1. Membership

1.1 Who qualifies as a dependant of a member?

- Spouse
- Partner of principal member
- Children, adopted children, stepchildren and foster children
- Brothers, sisters and parents of the principal member, if dependent on the principal member for family care and support

1.2 What proof is required by Topmed of a dependant's reliance on the member?

- In the case of a spouse, a marriage certificate
- In the case of a partner, the completed declaration on the Application Form
- In the case of children:
  – legal documents in respect of adoption for an adopted child
  – a court order for a foster child
- In respect of brothers, sisters and parents of the principal member, a sworn affidavit confirming the relationship to the principal member and stating that the family member is dependent on the principal member for care and support

1.3 How do I add a new dependant to my existing membership?

By completing an application form, which can be obtained from Topmed. If you are part of a company that belongs to Topmed send your completed application form to your HR or Payroll Department, or if registering as an individual member you may forward your application directly through to Topmed or via your appointed broker. Please call 0860 00 21 58 if you have any enquiries about your application.

1.4 What happens in the event of the death of the principal member?

The eldest dependant may continue with the membership as the principal member, with the status of the other dependants remaining unchanged, provided that Topmed receives a death certificate. Membership will commence on the day following that of the principal member's death, unless Topmed is informed that the dependants choose to terminate their membership. Bank details should be furnished to Topmed to avoid any interruption in the payment of contributions and obtaining benefits.

1.5 When will Topmed have the right to cancel my membership or that of any of my dependants?

If you or any of your dependants:

- join another scheme
- provide false information, or fail to disclose material information when applying for registration
- provide false information when submitting a claim, submit a fraudulent claim, or intentionally allow a service provider to do so on your behalf
- allow any other person to use your membership cards
- without a good explanation, neglect to inform Topmed that it has paid for services or supplies that were not delivered or received
- commit any other fraudulent act
- fail to pay contributions within 14 days of the date on which they are due
- fail to repay an advance within 28 days from the date on which it is due

1.6 When am I entitled to benefits?

You are entitled to benefits from the inception date of your membership, provided that no general waiting period or condition-specific waiting period applies.

1.7 Waiting period

1.7.1 What is a general waiting period?

Topmed may impose a general waiting period of three months on all benefits in respect of all new applicants and dependants who:

- have not belonged to a previous medical scheme for the preceding 90 days;

or

- were members of another medical scheme for a period of more than 2 years

No benefits are payable during this period, not even if funded from the Medical Savings Account, except in respect of any treatment or diagnostic procedures covered within the Prescribed Minimum Benefits, where applicable.

Can I opt to make a payment in lieu of this waiting period, in order to have it waived?
No

1.7.2 What is a condition- specific waiting period?

Topmed may further impose a condition-specific waiting period of up to 12 months from the inception date of your membership, in respect of any pre-existing condition, in respect of any beneficiaries who:

- have not belonged to a previous medical scheme for the preceding 90 days;

or

- have not belonged to a previous medical scheme for a period of more than 2 years

1.7.3 No waiting periods will be imposed on:

- a beneficiary changing option within a scheme
- a child dependant born during the period of membership

1.8 Inception date

1.8.1 What is an inception date?

This is the date on which your membership and your dependants' membership is registered. Your contributions are payable from your inception date.

1.8.2 What is the inception date in respect of dependants?

- If the application is received within 30 days of the new dependant becoming eligible for registration (e.g. through marriage, birth or adoption), the inception date will be the date on which the dependant becomes eligible
- If the application is received after 30 days of the new dependant becoming eligible for registration, the inception date will be the first day of the month following the one in which the application was received
- Or the first day of the month following the one in which Topmed receives all the information it may need in respect of such an application

1.9 When do my dependants become entitled to benefits?

Your dependants are entitled to benefits from the inception date, unless a general waiting period and/or condition-specific waiting period is applicable., in which case benefits are payable after the duration of the general waiting period and/or condition-specific waiting period.

1.10 How are pro rata benefits applied?

Benefits will be applied pro rata in respect of principal members and dependants who join Topmed after 1 January of a particular year. This applies to all benefits that have an annual limit.

1.11 When can I Cancel my Membership?

1.11.1 Employer Groups

As a member of a particular Employer your employer may cancel your membership as a group with at least 3 Month's written notice to Topmed.

1.11.2 Individual Members

As an Individual member you may cancel your membership with at least 1 Month's written notice to Topmed.

2. Pre-Authorisation (PAR)

2.1 What is pre-authorisation? (PAR)

Pre-authorisation (PAR) is the prior approval of any planned admission to a hospital, including an associated treatment or procedure (including dental procedures) performed by a medical practitioner or dentist during hospitalisation.

Please note that a PAR is merely a confirmation that the proposed Clinical Procedure or treatment is medically necessary and is not a guarantee that Benefits will be paid.

MRI- scans/CT-scans and radioisotope studies, whether during hospitalisation or not, require pre-authorisation. Please note that the following procedures do NOT require a PAR, and that benefits in respect of these will be paid from your option's radiology benefits:

- Dexa scans
- CT bone mineral density studies
- CT guided renal biopsy
- MRI-scan – low field peripheral joint examination of feet, hands and elbows in dedicated limb units.

2.2 When must I apply for a pre-authorisation reference number (PAR)?

Application for a PAR should be made for any procedure requiring a reservation for admission to a hospital or if certain scans or radio-isotope studies are planned. If you are unsure if the procedure requires a PAR, it is recommended that you call the Pre-Authorisation Department for advice.

Application for a PAR should be made as soon as possible, preferably when admission is confirmed by your doctor. You need not apply for authorisation more than one month in advance.

It is recommended that application be made at least two days ahead of a planned procedure, in case more information is required from your doctor. In the event of an emergency admission to hospital over a weekend or at night, you may apply for a PAR from the Pre-authorisation Department within two working days following the admission or scan.

2.3 Visits to a hospital's out-patient facility (not applicable to treatments which form part of Case Management)

Please note that visits to the doctor at a hospital's out-patient or casualty department will not be funded from your hospital benefit. For this reason, some hospitals may require that you pay cash for these visits. In this event, you may send the detailed account and proof of payment to Topmed and you will be refunded according to your option's day-to-day benefits (please refer to the Benefit Guide for more information).

2.4 What happens if I fail to apply for a PAR?

If no PAR is obtained or if a PAR is obtained late, no benefits will be paid by Topmed.

2.5 How do I contact the Pre-authorisation Department to obtain a PAR?

For general pre-authorisation

- By calling 0860 00 21 58

For admission to hospital for dentistry

- By calling 0860 10 49 31

2.6 What information should I provide when applying for a PAR?

- Membership number and dependant code
- Patient's full name
- Date of admission PLUS the date of the procedure. (This is particularly important, as we do not routinely authorise pre-operative procedures the day prior to planned surgery – this must be applied for and motivated.)
- Surname and initials of attending doctor or service provider (practice number, if available)
- Telephone number of attending doctor or service provider
- Name of hospital to which the patient will be admitted.
- The reason for the admission to hospital or the planned diagnostic procedure
- Ask your doctor for a full description of:
  - the reason for admission
  - the associated medical diagnosis and the applicable ICD-10 code
  - the planned procedure, as well as the procedural codes and tariffs he/she intends to use

2.7 What information must I obtain when calling the Pre-authorisation Centre?

- The unique PAR number
- The initial length of stay in an approved hospital
- The approved codes

2.8 What must I do if I stay in hospital longer than the initial length of stay approved by the Pre-authorisation Centre?

A family member, your doctor or a hospital staff member must immediately inform the Pre-authorisation Centre, and the clinical indications for the extended stay will be evaluated. An extended length of stay must be authorised to qualify for benefits as no retrospective PAR's will be granted.

2.9 How will the medicine I receive on discharge from hospital be paid for?

You will qualify for a maximum of seven days' supply, subject to your acute medicine benefit. Please note that even if you have a chronic medicine authorisation, the medicine dispensed when you leave the hospital, will always be paid for from your acute medicine benefits, or medical savings account. If you have a chronic medicine authorisation, you should obtain your medicine from a retail pharmacy.

3. Medicine

3.1 Chronic Medicine Benefit

The chronic medicine benefit is a benefit that covers medicine for a specified list of conditions according to your option (Refer to page 23). These conditions have been selected according to clinical and actuarial criteria. This means that although a condition may be defined as chronic, it may not meet the criteria for cover from your Chronic Medicine Benefit.

Access to the Chronic Medicine Benefit is subject to clinical entry criteria. These entry criteria are in line with evidence based practices and legislative requirements. The Chronic Benefit consultants use evidence based guidelines and protocols to clinically assess each application for chronic benefits and ensure that the drugs used are appropriate, cost effective and prescribed in the correct therapeutic dosages.

