Pre-authorisation required)			
	Up to annual overrall limit per family	Up to annual overrall limit per family	N/A
12. Specified Sickness Conditions (Subject to Pre-Authorisation)			
12.1 Psychiatry Medicines	**P12,000** per family	**P7,100** per family	**P5,000** per family
12.2 Alcoholism and/or Drug addiction (Rehabilitation)	**P12,000** per family	**P3,200** per family	**P3,200** per family
12.3 HIV/AIDS (Antiretroviral benefit drugs only)	**P10,703** per beneficiary	**P10,703** per beneficiary	N/A
12.4 Chronic Medication	**P13,200** per beneficiary	**P12,100** per beneficiary	N/A

Limit Qualifications

1. Per annum means the cost of treatment received from 01 April to 31 March of any year.
2. Per member / family means the costs incurred by the member and his/her registered dependants.
3. Per beneficiary means the costs incurred by the patient who is either a member or a member's dependant.

SCOPE OF BENEFITS

The scope of benefits or levels of benefits are based on membership categories and the annual overall limit per benefit option.

Membership Categories

M+0	Member without dependants
M+1	Member with one (1) dependant
M+2	Member with two (2) dependants
M+3	Member with three (3) dependants
M+4	Member with four (4) dependants
M+5+	Member with five (5) or more dependants

Proration of Benefits in the First Year of Membership

In the first year of membership, the annual benefit maxima shall be based on the number of months left in that financial year.

Recognised Tariff

Recognise tariff in respect of various categories of health services shall mean; medical tariff, dental tariff, hospital tariffs and medicine cost as approved by the Scheme from time to time.

Co-Payments

The ten percent (10%) contribution towards the cost of services rendered must be paid by the member and, or dependant directly to the service provider.

The Scheme will pay one hundred percent (100%) of all bills incurred by the member / dependant, including the ten percent (10%) co- payment, where such bills are cumulatively in excess of Ten Thousand Pula (P10,000) in any one financial year, subject to availability of benefits and provided such payments are in accordance with Rule 19.

The Scheme will absorb one hundred percent (100%) of the VAT cost on in-hospital services for the local hospitals where VAT is applicable.

Limitation On General Medical Practitioner (GP) Consultation per Beneficiary Per Benefit Option

The number of GP consultations per beneficiary per annum are follows:

1. Standard Benefit Option: **6 consultations** per beneficiary per annum
2. High Benefit Option: **8 consultations** per beneficiary per annum
3. Premium Benefit Option: **10 consultations** per beneficiary per annum

Waiting Periods

Generally, the Scheme doesn't apply waiting periods on the new members. A new member who has never been a member of any recognised medical aid scheme or has a break in membership of more than three (3) months will be subjected to the following waiting periods, where applicable:

1. Limited Dentistry

The waiting period for limited dentistry shall be twelve (12) months for a new member/beneficiary who joins the Scheme without previously having been a member of a recognised medical aid scheme for at least one (1) year.

2. Maternity

i. Any member/beneficiary who joins the Scheme without previously having been a member of a recognised medical aid scheme for at least one (1) year shall be excluded from maternity benefits for a period of nine (9) months.

ii. Where a member has been with the Scheme for at least one (1) year, the member's wife shall be exempted from the maternity waiting period, whether or not the wife was previously a member of a recognised medical aid scheme.

3. Birth or Adoption of Infants

A member's infant child who after birth or adoption, is not registered as a dependant within thirty (30) days of birth or adoption, shall be excluded from benefit for a period of three (3) months.

4. Adult Child Dependant

The waiting period for an adult child dependant (as defined under Rule 4.14.4) who applies after three (3) months of ceasing to be a member shall be three (3) months.

5. Parent Dependant

The waiting period for a parent dependant (as defined under Rule 4.14.5) shall be three (3) months.

Limitation On Dread Disease Cover For The High And Premium Benefit Options

1. The Dread Disease Cover for the High Option is limited to One Hundred and Sixty-Five Pula **(P165,000)** per member annum.

2. The Dread Disease Cover for the Premium Benefit Option is limited to Three Hundred Thousand Pula **(P300,000)** per member per annum.

Limitation Of Benefits

1. The maximum benefits to which a member and his/her dependants shall be entitled in any financial year shall be limited as set out in the Benefits and Contributions Schedule published by the Scheme from time to time.

