



TopMedtm

Member Guide

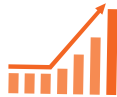
2011



Transparency



**Comprehensive
Range of Options**



Stability and Growth



Customer Centricity



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Membership

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 or Membership Change Form, which can be obtained from Topmed, or downloaded from the website on www.topmed.co.za. If you are part of a company that belongs to Topmed send your completed Application Form/Membership Change Form to your HR or Payroll Department, or if registering as an individual member you may forward your Application/Membership Change Form 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 (PMB's), 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

*** If a general waiting period or condition specific waiting period is imposed please note that Topmed will not pay for PMB's if a member as had no previous medical cover or had a break of cover for more than 90 days.**

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.

1.11.3 Network Members

Back dated terminations will not be granted for members on the Network Option.





Pre-Authorisation

2. Pre-Authorisation (PAR)

2.1 What is pre-authorization? (PAR)

Pre-authorization (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 radio-isotope studies, whether during hospitalisation or not, require pre-authorization. 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-authorization 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-authorization 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 Summary of Benefits for your particular option 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-authorization Department to obtain a PAR?

For all pre-authorisations

- By calling **0860 00 21 58**
- Alternatively, you can request a pre-authorization number via the web (www.topmed.co.za) for pre-planned non emergency admissions. Login to the Member's secure site for access to this functionality.

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 Department?

- 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.





Medicine

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 24/25). 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. Topmed covers the 25 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions at 100%, provided that these medicines are obtained from the Scheme's Designated Service Provider (DSP), and subject to Topmed's formulary, which is amended from time to time). Should you choose not to utilise Topmed's DSP and/or utilise medicines that are not part of the formulary, Topmed will only pay a 70% benefit., and you will be liable for a co-payment of 30%.

To obtain an application form to register with Topmed's DSP you may contact the Client Services Department (**0860 00 21 58**), or visit Topmed's website (www.topmed.co.za),

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 condition/medication approved.
- Once your doctor has provided you with your script you will need to provide a copy to either your pharmacy or Topmed's DSP to obtain your 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 Medicine 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), where after 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/ DSP to ensure that you may continue to receive your medication.
- (iii) **Clinical/ Payment Rules** - The payment of your medicine is subject to a number of clinical/ payment rules to include but not limited to
 - Drug to drug interactions
 - Gender / age checks
 - Early refill limitations (1 script per 24 days)
 - Quantity / Dosage checks

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 changes to an existing chronic authorisation.

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) Chronic Disease (CDL) condition?

In the event that either you or your dependants are registered for one or more of the 25 PMB CDL conditions (see list of chronic conditions on page 24 for details) and your Chronic Limit (where applicable) is exhausted. Topmed will continue to provide a 100% benefit subject to the criteria listed above (Paragraph 3.1)

3.8 Medical Management of your PMB CDL 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 pay from your day-to-day benefits and not from 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 Summary of Benefits for your option).





Contributions

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 Traditional Option

| | |
|---|----------------|
| Your contribution as a principal member | R 3 073 |
| One additional adult dependant | R 2 636 |
| One additional minor dependant | R 863 |
| Total insured contribution | R 6 572 |

Please note that the contributions payable on the Network Option are based on the highest income of either the Principal Member and/or spouse/partner. Proof of income will be validated each year to ensure that you are paying the correct contributions.

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 your dependant turns 21 irrespective of whether your dependant is a student or not.

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.



Operation of Topmed Options

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 Traditional

New Generation options

- Topmed Incentive Savings
- Topmed Incentive Comprehensive

General Options

- Topmed Hospital Plan
- Topmed Network (Capitated Product through CareCross Health)

For more details on each of the options offered, please refer to the Summary of Benefits for each option.

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's Client Service Department or from the website (www.topmed.co.za). Such a change will only be allowed once annually on 1st January of each year.

Please note that if you belong to an employer group, your option change form must be returned to your HR or payroll department. Individual members may submit their option changes directly to Topmed.

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 Summary of Benefits. 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 if 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 | R 7 400 |
| Adult dependant | R 6 100 |
| One minor dependant | R 1 430 |
| Total threshold | R 14 930 |

The threshold for this family of three is R 14 930. It makes no difference if the principal member is the only one to receive medical treatment and utilises the full R 14 930. 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?

All benefits that have limits have these limits applying even before the threshold is reached. This means that if for example, there is a limit of R 5,000 on your acute medicines benefit and you utilise the full amount before 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 medicines 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 R 14 930

Example:

- If the family joins Topmed on 1 July, their threshold will be R 7 465 (50% of R 14 930)
- Even if they join Topmed on 1 December, their threshold will still not be less than 50% of R 14 930 which is R 7 465.