3.1.1 How do I apply for a Chronic Medicine Benefit?

- The treating Doctor must contact the Chronic Medicine Department on 0860 00 21 58 to register a new chronic condition. This involves a clinical discussion as to whether the request meets all the necessary clinical entry criteria.
- If the criteria are met, the chronic condition will be registered. Each chronic condition has a list of medication that is clinically appropriate to treat this condition. This excludes certain high costing medications that are subject to motivation and approval by the Clinical Governance Committee.

3.1.2 Chronic Registration Process

Once your doctor has diagnosed your chronic condition and codes the condition as per the relevant ICD 10 coding (refer (i) Paragraph 3.1.3 below), your doctor needs to contact the Chronic Medicine Department on 0860 00 21 58 to register your chronic condition.

- All diagnostic and entry criteria pertaining to the chronic condition will be requested including the ICD 10 code.
- The Chronic Consultant will evaluate the information, based on the clinical entry criteria, and if appropriate will provide the authorisation to your doctor.
- In addition, you will receive a letter of confirmation, providing you with the details of the chronic medication approved.
- Once your doctor has provided you with your script you will then be able go directly to your Pharmacy with the prescription and obtain the medication (refer (ii) Paragraph 3.1.3 below).
- Should your medication not be approved as part of your Chronic Medicine Benefit , the Chronic Consultant will advise your doctor as well as sending you a letter ,advising you of the rejection.

Chronic consultations and medication will only be paid from your chronic benefit if registration of the chronic condition is approved. If registration of the chronic condition is declined, chronic consultations and medication may be paid from your acute medicine benefit or medical savings account.

Once the request has been approved, you will receive a letter indicating your authorised chronic diagnosis and medication. Your prescription must be taken to your service provider (pharmacist), whereafter claims can be submitted for the approved condition. Once the period of authorisation has expired and there is no change in the medicine required for the specific condition your doctor or pharmacist can contact the Chronic Medicines Department on 0860 00 21 58 to reinstate your authorisation. The same can be done when any changes or additions to a current authorisation is required.

3.1.3 Important points to note

(i) ICD Codes - Every medical condition and diagnosis is allocated a specific code which is referred to as the ICD 10 code. The ICD 10 coding system ensures that claims are paid out of the correct benefit, and currently forms part of the legislative requirements.
What this means is that every service provider/doctor will need to submit a valid and appropriate ICD 10 code for registration onto the Chronic Medicine Benefit and on the subsequent claim that is sent through to Topmed. Legislation dictates that failure by the service provider to submit a valid ICD 10 code will result in the non-payment of the claim by any medical scheme.

(ii) Prescriptions are valid for six (6) months only - The telephonic authorisation does not replace the official document of a script. A script is still required to be written by your prescribing service provider every six (6) months. It is important to note that your authorisation may extend beyond the validity of the script that your doctor gives you. When your repeat script expires, you will need to obtain a new one from your doctor to give to your pharmacist, to ensure that you may continue to receive your medication.

3.1.4 Why the telephonic Process?

Topmed will automatically reimburse doctors a one-off amount payable at the Topmed tariff for fully completing a telephonic request for chronic medicine benefits as part of your Major Medical Benefits and does not count towards your annual consultation limit. This payment will be made for applications for disease conditions which are included in the Chronic Conditions List. Please note that this payment is only applicable for the first application of a condition. Members are encouraged to advise doctors and pharmacists to use the share-call number indicated above to register new conditions and update

Advantages:

- Simple, paperless and on-line authorisation process.
- Immediate registration onto the chronic medicine benefit and thus real time claiming.
- A clinical discussion with your provider thus ensuring the best treatment for the member.
- Prevents delays that were part of the paper process.
- No long forms to be filled out or completed by your doctor.

3.2 What is MMAP?

MMAP is the Maximum Medical Aid Price paid by Topmed for the cost of generic medicine, where a generic alternative exists for branded medicine. Only the cost of the generic equivalent is covered. If no generic equivalent exists, Topmed will cover the cost of the prescribed (branded) medicine. However, if a generic alternative exists and you select the branded product, you will be liable to pay the difference between the generic and branded product. The price difference is payable when the medicine is purchased.
Please ask your pharmacist to advise you on generic equivalents.
MMAP is applicable to all medicines, except non-prescribed (PAT) medicines. Should a brand product be used where a generic product exists, only MMAP for the generic product will accumulate to threshold, where applicable.

3.3 What is generic medicine?

Generics are medicines that contain exactly the same active ingredients as branded products. These medicines are manufactured by the same or another company once the patent on the branded product has expired. As a result, the price of generic medicine is usually considerably lower.

3.4 What are patented or branded medicines?

Pharmaceutical companies incur high research and development (R&D) costs before a product is finally manufactured and released onto the market. The pharmaceutical company is therefore given the patent right to be the only manufacturer of that specific medicine (brand) for a number of years, in order to recover R&D costs.

3.5 Why use a generic medicine?

Generics are more cost-effective, which means you gain optimum usage in respect of your medicine benefit limit. As a result of cheaper generic alternatives, levies payable per prescription are reduced. The use of generic medicines therefore helps to limit total medicine expenditure, which in turn limits annual contribution increases.

3.6 How do I ensure that I use a quality generic medicine?

In South Africa, generic medicines are subject to the same stringent quality control measures as all other medicines.

3.7 What happens if my chronic limit is exhausted and I have a Prescribed Minimum Benefit (PMB) condition?

In the event that either you or your dependants are registered for a PMB condition (see list of chronic conditions on page 23 for details) and your chronic limit is exhausted you will be able to continue receiving medication for your PMB condition through either a Public Health facility or by registering with Pharmacy Direct, the Scheme's Designated Service Provider.

To obtain an application form for Pharmacy Direct you may contact the Client Services Department (0860 00 21 58), visit Topmed's website (www.topmed.co.za), visit Pharmacy Direct's web site (www.pharmacydirect.co.za), or contact Pharmacy Direct on (0860 02 78 00).

Please note that in order to obtain the extended PMB chronic benefit, you are required to register through the Chronic Medicine Department, noting that the benefit available will be subject to Topmed's formulary as amended from time to time.

3.8 Medical Management of your PMB Chronic Condition

In addition to the benefits provided for your chronic medicines, you may be eligible for the treatment of your PMB condition, subject to Topmed's Treatment Algorithms (Plans), to include certain consultations, pathology tests etc. To qualify for these benefits you will be required to register for them when registering for your PMB condition.

To obtain a 100% benefit you will be required to obtain the above services from the Public Healthcare Sector. Should you use your own service provider, Topmed will pay a 70% benefit. Please note that it is very important for your service providers to submit these claims with the correct ICD-10 code to ensure that your claims match to the correct benefit. If your providers submit the "general' ICD-10 code, whilst valid, will map to your day-to-day benefits and not to the benefits provided by your treatment plan. In addition, these benefits are not unlimited, and are provided in accordance with the general guidelines provided by the Board of Healthcare Funders and in consultation with clinical experts in the various disciplines. Additional benefits may be granted upon motivation from your service provider.

3.9 Non-prescribed medicine (Pharmacist Advised Therapy - PAT)

Most common ailments can be treated effectively by medicines available at a pharmacy without a doctor's prescription. These medicines may be claimed from your PAT benefit. (Refer to the Benefit Guide for your option).

4. Contributions

4.1 How is my contribution calculated?

A fixed amount is payable for each principal member, irrespective of your age, together with a fixed amount for each adult dependant (21 years or older) and each minor dependant (younger than 21 years) registered under your membership.

Example:
This table applies to the Topmed 80% option.

Your contribution as a principal member	R2 472
One additional adult dependant	R2 046
One additional minor dependant	R 652
Total insured contribution	R5 170

4.2 When are membership contributions payable?

Contributions are payable monthly by the 3rd of the month, effective from your inception date.

4.3 At what stage does my contribution increase when a minor dependant turns 21?

The increased contribution for an adult dependant becomes due on the first day of the following month in which the dependant turns 21.

4.4 When do increased contributions become due in respect of a new dependant?

The first increased contribution is payable from the first day of the month in which your dependant is added.

4.5 What happens if my contributions fall into arrears?

If your contributions are not paid to Topmed within 14 days from the date on which they are due, the payment of benefits in terms of your membership is suspended until such time as all arrear contributions are received. If your contributions are more than 28 days in arrears, your membership will be terminated immediately without further notice.

4.6 What is a late joiner?

An applicant or the dependant of an applicant who, on the Application Date, is 35 years or older and has not been a member or a dependant of a member of a medical scheme for a period of two years prior to applying for membership or the registration of a dependant.

4.7 How do late joiner penalties work?

Topmed may increase the contributions of a late joiner in accordance with the stipulations of the Medical Schemes Act. The number of years with no medical cover is converted into a percentage as prescribed by the Act. The late joiner penalty amount is therefore the prescribed percentage of the normal monthly contribution.