2. All new members admitted during the course of a financial year shall be entitled to the benefits set out in the Benefits and Contributions Schedule with the maximum benefits pro-rated to the period of membership from the date of admission to the end of the particular financial year.

3. In cases of illness of a protracted nature, the Scheme shall have the right to insist upon a member or dependant of a member consulting any particular specialist the Scheme may nominate in consulta tion with the attending practitioner. In such cases, if the specialist's advice is not acted upon, no further benefits will be allowed for that particular illness.

4. In cases where a specialist, except an eye specialist or gynaecologist, is consulted without the recommendation of a general practitioner, the benefit allowed by the Scheme may be limited to the amount that would have been paid to the general practitioner for the same service.

5. Unless otherwise approved by the Scheme, benefits in respect of medicines obtained on a prescrip tion are limited to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof

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Benefits Excluded

1. All costs incurred for treatment or surgery not medically necessary for obesity.

2. All costs for operations, medicines, treatments and procedures for cosmetic purposes.

3. All costs related to willfully self-inflicted injuries.

4. All costs for the treatment of erectile dysfunction, infertility, including artificial insemination of a person (Intro-vitro Fertilisation (IVF).

5. All costs in respect of injuries arising from speed contests and speed trials.

6. All costs that are in excess of the annual maximum benefit to which a member is entitled in terms of the Rules of the Scheme.

7. All costs in respect of sickness conditions that were specifically excluded from benefits when the member joined the Scheme.

8. All costs of whatsoever nature for treatment of sickness conditions or injuries sustained by a member or a dependant and for which any other party may be liable, unless the Scheme is satisfied that there is no reasonable prospect of the member or dependant recovering adequate damages from the other party.

9. All costs incurred for treatment of an illness or injury sustained by a member or a dependant of a member where such illness or injury is directly attributable to, failure to carry out the instructions of the health practitioner or negligence on the part of the member or dependant.

10. The purchase of medicines not included in a prescription from a person legally entitled to prescribe.

11. All costs for services rendered by:

    i. any person not registered with the Botswana Health Professions Council or similar body or with the Botswana Nursing and Midwifery Council or similar body of the country in which he practices;

    iii. any place, nursing or similar institution, except a state hospital, not registered in terms of the applicable legislation as a private hospital, nursing home, unattached theatre or day clinic and any institution not licensed in terms of the appropriate legislation of the country concerned.

12. Purchase of:

    i. patent medicines and proprietary preparations;

    ii. applicators, toiletries and beauty preparations;

    iii. bandages, cotton wool and similar aids;

    iv. patented foods, including baby foods;

    v. contraceptives and apparatus to prevent pregnancy;

    vi. tonics, slimming preparations and drugs as advertised to the public;

    vii. household and biochemical remedies;

13. All costs for vaccinations, except vaccinations approved for cover by the Scheme;

14. All costs for prophylactic treatment, except for HIV/AIDS related opportunistic infections and condi tions / incidents that recognised by the Scheme from time to time.

15. All costs for medical examinations other than those ordered by a medical doctor in order to deter mine treatment for a sickness condition;

16. All costs for holidays undertaken for recuperative purposes.

MANAGING YOUR BENEFITS

Chronic Medicine Programme

Chronic medicine is used on an ongoing basis to treat long-lasting (chronic) illnesses that can be disabling and/ or potentially life-threatening, such as diabetes or high blood pressure. These illnesses have a negative effect on your quality of life. Chronic medicines need to be taken regularly, over a long period to manage the symptoms or control the effects of the chronic illness.

You, your doctor, or your pharmacist may call **+267 316 8900** or **email managedcare@bpomas.co.bw** to obtain authorisation for new chronic conditions. Medicines will be paid from the chronic medicine benefit only if your conditions has been pre-authorised or registered.

Below are steps to Register for Chronic Illnesses.

STEP 1

You have been diagnosed with a Chronic Condition.

STEP 2

You are required to register the chronic condition. To register, Download the **CHRONIC MEDICATION APPLICATION FORM from the BPOMAS** website, **www.bpomas.co.bw**. Alternatively you may call **+267 316 8900** or email **managedcare@bpomas.co.bw** to request for one.

