

**ANNEXURE B.8  
PULSE1****8.1 GENERAL CONDITIONS OF THE BENEFIT OPTION**

- (a) This option is a network benefit option which means that a third party provider is contracted to provide primary healthcare services/day-to-day services to members through CareCross accredited providers and Preferred Specialist providers. Members may only visit service providers registered on the CareCross National Network.
- (b) A Hospital network shall apply for all in-hospital services and benefits
- (c) The Scheme/CareCross benefits on accounts properly submitted in terms of rule 15 shall be granted as shown in each paragraph hereunder, and the member shall be liable for the difference between Scheme tariff or contracted tariff and the full amount of the account.
- (d) Where an account has been paid by the member in cash, such specified account plus proof of payment must be submitted to the Scheme/CareCross before the last day of the fourth month following the date on which the service was rendered. The member will be refunded accordingly.
- (e) Direct payment will be made to a supplier of service who renders accounts in accordance with the Scheme tariff or contracted fee as agreed upon.
- (f) No benefits shall be granted on accounts reaching the Scheme or CareCross after the last day of the fourth month following the date on which the service was rendered.
- (g) A member shall be entitled to pro-rata benefits calculated from the date of enrolment up to the end of the relevant financial year.
- (h) Benefits shall be based on the Scheme tariff or contracted fee as agreed by Bestmed/CareCross and the supplier of service, whichever is applicable.

- (i) Bestmed's financial year shall run from 1 January to 31 December.
- (j) The benefits of the option shall be divided into two parts, namely:
  - ◆ Primary care services as rendered at a CareCross accredited provider
  - ◆ The Scheme benefits that includes all hospital services and preventative care.
  - ◆ Specialist benefits as provided by the Scheme
- (k) Granting of benefits under the primary care services and the Scheme benefits shall be subject to treatment protocols, preferred providers, DSPs, dental procedure codes, pathology and radiology list of codes and medicine formularies as accepted by the Scheme.
- (l) A member shall qualify for the extent and level of minimum benefits provided for in regulation 8 in terms of the Medical Schemes Act (No. 131 of 1998) and Annexure D1 of these Rules, without deductibles or the use of co-payments.

## **8.2 PRIMARY CARE BENEFITS PAID BY CARECROSS**

- (a) The benefits set out in this part may only be obtained from Carecross Providers.
- (b) CareCross shall render the services in accordance with the provisions of a contract entered into by the Scheme and the preferred provider on a capitation basis.
- (c) Claims relating to the benefits set out below shall be referred to Carecross for payment.

### **8.2.1 Consultations, visits, maternity visits and treatments by general practitioners of the network**

100% of the Scheme tariff for the following:

- Unlimited medically necessary consultations for basic primary care;
- Pre- and postnatal care, including supervision of an uncomplicated pregnancy up to week 20 and 2 sonar scans;

- Specified minor trauma treatment, including stitches, excision and repair, drainage of abscess and limb cast.

### **8.2.2 Out of network and emergency visits.**

Every family qualifies for out-of-network visits with a general practitioner (GP). This benefit is limited to R1 000 per family per year. In the event where the family elects to utilize State facilities for emergency visits, such emergency visits shall be unlimited, in addition to the benefits to which the family is already entitled to. All radiology and pathology investigations that fall within the primary care radiology and pathology benefit schedule will be included in the R1 000 limit.

Once the R1 000 limit is reached, cost will be for the member's account. The member shall pay for the visit first and then claim back from CareCross. This benefit excludes services by General Practitioners not registered with the Health Profession Council of South Africa (HPCSA).

### **8.2.3 Medicine**

- (i) 100% of the cost (with no levies or surcharges) for acute or chronic medicine appearing on the CareCross Network formulary and prescribed and/or dispensed by a contracted network provider. .
- (ii) Chronic medicine for CDL medicine only. Unlimited chronic medicine approval will be subject to pre-authorisation by the Clinical Department and according to the CareCross formulary.
- (iii) Chronic medicine prescribed by a specialist, out-of-hospital, shall only be covered on registration and if approved by CareCross and in accordance to the Network formulary.
- (iv) Over the counter medicine can be obtained at the preferred network provider pharmacy and is subject to the CareCross OTC formulary. This benefit is limited to 3 events per beneficiary or a maximum of 5 events per family per year.

All medicine is subject to the Scheme exclusions and reference pricing.