5. Operation of Topmed Options

5.1 Options available

5.1.1 What is an option?

An option is a product registered by Topmed which offers a specific structure of benefits.

5.1.2 What options does Topmed offer?

Traditional options

- Topmed 100%
- Topmed 80%
- Topmed Limited 100%

New generation options

- Topmed Incentive Savings
- Topmed Incentive Comprehensive
- Topmed Hospital Plan
- Topmed Network (Capitated Product through Prime Cure)

For more details on each of the options offered, please refer to the Benefit Guide.

5.1.3 When may I change my option?

You may change your option on the first day of January, after giving Topmed at least 30 days' written notice.

5.1.4 How do I change my option?

By completing an option change form, which can be obtained from Topmed. Such a change will only be allowed once annually on 1st January.

5.2 Threshold Cover

(Only applicable to the Topmed Incentive Comprehensive Option)

5.2.1 How does the Threshold Cover work?

A threshold is a set value to be reached before claims for day-to-day medical expenses are paid out by Topmed. All your medical claims for day-to-day expenses are processed and will accumulate towards reaching this threshold, to include claims paid from your Medical Savings Account or paid from your own pocket. The value accumulated to your threshold is based on the value of the benefit payable by Topmed, and not necessarily the amount that you have paid. Once your accumulated claims reach the threshold value, further day-to-day claims will be paid by Topmed as per the benefits stipulated in your Benefit Guide. You may use your Medical Savings Account, to pay for day-to-day medical expenses incurred before your threshold is reached, or from your own pocket should your Medical Savings Account balance be exhausted.

As noted above only the applicable percentage of the benefit amount, and not the cost, will accumulate towards the threshold, even if the cost is paid from the savings account.
In addition, if a claim does NOT qualify for benefits, it will NOT accumulate towards the threshold, even it is paid from your Medical Savings Account, such as the PAT Benefit.

Example: Topmed Incentive Comprehensive Option
The threshold for a family of three (principal member, adult dependant and minor dependant) will be calculated as follows:

Principal member	R6 850
Adult dependant	R5 650
One minor dependant	R1 325
Total threshold	R13 825

The threshold for this family of three is R13 825. It makes no difference if the principal member is the only one to receive medical treatment and utilises the full R13 825. Although the threshold is calculated per dependant, it is applied to the family as a whole.

It is important to remember to continue to submit your claims to Topmed for accumulation to threshold, even if it is during the period when claims are paid from your own pocket.

5.2.2 If a Benefit Limit applies before Threshold, how will it affect my benefits after Threshold?
Some day-to-day benefits have limits that apply even before threshold is reached. One such limit is that of Acute Medicine. This means that if you, for example, have a R5 000 limit on medicine and you utilise the full amount prior to reaching your threshold, i.e. during the period when you pay your claims from your Medical Savings Account or own pocket, you will have NO BENEFITS for acute medicine after reaching your threshold, i.e. during the period when Topmed starts paying day-to-day claims again.

5.2.3 How will my threshold be affected if I join on a date other than 1 January?
The total threshold amount is calculated on a pro rata basis, but will not decrease to less than 50% of what the amount would have been for 12 months. The threshold for the family mentioned above for 12 months is R13 825.
Example
- If the family joins the Scheme on 1 July, their threshold will be R6 912 (50% of R13 825)
- Even if they join the Scheme on 1 December, their threshold will still not be less than 50% of R13 825 which is R6 912.

5.2.4 How will my threshold be affected if I add a dependant to or remove a dependant from my membership?
Your threshold will be adjusted accordingly.

Please note: Your contributions will change on the first day of the month in which you add or remove dependants.

5.2.5 How will my threshold be affected if my dependant turns 21 during the year?
If your dependant's status changes to an adult dependant during a year, your threshold will be adjusted accordingly.

5.3 Medical Savings Account

5.3.1 How does a Medical Savings Account work?
(Only applicable to the new generation options)
Your Medical Savings Account is designed to cover your day-to-day expenses. It works like this:
- You contribute a fixed monthly amount
- The total annual amount available under your Medical Savings Account is available in advance for medical expenses.

5.3.2 How much can I contribute towards my Medical Savings Account?
The amount is fixed per option as required by legislation. Consult the Benefit Guide for the savings amount for your chosen option.

5.3.3 What can I use my Medical Savings Account for?
- Medical services, including medicine that do not form part of your choice of benefits
- Medical services rendered by a registered supplier that do not qualify for benefits in terms of the list of exclusions. (Please refer to the section of this guide dealing with exclusions.)
- Medical services for which the annual sub-maximum has been reached
- Non-prescription Schedule 1 and 2 medicines (PAT) are paid out at 100% of cost
- The difference, if any, between the allowed benefits, as described in the Benefit Guide, and the actual cost charged for the service

Please note: In order to have the difference between the cost of branded medicine and the generic equivalents claimed from the Medical Savings Account, you will have to submit a separate claim to the Scheme, as these benefits will not automatically be allocated from your Medical Savings Account.

5.3.4 What happens to my savings balance if I die?
Any positive balance will be paid out to your estate after four and a half months if your dependants decide not to continue as members of Topmed.

5.3.5 What happens to my savings balance at the end of the year?
Any positive balance will be transferred to the Medical Savings Account for the following year.

5.3.6 What happens to my savings balance if I change from a new generation option to a traditional option, or decide to leave Topmed ?
Any positive balance will be refunded to you after four and a half months. However, should you leave Topmed to join another medical scheme with a Medical Savings Account, any credit balance will be transferred to the other medical scheme.

5.3.7 What happens to the debits accrued on the savings balance of a member who leaves the Scheme?
Should there be a negative balance, you will be responsible for refunding the amount to Topmed within 30 days of notification.

5.4 Valuable information only applicable to members of the Topmed Network Option

5.4.1 WHAT/WHO is a Primary Healthcare Provider?
A Primary Healthcare Provider deals with you and your family's day-to-day basic healthcare needs, e.g. the treatment of flu. The Primary Healthcare Provider network used by Topmed is PRIME CURE. PRIME CURE makes use of the services of registered nurses and general practitioners (GP's) at Prime Cure Clinics countrywide and also makes use of the services of contracted doctors (GP's) in areas where there are no Prime Cure Clinics.

Information and details of the nearest Prime Cure Clinics or doctors can be found on Prime Cure's website: www.Primecure.co.za

5.4.2 What services are offered by my Primary Healthcare Provider?
You may visit your Prime Cure Provider if you need any of the following services:

- If you or any of your dependants have any complaint or ailment, e.g. your child has a fever
- Prime Cure will provide both your acute and chronic medicine as part of certain treatments and according to a fixed formulary
- Basic dentistry services are provided at the primary healthcare providers,and include fillings, cleaning, extractions and preventative treatment
  Note: If these basic dental services cannot be offered at the healthcare provider, the healthcare provider will refer you to a dentist contracted to Prime Cure in the same area at no extra cost. Should you use a non-contracted dentist you will be liable for the cost.
- This option's benefits entitle you or your dependants to an eye test and a pair of spectacles once every two years.
  Note: IIf these optical services cannot be provided at the primary healthcare provider, you will be referred to an optometrist contracted to Prime Cure in the same area at no extra cost. Should you use a non-contracted Optometrist you will be liable for the cost.
- Even if you only need advice on birth control and family planning, your network provider will be able to meet your needs
- Certain blood tests and basic radiology services, e.g. x-rays, are provided.

Note: When visiting your Primary Healthcare Provider, always take your Topmed membership card with you. This will ensure that you do not need to pay for any services rendered.

5.4.3 Do you and your dependants have to visit the same Prime Cure Clinic or Prime Cure contracted GP?
No, each of you can choose the Prime Cure Clinic or contracted GP that is nearest to you. If you want to change to another Prime Cure Clinic at a later stage, you can do so by completing a form that you can obtain from your present or new Prime Cure Clinic.

5.4.4 What must I do in an emergency after hours or if I am on holiday and not close to the Prime Cure Clinic I selected?
You have the following options:

- Call Topmed 's Assistance Hotline for immediate and professional advice on what you should do in the situation.
  Note: For more information on the Assistance Hotline, please refer to 7.4.2 in this Members' Guide.
- You can visit the Prime Cure Clinic closest to you at that specific time.
  Please Note: In this case you are still entitled to benefits, although they are not supplied by the Prime Cure Clinic where you have been registered.
- Use an out of network GP (See Benefit Guide for Details).
- Go to a public hospital for outpatient treatment or to the emergency room of a public hospital. Please note that you will have to pay for this account out of your own pocket if it does not meet Prime Cure's definition of an emergency medical condition.

5.4.5 Will Topmed grant benefits if I want to consult a specialist?
You qualify for specialist benefits to the maximum of R 1500 per family. This will include a consultation and tests/procedures to the maximum benefit allowed.

