



Pulse1

# Benefit Summary 2016

**bestMed**

Better living. Better life.

## Pulse1

Pulse1 is our entry-level option. It is excellent value for money where primary healthcare services are provided by a network of providers (CareCross) and private hospital cover is provided at our network of hospitals (mostly Netcare). These comprehensive benefits with additional travel cover and preventative care benefits make this the ideal option for a young individual that needs peace of mind for their health and well-being.



## Method of Scheme benefit payment

On the Pulse1 option in-hospital services are paid from Scheme risk benefit. The designated network provider, CareCross, covers most out-of-hospital services. Some preventative care services are available from Scheme risk benefit. (Out-of-network visits with GPs must be paid by members upfront and then claimed back from the available out-of-network benefit with CareCross)



Bestmed provides great healthcare benefits to approximately 200 000 beneficiaries.



## In-hospital benefits

Please familiarise yourself with the Designated Service Providers (DSPs) and networks for this option. This includes network specialists and DSP hospitals. Hospital costs will be covered unlimited at the Scheme negotiated tariff at the Bestmed hospital network as listed on the website.

The DSP hospital network consists of all Netcare hospitals in South Africa. In areas where there are no Netcare hospitals, other hospitals are contracted as DSPs.

Please refer to the Bestmed website on [www.bestmed.co.za](http://www.bestmed.co.za) for a list of the DSP hospitals.

Voluntary use of a non-DSP hospital (except in the case of an emergency) will result in a co-payment of up to R10 000 for the member's account.

### Process for Hospital authorisation

- All members on the Pulse1 option must make use of CareCross general practitioners (GPs).
- The CareCross GP will refer the member to a CareCross specialist (as DSP) should a specialist consultation be required.
- Should the CareCross specialist (as DSP) indicate that hospitalisation is required, the member needs to contact Bestmed on 080 022 0106 for pre-authorisation. Bestmed will only authorise admissions to contracted DSP hospitals.

### Emergency admittance in a non-DSP hospital

- Should a member be admitted for an emergency condition in a non-DSP hospital, Bestmed will require the patient to be stabilised in that non-DSP hospital.
- As soon as the patient is stabilised, he/she will be transferred to the closest DSP hospital by ER24.



## In-hospital benefits

- All benefits below may be subject to pre-authorisation and clinical protocols and designated hospital networks.
- Co-payments up to a maximum of R10 000 per event for voluntary use of a non-DSP hospital will be charged.

### MEDICAL EVENT

### SCHEME BENEFIT

#### Accommodation (hospital stay) and theatre fees

100% Scheme tariff at a Netcare DSP hospital.

#### Take-home medicine

100% Scheme tariff.  
Limited to 3 days' medicine.

#### Treatment in mental health clinics

100% Scheme tariff.  
Limited to 21 days per beneficiary.

#### Treatment of chemical and substance abuse

100% Scheme tariff. (Only PMBs)

#### Consultations and procedures

100% Scheme tariff.

#### Surgical procedures and anaesthetics

100% Scheme tariff.  
Excluded from benefits: functional nasal surgery, surgery for medical conditions e.g. epilepsy, Parkinson's disease etc., and procedures where stimulators are used.

#### Organ transplants

100% Scheme tariff. (Only PMBs)

#### Major medical maxillo-facial surgery strictly related to certain conditions

No benefit.

#### Dental and oral surgery

No benefit.

#### Prosthesis (Subject to preferred provider, otherwise limits and co-payments apply)

100% Scheme tariff.  
Limited to R39 450 per family.

#### Prosthesis - Internal

Note: Sub-limit subject to the above prosthesis limit

\*Functional: Items utilised towards treating or supporting a bodily function

Sub-limits per beneficiary:

- Functional R8 000
- Vascular R18 650
- Pacemaker (dual chamber) R30 500
- Endovascular - no benefit
- Spinal R18 650
- Artificial disk - no benefit
- Drug-eluting stents - no benefit
- Mesh R6 800
- Gynaecology/Urology R5 650
- Lens implants R3 900 per lens

#### Prosthesis - External

No benefit.