#### **8.2.4 Standard diagnostic imaging and pathology**

Standard diagnostic imaging and pathology services requested by a network provider - 100% of the Scheme tariff.

- (i) Standard diagnostic imaging according to an approved codes list provided by the network to the contracted service provider.
- (ii) Basic pathology shall include all approved codes as per the network approved codes supplied to contracted services providers.

#### **8.2.5 Basic dentistry**

100% of the Scheme tariff when clinically appropriate subject to a designated service provider, the network approved tariff list and conditions as well as the following provisions:

- Two consultations for full month examination per beneficiary per financial year, subject to the CareCross list of dental codes;
- Extractions if clinically necessary.
- Preventative treatment per beneficiary per financial year including scaling and polishing and fluoride treatment.
- One set of dentures per family per 24 months older than 21 years old. A co-payment of 20% and pre-authorisation shall apply for accredited dental laboratories and CareCross list of codes.
- No benefits shall apply for root canal treatment and other specialised dentistry.

#### **8.2.6 Optical benefits**

100% of the cost for benefits rendered by the CareCross contracted optometrist subject to the following conditions:

- Pre-authorisation by CareCross shall apply for contracted designated providers.
- Qualifying norms shall apply for near and distance visions.
- One eye examination per beneficiary per financial year.

- One pair of white mono- or bi-focal lenses in a standard frame per beneficiary per 24 months OR contact lenses limited to R395-00 in lieu of spectacles.
- A benefit of R150 will be paid for a frame outside of the standard range.
- No benefit shall apply for contact lens solutions, tinted lenses, enhancements, acute medicine, non-network providers and accessories.

### **8.2.7 Immunisation**

100% of the cost for Influenza vaccine (Flu vaccine), limited to one per beneficiary per year. This benefit shall only be obtained by a Carecross General Practitioner or network pharmacy, subject to protocols and where clinically indicated.

### **8.2.8 Prescribed Minimum Benefits**

The treatment for the medical management of the 25 Prescribed Minimum CDL conditions at primary care level will be covered according to CareCross protocols and approved tariff lists if requested by the CareCross General Practitioner. All treatment will be paid according to the treatment pairs as prescribed by the Medical Schemes Act.

## **8.3 CONDITIONS FOR SCHEME BENEFIT PAYMENT**

- (a) Comprehensive benefits are offered for all pre-authorized services and authorised emergency services rendered during hospitalisation, i.e. from the day of admission up to and including the day of discharge.
- (b) Full cross subsidisation between members shall apply without an annual limit.
- (c) Granting of benefits under the Scheme benefits shall be subject to treatment protocols, preferred providers, designated service providers, network option services and/or medicine formularies accepted by the Scheme

- (d) The Netcare hospital group is contracted as the Designated Service Provider (DSP) for all in-hospital services. A maximum co-payment of R5 000 shall apply for the voluntary use of a non-DSP.
- (d) No benefits in a private DSP network and/or public hospital or day clinic shall be granted if an authorisation number has not been obtained in advance (in the case of planned major operations and dental procedures – preferably 14 days in advance) or, in an emergency, on the first working day after admission to a hospital, by the Scheme or its proxy.
- (e) If a member or his dependents receive treatment in a private DSP network and/or public hospital or day clinic without an authorisation number having first been obtained (due to either prior application not made or because a prior application was refused), a R500 surcharge per permission will be imposed whenever an application is approved with retrospective effect.
- (f) If an authorisation number has been obtained for treatment in a private DSP network and/or public hospital or day clinic but the treatment cost exceeds the authorised benefits, only the benefits of the authorised treatment cost shall be granted and the member shall be liable for payment of the excess to the service provider.
- (g) Functional nasal surgery and surgery procedures where CNS stimulators are used for example epilepsy, Parkinsonism, etc. will be excluded from benefits except for PMB conditions.
- (h) The following co-payments will be applicable on each hospital admittance once pre-authorisation was granted by the Scheme or its proxy:
- |                                     |         |
|-------------------------------------|---------|
| All laparoscopic procedures         | R2 500  |
| Prostate procedures                 | R2 500  |
| Prolapsed/Incontinence              | R2 500  |
| Arthroscopy other than acute trauma | R2 500  |
| Endoscopic investigations           | R2 000. |
- (i) Joint replacement surgery (A joint connects two bones in the body and includes skull joints, throat joints, thorax joints, spine and pelvis joints, both upper limbs and both lower limbs) will be excluded from benefits except for

PMB conditions. The following maxima will apply to the prosthesis if pre-authorized by the Scheme or its proxy:

- (i) Hip prosthesis and other major joints shall be limited to R17 000
- (ii) Knee prostheses shall be limited to 21 500.
- (iii) Other minor joints shall be limited to R8 000.