5.4.6 What must I do if I have to go to hospital?

If you and/or any of your dependants have to be admitted to a private or provincial hospital, Topmed will pay the cost of your hospitalisation, and the costs of the treatment you receive whilst in hospital. To obtain an authorisation (PAR) you will need to call 0860 00 21 58

Kindly note that no benefits will be paid by Topmed if a PAR is not obtained.

5.4.7 What must I do in case of an emergency

(e.g. I was involved in a car accident and rushed to hospital) and I could not obtain the pre-authorisation number before the time?

You and/or your family have two working days from the time that you are admitted to inform Topmed that you are in hospital.

Note: For a detailed breakdown on the information you need to supply and obtain when applying for a PAR, please refer to section 2 – Pre-Authorisation in this Members' Guide.

5.4.8 Will I have to pay when visiting my Primary Healthcare Provider?

No, as long as your contributions have been paid, you may visit your Primary Healthcare Provider as often as necessary without having to make any payments.

5.4.9 How are my claims paid?

- Services rendered at your Primary Healthcare Provider:
  You will not receive an account for any services and will not have to make any excess payments.
- Services rendered at a specialist:
  This account must be submitted directly to Topmed.
- Services rendered at a hospital:
  Submit hospital related claims directly to Topmed.
  Note: All claims must reach Topmed for payment within 4 months from the end of the month in which treatment was rendered. After these 4 months, the claims become stale and will no longer be paid by the Scheme.

For more information on Claims, please refer to section 6 – Payment of Claims in this Members' Guide.

5.4.10 When do I have to pay my contributions?

Contributions are payable monthly in advance. If contributions are not paid within 14 days from the date that it is due, your membership will be suspended.

If your contributions remain in arrears for more than 28 days, your membership will be cancelled immediately, without further notice.

Note: For more information on Contributions, please refer to section 4 – Contributions in this Members' Guide.

5.4.11 Are benefits allowed in respect of foreign claims?

No.

5.4.12 Is HIV/AIDS covered?

Yes. The Prime Cure HIV programme assists people living with HIV/Aids to access quality care and to make optimal use of the benefits available to them.

The programme will include the necessary pathology tests, anti-retroviral medication (if required), doctors consultations, information, counselling and advice.

To access these benefits you may consult with your Prime Cure doctor who will assist you with the completion of the registration forms.

Should you need additional assistance you may access information through the following means, viz:

Telephone:	0861 665 665 option 7
Fax:	0866 417 279
Email:	hiv@primecure.co.za

5.4.13 Are dialysis and organ transplants covered?

This condition is covered in a public hospital under the Prescribed Minimum Benefits (the minimum benefits the Scheme is compelled to offer in terms of the Medical Schemes Act, 1998).

5.4.14 Are benefits paid for confinements in a private hospital?

Yes, but benefits are limited to one confinement per family per year in a private hospital AND the mother must, obtain Pre-authorisation for the admission, within 24 – 48 hours of the admission.

6. Payment of Claims

6.1 What information should be contained in a claim in order for it to be processed?

- Surname and initials of the member, membership number, name and date of birth of the patient, as well as the doctor's practice number and the nature, relevant ICD code, service date and cost of each service rendered or item supplied.
- Medicine claims: the name, quantity, dosage, the gross amount of the claim, the relevant discount received by the member, and a receipt confirming the net amount payable by the member in respect of the medicine dispensed, the relevant national pharmaceutical product interface (NAPPI) code, and the relevant ICD-10 code. Non-electronic accounts payable by the member must also be accompanied by a copy of the original prescription made out by a person legally authorised to prescribe the medicine (if applicable) and proof of payment must be attached.
- Medicine prescriptions that are repeated: in addition to the above, a notation from the medical practitioner who prescribes the medicine, specifying the number of repeats.
- Dental claims: the number of each tooth treated. Please include the laboratory slip when submitting your claim to Denis.
- Surgical claims: the name, practice code number and registration number issued by the relevant registering authority of every medical practitioner or dentist who assisted in the performance of that operation.

* Please note: Failure by your Service Provider to include the mandatory ICD-10 code on a claim will lead to the rejection of that claim and non-payment by Topmed.

6.2 What is the deadline for the submission and payment of a claim?

A claim must be submitted within four months from the end of the month in which the service was provided, or within four months from the end of the month in which it was returned by Topmed for any corrections. If not submitted within this period, the account will NOT be paid. This deadline also applies to claims paid from your Medical Savings Account.

6.3 How will I know when my claim has been settled?

After your claim has been processed, you will receive a claim statement incorporating the following information:

- The benefit amount paid by Topmed and the person/service provider to whom payment has been made
- The money owed to you by Topmed (if any)
- The amount owed by you to Topmed or any provider (doctor, hospital etc) if any

Note: If you received a discount on an account, you will only be entitled to the lower benefit amount after the discount was taken into consideration.

6.4 Are benefits allowed in respect of foreign claims?

Yes, but only in respect of emergencies. The benefits payable will be subject to the same benefits that apply to local services, and are subject to the same limits where applicable. Foreign claims will be processed and refunded to members in South African rands, and only on your return to South Africa. In order to expedite payment please ensure that medical claims originating in foreign countries contain as much information as possible. (Please note that this is not applicable to the Topmed Network Option.)

6.5 Tariff's Payable

Please note that the payment of claims is subject to the National Health Reference Price List Guidelines which are subject to certain rules as outlined in the tariff guide. As an example, when multiple procedures are performed, modifiers are used, as follows, viz;

Main Procedure - 100% of the TT is payable
2nd procedure - 75% of the TT is payable
3rd procedure - 50% of the TT is payable etc.

These rules are an industry standard and will apply where applicable.

7. Managed Healthcare

Managed healthcare is defined as any effort to promote the rational, cost-effective and appropriate use of healthcare resources. The philosophy of Topmed is to work with members and service providers in achieving these aims.
Topmed's managed healthcare provider uses clinical funding guidelines and evidence based medicine in respect of certain services and supplies for which Topmed allows benefits. Beneficiaries will only qualify for benefits in respect of those services and supplies if the clinical guidelines and protocols have been complied with.

7.1 Disease Management

Disease Management is a holistic approach that focuses on the patient's disease or condition, using all the cost elements involved. The intervention takes place by means of patient counselling and education, behaviour modification, therapeutic guidelines, incentives and penalties and case management. If a beneficiary, however, does not co-operate with the programme, Topmed may refuse to allow further benefits insofar as it is related to the specific disease/condition. Or alternatively, Topmed may decide to only allow benefits for a lower level of service. For more information, contact Topmed's Disease Management Programme on 0860 00 21 58

7.1.1 Oncology (Cancer Management)

It is important that prior to commencing active treatment for cancer, you are registered on the Oncology Disease Management Programme (See Benefit Summary for applicable benefits and limits per your chosen option).

7.1.1.1 What benefits does the Scheme provide in respect of cancer treatment?

- The fees charged by your doctor for administering medication, regardless of whether it is done intramuscularly, sub-cutaneously or intravenously, are paid at 100% of the Topmed Tariff, irrespective of whether or not treatment forms part of hospitalisation.
  Note: Medicine to counteract the side effects of chemotherapy and radiotherapy will be paid according to the Topmed's Oncology Disease Management Program's guidelines.
- Cancer medicine, chemotherapy and radiotherapy is subject to Disease Management under the care of a medical professional. Please note that benefits may be forfeited if members do not comply with the treatment plan.
- Cancer medicine received on discharge from hospital will be limited to 7 days' supply and is subject to available day-to-day benefits.
- Pathology, X-rays, doctor visits during active treatment, materials and items claimed as materials will also be paid from the members' major medical benefits.
- Consultations, pathology and radiology related to cancer will continue to be paid one year after active treatment has been completed.
- Long-term chronic conditions that develop as a result of chemotherapy and radiotherapy are not covered under this benefit.

7.1.1.2 How to register on the Oncology Disease Management Programme

Please follow these steps:

- Either you or your treating doctors can us on 0860 00 21 58 or Fax through your treatment plan to (031) 580 0492
- After the treatment plan has been assessed and authorised, an authorisation number is sent to the treating oncologist or physician, within 48 hours.
- In the event of a change in your treatment please ensure that either your or your treating doctor advised your case manager, to ensure that your authorisation is updated accordingly.

7.1.2 HIV/AIDS

The medical expenses with regard to medicine, pathology and other services as well as doctors consultations will be handled and managed in the strictest confidence when members register on the Scheme's Aid for AIDS (AfA) Disease Management Programme (not applicable to the Topmed Network Option). Support and literature is available to the relevant member and family, if required. Specific benefits are available for medicine, pathology, psychology and doctors consultations to include prophylactic medication in the event of trauma such as rape or needle stick injury.
For more information:
Call: 0860 10 06 46 or (021) 514 1769
Fax: 0800 60 07 73 (021) 514 1771.
Please refer to the Benefit Guide for more information.