#### Exclusions

(Prosthesis sub-limit subject to preferred provider, otherwise limits and co-payments apply)

Joint replacement surgery (except for PMBs). PMBs subject to prosthesis limits:

- Hip replacement and other major joints R19 150
- Knee replacement R24 200
- Minor joints R9 050

# In-Hospital benefits

MEDICAL EVENT	SCHEME BENEFIT
Orthopaedic and medical appliances	100% Scheme tariff. Limited to R4 850 per family.
Pathology	100% Scheme tariff.
Diagnostic imaging	100% Scheme tariff.
Specialised diagnostic imaging	100% Scheme tariff.
Oncology	DSP: State Facilities. Oncology Programme. 100% Scheme tariff.
Peritoneal dialysis and haemodialysis	100% Scheme tariff. Subject to pre-authorisation (and DSPs) National Renal Care. (NRC)
Confinements	100% Scheme tariff. Subject to pre-authorisation (PMBs)
Refractive surgery	No benefit.
Midwife-assisted births	100% Scheme tariff.
Supplementary services	100% Scheme tariff.
Alternatives to hospitalisation	100% Scheme tariff.
Emergency evacuation	100% Scheme tariff. Pre-authorised and rendered by ER24.
Co-payments	Co-payment where procedure has been clinically approved: <ul style="list-style-type: none"> <li>■ R2 800 on all laparoscopic procedures,</li> <li>■ R2 800 on prostate procedures,</li> <li>■ R2 800 on procedures for prolapse/incontinence,</li> <li>■ R2 800 on arthroscopy other than acute trauma,</li> <li>■ R2 800 on endoscopy investigations done primarily in hospital,</li> <li>■ Co-payment of up to R10 000 per event for voluntary use of a non-DSP hospital.</li> </ul>

With us you get the best when it comes to accessing quality healthcare.



# Out-of-hospital benefits



Out-of-hospital benefits are paid at 100% of CareCross tariff and are subject to CareCross protocols, unless otherwise stated.

**Note:** 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 lists of codes and medicine formularies as accepted by the Scheme.

## What are the benefits covered by CareCross General Practitioners (GPs)?

- As many consultations as are medically necessary to get you healthy.
- Selected minor trauma treatment, such as stitching of wounds.
- Medicine for acute ailments, subject to the CareCross formulary.

You will be responsible for the payment of any services **outside** of the CareCross benefits. Accounts for services rendered at your chosen CareCross GP will be submitted by your CareCross GP to CareCross on your behalf.

## CARECROSS PRIMARY CARE BENEFITS

DISCIPLINE	BENEFIT DESCRIPTION
GP consultations	<ul style="list-style-type: none"> <li>■ CareCross agreed tariff.</li> <li>■ Unlimited medically necessary consultations with a CareCross accredited GP for basic primary care.</li> <li>■ Pre- and postnatal care: <ul style="list-style-type: none"> <li>- Supervision of uncomplicated pregnancy up to week 20.</li> <li>- Includes two 2D sonar scans per pregnancy during the 1st and 2nd trimesters .</li> </ul> </li> </ul> <p>(Specified minor trauma treatment)</p>



# Out-of-hospital benefits

## What happens if I need a GP after hours or while on holiday?

- The CareCross benefit makes provision for after-hours emergency visits outside of the network.
- The benefit for after-hours, out-of-network visits is limited to a maximum of R1 050 per family per year.
- You will be required to pay for all treatment received at the point of service. The costs of these services may be claimed back from CareCross by completing a reimbursement form which can be downloaded from [www.carecross.co.za](http://www.carecross.co.za) or obtained from CareCross. The reimbursement will be subject to CareCross protocols.

## CARECROSS PRIMARY CARE BENEFITS

DISCIPLINE	BENEFIT DESCRIPTION
Out-of-network and emergency visits	<p>Out-of-network visits to a GP are limited to a maximum of R1 050 per family per year.</p> <p><b>Member must pay the claim and thereafter submit the claim to CareCross for reimbursement.</b></p> <p>Any radiology and pathology treatment received as a result of the out-of-network/emergency visit will be paid from the R1 050 out-of-network visit limit. Once limit has been reached, the costs will be for the member's own account.</p> <p>Excludes services provided by GPs who are not registered with the Health Professionals Council of South Africa (HPCSA).</p> <p>Emergency visits are unlimited at any State facility.</p>

## CARECROSS PRIMARY CARE BENEFITS - ACUTE MEDICINE

- Reference pricing is applied. If a product is prescribed that is more expensive than the reference price, the patient will need to pay the difference in price at the point of dispensing.
- Quantity limits apply to some items on this formulary. Quantities in excess of this limit will need to be funded by the member at the point of dispensing, unless an authorisation has been obtained for a greater quantity.
- Other generic products not specifically listed will be reimbursed in full if the price falls within the reference price range for that group.
- The formulary is subject to regular review. CareCross Health reserves the right to update and change the formulary when new information becomes available, prices change or when new medicines are released.
- While every effort has been made to ensure that products listed are available on the market, it is possible that some products may be discontinued by the manufacturers during the course of the year.

