MEMBER GUIDE





TopMedtm

Your Plan For A Healthier Life

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INDEX

1. HISTORY

TopMed…. Your trusted health partner

TopMed Medical Scheme was registered on 24 April 1972, and has been providing a comprehensive benefit offering to its Members for 40 years. TopMed provides a wide range of affordable and transparent healthcare options especially tailored to suit corporate clients, SME's and professional individuals. We have a holistic and innovative approach and offer financial stability, efficiency and personal service: customer centricity being an essential cornerstone. We are passionate about healthcare and partner with third parties to ensure we deliver the highest levels of excellent service. Sound governance and above statutory solvency levels ensures that in a changing and complex environment, TopMed remains relevant in the current private healthcare industry. Our Board is 100% Member elected, ensuring that, at TopMed, our Members really do come first!

Why TopMed?

Comprehensive Range of Options

- TopMed focuses on offering a wide range of products that provide value for money to our customers
- The options include: Traditional, New Generation, Hospital, Limited Benefits and Capitation-based options

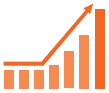
Customer Centricity

We focus on health and wellness through our benefit design

- Wellness (the preventative screening programme)
- Extended Major Medical Benefits
- Trauma Benefits

Transparency

- Clear and Transparent communication
- Comprehensive and informative Member Guide
- Very effective managed care tools
- Excellent administration



Stability and Growth

- TopMed's financial position is strong and stable
- TopMed has a long-term stability and growth approach through our benefit design and partnerships
- Retention of existing clients

One of the significant strengths of TopMed Medical Scheme is the wide range of benefit options. We are highly competitive in both the corporate and small and medium enterprise/individual markets.

The Key Features of TopMed's Product Range include:

- Private Hospitalisation
- TopMed Wellness - our Preventative Care Programme
- Chronic Medication Benefits
- Day-to-Day Benefits
- Extended Major Medical Benefits
- International Travel Cover

2. MEMBERSHIP

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.

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 stating that the family member is dependent on the principal member for care and support.

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

By completing an Amendment 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, please send your completed Amendment Form to your HR or Payroll Department, or if registering as an individual member you may forward your Amendment Form directly through to TopMed or via your appointed broker. Please call **0860 00 21 58** if you have any enquiries about your application.

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.

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

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.

Waiting period

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 more than 90 days prior to joining TopMed;
  or
- were members of another medical scheme for a period of more than 2 years, and joined TopMed within 90 days of leaving their previous medical scheme

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*.

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 more than 90 days prior to joining TopMed
  or
- have belonged to another medical scheme for less than 2 years, and joined TopMed within 90 days of leaving their previous medical scheme

No waiting periods will be imposed on:

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

Can I opt to make a payment in lieu of this waiting period, in order to have it waived?

No

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

Inception date

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.

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

- 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

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.

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.

What is Non Disclosure?

There is a LEGAL requirement to tell TopMed (on joining) about any:

- Current conditions and/or treatments
- Previous conditions and/or treatments
- Planned procedures and/or treatments

Failure to disclose can lead to Termination of Benefits and/or Membership so please make sure that you do not leave anything off your application form even if you think it is something small.

When can I cancel my Membership?

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.

Individual Members

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

Network Members

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

When can I change my option?

You may only change your option once a year effective from on the first day of January, after giving TopMed at least 30 days' written notice.

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 1 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 via email, fax, the web or by calling Client Services on 0800 00 21 58.

3. CONTRIBUTIONS

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, to a maximum of 3 child dependants*) registered under your membership.
*Not applicable to the TopMed Active Saver and TopMed Network Option.

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.

When are membership contributions payable?

Contributions are payable monthly in advance, by the third of the month, effective from your inception date.

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 month following that in which your dependant turns 21 unless your dependant is a full time student.

Students

If your dependant is a full time student between the ages of 21 to 24 they will qualify for the student concession and continue paying the child rate whilst they are studying. Proof of full time study from the relevant Educational Institution will be required to be submitted to TopMed by the end of February of each year.

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.

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.

What is a late joiner?

An applicant or the adult dependant of an applicant who, at the date of application for membership, is 35 years or older, but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without a break in membership in coverage exceeding three consecutive months since 1 April 2001.

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.

4. OPERATION OF TOPMED OPTIONS

TopMed provides a comprehensive spectrum of options, encompassing New Generation Savings Options, Traditional Option, Capitation Option, Hospital Option and a Limited Option.