7.1.3 Disease Management Programmes

Manged Care Programmes manage specific chronic diseases such as diabetes and cardiovascular diseases. These programmes improve control of the conditions, prevent illness progression and improve your health.

7.1.3.1 Diabetes management program

Although diabetes cannot be cured, it can be managed. Proper management leads to dramatic health improvements. At Topmed our comprehensive diabetes disease and case management program is designed to significantly improve the treatment and compliance of our diabetic members.

Our program:

- Identifies patients with diabetes and their co- morbidities.
- Enroll patients onto the program for primary and secondary prevention.
- Risk Stratification: Stratify members into low, moderate and high risk groups for targeted intervention.
- Ongoing monitoring evaluations and automatic reminders.
- Comprehensive reporting on quality improvements with positive health and financial outcomes on an ongoing basis.

Benefits of the program:

- By means of our ongoing assessment and gathering of pertinent information we are able to assess severities and other co morbidities.
- We are able to pick up trends in a patients health profile and intervene to avoid expensive hospital care.
- Discreet packages of care are allocated where clinically appropriate.
- Encourage healthy living by means of our interventions.

7.1.3.2 Cardiovascular disease management program

The aim of Topmed's cardiovascular program is to accomplish common goals- I.e. early identification and prevention of cardiovascular events, optimization of medical therapy and ultimately improving clinical outcomes by decreasing the risk of heart attack, stroke and other cardiovascular events.

To obtain more information on the programmes highlighted above contact Topmed on 0860 00 21 58.

7.2 Breast Reconstruction

Benefits are allowed in respect of reconstructive surgery after a mastectomy due to proven breast cancer. Benefits will be paid once only for full reconstruction by whichever method, as well as for reduction surgery on the unaffected side for symmetry where indicated as per motivation. Only complications of a true medical nature will be considered for benefits and not failed cosmetic surgery.

7.3 Organ transplants and dialysis

Benefits in respect of organ transplants and dialysis are subject to treatment forming part of a Case Management Programme.

Benefits are allowed in respect of kidney dialysis and the following organ transplants: heart, lung, heart-and-lung, bonemarrow, and renal dialysis.

Please refer to the Benefit Summary for more information about the benefits that your option offers. To obtain authorisation for this benefit call 0860 00 21 58

7.4 Ambulance services ER 24

7.4.1 Who should I call for ambulance services?

ER 24 is the Scheme's Preferred Provider for any ambulance services. If services are not rendered by (or through the intervention of) ER 24, benefits will be limited to a specified maximum (please refer to the Benefit Guide for details).

7.4.2 How do I contact ER 24?

For access to the Assistance Hotline or to request medical emergency transport, phone 084 124.
For claims enquiries, you can phone 0861 084 124.

7.4.3 How much time do I have to inform ER 24 that I have made use of another ambulance service as a result of an emergency?

In the event of an emergency, you should inform ER 24 within 24 hours of the date on which the service was rendered to qualify for unlimited benefits.
Note: The services of ER 24 are only available in the RSA, Swaziland and Lesotho.

7.4.4 What services does the Assistance Hotline offer?

- General Medical Advice
- Poison Advice
- Suicide Hotline
- Substance Abuse and Misuse Advice
- Generic Medication Advice
- Medical Referrals
- Child Abuse
- Rape Counseling
- Bereavement Counseling
- Trauma Advice and Counseling
- HIV/Aids Information and Counseling

7.5 Dental Benefits and Rules

7.5.1 General Information

Denis, www.denis.co.za, Africa's leading dental funder, manages your dental benefits on behalf of your medical scheme for all options with the exception of the Topmed Hospital Plan and Topmed Network.

Please note that the information provided below, refers to the Topmed 100%, Topmed 80%, Topmed Limited 100%, Incentive Savings, and Incentive Comprehensive Options only.

There is a pre-defined benefit per procedure which is paid at the published Topmed Tariff (see www.denis.co.za for the list of dental tariffs.
Your dentist will also be able to provide you with information regarding your benefits, as Denis supplies all dentists with a Chairside Guide, which illustrates the dental benefits for 2009.
Benefits for Dentistry are paid on a fee for service basis. This means that for every procedure done by a dentist there is a fee that is charged. These fees may differ from dentist to dentist. Topmed pays a benefit for each procedure which may differ from the fee charged by your dentist, which may result in a shortfall. However, it is your right to negotiate this difference with your dentist, to minimise your out-of-pocket payment.

Benefits payable

Topmed's benefits and protocols are defined below. Please note that Topmed covers all dentists, to include hospitalisation at 75% of the TT.
Please familiarise yourself with the defined benefits before visiting your dentist. By doing so, you will be fully aware of what Topmed will pay toward your treatment.
You are eligible for benefits, irrespective of which dentist treats you.
The following information illustrates how your benefits are structured so that you know before your treatment is rendered, what is covered and what is not.
For clinical definitions see www.denis.co.za.
Refer to the table in the Benefit Guide for detailed information on what is provided per option.

7.5.2 Conservative Dentistry

7.5.2.1 Consultations

Two general check-ups (consultations) are covered at the Topmed Tariff, per beneficiary per year.

7.5.2.2 Professional Oral Hygiene

There is no benefit for professional oral hygiene procedures on any of the Topmed options. This includes oral hygiene instructions, scaling and polishing and fluoride treatment. *See Periodontics

7.5.2.3 Fillings, Extractions and Root Canal Treatment

Benefit for fillings is available where clinically indicated. Benefit will be granted once per tooth in a 3 year period. There is no benefit for Amalgam (silver) fillings to be replaced with Composite (white filling material). A treatment plan and x rays will be requested for treatment plans of more than 5 fillings.

Extractions and root canal treatments are covered as required, at the Topmed Tariff.

7.5.2.4 Dentures

• Plastic Dentures

There is benefit on all options of Topmed for one set of plastic dentures (an upper and a lower) per beneficiary in a four year period.

• Partial Metal Frame Dentures

There is benefit on the Incentive Comprehensive option, for one metal frame (an upper or a lower), per beneficiary in a five year period.

Members on the Topmed 80% and Topmed 100% options have benefit for two metal frames (an upper and a lower), per beneficiary in a five year period.

Full metal dentures are not covered.

7.5.3 Specialised Dentistry

Pre-authorisation(PAR) is required for Crown procedures; Orthodontics; Implants and Hospitalisation.

If no PAR is obtained or if a PAR is obtained late, no benefits will be paid by Topmed.

This does not apply to emergencies.

Call 0860 10 49 31 for benefit pre-authorisation.

7.5.3.1 Crowns

Crowns are limited in quantity per family, regardless of the type of crown being placed.

There is no crown benefit for members on the Incentive Savings and Topmed Limited 100% options. Members on the Incentive Comprehensive option have benefit for 1 crown per family per year. On the Topmed 80% and Topmed 100% options, there is benefit for 3 crowns per family per year.

Benefits for crowns will be granted once per tooth in a 5 year period, and is covered at 75% of the TT

7.5.3.2 Orthodontics

Orthodontic benefits are available on the Incentive Comprehensive, Topmed 80% and Topmed 100% options, subject to pre-authorisation.

Benefit on pre-authorisation will only be applied to cases assessed as “treatment mandatory”, as per an orthodontic index.

A 25% co payment of the TT will apply to members on the Incentive Comprehensive and Topmed 80% options.

A deposit is paid at the start of treatment and the balance is paid over the estimated treatment period.

Orthodontic benefit protocols

- Benefits for Orthodontic treatment are only available to beneficiaries whose treatment commences before their 18th birthday.
- Only one family member may commence orthodontic treatment in a calendar year, except in the case of identically aged siblings.
- Orthodontic re- treatment is not covered.
- Orthognathic surgery (jaw correction surgery) is only covered and is covered at 75% of the TT in the case of severe facial deformities. This benefit is subject to pre-authorisation and is only applicable to the Topmed Limited 100%; Incentive Comprehensive; Topmed 80% and Topmed 100% options.

7.5.3.3 Implants

There is benefit for two implants per beneficiary, in a five year period on the Topmed 80% and Topmed 100% options.

A 25% co payment of the TT applies. Cost of implant components is limited to R1200 per implant and R1500 per implant on the Topmed 80% and Topmed 100% options respectively.

All associated surgical procedures, including hospitalisation, are not covered for implantology.

7.5.3.4 Periodontics

Benefit for gum disease is restricted to conservative, non-surgical therapy only (root planing).

This benefit is only available to those members on the Incentive Comprehensive; Topmed 80% and Topmed 100% option who are registered on the Perio Programme.

To apply for the Perio Programme, submit your CPITN score (supplied to you by your dental practitioner), together with your Periodontal treatment plan to perio@denis.co.za, or alternatively fax to 021 673 6633.

Further clinical records may be requested to process your application.

Periodontal benefits will be applied to cases assessed as periodontally compromised, as per the CPITN score.

