ANNEXURE B.8
PULSE1

8.1 GENERAL CONDITIONS OF THE BENEFIT OPTION

8.1.1 The benefit option in this Annexure is a network benefit option as per an arrangement entered into between the Scheme and a third party provider, CareCross. As such CareCross 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.

8.1.2 A Hospital Network shall apply for all in-hospital services and benefits, as per an arrangement entered into between the Scheme and the hospital network. As such a pre-negotiated fixed fee will be paid in return for the delivery or arrangement of the delivery of benefits by such a hospital network.

8.1.3 The Scheme or CareCross benefits on accounts properly submitted in terms of rule 15 of the registered Rules 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.

8.1.4 Where an account has been paid by the Member in cash, such specified account plus proof of payment must be submitted to the Scheme or CareCross before the last day of the 4th (fourth) month following the date on which the service was rendered. The Member will be refunded accordingly.

8.1.5 Direct payment will be made to a supplier of service who renders accounts in accordance with the Scheme tariff or contracted fee as agreed by the Scheme and the supplier.

8.1.6 No benefits shall be granted on accounts reaching the Scheme or CareCross after the last day of the 4th (fourth) month following the date on which the service was rendered.

8.1.7 A Member shall be entitled to pro-rata benefits calculated from the date of enrolment up to the end of the relevant financial year.

8.1.8 Benefits shall be based on the Scheme tariff or contracted fee as agreed by Bestmed or CareCross and the supplier of service, whichever is applicable.

8.1.9 Bestmed's financial year shall run from 1 January to 31 December.

8.1.10 The benefits of the option shall be divided into the following:

8.1.10.1 Primary care services managed and paid by the Scheme's Preferred Provider CareCross, as rendered at a CareCross accredited provider;

8.1.10.2 Scheme Benefits that includes all hospital services and preventative care; and

8.1.10.3 Specialist benefits as provided by the Scheme.

8.1.11 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.

8.1.12 A Member shall qualify for the extent and level of prescribed 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

8.2.1 The benefits set out in this part of the Annexure may only be obtained from CareCross preferred providers.

8.2.2 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.

8.2.3 Claims relating to the benefits set out in rule 8.2 of this Annexure shall be referred to CareCross for payment.

8.2.4 Consultations, visits, maternity visits and treatments by general practitioners of the network

100% of CareCross tariff for the following:

8.2.4.1 Unlimited medically necessary consultations for basic primary care;

8.2.4.2 Pre- and postnatal care, including supervision of an uncomplicated pregnancy up to week 20 (twenty) and 2 (two) sonar scans; and

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

8.2.5 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 utilise 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).

8.2.6 Medicine

8.2.6.1 100% 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;

8.2.6.2 Chronic medicine for CDL medicine only. Unlimited chronic medicine approval will be subject to Pre-Authorisation by the CareCross Clinical Department and according to the CareCross formulary;

8.2.6.3 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;

8.2.6.4 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 (three) events per beneficiary or a maximum of 5 (five) events per family per year; and

8.2.6.5 All medicine is subject to CareCross protocols and reference pricing.

8.2.7 Standard diagnostic imaging and pathology

Standard diagnostic imaging and pathology services requested by a CareCross GP - 100% of CareCross tariff:

8.2.7.1 Standard diagnostic imaging according to a list of – codes approved by CareCross; and

8.2.7.2 Basic pathology according to a list of codes approved by CareCross.

8.2.8 Basic dentistry

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

8.2.8.1 2 (two) consultations for full mouth examination per beneficiary per financial year, subject to the CareCross list of dental codes;

8.2.8.2 Extractions if clinically necessary;

8.2.8.3 Preventative treatment per beneficiary per financial year including scaling and polishing and fluoride treatment;

8.2.8.4 1 (one) set of dentures per family per 24 (twenty-four) months for beneficiaries older than 21 (twenty-one) years old. Benefits shall be subject to Pre-Authorisation by CareCross, a co-payment of 20% (twenty percent) and the use of accredited dental laboratories; and

8.2.8.5 No benefits shall apply for root canal treatment and other specialised dentistry.

8.2.9 Optical benefits

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

8.2.9.1 Pre-Authorisation by CareCross shall apply for contracted designated providers;

8.2.9.2 Qualifying norms shall apply for near and distance visions;

8.2.9.3 1 (one) eye examination per beneficiary per financial year;

8.2.9.4 1 (one) pair of white mono- or bi-focal lenses in a standard frame per beneficiary per 24 (twenty-four) months OR contact lenses limited to R395 in lieu of spectacles;

8.2.9.5 A benefit of R150 will be paid for a frame outside of the standard range; and

8.2.9.6 No benefit shall apply for contact lens solutions, tinted lenses, enhancements, acute medicine, non-network providers and accessories.