The flexibility of the product offering ensures that the healthcare needs of a diverse profile of individuals can be covered within the TopMed Medical Scheme range of options.

For more details on each of the options offered, please refer to the Benefit Booklet for each option on the website, www.topmed.co.za or call Client Services on 0800 00 21 58.

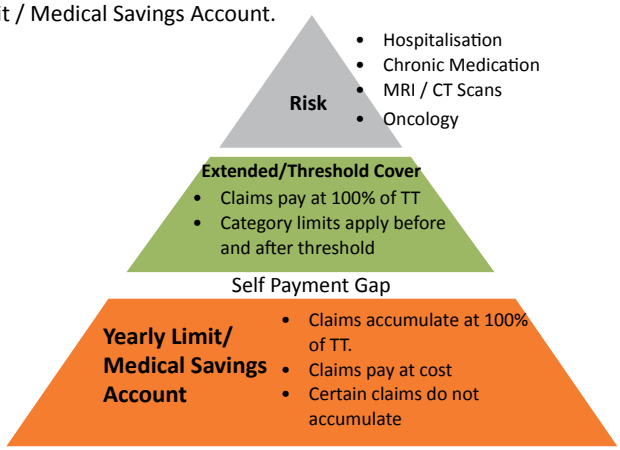
Extended / Threshold Cover

(Applicable to the TopMed Comprehensive, TopMed Executive and TopMed Family)

How does the Extended/Threshold Cover work?

A threshold is a set value to be reached before claims for day-to-day medical expenses are paid by TopMed. Claims for day-to-day expenses are processed and will accumulate towards reaching this threshold. This includes claims paid from your Yearly Limit and Medical Savings Account or paid from your own pocket. The value accumulated to your threshold is based on the TopMed Tariff (TT), and not necessarily the amount that you have paid. Once your accumulated claims reach the threshold value (and you have exhausted your Yearly Limit or Medical Savings Account), further day-to-day claims will be paid by TopMed as per the benefits stipulated in your Summary of Benefits. You may use your Yearly Limit / Medical Savings Account to pay for day-to-day medical expenses incurred before your threshold is reached, or pay from your own pocket should your Yearly Limit / Medical Savings Account be exhausted.

As noted above only the applicable percentage of the benefit amount, i.e. the TopMed Tariff and not the cost, will accumulate towards the threshold, even if the cost is paid from your Yearly Limit / Medical Savings Account. Certain claims will NOT accumulate towards the threshold, even if paid from your Yearly Limit / Medical Savings Account.



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.

If a Benefit Limit applies before Threshold, how will it affect my benefits after Threshold?
For all benefits that have limits, these limits apply before and after the threshold is reached. This means that if for example, there is a limit of R5 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 Yearly Limit / Medical Savings Account, or your 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.

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.
Example:
The threshold for a family for 12 months is R20 000

- If the family joins TopMed on 1 July, their threshold will be R10 000 (50% of R20 000)
- Even if they join TopMed on 1 December, their threshold will still not be less than 50% of R20 000, which is R10 000.

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 from which you add or remove dependants.

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.

Medical Savings Account (TopMed Executive, TopMed Family, TopMed Savings, TopMed Active Saver)

How does a Medical Savings Account work?
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 is available in advance for medical expenses

How much can I contribute towards my Medical Savings Account?
The amount is fixed per option. Refer to the Benefit Booklet per Option for further details.

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 exclusions in Benefit Booklet)
- Medical services for which the annual sub-limit 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.

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

What happens to my savings balance if I change from a New Generation Option to another 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.

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.

What happens to my savings balance if I pass away?
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.

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.

Yearly Limit (TopMed Comprehensive)

What is a Yearly Limit
A Yearly Limit is a portion of your monthly contribution which is set aside to pay for day-to-day benefits before you have reached your annual threshold level. It is similar to a Medical Savings Account in that it is used to fund day-to-day benefits.

What can I use my Yearly Limit for?
Refer to your Benefit Booklet for details of claims that can be funded from your Yearly Limit.

What happens to my Yearly Limit if I leave the Scheme or change to a benefit option that does not have a Yearly Limit?
As the Yearly Limit is considered a Risk Benefit, when you leave the Scheme or change to a option that does not have a Yearly Limit , your Yearly Limit benefit will fall away and the balance remains with the Scheme.

What happens to my Yearly Limit balance at the end of the year?
Any Yearly Limit balance at the end of the year will fall away and you will be allocated a new balance at the beginning of the next year.