Surgical periodontics is a scheme exclusion.

7.5.3.5 Oral Surgery

Oral Surgery in the dental chair:

Oral Surgery in the dental chair is covered at the Topmed Tariff.

General Surgery Exclusions (in the dental chair and in hospital) include:

- Bone Augmentations
- Sinus Lifts
- Bone and Tissue regeneration
- Gingivectomies
- Surgical procedures associated with dental implantology

The surgical procedures listed above are not covered by your scheme. The member is liable for the full account.

Oral Surgery in hospital:

See General Anaesthetic and Hospitalisation

7.5.3.6 Anxious Patients

Hospitalisation and general anaesthesia is not covered where patients require anxiety control only.

Many people are anxious about dental treatment and mild sedation is sometimes required.

Benefits are payable for sedation methods such as laughing gas or sedative medications. No pre-authorisation is required for laughing gas or sedative medications.

Conscious sedation (IV sedation) is available for surgical procedures. This requires benefit pre-notification and is subject to clinical protocols.

7.5.3.7 General Anaesthetic and Hospitalisation

Benefit for hospitalisation for dentistry is not automatically covered and is subject to pre-authorisation.

• Incentive Savings and Topmed Limited 100% options:

Hospitalisation benefits are only available for the removal of impacted teeth.

Children and adults (needing dental treatment other than removal of impacted teeth) may qualify for a maximum benefit of IV sedation (anaesthetic benefit, as per the table in the benefit summary), subject to clinical protocols

• Incentive Comprehensive; Topmed 80% and Topmed 100% options:

Certain Maxillo-Facial procedures are covered in-hospital subject to pre-authorisation, where admission protocols apply.

General Anaesthetic benefits are available for very young children for extensive dental treatment (multiple extractions and fillings), subject to admission protocols. Multiple hospital admissions are not covered.

Hospitalisation protocols:

- Where an underlying medical condition: creates a substantially increased risk of treating in the dentist's rooms and indicates a higher level of care, benefits for hospitalisation will apply. A medical report confirming the medical condition will be requested.
- Multiple hospital admissions are not covered.
- In some instances, an x ray or clinical report will be requested in order to process a hospital pre-authorisation.
- Removal of impacted teeth in hospital will attract benefit where the tooth is associated with pathology or severe pain. Hospitalisation for teeth impacted by soft tissue only is not covered.
- Hospitalisation is not covered where anxiety of dental treatment is the reason for the admission.

7.5.3.8 General in hospital exclusion summary

The following procedures are not covered in hospital. The member is liable for the full account.

- Dentectomies
- Apisectomies
- Frenectomies
- Implantology and associated surgical procedures
- Surgical exposure of teeth for orthodontic reasons
- Conservative dental treatment (fillings; extractions and root canal therapy) for adults
- Professional Oral Hygiene Procedures (scale and polish and fluoride treatment)

7.5.3.8 How to get authorisation before going to hospital

Contact us on 0860 104931, at least 48 hours prior to the planned procedure.

Have the following information ready when you phone us:

- Your Topmed membership number
- The date of admission
- Name of the practitioner and his/her telephone number and practice registration number
- The anaesthetist's practice number and contact details
- The name and telephone number of the hospital
- All relevant procedure codes

In certain instances an x-ray or clinical report will be requested in order to process your pre-authorisation.

If the hospital admission is authorised, you will be supplied with an authorisation number, via your preferred method (SMS; fax or e-mail).

The hospital account will be paid at the rand value, stipulated on the authorisation letter. Hospital accounts exceeding this amount will be the member's liability.

In the event of an emergency, after hours, let us know about your hospitalisation as soon as possible.

7.5.3.9 General Benefit Exclusion Summary

The following treatment is not covered. The member is liable for the total cost of these procedures:

- Oral hygiene instructions; scaling and polishing, and fluoride treatment
- Nutritional and tobacco counselling
- Caries susceptibility and microbiological tests
- Electrognathographic recordings and other such electronic analyses
- Fissure sealants on patients older than 16 years
- Root canal treatment on third molars (wisdom teeth) and primary teeth
- Pulp capping (direct and indirect)
- Polishing of restorations
- Ozone therapy
- Metal base to full dentures, including the laboratory cost
- Soft base to new dentures
- Diagnostic dentures
- Provisional crowns
- Laboratory cost of provisional and emergency crowns
- Resin bonding for restorations charged as a separate procedure
- Dental bleaching and porcelain veneers
- Metal, porcelain or resin inlays except where such inlays form part of a bridge
- Crowns on third molars (wisdom teeth)
- Pontics on second molars
- Laboratory fabricated crowns on primary teeth
- Fixed prosthodontics used to repair occlusal wear
- Gingivectomy
- Periodontal flap surgery and tissue grafting
- Perio Chip
- Apisectomies in hospital
- Orthodontic re-treatment
- Orthognathic (jaw correction) surgery and the related hospital cost, except in the case of severe facial deformity
- Hospitalisation for dental implantology
- Hospitalisation for surgical tooth exposure for orthodontic reasons
- Hospitalisation for any dental treatment, other than the removal of impacted teeth, on the Incentive Savings and T Topmed Limited 100% options.
- Sinus lifts
- Bone augmentations
- Bone and other tissue regeneration procedures
- Dolder bars and associated abutments on implants (including the laboratory cost)
- Laboratory costs, where the associated dental treatment is not covered
- Laboratory cost associated with mouth guards (including material cost)
- Snoring appliances
- High impact acrylic
- Cost of Mineral Trioxide
- Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments
- Cost of gold, precious metal, semi-precious metal and platinum foil
- Cost of invisible retainer material
- Cost of bone regeneration material

7.5.3.10 Supplementary Clinical Protocols

- For extensive restorative treatment plans (more than 5 fillings per member) a treatment plan and x rays will be requested.
- If a procedure does not attract benefit; all other treatment associated with the specific event does not receive benefit.
- Benefits for conservative dental restorations will be granted once per tooth in a 3 year period.
- Benefits for amalgam (silver) restorations to be replaced with composite (white filling material) are available where such treatment is necessary to restore cavitation.
- Benefits for crowns will be granted once per tooth in a 5 year period.
- Where root canal treatment has failed; benefits are allocated for a re-root canal treatment on the tooth. In the event that the re-root canal treatment fails, benefits will be available for an apisectomy.
- Claims for biopsies must be accompanied by a laboratory report.

7.5.3.11 Smile

As a Topmed member, you are automatically a member of the Smile Wellness and Education program. You will receive various treatment related information leaflets and in some cases, oral health products, after visiting your dentist.
Visit www.denis.co.za for more information on our SMILE program.

7.5.3.11 Get your claims to Denis!

Post the original copies of your dental claims to:
Private bag X26
Rondebosch
7701
Cape Town

When submitting a claim, please ensure the following details are clearly visible:

- Your membership number
- The dentist's details and practice registration number
- The correct dependant code (see your membership card)
- The treatment date
- If you have already paid for the treatment, ensure that the appropriate receipt is attached.

7.5.3.12 Stale claims

Claims that are not received within 4 (four) months of date of treatment are, in terms of the Medical Schemes Act, regarded as stale and will not be eligible for benefit.

Kindly note: The Topmed Network and Topmed Hospital options are not administered by Denis.

7.6 Optical Benefits

The optical benefit offers members enhanced benefits through Preferred Provider Negotiators (PPN), a network of more than 1200 optometrists nationwide. Members on the traditional options may elect to utilise the services of PPN. Details of the providers in the network can be found on the Scheme's website (www.topmed.co.za) or by contacting PPN on 0860 10 35 29. The enhanced benefits available through PPN are detailed in the Benefit Guide for each option . Should members utilise the services of a non-preferred provider, limit benefits as outlined in the Benefit Guide will be provided (See your relevant option for details).

In addition, members on the New Generation options will be able to obtain an enhanced benefit should they utilise the services of PPN as they will be entitled to reduced pricing based on Topmed's arrangement with PPN.

8.UNIQUE FEATURES

To ensure that members receive adequate care when recovering from a major hospital procedure without being restricted by the availability of day-to-day benefits Topmed provides an Extended Major Medical Benefit.

This benefit allows members access to extended rehabilitation benefits for 5 major events, as outlined below, which is funded from the Major Medical Benefits portion and not from day-to-day benefits. Please refer to the Benefit Guide for details on your benefit option.

8.1 Post Total Hip Replacement

Effective mobilisation after a hip replacement is always difficult yet critical to the success of this expensive operation.
This benefit will entitle you to 8 physiotherapy sessions within 3 months after you have been discharged from hospital.
This benefit will only be paid once per year per hip.
If you have both hips done in 1 calendar year at different times then you will receive this benefit for each event.