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 Incentive Savings and Incentive Comprehensive 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 Summary of Benefits per Option 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 Summary of Benefits, and the actual cost charged by your service provider.

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 contact the Client Services Department to request the payment, as these benefits will not automatically be allocated from your Medical Savings Account. The full claim must be submitted to Topmed for this to be processed.

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 Topmed?

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 is a Primary Healthcare Provider?

A Primary Healthcare Provider is appointed by Topmed to manage your family's day-to-day basic healthcare needs, e.g. the treatment of flu.

5.4.2 WHO is the Primary Healthcare Provider on Topmed?

Topmed has appointed CareCross Health to render primary healthcare services to the members of the Network option. CareCross Health has a countrywide network of doctors, dentists and optometrists from whom you may obtain these services.

To locate your nearest CareCross provider, please log onto www.carecross.co.za for the information and details of CareCross doctors.

5.4.3 What are my benefits at a CareCross GP?

- The first and most important step is to ensure that you select and consult with your chosen CareCross GP.
- You never have to worry about "running out" of doctor visits as you may have as many medically necessary visits to the CareCross GP as you need to remain healthy
- In his treatment, the CareCross GP may also:
 - Provide you with **acute and chronic medication** according to a medicine list
 - Perform some **minor surgical procedures**
 - Call for listed **blood tests and X-rays**
 - Offer **pre- and post-natal care** including two ultrasound scans per pregnancy.

5.4.4 What is acute medication?

It is medication that is used for a short period of time to help you recover from a common illness, such as influenza (flu). Dispensing GP's will provide you with this medication when you consult with him. Some CareCross GP's (Scripting) will give you a prescription with which you are able to obtain your acute medicines at any Medikredit enabled pharmacy.

5.4.5 What do I do if I have a chronic condition?

Do consult your CareCross GP to confirm the diagnosis and for the completion of a chronic application form which must be submitted to CareCross. On approval of the application, CareCross will arrange for the delivery of the medicines to your nearest Post Office.

5.4.6 What other benefits do I have?

- You are also entitled to basic **dental benefits** such as fillings, extractions and cleaning.
- In addition, you have access to **optical benefits** that offer a choice between spectacles and contact lenses. This benefit is available to each beneficiary every 24 months.
- These services are only obtainable from CareCross contracted providers.

5.4.7 Do I and my dependants have to visit the same CareCross contracted GP?

No, each of you can choose the CareCross contracted GP that is nearest to you. If you want to change to another CareCross at a later stage, you can do so by completing a form that you can obtain from your present CareCross provider.

5.4.8 What must I do in an emergency after hours or if I am on holiday and not close to a CareCross Provider I selected?

- CareCross benefits make provision for after hours emergencies or visits outside of the network. This benefit is limited to 3 visits per family per annum to a maximum of R1 000 per family per annum.
- You have the following options:
 - You may visit any CareCross contracted or non-contracted GP close to you
 - Alternatively, you may go to an emergency room at the nearest private or public hospital. (See Summary of Benefits for details.)
 - Please note that you will have to pay upfront for the service obtained outside of the network.
- You may, however, claim back the costs from CareCross subject to the benefit limit.

5.4.9 Will I have to pay when visiting CareCross providers?

No, as long as your contributions have been paid, you may visit CareCross Providers as often as necessary without having to make any payments for CareCross services.

5.4.10 Will Topmed grant benefits if I want to consult a specialist?

You qualify for specialist benefits to the maximum of R2 100 per family per annum. This will include a consultation and tests/procedures (such as an ECG performed by a specialist) to the maximum benefit allowed, and is payable by Topmed. This benefit does not include any Radiology or Pathology tests as these are covered by CareCross, and also does not include any Auxilliary Services.

Please ensure that your specialist claims are submitted directly to Topmed.

5.4.11 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, you must obtain an authorisation (PAR) by contacting **0860 00 21 58**. Topmed will pay the cost of your hospitalisation, and the costs of the treatment you receive whilst in hospital.

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

5.4.12 What must I do in case of an emergency?

If in an emergency you are unable to obtain authorisation prior to being rushed to hospital for example in the case of an accident, 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 Member Guide.

5.4.13 How are my claims paid?

- **Services rendered at CareCross providers:**
You will not receive an account for any CareCross 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 Topmed.

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

5.4.14 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 Member Guide.

5.4.15 Are benefits allowed in respect of foreign claims?

No.

5.4.16 Is HIV/AIDS covered?

Yes. The CareWorks HIV/Aids 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), doctor's consultations, information, counselling and advice.

To access these benefits you should contact the CareWorks call centre on **0860 10 11 10** to register on the programme.