#### **8.3.1 Hospitals: DSP network providers and non-DSP providers**

Claims submitted by a DSP network provider for accommodation in a general ward, intensive-care and high-care unit, theatre- and material – 100% of the **contracted fee**. -

Claims submitted by non-DSP providers – 100% of the Scheme tariff and a co-payment of up to R5 000.

#### **8.3.2 Mental health clinics: contracted and non-contracted providers**

Claims submitted by a contracted provider for accommodation and treatment of psychological and psychiatric conditions – 100% of the **contracted fee**.

Claims submitted by non-contracted providers – 100% of **Scheme tariff**.

Benefits shall be subject to the following:

- (i) The length of stay shall be limited to 21 days per beneficiary per financial year

#### **8.3.3 Registered institutions for the treatment of chemical and substance dependence/abuse**

100% of cost for PMB conditions only. A member shall qualify for benefits to the scope and level of the Prescribed Minimum Benefits provided for in the Act and set out in the Regulations as well as Annexure D1 of these Rules.

#### **8.3.4 Consultations, visits, operations, surgical procedures and anaesthetics for surgical procedures during hospitalisation**

Claims submitted by General Practitioners and Specialists for treatment during hospitalisation – 100% of the Scheme tariff or contracted fee.

### **8.3.5 Confinements (pre-authorisation is required)**

Benefits shall be paid as follows even if the baby dies before registration;

- (i) Medical practitioners – 100% of the Scheme tariff.
- (ii) Nursing home and hospital fees in accordance with the provisions of paragraph 8.3.1
- (iii) Midwife assisted births in an Active Hospital birth unit or Home confinement by a midwife – 100% of the Scheme tariff. Transport fees, hospital facility fees, renting of a birth pool, medical disposables or medication, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits.
- (iv) Midwife assisted births at a private midwife birth house – 100% of the Scheme tariff. Transport fees, hospital facility fees, renting of a birth pool, medical disposables or medication, antenatal consultations, doulas and breastfeeding supports shall be excluded from benefits.

### **8.3.6 Internal prosthesis surgically implanted during operations/ hospitalisation**

Prosthesis surgically implanted during operations for the replacement of parts of the human body for functional medical reasons – 100% of the cost after discount with a maximum of R35 000 per family per financial year. Benefits will not be pro-rated but will be subject to the following condition and maxima:

- (i) Pre-authorisation by the Scheme.
- (ii) Preferred providers may be appointed by the Scheme.
- (iii) Co-payments may apply if preferred providers are not utilised
- (iv) Vascular prosthesis shall be limited to R16 500.
- (v) Endovascular prosthesis – no benefit
- (vi) Spinal prosthesis shall be limited to R16 500.
- (vii) Artificial disk (single level based) – no benefit.
- (viii) Drug eluting stent – no benefit.
- (ix) Mesh shall be limited to R6 000.
- (x) Gynaecological/Urological prosthesis shall be limited to R5 000.
- (xi) Lens implant shall be limited to R3 500 per lens.

**8.3.7 Pathology and standard diagnostic imaging during hospitalisation**

100% of the Scheme tariff.

**8.3.8 Specialised diagnostic imaging during hospitalisation**

MRI scans, CT scans, computer tomographic studies and isotope studies – 100% of Scheme tariff, subject to pre-authorisation.

**8.3.9 Orthopedic, surgical and medical appliances during hospitalisation**

100% of the cost with a maximum of R4 300 per family per financial year on the following items if prescribed by a medical practitioner and where such prescription forms part of the in hospital treatment. Benefits shall only be granted if hospitalisation was authorised beforehand by the Scheme.

- (i) Back, leg, arm and neck supports
- (ii) Crutches
- (iii) Surgical footwear (excluding health footwear)
- (iv) Elastic stockings
- (v) Oxygen, diabetic and stoma aids continually essential for the medical treatment of the patient
- (vi) Medical apparatus continually essential for the medical treatment of the patient

**8.3.10 Blood transfusions**

Blood, operators' fees, transport charges and apparatus – 100% of the Scheme tariff.