8.2 Post Total Knee Replacement

As with a hip replacement effective mobilisation after a knee replacement is always difficult and, at times painful, yet critical to the success of this expensive operation.
This benefit will entitle you to 8 physiotherapy sessions within 3 months after you have been discharged from hospital.
This benefit will only be paid once per year per knee.
If you have both knees done in 1 calendar year at different times then you will receive this benefit for each event.

8.3 Post Crime Trauma

Crime touches most of our lives at some stage or another. This benefit is aimed at supporting you when you have been exposed to a traumatic crime-related incident.
To access this benefit you need to report the event at your nearest Police Station and obtain a Police Reference Number (MR Number).
This benefit is subject to authorisation and will be considered after you or a family member has been involved in:

- a hijacking or attempted hijacking
- attempted murder
- assault or attempted assault, including sexual assault
- robbery (including armed robbery) or attempted robbery
  You will be able to receive a combined total of 12 consultations for 6 months from the date of the event per dependant, with any of the following registered specialists:
- psychologist
- psychiatrist
- social worker

To obtain authorisation for this post-trauma counselling you need to contact Topmed for authorisation and to provide the details of the event PLUS the police reference number.
Fax: 031 5800492
Phone: 0860 00 21 58

8.4 Heart Attack

A heart attack (Medical term: Myocardial Infarction) is caused by a blockage in the arteries supplying your heart muscle. If you have been diagnosed with Ischaemic Heart Disease and suffer from Angina you are at risk of a heart attack. If you are admitted to hospital with an acute myocardial infarction you will be entitled to register for a "Cardiac Rehabilitation Programme" on discharge from hospital.

The purpose of this programme is to offer the patient optimal recovery after the heart attack through exercise, training and education regarding risk factor reduction.
This new and extended benefit which optimises your recovery to full health after a heart attack is subject to Case Management and must be prescribed by the treating cardiologist / physician.

To obtain authorisation for this programme you need to contact Topmed for authorisation.

Fax: 031 5800492
Phone: 0860 00 21 58

8.5 Stroke

The medical term for a "stroke" is a "cerebro-vascular accident" and occurs when the blood supply to the brain tissue is compromised - either by a blockage of a blood vessel or a brain haemorrhage. The severity of the stroke depends on its locality in the brain. Common signs seen and problems experienced after an acute cerebro-vascular incident include:

- weakness of limb / s
- paralysis of limb /s
- aphasia (inability to speak)
- dysphagia or aphagia (difficulty with / or inability to swallow)

The degree of recovery after a stroke depends very much on your state of health prior to the event as well as the size and site of the stroke.
Your full recovery may be facilitated by a comprehensive rehabilitation programme including therapy from a multi-disciplinary team for a period of three months after the ACUTE event.
The team of therapists may comprise of a:

- physiotherapist
- occupational therapist
- speech therapist

This benefit is subject to case management.

To obtain authorisation for this programme you need to contact Topmed.

Fax: 031 5800492
Phone: 0860 00 21 58

9. Exclusions

The following are exclusions on all options. Benefits for any of these exclusions can be claimed from your Medical Savings Account, except for those listed under 9.4.2.

9.1 Exclusions applicable to dentistry

See paragraph 7.5.3.9 on page 18 for details.

9.2 Exclusions applicable to prescribed medicine

- Patent and secret medicine, patent preparations and household remedies
- Patent foodstuffs, including baby food and special formulas
- Tonics, food supplements, multivitamin preparations and vitamins, except vitamins for antenatal, lactation and paediatric use
- Slimming preparations
- Birth control preparations, except oral and injectable contraceptives and IUDs (intra-uterine device)
- Anti-smoking preparations
- Surgical appliances and devices
- Diagnostic agents and appliances, except for diabetic accessories
- Medicine used specifically to treat alcoholism, except if used as part of a beneficiary's rehabilitation treatment at a recognised facility
- Oxygen and the purchase or rental of oxygen-supply systems
- Aphrodisiacs
- Anabolic steroids
- Sunscreens and sun-tanning preparations, including emollients and moisturisers
- Cosmetic preparations, soap, shampoo and other topical applications, whether medicinal or otherwise, except those used for the treatment of lice, scabies and other parasitic and fungal infections
- Single or combined mineral preparations, except for calcium preparations with 300mg or more of elemental calcium used for the prevention and treatment of osteoporosis and potassium when used in conjunction with a diuretic
- Contact lens preparations
- Preparations that are not easily classifiable
- Stimulant laxatives
- Treatments for erectile dysfunction, for example Sildenafil and/or other treatments
- Products for incontinence
- Immunoglobulins
- Injection material, except diabetic injection material
- TNF-alpha inhibitors (infliximab, etanercept etc.) as used in the treatment of Rheumatoid Arthritis

9.3 Exclusions applicable to optical benefits

- Adjustments to frames
- Fitting of contact lenses
- Sunglasses or tinted lenses
- Coloured or tinted contact lenses
- Hard coatings and other extras
- Contact lens solution

9.4 General exclusions

9.4.1 The following are general exclusions, but may be claimed from the Medical Savings Account/In-Scheme Benefit:

- Costs arising directly or indirectly from intentional, self-inflicted injury, even if the member or dependant was psychologically unstable at the time – unless it was to save a life or to protect the property of the member or dependant or another person
- Substance dependency, unless treatment forms part of a Case Management Programme.
- Bandages, cotton wool, plasters and other household first-aid items, unless these are supplied during a stay in hospital
- Examinations for purposes of insurance, employment, lawsuits and similar purposes
- Cosmetic and reconstructive surgery, including surgery for protruding ears, either by the member's or dependant's own choice, or where recommended for psychological reasons only – and any complications arising from such surgery
- Where more than one clinical procedure or diagnosis requiring a PAR is performed at the same time and a PAR was not obtained for all the procedures, no benefits will be granted for complications arising from any of the procedures
- Beauty treatments, beauty preparations and cosmetics
- Examinations and/or treatment where no real or diagnosed illness exists and such examination or treatment was recommended purely for psychological reasons
- Examinations and/or treatment for sterility or erectile dysfunction
- Artificial insemination
- Marriage counselling
- Birth control, except oral and injectable contraceptives and IUDs
- Breathing exercises, antenatal and post-natal exercises, group exercises and fitness tests
- Treatment of obesity
- Hyperbaric oxygen treatment
- Telephonic consultations
- Services of social workers
- Fees for medical reports
- All desensitisation treatment and ALCAT allergy tests
- Sclerotherapy treatment, unless a vascular surgeon is responsible for the treatment where it forms part of the surgical removal of varicose veins
- Treatment of keloids, except in the case of burns requiring a PAR
- Refractive surgery
- Functional reconstruction of palate and uvula (uvulapalatopharyngoplasty)
- Acupuncture
- Reflexology and Aromatherapy
- Injuries relating to dangerous past-times and professional sport, where participation takes place on a regular basis
- Pet-scans unless forming part of a Disease Management Program
- Haemapure blood products
- Treatment forming part of a Clinical Trial or Experimental Drugs
- Drugs for septic shock and septicaemia (Protein C Inhibitors eg. Xigus)
- Berlin Hearts
- All associated costs for Elective/Knee Hip Replacements on the Topmed Network and Hospital Options only (Only covered in the event of trauma)
- Biological drugs/medicine unless forming part of a Disease Management Programme and subject to clinical protocols.

9.4.2 The following are general exclusions but cannot be claimed from the Medical Savings Account

- Eye examinations or vision testing by anyone other than an eye specialist or registered optometrist, and the cost of any instrument other than spectacles or contact lenses
- Travel expenses – except for the transportation of the patient to and from hospital
- Applicators, toilet preparations and cosmetics
- Holidays for recuperative purposes
- Accommodation in retirement homes, frail-care units, long-term-care units and similar institutions
- Non-prescription sunglasses
- Costs rejected by the Scheme, due to it either being fraudulent or not clinically or medically necessary, as indicated by the Scheme's external auditing company
- The difference between the cost of generic and branded medicine.

10. List of Chronic Conditions

10.1 Prescribed Minimum Benefit – Chronic Condition Disease List

Applicable to Incentive Savings, Topmed Hospital and Topmed Network Options Only

- Addison's Disease
- Asthma
- Bronchiectasis
- Cardiomyopathy
- Chronic Renal Failure
- Cardiac Failure
- Chronic Obstructive Pulmonary Disorder (COPD)
  - Emphysema
- Coronary Artery Disease
  - Ischaemic Heart Disease
- Crohn's Disease
- Diabetes Insipidus
- Diabetes Mellitus (Type I and II)
- Dysrhythmias
  - Ventricular Tachycardia
  - Arterial Fibrilation Flutter
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia
- Hypercholesterolaemia
- Hypertension
- Multiple Sclerosis
- Parkinson's Disease
- Psychiatric Disorders
  - Bipolar Mood Disorder
  - Schizophrenia
- Rheumatoid Arthritis
- Systemic Lupus Erythematosus
- Ulcerative Colitis

10. 2 Extended Chronic Conditions

In addition to the above conditions listed in 10.1, the following conditions are also available on the Topmed 100%, Topmed 80%, Topmed Limited 100%, and Topmed Incentive Comprehensive Options. (Please note that these are only applicable whilst your Chronic Medicine Limits are available).