STEP 3

You will have your doctor to fill in this document and attach necessary or required documentation

STEP 4

Submit the completed form and supporting documents by:

Email to: managedcare@bpomas.co.bw or

Hand delivery to any of our offices closer to you or,

Fax to +267 316 8910

BPOMAS MEDICINE BENEFIT

Medicines: Know the difference

Chronic Medicine

These are prescribed medicines for the long-term management of chronic illnesses and covered under the chronic medicine benefit, and are subject to pre-authorisation on the relevant disease management programmes and managed care rules e.g. Diabetes, High Blood, Asthma, etc.

Acute Medicine

Acute medicines are prescribed for the treatment of a disease or disorder that lasts for a short period of time, e.g antibiotics, painkillers, e.tc.

Over The Counter Medicine

Over the counter Medicine does not require a prescription from your doctor. For example, medicine for ailments such as a headache, cold or an upset stomach. These medicines may be obtained from any pharmacy or dispensing unit. Your pharmacist will be able to tell you if your medicine will be covered by the Scheme.

DREAD DISEASE COVER

The annual Dread Disease Benefit or a proportion thereof shall be available to cover all or anyone (1) of the conditions listed below, subject to the Scheme Rules and preauthorisation. The Cover is provided as a benefit per family per annum regardless of family size and is extended to maintenance treatment of the qualifying conditions.

The Dread Disease Cover is available to members of the Premium Benefit Option and High Benefit Option only. For each of the two (2) benefit options the annual overall limits are as follows:

PREMIUM BENEFIT OPTION	HIGH BENEFIT OPTION
P300 000	P165 000

For purposes of providing health cover beyond the annual overall limit through the Dread Disease Benefit, the following list of dread diseases shall apply: '

A heart attack is the death of a segment of heart muscle caused by a loss of blood supply. The blood is usually cut off when an artery supplying the heart muscle is blocked by a blood clot. If some of the heart muscle dies, a person experiences chest pain and electrical instability of the heart muscle tissue.

Coronary Heart Disease (CHD), also known as ischemic heart disease (IHD), involves the reduction of blood flow to the heart muscle due to build-up of plaque in the arteries of the heart. It is the most common of the cardiovascular diseases. Stroke is a disease that affects the arteries leading to and within the brain. A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts (or ruptures).

Cancer is a group of diseases involving abnormal cell growth with the potential to invade or spread to other parts of the body. These contrast with benign tumors, which do not spread.

Kidney failure, also called end-stage renal disease (ESRD), is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you not to survive without dialysis or a kidney transplant.

Organ transplantation is a medical procedure in which an organ is removed from one body and placed in the body of a recipient, to replace a damaged or missing organ. The donor and recipient may be at the same location, or organs may be transported from a donor site to another location.

Paraplegia is an impairment in motor or sensory function of the lower extremities. The word comes from Ionic Greek "half-stricken". It is usually caused by spinal cord injury or a congenital condition that affects the neural (brain) elements of the spinal canal.

Blindness is a lack of vision. It may also refer to a loss of vision that cannot be corrected with glasses or contact lenses. Partial blindness means you have very limited vision. Complete blindness means you cannot see anything and **DO NOT** see light.

Systemic Lupus Erythematosus (SLE), also known simply as lupus, is an autoimmune disease in which the body's immune system mistakenly attacks healthy tissue in many parts of the body. Multiple Sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body.

Motor Vehicle Accident extends to both physical and mental injuries resulting from an event involving a vehicle accident.

Hepatitis C is an infectious disease caused by the hepatitis C virus (HCV) that primarily affects the liver. During the initial infection people often have mild or no symptoms. Occasionally a fever, dark urine, abdominal pain, and yellow tinged skin occurs.

Note that the list of Dread diseases are not limited to the above examples.

Managing your Membership

As an active member of BPOMAS medical aid scheme, there are various scenarios or incidents that could warrant your membership to be suspended and thus being unactive. These may include and not limited to non-payment of monthly subscriptions. Some examples that my let to suspension of an account or member may include :

i) Not informing the Scheme of the Principal Members Employment Transfer

ii) A member who is retiring and does not inform the scheme of their wish to continue their medical aid cover.

iii) A child dependant who turns 21 and is a student and does not submit proof of schooling.