DISCIPLINE	BENEFIT DESCRIPTION
Acute medicine	<p>CareCross agreed tariff.</p> <p>Unlimited acute medicine as dispensed or prescribed by a CareCross GP and dispensed at a preferred network pharmacy.</p> <p>Subject to reference pricing and the CareCross acute medicine formulary.</p>

## What if I have a chronic condition?

- Please consult your CareCross GP to confirm your diagnosis.
- Once confirmed, the CareCross GP will complete a chronic application form to register you for chronic medicine benefits.
- This form will be forwarded to CareCross by your GP for evaluation.
- You will be notified via SMS as soon as the chronic application has been processed.
- Approval of chronic medicine benefits is subject to the clinical protocols for the chronic conditions covered by CareCross and a chronic medicine formulary.
- Should you have any enquiries in this regard, please contact the CareCross Call Centre on 086 010 2182.



Want your medicine benefits to last longer? Ask your doctor to prescribe generic medicines. Generics have the same quality, safety and efficacy as the original brand medicine.



# Out-of-hospital benefits

## CARECROSS PRIMARY CARE BENEFITS - CHRONIC MEDICINE

- Chronic application forms must accompany all first-time applications. All applications **MUST** include valid ICD10 codes.
- Risk Equalisation Fund criteria must be met.
- If the prescriber or patient insists on a non-formulary product, where a generic equivalent is available on the formulary, a co-payment will be levied at the point of dispensing.
- Reference pricing is applied. If a product is prescribed that is more expensive than the reference price, the patient will need to pay the difference in price at the point of dispensing.
- Other generic products not specifically listed will be reimbursed in full if the price falls within the reference price range for that group.
- A clinically relevant motivation is required when prescribing any product which does not appear on this list.

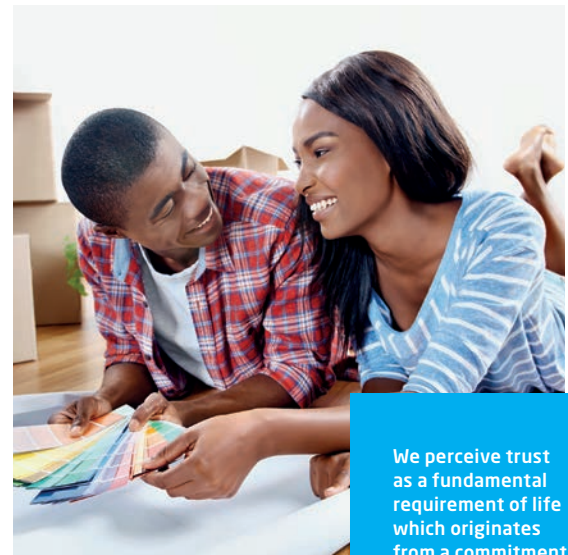
DISCIPLINE	BENEFIT DESCRIPTION
Chronic	<p>100% contracted tariff.</p> <p>Subject to reference pricing.</p> <p>If a product is prescribed that is more expensive than the reference price, the patient will need to pay the difference in price at the point of dispensing.</p> <p>Chronic medicine for CDL conditions only.</p> <p>Unlimited chronic medicine subject to registration and approval from the CareCross Clinical Department and according to the CareCross chronic medicine formulary only.</p> <p>Medicine to be supplied by a CareCross approved pharmacy as arranged with the beneficiary or supplier.</p> <p>Chronic medicine prescribed by a specialist out-of-hospital will only be covered on registration and if approved by CareCross according to the CareCross chronic medicine formulary or <b>will be referred to Bestmed for consideration if clinically necessary.</b></p>

## What if I need chronic medicine?

- You will be advised if your request for chronic medicine has been approved.
- If approved, you will be contacted by the CareCross chronic medicine provider to arrange access to your chronic medicines.
- Approved chronic medicines are obtainable from network pharmacies. The CareCross chronic medicine provider will assist you with selecting a pharmacy convenient for you.
- Note that most chronic medicines may only be collected once per month.
- It will be necessary for you to visit your CareCross GP to renew your chronic script at least every six months.
- This script should be submitted to CareCross for your chronic medicines authorisation to be updated.