TopMed Network Option

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.

Who is the Primary Healthcare Provider on TopMed?

TopMed Networks has appointed providers to render primary healthcare services to the members of the Network Option. TopMed Networks has a countrywide network of doctors, dentists and optometrists from whom you may obtain these services.

To locate your nearest Network provider, please log onto www.topmed.co.za for the information and details of the Network doctors, or use TopMed's Mobile Application which can be downloaded from Google Play or the AppStore.

What are my benefits at a Network General Practitioner?

- The first and most important step is to ensure that you select and consult with your chosen Network GP.
- You may have as many medically necessary visits to the Network GP as you need to remain healthy.
- In his treatment, the Network GP may also:
  - Provide you with **acute medication** according to a medicine list
  - Register you for **chronic medication** for a specific condition and according to a medicine list
  - Perform some **minor surgical procedures** in the rooms
  - Call for listed **blood tests and x-rays**
  - Offer **pre and post-natal care** including one ultrasound scan in the first trimester per pregnancy.

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 them. Some Network GP's (Scripting) will give you a prescription with which you are able to obtain your acute medicines at any Network pharmacy.

What do I do if I have a chronic condition?

Consult your Network GP to confirm the diagnosis and for the completion of a chronic application form which must be submitted to TopMed. On approval of the application, you will be informed where you may collect your medication. If there is no approved pharmacy close to you, your medication will be delivered to either your work or your home address.

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 Network-contracted providers and subject to Network protocols.

Do I and my dependants have to visit the same Network-contracted GP?

No, each of you can choose the Network contracted GP that is nearest to you. It is important that once you choose a GP that you are comfortable with, that you continue to consult with your chosen GP only. This is the best way for your health to be managed effectively.

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

- Your benefits make provision for after hours emergencies or visits outside of the network. This benefit is limited (refer to the TopMed Network Benefit Booklet).
- You have the following options:
  - You may visit any Network-contracted or non-Network GP close to you
  - Alternatively, you may go to an emergency room at the nearest private or public hospital. (refer to the TopMed Network Benefit Booklet).
- 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 TopMed subject to the benefit limit and TopMed rates.

Will I have to pay when visiting Network providers?

No, as long as your contributions have been paid, you may visit Network Providers as often as medically necessary without having to make any payments for Network services. Sometimes you may require medication, blood tests or x-rays that are not covered under your Network option. Your GP will inform you when you require such treatment and you will have to pay for these yourself.

What must I do if I need to see a Specialist?

- Specialist Benefits are provided by a Network of Specialists, subject to obtaining a referral from your Network GP.
- Your Network GP will need to complete a referral form (available on the website, www.topmed.co.za or via Client Services on 0860 00 21 58). The completed form must be emailed to referrals@topmedms.co.za.
- Please note that for your PMB Treatment Plan Specialist visit, if you are not referred by your chosen Network GP, or do not see a Specialist on the Network, TopMed will pay only 70% of the TT and you will be required to pay the balance to your Specialist.

What Specialist Benefits are provided?

- The Specialist benefit is limited (refer to the TopMed Network Benefit Booklet).
- Specialist services are subject to referral by a Network GP to a Network Specialist and pre-authorisation.
- Any radiology or pathology called for by the Network Specialist will also be paid from this benefit.

Should you receive any other treatment from a Specialist, other than the benefits listed above, you will be liable for the full cost of that treatment.

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 at 100% of the agreed tariff if you were referred by the Network GP or Specialist. (Please note if the admitting provider is a Network Provider, TopMed will pay 100% of the TT). If your provider is not a Network Provider, TopMed will pay 70% of the TT, and you will be required to pay the balance to your provider.

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 of the information you need to supply and obtain when applying for a PAR, please refer to page 14 (Pre-Authorisation) in this Member Guide.

How are my claims paid?

- **Services rendered at Network providers:**
  You will not receive an account for any services. The provider will send the account directly to TopMed.
- **Services rendered at a Specialist (out-of-hospital):**
  This account must be submitted to TopMed.
- **Services rendered at a hospital:**
  Submit hospital-related claims 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 page 36 - Payment of Claims in the Member Guide.

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 they are 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 page 06 (Contributions) in this Member Guide.

Are benefits allowed in respect of foreign claims?

No.

Is HIV/AIDS covered?

Yes. The HIV/Aids Programme assists members 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 call **0860 448 2273** to register on the programme. This is a fully confidential line.

Are dialysis and organ transplants covered?