5.4.17 Are dialysis and organ transplants covered?

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

5.4.18 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.

Important things to remember

- **Always take your Topmed membership card with you when visiting a CareCross provider.**
- Know your CareCross GP's room hours
 - Normal business hours to a maximum of
 - Monday to Friday: 09:00 to 17:00
 - Saturdays: 09:00 to 11:00
 - **Not required to be open** after hours, Sundays or public holidays
- Protocols and medicine lists apply
- You are **not required** to pay cash for CareCross services
- Ask your doctor if tests/medicines are covered
- Ask questions if you are unsure



Payments of Claims

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 claims.
- 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, Topmed provides a benefit for Foreign Claims. However, 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.



Managed Healthcare

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 Summary of Benefits for applicable benefits and limits per your chosen option).

7.1.1.1 What benefits does Topmed 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 Programme'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 call 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 you or your treating doctor advise the case manager to ensure that your authorisation is updated accordingly.

7.1.2 Your Life - HIV Management Programme

Members and beneficiaries of Topmed have access to benefits for the treatment and management of HIV/AIDS, which includes benefits for medicines, pathology and other services required to treat you. To access these benefits you need to join Topmed's HIV/Aids Programme, called Your Life.

7.1.2.1 We care about your quality of life

People with HIV are entitled to live normal, productive lives, free from discrimination or misunderstanding. With advances in medical research, HIV infection and AIDS need no longer be considered as a death sentence, but rather a chronic manageable infectious disease. Every person needs to take care of his/her body and health. For people who are HIV positive, this is more important because their immune systems are unable to fight off diseases or minor ailments.

7.1.2.2 When should I join?

Join us today! By joining the HIV programme, you will benefit even if you are at a stage before you and/or your beneficiaries get ill or require treatment with anti-retrovirals.

Over the years of running this programme, we have achieved wonderful outcomes with members who have had the courage to join the programme. We encourage all members and/or beneficiaries who test HIV-positive to join the programme as soon as the diagnosis is made. It is very important that pregnant females who test HIV-positive during the pregnancy, or are already aware of their HIV status when they fall pregnant, to inform us as soon as they are aware of the status. Mother-to-child transmission is very successfully prevented if the pregnant mother receives treatment with antiretrovirals.

7.1.2.3 How do I register?

The registration process is easy and confidential. Please call our confidential telephone line on **0860 10 97 93** or **082 821 0994** to start the process.

7.1.2.4 Will my condition remain confidential?

We do respect and salute members who have the courage to disclose their condition and rise above all the stigma. The programme is a confidential programme. Please be assured that confidentiality will be respected by all staff managing your condition. Our nursing sisters and the doctor who will be responsible to treat your condition form part of a dynamic team. A confidential clause ensures that all registered members' details are treated with the strictest of confidence. Your status will under no circumstances be disclosed to anyone, including your employer.

7.1.2.5 What benefits do I qualify for?

Your benefits are focussed on your total wellness and not just the virus. We have experienced that AIDS may not be the same in everybody and that each member has special needs. On registration, you are allocated a dedicated individual who will manage your condition within an allocated budget.

7.1.2.6 Benefits for Post-Exposure Treatment

Please call our share call line on **0860 10 97 93** or the after hours mobile line, which is **082 821 0994**. This will enable members to get access to recommended treatment with antiretrovirals specific for the prevention of infection by the virus after accidental exposure. It is important to do this within at least two to six hours after the possibility of having come into contact with the virus in order to meet the optimal treatment guidelines.

We understand that this diagnosis brings with it added social burdens and emotions. Our experienced staff are there to assist you to overcome your fears, and most of all teach you to live a positive and healthy life.

Should you require further information or support, please do not hesitate to contact the HIV Programme on:

Tel: 0860 10 97 93 or 002731 573 4089 (if you are calling outside of South Africa)

Mobile: 082 821 0994

Fax: (012) 675 3848

Please note that this benefit is applicable to all options except the Network Option, Network members are required to register through CareWorks (see page 12). (Refer to the Summary of Benefits for more information)

7.1.3 Disease Management Programmes

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

7.1.3.1 Diabetes Management Programme

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 programme is designed to significantly improve the treatment and compliance of our diabetic members.

Our programme:

- Identifies patients with diabetes and their co-morbidities.
- Enroll patients onto the programme 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 programme:

- 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 Programme

The aim of Topmed's cardiovascular programme is to accomplish common goals, i.e. early identification and prevention of cardiovascular events, optimisation 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 Topmed'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 Summary of Benefits 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

Topmed provides a comprehensive set of Dental Benefits, payable from your Major Medical Benefit (where applicable) on the Traditional Option, Incentive Savings and Incentive Comprehensive Options (See Summary of Benefits for the benefits and limitations provided per option).