## What is over-the-counter (OTC) medicine and where do I get it?

- Over-the-counter (OTC) medicine is available for self-diagnosis and treatment, for example, if you have a cold and you need to buy medicine without seeing your CareCross GP.
- Benefit is limited to three events per beneficiary or a maximum of five events per family per year.
- Subject to CareCross OTC medicine formulary and medicine being obtained from MediKredit-enabled pharmacies.
- Subject to reference pricing and Scheme exclusions.



We perceive trust as a fundamental requirement of life which originates from a commitment to approach all relationships with honesty and integrity.



# Out-of-hospital benefits

## What are my dental benefits?

- Dental benefits are obtainable from a CareCross network dentist.
- The dental benefits are for basic dentistry only and are subject to clinical protocols and an approved tariff list.
- Benefits are limited to primary extractions, fillings, scaling and polishing as well as emergency pain relief.
- Dentures: One set of acrylic dentures is covered per family every 24 months. There is a co-payment of 20% of the total fees which the member must pay directly to the dentist. This benefit is paid according to a list of approved codes and is only available to patients over the age of 21. Pre-authorisation is required.
- *Root canal treatment, crowns and other specialised dentistry are not covered.*
- Please contact CareCross to confirm which benefits are covered.

## CARECROSS PRIMARY CARE BENEFITS

DISCIPLINE	BENEFIT DESCRIPTION
Basic dentistry	CareCross agreed tariff. When clinically appropriate and subject to CareCross protocols; includes consultations, primary extractions, fillings, scaling and polishing. Limited to CareCross accredited providers and CareCross list of approved dental codes. Two consultations for a full mouth examination per beneficiary per year subject to CareCross list of dental codes. Preventative treatments cover scale and polish, fluoride treatment. No benefit for root canal treatment or other specialised dentistry.
Dentures	Limited to one set of dentures per family per 24 months cycle. Covers beneficiaries over the age of 21 years. Co-payment of 20% of total fee. At CareCross network dental provider and accredited dental laboratories and in accordance with the CareCross list of approved codes only.

## What cover do I have for optometry?

- To qualify for the optical benefits, you need to consult a CareCross network optometrist.
- The CareCross benefit covers an optical test, a basic frame from a selected range of frames, with white standard mono- or bifocal lenses; or contact lenses to the value of R400. If you choose a frame outside of the selected range of frames, CareCross will pay R150 towards this frame. You will have to pay the balance of the frame directly to the optometrist.
- *Kindly note that any additional services such as accessories, tinting, enhancements, etc. are not covered under this benefit. You will have to pay these services yourself.*
- *Eye test is limited to one test per beneficiary per annum.*
- The optical benefit is available per beneficiary, every 24 months. Diopter will be paid or considered for payment.
- No varifocals to children under age 18 years will be paid or considered for payment with the exception of post cataract surgery. Bifocals to be considered for children under the age of 18 years on motivation only.
- No contact lenses to children under age 16 years unless motivated.
- Vertical prism greater than one Diopter should be motivated.

DISCIPLINE	BENEFIT DESCRIPTION
Optometry	Subject to CareCross protocols. One pair of white standard mono- or bi- focal lenses in a standard frame. OR Contact lenses to the value of R400 in lieu of spectacles. A benefit of R150 will be paid towards a frame selected outside of the standard range. <b>Exclusions:</b> <ul style="list-style-type: none"><li>■ Tinted lenses</li><li>■ Accessories and enhancements</li><li>■ Acute medicine</li><li>■ Contact lens solutions, etc.</li></ul> <b>No benefit if a non-network provider is used.</b>



# Out-of-hospital benefits

## What about blood tests (pathology)?

- Basic blood tests are only covered if requested by your CareCross GP according to an approved tariff list.
- Your CareCross GP has a list of approved tests and will advise you if the required tests are covered by CareCross.
- You will be responsible for payment of pathology tests not covered under the CareCross benefits.