8.2.10 Immunisation

100% of the cost for Influenza vaccine (Flu vaccine), limited to 1 (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.

8.2.11 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 diagnostic treatment pairs as prescribed by the Medical Schemes Act.

8.3 CONDITIONS FOR SCHEME BENEFIT PAYMENT

8.3.1 Comprehensive benefits are offered for all pre-authorised services and authorised emergency services rendered during hospitalisation, i.e. from the day of admission up to and including the day of discharge.

8.3.2 Full cross subsidisation between Members shall apply without an annual limit.

8.3.3 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.

8.3.4 The Netcare hospital group is contracted as the Designated Service Provider (DSP) for all in-hospital services. Should a Member voluntarily choose not to make use of a Hospital forming part of the Hospital Network for this benefit option, a maximum co-payment of R5 000 shall apply to the voluntary use of a non-designated service provider.

8.3.5 No benefits in a Hospital forming part of the Hospital Network or day clinic shall be granted by the Scheme or its proxy, if Pre-Authorisation and an authorisation number have not been obtained in advance:

8.3.5.1 In the event of planned major operations and dental procedures, at least 14 (fourteen) days before the event; or

8.3.5.2 In an emergency, on the 1st (first) working day after admission.

8.3.6 If a Member or his Dependant(s) receive treatment in a Hospital forming part of the Hospital Network or day clinic without first obtaining Pre-Authorisation and an authorisation number, 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.

8.3.7 If Pre-Authorisation and an authorisation number has been obtained for treatment in a Hospital forming part of the Hospital Network 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.

8.3.8 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.

8.3.9 The following co-payments will be applicable on each hospital admission once Pre-Authorisation was granted by the Scheme or its proxy:

8.3.9.1	All laparoscopic procedures	R2 700;
8.3.9.2	Prostate procedures	R2 700;
8.3.9.3	Prolapsed/Incontinence	R2 700;
8.3.9.4	Arthroscopy other than acute trauma	R2 700; and
8.3.9.5	Endoscopic investigations	R2 200.

8.3.10 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 where services are authorised or approved by the Scheme, in its sole discretion.

8.3.11 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** where services are authorised or approved by the Scheme, in its sole discretion. Benefits shall be subject to the following:

8.3.11.1 The length of stay shall be limited to 21 (twenty-one) days per beneficiary per financial year.

8.3.12 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.

8.3.13 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.

8.3.14 Confinements

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

8.3.14.1 Medical practitioners – 100% of the Scheme tariff;

8.3.14.2 Nursing home and hospital fees in accordance with the provisions of rule 8.3.10 of Annexure B8 of the registered Rules;

8.3.14.3 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; and

8.3.14.4 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.

8.3.15 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 Scheme tariff after discount with a maximum of R38 300 per family per financial year. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act. Benefits will not be pro-rated but will be subject to the following condition and maxima:

8.3.15.1 Pre-Authorisation by the Scheme;

8.3.15.2 Preferred providers may be appointed by the Scheme;

8.3.15.3 Co-payments may apply if preferred providers are not utilised;

8.3.15.4 Vascular prosthesis shall be limited to R18 100;

8.3.15.5 Pacemaker dual chamber R29 600*;

8.3.15.6 Endovascular prosthesis and delivery mechanisms– no benefit;

8.3.15.7 Spinal prosthesis shall be limited to R18 100;

8.3.15.8 Artificial disk, spacers and similar devices – no benefit;

8.3.15.9 Drug eluting stent – no benefit;

8.3.15.10 Mesh shall be limited to R6 600;

8.3.15.11 Gynaecological/Urological prosthesis shall be limited to R5 500;

8.3.15.12 Lens implant shall be limited to R3 800 per lens; and

8.3.15.13 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-authorised by the Scheme or its proxy:

8.3.15.13.1 Hip prosthesis and other major joints shall be limited to R18 600;

8.3.15.13.2 Knee prostheses shall be limited to R23 500; and

8.3.15.13.3 Other minor joints shall be limited to R8 800.

* Subject to clinical motivation, treatment protocols, DSP and Scheme approval.

8.3.16 Pathology and standard diagnostic imaging during hospitalisation

Benefits at 100% of Scheme tariff.