Benefits are payable at 80% of the TT on the Topmed Traditional Option and 75% of the TT in respect of the Incentive Savings and Incentive Comprehensive Options, which is applicable to all your Dental Benefits, including hospitalisation (where clinically approved). Should your dentist charge above the TT, you will be liable for the applicable co-payment as well as the difference between the TT and the fees that your dentist charges. However, it is your right to negotiate this difference with your dentist, to minimise your out-of-pocket payment.

Benefits payable

For information on the benefits provided refer to the Summary of Benefits per option, which will outline the benefits provided per option.

7.5.2 Conservative Dentistry

The benefits provided as part of your Conservative Dentistry are highlighted in the Summary of Benefits.

7.5.3 Specialised Dentistry and Hospitalisation

The provision of Specialised Dentistry and Hospitalisation benefits are based on clinical criteria, subject to obtaining pre-authorisation (PAR) from Topmed, prior to treatment being received.

If no PAR is obtained or if a PAR is obtained late, no benefits will be paid by Topmed. Refer to page 3 for additional information on obtaining pre-authorisation.

As part of the pre-authorisation process please be advised that treatment plans/tooth numbers/x-rays etc will be required for certain Specialised Dentistry benefits. In addition, all requests for hospitalisation will require letters of motivation together with the relevant radiographs from your dentist before any procedures will be authorised.

Call **0860 00 21 58** to obtain a PAR.

7.5.3.4 General Benefit Exclusion Summary

See Dental Exclusion List (page 20)

7.5.3.5 Dental Claims

All dental claims must be submitted to Topmed
PO Box 2338
Durban
4000

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

7.6 Optical Benefits

The optical benefit offers members on the Topmed Traditional option enhanced benefits through Preferred Provider Negotiators (PPN), a network of more than 1200 optometrists nationwide. Members on this option may elect to utilise the services of PPN. Details of the providers in the network can be found on Topmed'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 Summary of Benefits. Should members utilise the services of a non-preferred provider, limit benefits as outlined in the Summary of Benefits will be provided.

7.7 Maternity Program

Topmed offers a Maternity Program on all options (except the Network Option). To access this benefit you are required to register when you are between 12 to 20 weeks in your pregnancy.

When you call to register please have the following information ready: -

- a contact e-mail address -
- your GP, gynaecologist or registered midwife's name and surname -
- your GP, gynaecologist or registered midwife's practice number -
- whether or not you've had a miscarriage before -
- whether this is your first child -
- your expected date of delivery

Once you are registered on the Maternity Program you will be forwarded a copy of "The pregnancy and birth book" (by Tina Ottles), and should it be your second pregnancy the "You & the Toddler" by Dr Mirriam Stoppard is sent as well.

Should your pregnancy be deemed high-risk one of Topmed's in-house midwives will contact you on a regular basis to offer advice, support and encouragement, and you will be continuously monitored throughout your pregnancy.

As part of the Maternity Program you will be entitled to 12 antenatal visits at either a GP, gynaecologist or a registered midwife, 2 out-of-hospital scans, antenatal vitamins and antenatal classes.

In addition, if you have a Multiply Membership you will have access to the Momentous Baby Program which offers access to great information during your pregnancy as well as receiving the Momentous Baby Hamper.



Unique Benefits

8. Unique Benefits

8.1 Extended Major Medical Benefit

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 on the Traditional, Incentive Savings and Incentive Comprehensive Options and limited cover on the Hospital Option.

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 Summary of Benefits for details on your benefit option.

8.1.1 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 one calendar year at different times then you will receive this benefit for each event.

8.1.2 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 one calendar year at different times then you will receive this benefit for each event.

8.1.3 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) 580 0492

Phone: 0860 00 21 58

8.1.4 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) 580 0492

Phone: 0860 00 21 58

8.1.5 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:

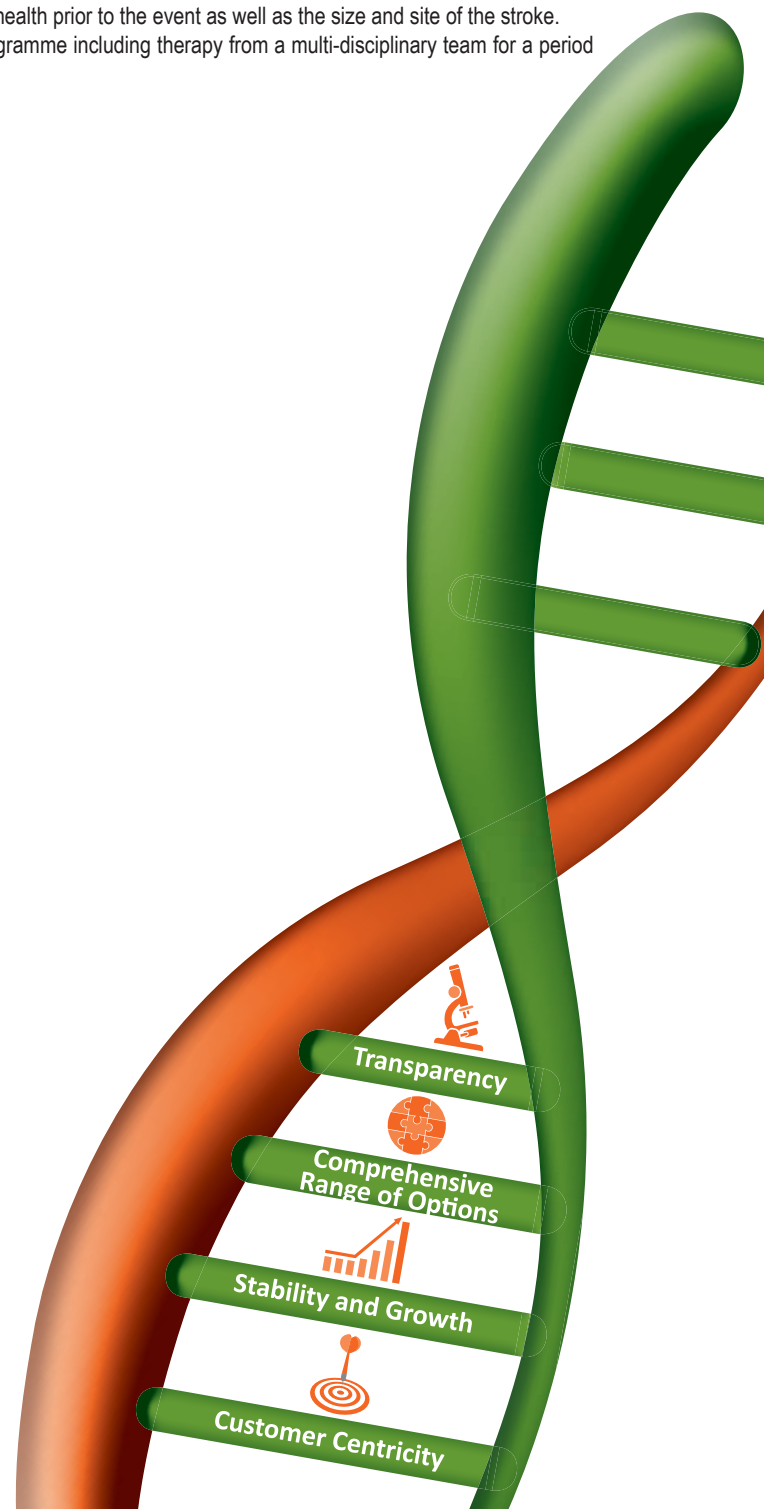
- physiotherapist
- occupational therapist
- speech therapist

This benefit is subject to case management.

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

Fax: (031) 580 0492

Phone: 0860 00 21 58



8.2 Internal Prosthesis Benefit

Topmed offers a unique benefit for the prosthesis benefit, providing a sub-limit for a number of different prosthesis categories, as outlined below.