These condition are 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).

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 Network provider.**
- Know your Network 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 formulary lists apply
- Ask your doctor if tests/medicines are covered
- Ask questions if you are unsure

5. PRE-AUTHORISATION (PAR)

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 radio-isotope 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.

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 on **0860 00 21 58**.

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.

Visits to a hospital's out-patient facility in the event of Trauma (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 Booklet for your particular option for more information).

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 (excluding PMB's).

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

For all pre-authorisations call **0860 00 21 58.**

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

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

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

A family member, your doctor or a hospital staff member must immediately inform the Pre-authorisation Department, 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.

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

You will qualify for a maximum of seven days' supply. This benefit will be paid from Risk (except for the Network option). 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 Risk to a maximum of seven days' supply. If you have a chronic medicine authorisation, you should obtain your medicine from a DSP retail pharmacy.

6. MEDICINE

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 22). 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 26 Prescribed Minimum Benefit (PMB) Chronic Disease List (CDL) conditions at 100% of the Agreed Tariff (TRP applies), provided that these medicines are obtained from the Scheme's Designated Service Providers (DSP's), and subject to TopMed's formularies, which are amended from time to time. Should you choose not to utilise TopMed's DSPs and/or utilise medicines that are not part of the formularies, TopMed will only pay a 70% benefit, and you will be required to pay the balance.

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.

How do I apply for a Chronic Medicine Benefit?

- The treating doctor must contact us 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 a Clinical Committee.

Chronic Registration Process

Once your doctor has diagnosed your chronic condition and codes the condition as per the relevant ICD-10 coding (refer to page 19), your doctor needs to contact us 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's to obtain your medication (refer to page 19).
- Should your medication not be approved as part of your Chronic Medicine Benefit, the Chronic Consultant will advise your doctor as well as send you a letter, advising you of the rejection.

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), thereafter 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 us on **0860 00 21 58** to reinstate your authorisation. The same can be done when any changes or additions to a current authorisation are required.

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 Yearly Limit / Medical Savings Account.

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 which does not count towards your annual consultation limit. This payment will be made for applications for disease conditions which are considered Chronic Conditions. 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 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.
- No long forms to be filled out or completed by your doctor.

Important points to note

- **ICD-10 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.

  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.

- **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.

- **Clinical/Payment Rules** - The payment of your medicine is subject to a number of clinical/ payment rules including but not limited to:
  - Drug to drug interactions
  - Gender/Age checks
  - Early refill limitations (1 script per 24 days)
  - Quantity/Dosage checks
  - Generic substitutions
  - TopMed Reference Price (TRP)
  - Formularies

TopMed Medical Scheme uses Utilisation Management Rules to enable early detection of chronic diseases and enhance disease management for members.

The following Utilisation Management Rules apply:

- Aero-chambers and spacers (for admission of inhalant medication): Restricted to 1 device per beneficiary per year.
- Medication for treatment of pain: Restricted to 150 tablets/capsules per beneficiary per year.
- Anti-asthmatic inhalers: Restricted to 3 prescriptions per year from acute benefit , thereafter pre-authorisation is required.
- Medicines for treatment of depression: Require pre-authorisation from ChroniLine™.
- Medicines for treatment of psychosis: Require pre-authorisation from ChroniLine™.
- Medicines for treatment of anxiety: Limit to a maximum quantity of 30 per month and 3 prescriptions per year from the acute benefit.
- Sedative medicines: Restricted to 3 prescriptions per year per beneficiary from the acute benefit.
- Contraceptives: Limited to 1 prescription per month for females only.
- Ear preparations: Restricted to 1 bottle/tube per month with a maximum of 4 prescriptions per beneficiary per year.
- Eye preparations (except for the treatment of glaucoma): Restricted to 1 bottle/tube per month with a maximum of 4 prescriptions per beneficiary per year.
- Estring™: Restricted to 1 device and 4 prescriptions per year for females only.