1. Employee / Member Transfer

STEP 1

Download form from our website www.bpomas.co.bw
Click on information centre to access form

STEP 2

Complete the form, make sure you complete all sections in full
Ensure it is completed, signed and stamped by your employer

STEP 3

Send us the completed form and supporting documents by:

- Scan and email: membership@bpomas.co.bw
- Hand delivery at our offices
- Fax: +267 316 8910

2. Pensioner Cover

Active members who wish to continue with their membership after retirement are required to provide the following:

- Letter of retirement from the public service issued by employer
- Letter from the member informing us about their retirement and interest in continuation with membership cover.

NB: Documents must be provided 3 months before retirement.

Send us the supporting documents by:

- Scan and email: membership@bpomas.co.bw
- Hand delivery at our offices
- Fax: +267 316 8910

3. Child Dependant School Confirmation

Procedure to Follow for submission

Step 1

- Visit our website www.bpomas.co.bw and download the child dependant school confirmation
- form or contact **370 2907** and have it emailed to you
- Click on information centre to access form

Step 2

- Principal member to complete section 1 and 2 of the form
- Form to be signed and completed at the academic institution in section 3

Step 3

Send us the completed form by:

- Scan and email: marketing@bpomas.co.bw
- Hand delivery at our offices
- Fax: +267 316 8910

www.bpomas.co.bw

Get your **FREE** Flu Vaccine shot

BPOMAS offers **100%** cover for flu vaccine for the following members:

- Children aged **6 months** to **10 years**
- Elderly members aged **65 years** and above
- Members enrolled under chronic disease programmes

For more information call: **+267 316 8900**

bpomas

2023/24 MONTHLY CONTRIBUTIONS

WHAT TO PAY

This will depend on;

1. The benefit option you choose
2. How much is your basic salary
3. How many dependants you have

STANDARD BENEFIT OPTION							
SCALE A & B		M+0	M+1	M+2	M+3	M+4	M+5+
	Member	76	98	103	109	127	139
	Employer	304	390	409	437	507	557

STANDARD BENEFIT OPTION							
SCALE C & ABOVE		M+0	M+1	M+2	M+3	M+4	M+5+
	Member	190	244	256	273	317	348
	Employer	190	244	256	273	317	348

HIGH BENEFIT OPTION

HIGH BENEFIT OPTION							
Monthly Basic Salary		M+0	M+1	M+2	M+3	M+4	M+5+
UP TO 3500	Member	339	505	525	570	605	647
	Employer	339	505	525	570	605	647
P3501-P5500	Member	436	560	612	669	719	789
	Employer	436	560	612	669	719	789
P5501-P8000	Member	511	601	677	742	806	875
	Employer	511	601	677	742	806	875
P8001+	Member	538	637	712	789	855	923
	Employer	538	637	712	789	855	923

PREMIUM BENEFIT OPTION

PREMIUM BENEFIT OPTION				
Monthly Basic Salary		PM	AD	CD
UP TO 3500	Member	519	310	208
	Employer	519	310	208
P3501-P5500	Member	667	400	267
	Employer	667	400	267
P5501-P8000	Member	779	469	316
	Employer	779	469	316
P8001+	Member	821	494	330
	Employer	821	494	330

INDIVIDUAL MEMBERSHIP

INDIVIDUAL BENEFIT			
Membership category	Standard (P)	High (P)	Premium (P)
Grandchildren Under 21 years	137	251	488
Adult Child Dependant (21-30 years)	296	461	684
Adult Child Dependant (31-35 years)	305	584	979
Parent Dependant	386	1524	N/A

LATE JOINER PENALTY

Any applicant who is fifty (50) years of age or older who was not a member of one or more medical schemes at the time of joining the Scheme will incure a penalty by way of additional contributions as per Scheme rules as follows;

Years member was not a member of medical aid since the age of 50	Late joiner penalty
1-4 years	1.25
5-14 years	**1.5**
15-24 years	1.75
25 years +	**2**

Example; A first time new member applicant who joins the medical aid as the only dependant at age 56, with a monthly basic salary of P13 000 under the High Benefit Option would pay P807.

Monthly Premium: P538	**P538 x 1.5**
Late penalty fee: 1.5 *	**P807**

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ADDITIONAL BENEFITS

FUNERAL BENEFIT

The Scheme provides a funeral benefit at no additional cost to the monthly contributions. The benefit is available on the satisfaction of the following conditions.

1. Beneficiary should submit the claim for the funeral benefit within six months of the occurrence of death.
2. Provide a certified copy of the death certificate or death notification form
3. Where death occurred outside of a health institution, a police affidavit and letter from customary court will be required. The members has to nominate a member who will be registered to accept the payout. The nominated member should be endorsed by the Tribal Authority, District Commissioner or a similar authority.