| PROSTHESIS LIMITS | Topmed Traditional | Topmed Incentive Savings | Topmed Incentive Comprehensive | Topmed Network | Topmed Hospital |
|--|--------------------|--------------------------|--------------------------------|-----------------|-----------------|
| 100% of Cost Subject to the sub-limits listed per option | Per Beneficiary | Per Beneficiary | Per Beneficiary | Per Beneficiary | Per Beneficiary |
| | 2011 | 2011 | 2011 | 2011 | 2011 |
| Cerebral Aneurisma Coils | R 42,700.00 | R 42,525.00 | R 42,700.00 | Limited to PMB | R42,525.00 |
| Cardiac Stents | R 42,700.00 | R 42,525.00 | R 42,700.00 | Limited to PMB | R42,525.00 |
| Cardiac Valves | R 42,700.00 | R 42,525.00 | R 42,700.00 | Limited to PMB | R42,525.00 |
| Cardiac Pacemakers | R 42,700.00 | R 42,525.00 | R 42,700.00 | Limited to PMB | R42,525.00 |
| Shoulder Replacements | R 37,800.00 | R 37,380.00 | R 37,800.00 | Limited to PMB | R37,380.00 |
| Elbow Replacement | R 32,700.00 | R 32,340.00 | R 32,700.00 | Limited to PMB | R32,340.00 |
| Hip Replacement | R 37,800.00 | R 37,380.00 | R 37,800.00 | Limited to PMB | R37,380.00 |
| Knee Replacement | R 35,100.00 | R 35,175.00 | R 35,100.00 | Limited to PMB | R35,175.00 |
| Bone Lengthening Devices | R 37,800.00 | R 37,380.00 | R 37,800.00 | Limited to PMB | R37,380.00 |
| Spinal Plates and Screws | R 32,700.00 | R 32,340.00 | R 32,700.00 | Limited to PMB | R32,340.00 |
| Other Pre-authorized spinal implantable devices, including instrumentation, balloons and cement for spinal surgery - | R 32,700.00 | R 32,340.00 | R 32,700.00 | Limited to PMB | R32,340.00 |
| Internal Fixation Devices for fractures (non spinal) | R 32,700.00 | R 32,340.00 | R 32,700.00 | Limited to PMB | R32,340.00 |
| Carotid Stents | R 17,800.00 | R 17,535.00 | R 17,800.00 | Limited to PMB | R17,535.00 |
| Aorta Stent Grafts | R 42,700.00 | R 42,525.00 | R 42,700.00 | Limited to PMB | R42,525.00 |
| Peripheral Arterial Stents Grafts | R 27,300.00 | R 27,195.00 | R 27,300.00 | Limited to PMB | R27,195.00 |
| Emboic protection devices | R 22,700.00 | R 22,365.00 | R 22,700.00 | Limited to PMB | R22,365.00 |
| Internal sphincters & stimulators | R 42,700.00 | R 42,525.00 | R 42,700.00 | Limited to PMB | R42,525.00 |
| Neuro Stimulators | R 24,900.00 | R 24,990.00 | R 24,900.00 | Limited to PMB | R24,990.00 |
| All internal prosthesis not listed above, Other prosthesis, Surgical Prosthesis | R 11,400.00 | R 11,340.00 | R 11,400.00 | Limited to PMB | R11,340.00 |

8.3 Topmed Wellness

Topmed offers a Wellness Benefit on both the Incentive Savings and Incentive Comprehensive Options, allowing you access to certain preventative screening tests which are payable from Topmed's Major Medical Benefit, thus extending Members' day-to-day benefits. To obtain these benefits it is as simple as calling Topmed's Client Services department on **0860 00 21 58**. (See Summary of Benefits for Details). Should you be a member of Multiply (Topmed's Lifestyle Rewards Programme) you will be eligible to earn Multiply points by participating in the Topmed Wellness Programme.



Exclusions

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 Basic and Specialised Dentistry

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

- Ozone therapy
- Scaling and Polishing
- Orthognathic (jaw corrections) surgery and the related hospital cost, except in the case of severe facial deformity
- Snoring appliances
- Cost of Mineral Trioxide
- Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments
- Oral and/or facial image (Digital/conventional)
- Microbiological studies
- Caries susceptibility test
- Pulp test
- Occlusion analysis mounted
- Pantographic recording
- Electrognathographic recording without/with computer analysis
- Polishing – complete dentition
- Removal of gross calculus
- Topical application of fluoride - adult
- Nutritional and Tobacco counselling
- Occlusal/mouth guards
- Resin crown – anterior – anterior primary tooth (direct)
- Gold foil class I-V
- Inlay - Metal
- Inlay - porcelain
- Inlay - resin
- Cost of ceramic block
- Fabrication of computer generated ceramic restoration
- Crown ¾ cast metal/porcelain/ceramic
- Provisional crown
- Veneer – resin (chair side/lab/porcelain)
- Emergency crown
- Prefabricated metal or resin crown
- Re-burnishing and polishing of restorations – complete dentition.
- Carve restoration to accommodate existing clasps or rest
- Pulp cap - direct
- Apicectomy – anteriors/posterior (including retrograde filling)
- Clinical claim lengthening
- Pedicle flapped graft
- Bone regeneration – part of a flap operation
- Bone regeneration – at a single site
- Cost of bone regenerative/repair material
- Partial denture – cast metal framework with resin denture base
- Interim, partial or complete denture
- Diagnostic denture