- Flu vaccines: Restricted to 1 vaccine per beneficiary per year.
- Glucocorticosteroid nasal sprays: limited to a quantity per month according to maximum registered dosage
- Human Papilloma Virus (HPV) vaccines. eg. Gardasil™ and Cervarix™: Will pay from acute benefit with age and lifetime limits applied.
- Hypnotic Medicines: Restricted to a quantity of 30 per month per beneficiary and 3 prescriptions per year from the acute benefit.
- Products to treat lice infestations: Limit to 2 prescriptions per beneficiary per year from the acute benefit.
- Malaria prophylactic treatment: Restricted to 2 prescriptions per beneficiary per year.
- Medicated shampoos: Limited to 2 prescriptions per beneficiary per year from the acute benefit.
- Topical preparations for muscle aches: Limited to 2 prescriptions per beneficiary per year from the acute benefit.
- Anti-inflammatory Medicines: Restricted to a yearly quantity of 150 per beneficiary.
- Medication for the treatment of osteoporosis: Requires pre-authorisation from ChroniLine™ for the options where benefits are available.
- Prenatal vitamins: From maternity benefit for 9 prescriptions and for females only.
- Roaccutane™ and generic equivalents: Pay from acute and may be prescribed by any medical doctor.
- Stoma appliances: Pay from Stoma benefit. ChroniLine™ can authorize stoma appliances from chronic benefit where applicable.
- Topical acne preparations: Limited to 4 prescriptions per beneficiary per year from the acute benefit.
- Topical nasal preparations: Restricted to 1 bottle/tube per month and to annual prescriptions of 4 per beneficiary.
- Topical steroid preparations: Limited to 4 prescriptions per beneficiary per year from the acute benefit.

NOTE: Utilisation management rules do not apply to products if pre-authorised.

What is TRP?

TopMed Reference Price (TRP) sets a maximum reimbursable price for a list of generically similar products with a cost lower than that of the original medicine. It is the maximum price that TopMed is prepared to pay for a medicine with generic alternatives. This means that if you opt to use the original product, and a generic alternative is available, you will have to pay the difference between the price of the chosen original medicine and that of TRP.

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.

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.

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.

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.

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 26 PMB CDL conditions (see list of chronic conditions on page 22 for details) and your Chronic Limit (where applicable) is exhausted, TopMed will continue to provide a 100% benefit provided you obtain your medicine within the formulary and from the DSP.

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.

Please Note: Consultations for non PMB chronic conditions are covered from your available day to day benefit.

To obtain a 100% benefit you will be required to obtain the above services from the Public Healthcare Sector or from a the Network GP/Specialist. Should you use your own service provider, TopMed will only pay 100% of the TopMed Tariff. 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, TopMed will only 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 general industry guidelines and in consultation with clinical experts in the various disciplines. Additional benefits may be granted upon motivation from your service provider.

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 Booklet for your option).

7. CHRONIC CONDITIONS

Prescribed Minimum Benefit - Chronic Condition Disease List

Applicable to all options

- 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
- Hypothyroidism
- Hypertension
- Multiple Sclerosis
- Parkinson's Disease
- Psychiatric Disorders
  - Bipolar Mood Disorder
  - Schizophrenia
- Rheumatoid Arthritis
- Systemic Lupus Erythematosis
- Ulcerative Colitis

Extended Chronic Conditions

In addition to the conditions listed on page 22, the following conditions are also available.

(Please note that these are only applicable whilst your Chronic Medicine Benefit Limits are available).

Option	Extended Chronic Conditions
TopMed Comprehensive	Unlimited
TopMed Executive	• 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

TopMed Family	• Osteoporosis • Osteopaenia • Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD) • Gout • Depression other than provided for in PMBs • Allergic Rhinitis prevention (children only) • Psoriasis • Osteoarthritis

8. 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.

Part of TopMed's Managed Care approach is to ensure that members have access to healthcare benefits which will enable them to live healthier, more active lifestyles. TopMed's Management Programmes are available to members with chronic conditions (e.g. high blood pressure, cholesterol) and/or degenerative conditions (e.g. back and joint pain) where rehabilitation such as physiotherapy, biokinetics, prescribed diets and exercise can be effective in reducing reliance on chronic medicines or prevent/delay an operation.

Each member has different needs and conditions and a programme is individually tailored for the member's medical needs, in consultation with your doctor where necessary. Members who may benefit from these Management Programmes would be contacted by one of our Disease Management Nurses OR members can also contact us direct in order to apply for registration on one of the programmes.

In order to determine a member's suitability for these programmes, we will ask some questions about the member's medical history and where necessary a risk assessment will be required from the treating doctor. We would also gather some baseline medical indicators like blood pressure, blood sugar, weight and height.

Once this step is completed, an appointment will be scheduled with a relevant provider to do a detailed assessment and treatment plan. Once we receive this assessment, a detailed management plan is agreed with the Scheme and covered as part of the member's managed care programme or as an alternative to hospitalization.