### CARECROSS PRIMARY CARE BENEFITS

DISCIPLINE	BENEFIT DESCRIPTION
Pathology	CareCross agreed tariff. Basic blood tests as requested by a CareCross GP and subject to CareCross protocols and CareCross approved pathology list of codes.

Additional Scheme benefits on the Pulse options include international travel cover and preventative care.

## What if I need X-rays (radiology)?

- The CareCross benefits cover a list of X-rays that may be performed by a radiologist, if referred by your CareCross GP.
- Your CareCross GP will advise you whether or not the required X-ray is covered.
- You will be responsible for payment of X-rays not covered under the CareCross benefits.
- Your GP will refer you to the closest radiology practice to have the X-ray performed.

### CARECROSS PRIMARY CARE BENEFITS

DISCIPLINE	BENEFIT DESCRIPTION
Radiology	CareCross agreed tariff. Basic X-rays as requested by your CareCross GP and subject to CareCross protocols and CareCross approved radiology list of codes.

Midwife-assisted births are covered at 100% of Scheme tariff on all Pulse options.



## Maternity Care programme

With so many things to juggle, the Maternity Care programme is created to help moms and dads through the entire pregnancy and the first two years with a new little one in the home - without missing a beat. At Bestmed we want you to enjoy this entire experience.

Registering on this programme will give you the following support and benefits:

- A 24-hour professional medical advice line.
- Weekly e-mails packed with convenient information about your pregnancy, your baby's development, how to deal with unpleasant pregnancy symptoms and useful hints.
- Dads won't be left out as they will also receive e-mails every second week to inform them about the baby's development and Mom's progress.
- To make sure your pregnancy starts right, you will receive a welcome pack containing an informative pregnancy book to guide you through the stages and discount vouchers for various baby items. Mom can also expect a pregnancy health pack, via Fastmail, within the first month of registration.
- In your second month after registration, we will send you a beautiful baby bag, to your door, packed with products to use after baby's birth. Moms-to-be can expect their bag to contain wonderful products.

**Please note that you may only register on the Maternity Care programme after the 12th week of pregnancy.**



# Preventative care benefits

## Note:

- Benefits below may be subject to pre-authorisation, formularies, funding guidelines and MRP/MMAP. DSPs may apply.
- Paid by Bestmed unless otherwise stated.

PREVENTATIVE CARE BENEFIT	GENDER AND AGE GROUP	QUANTITY AND FREQUENCY	BENEFIT CRITERIA
Flu vaccines	All ages.	1 per beneficiary per year.	At a CareCross GP or Pharmacy only. Subject to CareCross protocols and where clinically necessary.
Pneumonia vaccines	Children < 2 years. High-risk adult group.	Once every 60 months.	<b>Funding for adults:</b> Bestmed will identify certain high-risk individuals who will be advised by the Scheme to be immunised.
Paediatric immunisations	Babies and children.	Funding for all paediatric vaccines according to the state-recommended programme.	
<b>Health Check</b> <b>(Biometric screenings):</b> <ul style="list-style-type: none"><li>■ Glucose test (finger-prick test)</li><li>■ Cholesterol test (finger-prick test)</li><li>■ Blood Pressure</li><li>■ Body Mass Index (BMI)</li></ul>	All beneficiaries 10 years and older.	1 per beneficiary per year.	All beneficiaries, 10 years and older, have access to 1 biometric benefit package from selected pharmacies (Dis-Chem, Clicks, ScriptSavers and Pick n Pay).

Disclaimer on exclusions: General and option-specific exclusions apply.  
Please refer to [www.bestmed.co.za](http://www.bestmed.co.za) for more detail.

We always strive  
to exceed your  
expectations.



Bestmed can negotiate with service providers to offer members benefits and services that offer, on a Rand-for-Rand basis, the best value compared to other large open medical schemes.