- Locks and milled rest
- Precision attachment
- Over, partial or complete denture
- Metal base to complete denture
- Remount crown or bridge for prosthetics
- Soft base to denture
- Altered cast technique
- Additive partial denture
- Connector bar – implant supported
- Prefabricated abutment
- Custom abutment
- Clasp or rest – stainless steel
- Repair of implant supported prosthesis
- Repair of implant abutment
- Surgical removal of implant
- Inlay/on-lay retainer – metal or porcelain – two surface
- Inlay/on-lay retainer – metal or porcelain – three surface
- Inlay/on lay retainer – metal or porcelain – four or more surface
- Retainer cast metal (Maryland type retainer)
- Connector Bar
- Stress breaker
- Coping Metal
- Alveolar ridge augmentation – total (by bone graft)
- Alveolar ridge augmentation – total (by all plastic material)
- Alveolar ridge augmentation – one to two tooth sites
- Alveolar ridge augmentation – three across 3 or more tooth sites
- Sinus lift procedures
- Ortho Tx-fixed lingual appliance – one arch
- Ortho Tx-fixed lingual appliance – one arch, moderate
- Ortho Tx-fixed lingual appliance – one arch severe
- Ortho Tx – fixed lingual appliance – both arches, Class 1 mild
- Ortho Tx – fixed lingual appliance – both arches, Class 1 moderate
- Ortho Tx – fixed lingual appliance – both arches, Class 1 severe
- Ortho Tx – fixed lingual appliance – both arches, Class 1 severe w/complications
- Ortho Tx – fixed lingual appliance – both arches, Class 2/3 mild
- Ortho Tx – fixed lingual appliance – both arches, Class 2/3 moderate
- Ortho Tx – fixed lingual appliance – both arches, Class 2/3 severe
- Therapeutic drug injection
- Cost of suture material
- Supply of bleaching materials
- Special report
- Appointment not kept/30min
- Sedative filling
- External bleaching – per arch
- Home bleaching – instructions and applicator
- Home bleaching – subsequent visit
- Internal bleaching – per tooth
- Internal bleaching – each additional visit
- Enamel micro abrasion
- Behaviour management

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, unless forming part of a Case/Disease Management Program
- 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 (uvulopalatopharyngoplasty)
- 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 Programme
- 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 Topmed, due to it either being fraudulent or not clinically or medically necessary, as indicated by Topmed's external auditing company
- The difference between the cost of generic and branded medicine.