The claim is valid for six (6) months and to be claimed, the following has to be provided;

- Certified death certificate
- The principal member has to nominate a beneficiary to accept the payment.

Nomination should be endorsed by Tribal Authority and the District Commissioner.

Claims to be submitted at any Metropolitan office countrywide.

The table below shows the detailed funeral benefits

	Member	Member's Spouce	Child 16 years & over but less than 21 years	Child 6 years & over but less than 16 years	Child less than 6 years including stillborn children
PREMIUM BENEFIT (P)	12 500	12 500	9 350	4 000	2 000
HIGH BENEFIT (P)	10 000	10 000	7 500	3 000	1 800
STANDARD BENEFIT (P)	5 000	5 000	3 750	1 800	1 200

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PREMIUM WAIVER

BPOMAS will continue to cover your loved ones to access services, for a period of **6 months** after death of the principal member. When the Principal Member passes on, his or her dependants (those covered under their membership) will continue to be covered by **BPOMAS** for a period of 6 months without them paying monthly contributions.

The dependants will continue to enjoy all the Scheme's benefits during this time.

How does it work?

1. The family notifies the Scheme on the passing of the principal member (and claim for the funeral benefit).

2. The dependants (those who had been covered at time of death) will have cover for **6 months** without paying monthly contributions.

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EMERGENCY ASSIST 991
24hrs Emergency Assistance

EMERGENCY MEDICAL SERVICES (EMS)

A BPOMAS Member is entitled to services such as;

Emergency Medical Evacuation

In-hospital Monitoring

EA991 will monitor the member's medical condition in the hospital and will keep nominated parties updated as per patient's instructions.

Medical Information 24 Hour Call centre

EA991 also provides expert medical advice telephonically to our clients available on a **24 hour** basis. The emergency call centre is manned by experienced call centre agents and onsite paramedics.

Medical Repatriation

After treatment outside Botswana, **EA991** may repatriate the member back to Botswana. In the unfortunate event of death after a member had been evacuated from Botswana, the service provider will assist with the repatriation of the mortal remains back to Botswana.

Escort of Minors

EA991 will take care and provide escortedtransport to stranded minors of hospitalized or deceased parents or guardians.

The available services include:

In the event of an emergency, the member calls 991 or 390 4537 to request for assistance. Our call centre will require the below to assist the caller.