## Other benefits

### PRIMARY CARE BENEFITS

DISCIPLINE	BENEFIT DESCRIPTION
<b>Chronic Disease List (CDL) Chronic medicine</b>	The treatment for the medical management of the 25 CDL conditions at primary care level will be covered according to CareCross protocols and approved tariff lists if requested by the CareCross GP. All other tests requested that are not on the CareCross approved tariff list will not be covered by CareCross.
<b>Specialist consultations (managed by Bestmed)</b>	Benefit limited to three specialist visits per family per year and a maximum of R1 050 per visit. (Visit includes all related services including medicine.)  Visits are subject to referral by the CareCross GP and limited to a Network specialist.  Pre-authorisation must be obtained at Bestmed.
<b>Medical aids, apparatus and appliances including wheelchairs and hearing aids and appliances</b>	No benefit.
<b>Supplementary services</b> (Services rendered by dieticians, chiropractors, homeopaths, orthoptists, acupuncturists, speech therapists, audiologists, occupational therapists, chiropodists, biokineticists, psychologists and social workers)	No benefit.
<b>Wound care benefit</b> (incl. dressings and negative pressure wound therapy (NPWT) treatment and related nursing services - out-of-hospital)	No benefit.
<b>Specialised diagnostic imaging</b>	No benefit.
<b>Oncology</b>	DSP: State facilities. Oncology programme. 100% Scheme tariff.
<b>Peritoneal dialysis and haemodialysis</b>	100% Scheme tariff. Subject to pre-authorisation and DSPs. National Renal Care. (NRC)
<b>Rehabilitation services after trauma</b>	No benefit. Subject to pre-authorisation.

Disclaimer on exclusions: General and option-specific exclusions apply.  
Please refer to [www.bestmed.co.za](http://www.bestmed.co.za) for more detail.



## Contributions

	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT*
<b>Total contribution income R0 - R6 000 p.m.</b>	R1 131	R1 075	R679
<b>Total contribution income R6 001 - R10 000 p.m.</b>	R1 357	R1 290	R814
<b>Total contribution income &gt; R10 001 p.m.</b>	R1 630	R1 466	R814



## FAQs and process flows

### A. CHOOSING / CHANGING GENERAL PRACTITIONER

#### 1. How do I choose a CareCross GP?

- Website address - [www.carecross.co.za](http://www.carecross.co.za)
- CareCross call centre telephone number - 086 010 3491

#### 2. How do I change to another CareCross doctor (GP)?

- You may consult with any CareCross network GP for your medically necessary consultations. You are not required to register with one specific CareCross GP. It is, however, recommended that you use one GP for continuity of care.

#### 3. Can every dependant choose a different GP?

- Yes.

### B. WHAT IF I NEED A DOCTOR AFTER-HOURS?

- CareCross benefit makes provision for after-hour emergency visits outside of the network.
- The benefit for after-hours, out-of-network visits is limited to a maximum of R1 050 per family per year.
- You will be required to pay for all treatment received at the point of service. The costs of these services may be claimed back from CareCross by completing a reimbursement form which can be downloaded from [www.carecross.co.za](http://www.carecross.co.za) or obtained from CareCross. The reimbursement will be subject to CareCross protocols.

## C. I NEED TO GO TO A SPECIALIST. WHAT DO I DO?

### 1. How do I qualify for access to a specialist?

- You need to be referred by your CareCross GP and you need to phone Bestmed for pre-authorisation.

### 2. Who may I consult?

- You can consult any specialist, but it is recommended that you consult one of the Bestmed network specialists. Why? By doing this you will limit the level of any potential co-payment.

### 3. How do I submit a claim?

- Specialist accounts need to be submitted to Bestmed - the authorisation number needs to be indicated on the account.

### 4. What amounts are paid?

- You have access to three visits and R1 050 for each of these visits are payable. Bestmed tariffs apply.

### 5. What if the specialist refers me for X-rays or pathology tests?

- This will also be paid from the specialist limit of R1 050 per visit.

### 6. What if the specialist prescribes medicine?

- If the medicine requested is for a chronic condition covered by the Scheme, the process for applying for chronic medicine will apply.
- If the specialist requests acute medicine, this will be paid from the specialist limit of R1 050 per visit.

### 7. What if my specialist consultation plus the related expenses (pathology, radiology, acute medicine) add up to more than the R1 050 limit per visit?

- You are responsible for the shortfall on such an account.



## FAQs and process flows

## D. I NEED TO GO TO HOSPITAL - WHAT DO I DO?

### 1. Who needs to refer me?

- Your CareCross GP.
- Your network specialist.

### 2. What do I need to do?

- You need to phone the Bestmed Pre-Authorisation Centre to obtain an authorisation number AND to confirm that the hospital is indeed a Bestmed network hospital.