8.3.17 Specialised diagnostic imaging during hospitalisation

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

8.3.18 Orthopedic, surgical and medical appliances during hospitalisation

100% of Scheme tariff with a maximum of R4 700 per family per financial year on the items listed below if prescribed by a medical practitioner and where such a prescription forms part of the in hospital treatment. Notwithstanding the maximum/s quantified, prescribed minimum benefit (PMB) conditions are paid in full at a designated service provider (DSP), as stipulated in the Medical Schemes Act. Benefits shall only be granted if hospitalisation was authorised beforehand by the Scheme.

8.3.18.1 Back, leg, arm and neck supports;

8.3.18.2 Crutches;

8.3.18.3 Surgical footwear (excluding health footwear);

8.3.18.4 Elastic stockings;

8.3.18.5 Oxygen, diabetic and stoma aids continually essential for the medical treatment of the patient; and

8.3.18.6 Medical apparatus continually essential for the medical treatment of the patient.

8.3.19 Blood transfusions

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

8.3.20 Ambulance and emergency evacuation services

Benefits shall be subject to Pre-Authorisation/approval by the Scheme's Preferred Provider for Ambulance services, ER24.

100% of Scheme tariff for ambulance services on condition that the service has previously or, in an emergency, on the 1st (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.

8.3.21 Peritoneal dialysis and hemodialysis during hospitalisation

100% of Scheme tariff subject to Pre-Authorisation, application of Scheme protocols and designated service providers (DSPs) appointed by the Scheme to provide diagnosis, treatment and care in respect of the aforesaid medical condition/s.

8.3.22 Oncology

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

8.3.22.1 Pre-Authorisation by the Scheme;

8.3.22.2 Preferred providers may be appointed;

8.3.22.3 Scheme protocols apply; and

8.3.22.4 Mediscor Reference Price (MRP) will be applied to medicine claims where applicable.

8.3.23 Organ transplants

Benefits for PMB conditions only. 100% of Scheme tariff subject to pre-authorisation, application of Scheme protocols and designated service providers (DSPs) appointed by the Scheme to provide diagnosis, treatment and care in respect of the aforesaid medical condition/s.

8.3.24 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 3 (three) days.

8.3.25 Preventative care

8.3.25.1 Benefits at 100% of Scheme tariff for:

Preventative Care Benefit	**Gender and Age Group**	**Quantity and Frequency**	**Benefit Criteria**
Paediatric immunization	Funding for all paediatric vaccines according to the State recommended programme for babies and children.		
Pneumonia Programme	Children < 2 (two) years High risk adult group	Once in 60 (sixty) months	<u>Funding for children < 2 (two) years:</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	All beneficiaries 10 (ten) years and	1 (one) per beneficiary	A screening benefit package at selected Preferred

(finger prick test) - Cholesterol test (finger prick test) - Blood Pressure - Body Mass Index (BMI)	older	per financial year	Providers.

8.3.26 International emergency medical cover

Over and above the provisions for foreign claims, referred to in Rule 16.12 of the registered Rules, Members and their Dependant(s) qualify for the following additional benefit:

100% of Scheme tariff for the cost of services for worldwide international emergency medical cover, Authorised/approved by the Scheme's Preferred Provider, ER24.
Benefits are subject to the following:

8.3.26.1 The cover is limited to R10 million per beneficiary per trip and includes emergency medical expenses and evacuation costs;

8.3.26.2 Beneficiaries have access to 90 (ninety) days cover per trip;

8.3.26.3 A Member has to notify the preferred provider at least 48 (forty-eight) hours in advance when he and or his Dependant(s) are travelling overseas. Failure to notify the preferred provider will result in claims not entertained; and

8.3.26.4 General exclusions to services apply Elective planned procedures undergone outside of South Africa are not covered.

8.3.27 Supplementary benefits during hospitalisation

Supplementary benefits include services rendered by physiotherapists, masseurs, chiropractors, orthoptists, audiologist/hearing aid acousticians, occupational therapists, podiatrists/chiropodist, 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 and is in line with the Scheme funding guidelines and protocols.

8.3.28 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.

8.3.29 Out of hospital specialist visits

Every family qualifies for 3 (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 Dependant(s) qualify shall be determined in accordance with the actual membership status at the date on which the service is rendered.

Benefit maxima for Members shall be calculated pro-rata for the financial year in which they join the Scheme as referred to in rule 8.1.7 of this Annexure B8 of the registered Rules.