**8.3.11 Ambulance and emergency evacuation services**

100% of the cost of ambulance services on condition that the service has previously or, in an emergency, on the first working day after evacuation has been approved as clinically necessary by the preferred provider for ambulance services. No benefits shall be payable if the evacuation service

was requested and delivered by a service provider other than the preferred provider.

### **8.3.12 Peritoneal dialysis and hemodialysis during hospitalisation**

100% of the Scheme tariff if the procedure is performed in a public hospital in terms of the minimum benefits.

### **8.3.13 Oncology**

Radiation, Chemotherapy, pathology, diagnostic imaging and consultations - 100% of the cost if the procedure is performed in a public hospital in terms of the minimum benefits. Benefits shall be subject to the following conditions:

- (i) Pre-authorisation by the Scheme;
- (ii) Preferred providers may be appointed
- (iii) Scheme protocols apply.
- (iv) Mediscor Reference Price (MRP) will be applied to medicine claims where applicable.

### **8.3.14 Organ transplants**

PMB conditions only. 100% of the Scheme tariff subject to pre-authorisation and application of Scheme protocols.

### **8.3.15 Take home medicine after discharge from hospital**

Medicine prescribed by the treating doctor upon discharge from hospital, to take home (and relating to the admission), will be paid at 100% of Scheme tariff, subject to MRP and a maximum supply of three days.

### **8.3.16 Preventative care**

- (i) 100% of the Scheme tariff for:

<b>Preventative Care Benefit</b>	<b>Gender and Age Group</b>	<b>Quantity and Frequency</b>	<b>Benefit Criteria</b>
Pediatric immunization	Funding for all pediatric vaccines according to the State recommended programme for babies and children.		
Pneumonia Programme	Children < 2yrs High risk adult group	Once in 60 months	<u>Funding for children &lt; 2years:</u> Parents to contact The Scheme in advance to pre-arrange funding prior to obtaining the vaccine <u>Funding for adults:</u> The Scheme will identify certain high risk individuals who will be invited to be immunised
Biometric screening: - Glucose test (finger prick test) - Cholesterol test (finger prick test) - Blood Pressure - Body Mass Index (BMI)	All beneficiaries 10 years and older	One per beneficiary per financial year	A screening benefit package at selected Preferred Provider Pharmacies.

### **8.3.17 International emergency medical cover**

Over and above the provisions for foreign claims, referred to in Rule 16.12, members and their dependents qualify for the following additional benefit:

100% for the cost of services for worldwide international emergency medical cover: Provided that benefits are subject to the following:

- (i) The cover is limited to R10 million per beneficiary per trip and includes emergency medical expenses and evacuation costs.
- (ii) Beneficiaries have access to 90 days cover per trip. .
- (iii) A member has to notify the preferred provider at least 48 hours in advance when he and or his dependants are travelling overseas.

Failure to notify the preferred provider will result in claims not entertained.

- (iv) General exclusions to services apply Elective planned procedures undergone outside of South Africa are not covered.

#### **8.3.18 Supplementary benefits during hospitalisation**

Supplementary benefits include services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologist/hearing aid acousticians, occupational therapists, podiatrists/chiropracist, dieticians, speech therapist, bio kinetics, private nursing and social workers – 100% of Scheme tariff on condition that the claim is related to the hospital admission of the patient.

#### **8.3.19 Alternatives to hospitalisation**

Services rendered by step-down facilities approved by the Scheme, registered private nurses and hospices – 100% of the fees approved by the Scheme. Pre-authorisation shall apply.

#### **8.3.20 Out of hospital specialist visits**

Every family qualifies for three out of hospital visits with a specialist per year. Mammograms are regarded as an out of hospital specialist visit. These visits must be referrals via the preferred provider network and must be pre-authorised by the Scheme. Each visit has a maximum of R1 000 and includes medicine and all related services. A co-payment of 35% shall apply if non-formulary medicine is prescribed by a specialist.

Specialists excluded from this benefit are radiologists, pathologists, dentists and opticians.

### **8.4**

#### **MAXIMUM BENEFITS**

Where a maximum amount of benefits has been imposed per financial year, the benefits shall be calculated at the maximum for the financial year in which the service was rendered. Where maximum benefits apply to a financial year,

the maximum benefits for which a member and his dependents qualify shall be determined in accordance with the actual membership status at the date on which the service is rendered.

Savings accounts and benefit maxima for members shall be calculated pro-rata as stated in paragraph 8.1 (f)