### 3. How would I know which are the hospitals on the network?

- The hospital list is available on the Bestmed secure website. The Bestmed network specialists work at the Bestmed network hospitals. It is therefore important that you consult a network specialist. When consulting your CareCross GP you need to ensure that you are referred to a network specialist. When you phone the authorisation centre at Bestmed, they too will confirm if you are being admitted to a Bestmed network hospital.

### 4. What if I am admitted to a hospital during a weekend in an emergency - what if this is not a Bestmed network hospital?

- You still need to phone for authorisation on the first working day after being admitted. Bestmed will then, if you have been admitted to a non-network hospital, transfer you (once you have stabilised) to a network hospital.

## PROCESS: AUTHORISATION FOR SPECIALIST CONSULTATIONS

### Confirmation 1

CareCross GP to refer member to contracted specialist. (Bestmed network specialist)

Member to phone the Bestmed Pre-Authorisation Centre at 080 022 0106 for authorisation.

### Confirmation 2

The Pre-Authorisation Centre will confirm whether the specialist is a Bestmed network specialist.

Member to consult the specialist.  
Authorisation number to be provided on all accounts submitted to Bestmed by the specialist.

## PROCESS: HOSPITAL ADMISSIONS AUTHORISATION (AFTER HOURS OR DURING AN EMERGENCY)

Being hospitalised after hours or during emergencies

Patient admitted to hospital after hours or in the case of an emergency.

First working day after admission - Patient/hospital must phone the Pre-Authorisation Centre at 080 022 0106 to obtain an authorisation number.

If admitted to network hospital - authorisation will be provided.

If admitted to a non-network hospital - patient will be monitored and as soon as the patient is stabilised - he/she will be transferred/transported to a network hospital, where appropriate.

## PROCESS: HOSPITAL ADMISSIONS AUTHORISATION (GENERAL)

Carecross GP and/or Bestmed specialist refers member to hospital

### Confirmation 1

Carecross GP or Bestmed network specialist determines whether patient needs to be admitted to hospital.

**Note:** Although CareCross GPs and Bestmed network specialists will be informed of the list of network hospitals, members are to ensure that they are admitted to Bestmed network hospitals.

### Confirmation 2

Member to obtain authorisation from the Pre-Authorisation Centre at 080 022 0106. Pre-authorisation is the responsibility of the member, but a Bestmed specialist or CareCross GP can also obtain pre-authorisation.

**Note:** The Pre-Authorisation Centre will confirm whether a chosen hospital and chosen specialist are on the Bestmed network.

The patient will be informed whether the hospital is a Bestmed network hospital or not. If the patient then chooses not to be admitted to the Bestmed network hospital the patient will be penalised with a co-payment of up to R10 000.

**Note:** The specific hospital needs to be authorised by Bestmed. This might not always be the hospitals on the lists published. It all depends on the specific procedure, the Bestmed network specialists or the geographical location.



For a more detailed overview of your benefit option and to receive a membership guide please contact [service@bestmed.co.za](mailto:service@bestmed.co.za)

### Abbreviations

CDL = Chronic Disease List; DSP = Designated Service Provider; GP = General Practitioner or Doctor; MMAP = Maximum Medical Aid Price; MRP = Mediscor Reference Price; NP = Network Provider; OTC = Over the Counter; PMB = Prescribed Minimum Benefits.

For a more detailed overview of your benefit option and to receive a membership guide please contact [service@bestmed.co.za](mailto:service@bestmed.co.za)

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For the most recent version please visit our website at [www.bestmed.co.za](http://www.bestmed.co.za)



# Contact details

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📠 012 472 6500  
🌐 [www.bestmed.co.za](http://www.bestmed.co.za)  
🐦 @BestmedSocial  
📘 [www.facebook.com/BestmedMedicalScheme](https://www.facebook.com/BestmedMedicalScheme)

## WALK-IN FACILITY

Block A, Glenfield Office Park, 361 Oberon Avenue  
Faerie Glen, Pretoria, 0081, South Africa

## POSTAL ADDRESS

P. O. Box 2297, Arcadia, Pretoria, 0001, South Africa

## ER24 AND INTERNATIONAL TRAVEL COVER

Tel: 084 124

## HOSPITAL AUTHORISATION

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E-mail: [authorisations@bestmed.co.za](mailto:authorisations@bestmed.co.za)

## CARECROSS HEALTH

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