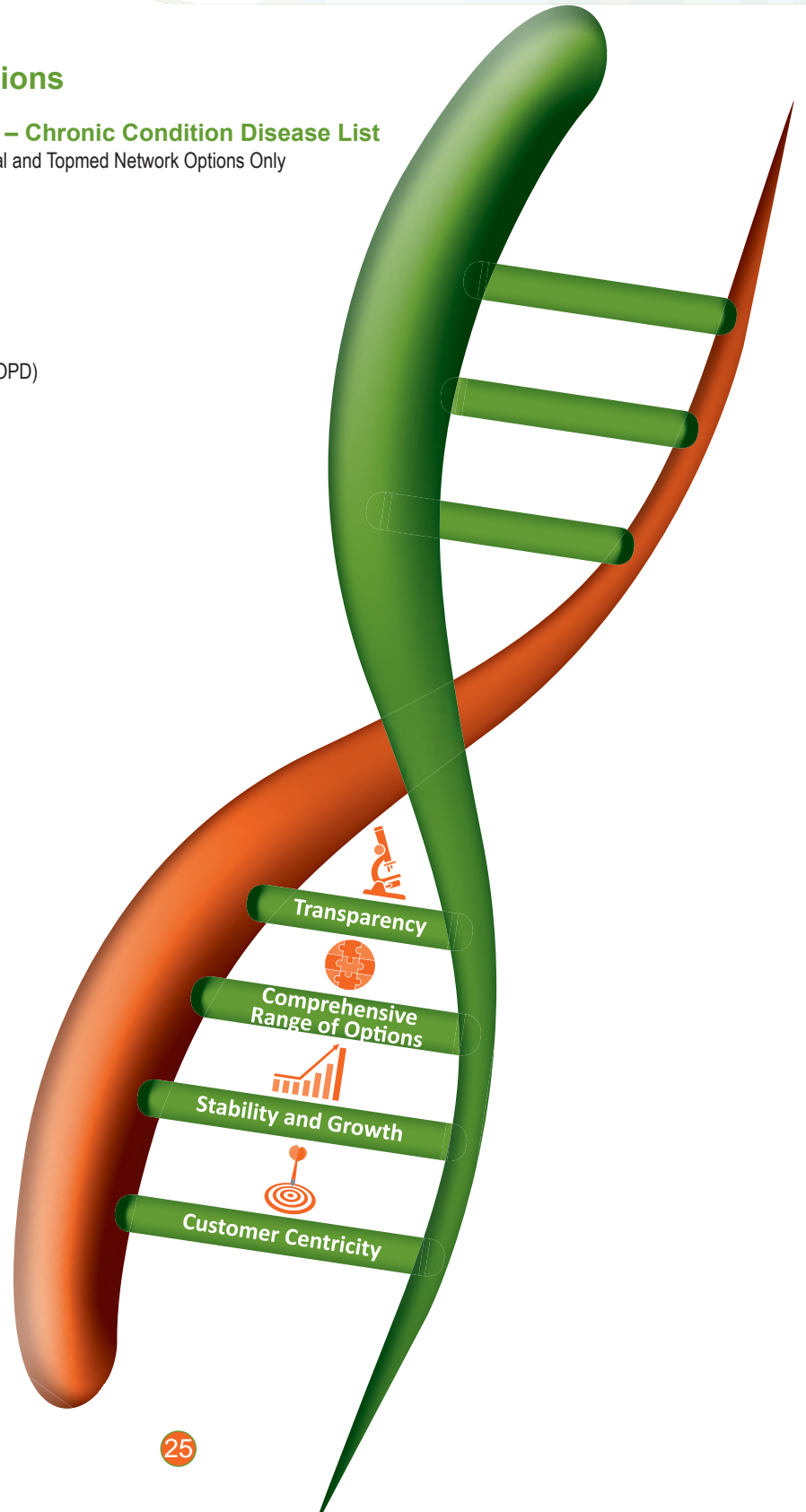
List of Chronic Conditions

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 Fibrillation 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 Traditional 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





Definitions

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 Topmed.

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 Topmed, or registration of a dependant, is actually received by Topmed.

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 Topmed prescribes it or approves it on application by a beneficiary.

11.8 Chemotherapy

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 Topmed'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 Topmed from time to time, and which application has been accepted by Topmed.

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 Topmed:

- 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 Topmed.

11.13 Designated Service Provider (DSP)

Topmed'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 Emergency

Emergency - a condition manifesting itself by acute symptoms of sufficient severity (including severe pain), where of the absence of immediate care could reasonably be expected to result in:

- 11.17.1 placing the health of a beneficiary or unborn child in serious jeopardy
- 11.17.2 serious impairment of bodily functions
- 11.17.3 serious dysfunction of any bodily organ, limb or system

11.18 Foreign Claims

Originating from countries outside the borders of the Republic of South Africa.

11.19 Formulary

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

11.20 Hospital

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

11.21 Inception Date

The date on which a person becomes a member of Topmed or on which a dependant's registration becomes effective.

11.22 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.

11.23 Major Medical Benefits

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

11.24 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.

11.25 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 of 1965, as amended or replaced from time to time.

11.27 Member

A person who has been registered as a member by Topmed.

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, based on the 2006 NHRP List published by the Council for Medical Schemes, with annual inflationary increases.

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 Topmed'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 Topmed, or who is part of a preferred provider network contracted for or on behalf of Topmed.

11.36 Prescribed Minimum Benefits

The minimum benefits that Topmed 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 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

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 your Medical Savings Account or from your own pocket. Once the threshold amount is reached, Topmed 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 CDL

Chronic Disease List

12.2 MMAP

Maximum Medical Aid Price

12.3 AT

Agreed Tariff

12.4 PAR

Pre-authorisation Reference Number

12.5 PAT

Pharmacist Advised Therapy

12.6 PMBs

Prescribed Minimum Benefits

12.7 TT

Topmed Tariff

12.8 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.

Contact Details

| | |
|--|--|
| Client Services | Tel: 0860 00 21 58 Cell: 082 235 0879 e-mail: info@topmedms.co.za Fax: (031) 580 0480 |
| Hospital Pre-Authorisation | Tel: 0860 00 21 58 |
| Chronic Medication | Tel: 0860 00 21 58 Fax: (031) 580 0471 |
| Case Management or Disease Management Programme | Tel: 0860 00 21 58 Fax: (031) 580 0492 |
| Oncology Management Programme (Cancer) | Tel: 0860 00 21 58 Fax: (031) 580 0492 |
| HIV/Aids Management Programme | Tel: 0860 10 97 93 Cell: 082 821 0994 (available 24 hours) Fax: (012) 675 3848 |
| ER 24 (Emergency Assistance) If you need an ambulance or Assistance Hotline For claims enquiries | Tel: 084 124 Tel: 0861 084 124 |
| Preferred Provider Negotiators (PPN) | Tel: 0860 10 35 29 www.preferredprovider.co.za |
| Pharmacy Direct | Tel: 0860 02 78 00 Fax: 0866 11 40 00/1/2/3 e-mail: topmed@pharmacydirect.co.za www.pharmacydirect.co.za |
| CareCross (Topmed Network Provider) CareWorks (Network HIV/Aids Provider) Email | 0860 10 11 59 0860 10 11 10 topmed@carecross.co.za |
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| Website | www.topmed.co.za |