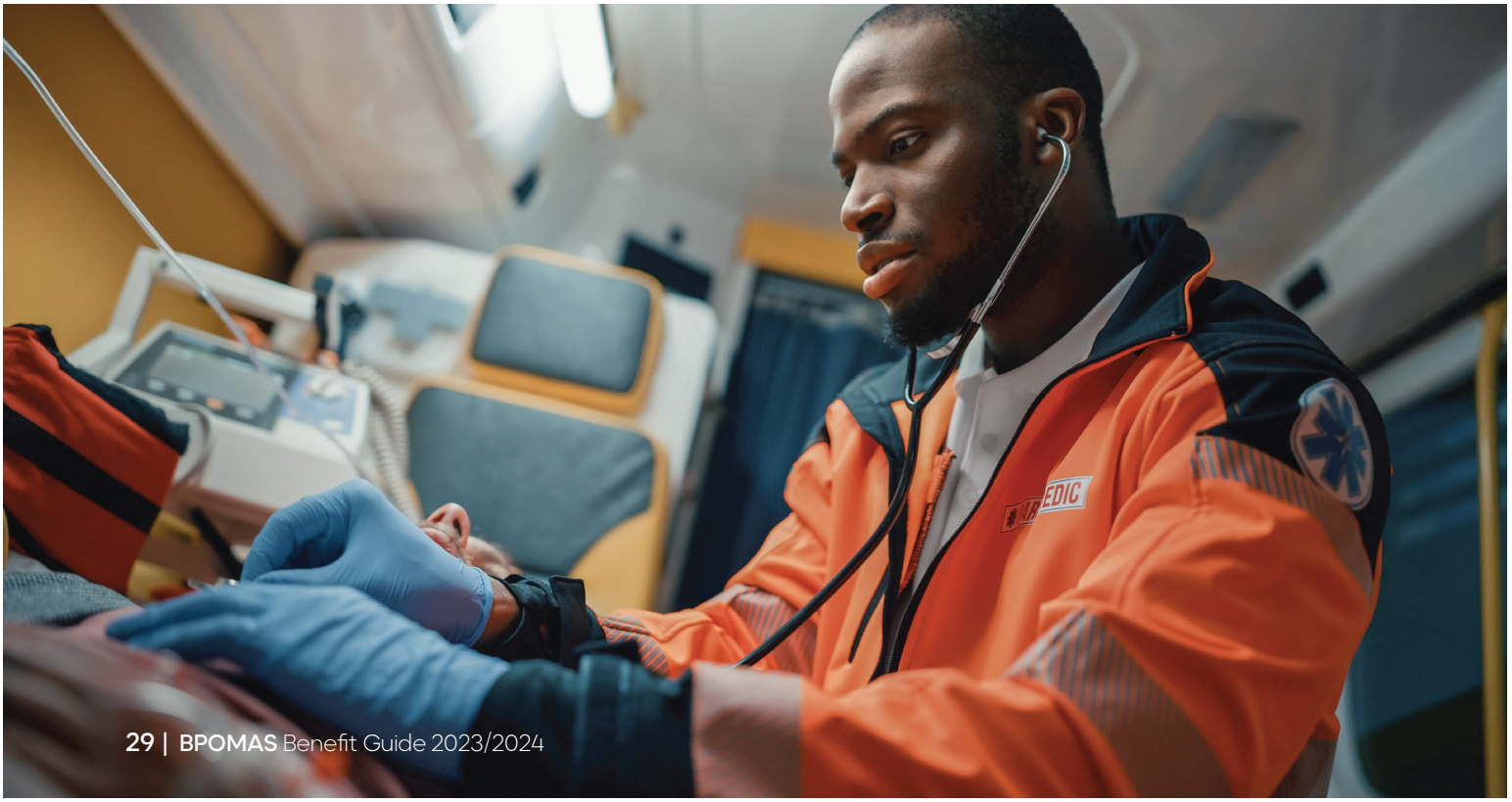
- Provide Bpomas membership or ID number for confirmation purposes.
- Describe the situation as concisely as possible as this will inform the level of assistance required by caller
- Provide location for ambulance dispatch
- Contact details of the caller

Inter-hospital Transfer

EA991 or reciprocal service provider will provide members transfers between hospitals when advanced medical care is required. Models of transport include dedicated ICU air and group ambulances.

Emergency Medical Assistance & Support Call Centre.

These services are provided at no cost to the member. The emergency centre can be contacted at **991 or 390 4537.** 24/7 : 365 Days.



FREQUENTLY ASKED QUESTIONS

1. **How long does it take for my membership to effect?**

   BPOMAS takes 2-3 weeks to process new application forms. Successful applicants are notified via text message with the membership numbers and benefit start date.

2. **Where do I get or access my medical aid card after I become effective?**

   Membership cards are automatically sent to new member applicants via their postal addresses/boxes.

3. **What is the procedure of card replacement?**

   Simply complete the card request form or write a letter requesting a replacement. Submit the document via email, fax or hand deliver to any of our offices and your card will be replaced. Note that card replacement costs P10 per card.

4. **How long does it take to pay claims? Local/International**

   BPOMAS claims processing time is 14 days and processing time may vary if claims submission requirements are not met.

5. **What is the criterion for assessment of claims?**

   Should you pay for services, claims will be reimbursed at 90% of the invoiced amount from the healthcare service provider, provided there is proof, and it does not exceed the agreed tariff.
   NB: *All claims are paid in accordance with the scheme rules and subject to availability of benefits.*

6. **When do I qualify for 10% member co-payment exemption?**

   When your 10% member co-payments total P1 000 within the given financial year, an exemption letter is generated and sent via email or post. The exemption will be effective only for the remainder of that financial year. The scheme financial year is 1st April to 31st March of the following year. A member your is exempted is notified via text.

7. **Am I covered for medical procedures outside Botswana?**

   Yes. BPOMAS requires a doctors motivation/referral for pre-authorisation. Pre- authorisations are confirmed within **24 hours.**

8. **Am I allowed to settle my medical bills and claim from the Scheme?**

   Yes, Members who have settled their medical bills in full are required to submit invoicefor claims.

(T's & C's Apply)

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Botswana Public Officer medical Aid Scheme

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