- Alzheimer's Disease
- Ankylosing Spondylitis
- Attention Deficit Disorder
- Barrett's Oesophagus
- Benign Prostatic Hyperplasia
- Cancer
- Conn's Syndrome
- Chronic Bronchitis
- Cushing's Syndrome
- Cystic Fibrosis
- Deep Vein Thrombosis
- Dermatomyositis
- Gout
- Hypoparathyroidism
- Menopause (Hormone Replacement Therapy)
- Motor Neuron Disease
- Muscular Dystrophy
- Myasthenia Gravis
- Organ Transplants (maintenance therapy)
- Osteoporosis
- Paget's Disease of Bone
- Pancreatic Disease
- Paraplegia/Quadriplegia (associated medicine)
- Pemphigus
- Polyarteritis Nodosa
- Psychiatric Disorders
  - Anorexia Nervosa
  - Bulimia Nervosa
  - Major Depression
  - Narcolepsy
  - Obsessive-compulsive Disorder
  - Panic Disorder
  - Post-traumatic Stress Syndrome
  - Tourette's Syndrome
  - Unipolar Mood Disorder
- Pulmonary Interstitial Fibrosis
- Scleroderma
- Stroke
- Thromboangiitis Obliterans
- Thrombocytopaenic Purpura
- Zollinger-Ellison Syndrome

11. Definitions

11.1 Act
The Medical Schemes Act, 1998, as amended or replaced from time to time, and the regulations promulgated thereunder.

11.2 Acute medicine
Medicine used for diseases or conditions that have a rapid onset, severe symptoms, and that require a short course of medicine treatment, as well as medicines that qualify for benefits but have not been classified as chronic medicine by the Scheme.

11.3 Adult
A dependant who is 21 years or older.

11.4 Agreed tariff
Where agreements have been entered into with preferred providers, the tariff as specified in the agreements, as amended from time to time, and/or for medicine the single exit price plus the negotiated dispensing fee subject to MMAP.

11.5 Application date
The date on which the application for membership of the Scheme, or registration of a dependant, is actually received by the Scheme.

11.6 Beneficiary
Each individual member and dependant.

11.7 Case Management Programme
A process whereby clinically indicated, appropriate and cost-effective healthcare, as an alternative to hospitalisation, or otherwise, is offered to beneficiaries with specific healthcare needs – whether the Scheme prescribes it or approves it on application by a beneficiary.

11.8 Chemotheraphy
Medication used in the cure and containment of cancer. This includes cytostatics and hormone inhibitors and excludes medication for the side effects of chemotherapy.

11.9 Chronic medicine
Medicine that meets all the following requirements:

11.9.1 prescribed by a medical practitioner for an uninterrupted period of at least three months; and
11.9.2 for a condition appearing on the Scheme's list of approved chronic conditions as amended from time to time; and
11.9.3 which has been applied for in the manner and at the frequency prescribed by the Scheme from time to time, and which application has been accepted by the Scheme.

11.10 Clinical procedure
A procedure categorised as such by the Board of Healthcare Funders.

11.11 Dental Implants
Placement of metal rods into the jaw bone in the place of a missing tooth to provide a structure upon which a crown or denture can be placed.

11.12 Dependant
The following persons for whom the member is liable for family care and support, and who are not members or dependants of members of any other medical scheme and, if applicable, who are duly registered as dependants by the Scheme:
11.12.1 a spouse; and/or
11.12.2 a child – including an adopted child, stepchild or foster child; and/or
11.12.3 the principal member's parents, sisters and brothers; and/or
11.12.4 any other person approved by the Scheme.

11.13 Designated Service Provider (DSP)
The Scheme's chosen service provider used to offer benefits in respect of the Prescribed Minimum Benefit conditions.

11.14 Disease management
A holistic approach focusing on the patient, using all the cost elements of the disease to identify the patient eligible for a disease management programme. The intervention takes place by means of:
- Patient counselling and education
- Behaviour modification
- Therapeutic guidelines (the application of)
- Incentives and penalties; and
- Case management.

11.15 Effective date
The date on which a beneficiary becomes entitled to benefits.

11.16 Family
A member and his/her dependants.

11.17 Foreign claims
Originating from countries outside the borders of the Republic of South Africa.

11.18 Formulary
A defined list of medicine used in the treatment of various diseases.

11.19 Hospital
Includes a mental health institution, registered unattached theatre and day clinic, but excludes an institution for rehabilitation for substance abuse.

11.20 Inception date
The date on which a person becomes a member of the Scheme or on which a dependant's registration becomes effective.

11.21 Late joiner
An applicant or the dependant of an applicant who, on the Application Date, is 35 years or older and has not been a member or a dependant of a member of a medical scheme for a period of two years prior to applying for membership or the registration of a dependant.

11.22 Major Medical Benefits
Insured benefits for services such as hospitalisation and the treatment/procedures performed whilst a beneficiary is hospitalised.

11.23 Maxillo-facial Surgery
The treatment of cysts and tumours of the jaw, as well as conditions of the saliva glands; the treatment of abscesses of the jaw, excluding periodontal therapy; and/or the treatment of all traumas to the bone and soft tissue of the face; or the surgical removal of teeth

11.24 Medical auxiliary services
A person or entity
- whose discipline is explicitly covered by the Scheme rules; or
- with a practice code beginning with 090 (issued by the Board of Healthcare Funders), whose type of service rendered has been approved (in writing) by the Scheme.

11.25 Medical Savings Account
A savings facility to which members contribute monthly. A credit equal to 12x the monthly savings contribution is available upfront to be utilised in respect of almost any medical services or supplies; even some of those that are otherwise excluded from benefits.

11.26 Medicine
A substance registered under the Medicines and Related Substances Control Act, 1965, as amended or replaced from time to time.

11.27 Member
A person who has been registered as a member by the Scheme.

11.28 Minor
A dependant who is not yet 21 years old.

11.29 NHRPL
National Health Reference Price List

11.30 NHRPL List
The tariff and applicable rules for specific services or supplies provided, as determined and published by the Department of Health from time to time.

11.31 Orthodontics
Braces and removable plates which realign the teeth within the jaw bone.

11.32 Orthognathic Surgery
Dealing with the cause and treatment of malposition of the jaw-bones.

11.33 Periodontal surgery
Advanced treatment of gum infection which includes deep cleaning of roots with the gum flapped open and grafting of oral tissue.

11.34 Pre-authorisation reference number (PAR)
A number allocated by the Scheme's managed healthcare agent, which is required before certain services qualify for benefits.

11.35 Preferred provider
A Service Provider with whom preferential rates were negotiated by or on behalf of the Scheme, or who is part of a preferred provider network contracted for or on behalf of the Scheme.

11.36 Prescribed Minimum Benefits
The minimum benefits that the Scheme is obliged to provide under the Act.

11.37 Registrar
The Registrar of Medical Schemes appointed in terms of the Medical Schemes Act.

11.38 Self-payment gap
A period during which a member will be required to fund a certain portion of day-to-day claims from his/her own pocket after the In-Scheme Benefit and/or Medical Savings Account is depleted.

11.39 Service date
In the event of:

11.39.1. hospitalisation – the date of each discharge from a hospital; or termination of membership, whichever takes place first

11.39.2 any other service or supplies – the date on which the service was rendered or the supplies obtained, whether for the same illness or not.

11.40 Service provider
A medical practitioner, dentist, pharmacist, nurse, medical auxiliary or hospital duly registered or licensed as such with a statutory council or relevant state department – or if practising in a territory outside South Africa, registered or licensed as such with a similar body in that territory.

11.41 Spouse
A person to whom a member is married under a system recognised by South African law.

11.42 Topmed Tariff (TT)
The rate that is applicable for the payment of benefits, including the NHRPL Rate or amended rate as published by Topmed or its agent from time to time.

11.43 Threshold
A specified amount, calculated according to family size, to which all day-to-day claims accumulate when paid from the In-Scheme Benefit, Medical Savings Account or from own pocket. Once the threshold amount is reached, the Scheme will start paying further day-to-day claims again.

11.44 Year
A period of 12 months beginning on 1 January and ending on 31 December.

12. Abbreviations

12.1 MMAP
Maximum Medical Aid Price

12.2 AT
Agreed Tariff

12.3 PAR
Pre-authorisation Reference Number

12.4 PAT
Pharmacist Advised Therapy

12.5 TT
Topmed Tariff

12.6 SEP (Single Exit Price)
The price set by the manufacturer or importer of medicine or scheduled substance, combined with the logistics fee and VAT, as regulated.