The member will be advised of the benefits that will be covered by the Scheme and will be asked to commit to a regular follow up programme with a Dedicated Professional Nurse, which includes gathering results of tests and progress reports in order to evaluate whether the member is benefiting from the programme. These programme would typically run over a 6 month period with extension to a year if it is agreed with the doctor and providers that the member will continue to benefit.

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 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 Department on **0860 00 21 58**.

Oncology (Cancer Management)

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

Who needs to register?

Beneficiaries diagnosed with a positive malignant histology that requires some form of chemotherapy, radiotherapy, hormonal therapy and/or supportive therapy.

How to register

1. After you have been diagnosed with cancer your Oncologist must fax a treatment plan and the histology results to the Scheme's Oncology Department on **086 762 4050**.
2. Once received by TopMed, the oncology disease manager will review the request in accordance with recognised treatment protocols and guidelines for oncology treatment based on clinical appropriateness, evidence-based medicine and the chosen benefit option. If appropriate, an authorisation is generated and a response is provided to the treating oncologist, who in turn will notify member.
3. Additional information may be required from the oncologist, such as test results, in order to complete the registration process.

In the event of any changes, renewals and amendments to your treatment plan, please ensure that either you or your treating doctor advise the case manager to ensure that your authorisation is updated accordingly subject to approval and available limits.

Overview of TopMed's Oncology Benefits

Depending on your treatment plan the following benefits could be included:

- Chemotherapy, radiotherapy and supportive treatment. This is referred to as an Active Treatment Plan.
- Materials that are used in the administration of your active treatment, for example drips and needles, is covered with the Active treatment.
- Technical planning scans.
- Hormonal therapy related to your cancer regardless of route is paid at 100% of the TopMed Tariff.
- Consultations with your oncologist.
- Fees charged by accredited facilities.
- Pathology tests related to your condition during active treatment and after treatment for follow-up as required.

- Supporting medication, pain, nausea as well as other medicine used to treat the side effects resulting from the disease, will be covered.

  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 received on discharge from hospital will be limited to seven days' supply and is paid from risk.
- External breast prostheses, special bras, stoma products and oxygen are paid from your appliance limit.
- 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 member's 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.

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.

HIV/AIDS Programme

At TopMed we have been covering HIV/AIDS as a benefit (including the provision of anti-retroviral treatment and, ART) since the inception of ART. The TopMed HIV/ AIDS Programme goes beyond registering a condition and allocating benefits and is designed to address the needs of patients and families affected by HIV and AIDS.

Managed by our Dedicated Professional Nurses, together with a dedicated HIV/AIDS Programme Coordinator, the TopMed programme is a fully confidential programme that covers issues such as:

- Pre-testing and pre-treatment counselling and planning
- Help in choosing the treatment that suits your needs
- Education regarding the prevention of transmission as well as healthcare and nutritional guidance
- Monitoring of side effects and response to treatment to make sure your medication is working for you
- Encouragement of adherence and compliance with the programme and medication
- Liaison with your medical provider when necessary and at your request
- Medication benefits including anti-retroviral drugs
- Consultation and diagnostic benefits
- Prevention of mother to child transmission
- Occupation injury and exposure to HIV positive blood e.g. sexual assault
- Management of opportunistic infections

If you or any of your beneficiaries are affected by HIV/AIDS, please contact the HIV Programme Coordinator who is in the best position to assist you with the registration process and ongoing management.

0860 448 2273 (0860 HIV CARE).

This is a fully confidential line.

Please note that anti-retroviral drugs may only be obtained once registration has occurred and cannot be authorised through the chronic medication process. HIV/AIDS benefits are authorised by TopMed HIV/AIDS Programme only.

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.

Diabetes Management

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.
- Enrolls patients onto the programme for primary and secondary prevention.
- Risk Stratification: Stratifies 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 on-going 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 patient's 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.

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, bone marrow, and renal dialysis.

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

Mental Wellness

Do you experience some or all of these symptoms on a daily basis?

- Feelings of helplessness and hopelessness. A bleak outlook—nothing will ever get better and there's nothing you can do to improve your situation.
- Loss of interest in daily activities. No interest in former hobbies, pastimes, social activities, or sex. You've lost your ability to feel joy and pleasure.
- Appetite or weight changes. Significant weight loss or weight gain—a change of more than 5% of body weight in a month.
- Sleep changes. Either insomnia, especially waking in the early hours of the morning, or oversleeping (also known as hypersomnia).
- Anger or irritability. Feeling agitated, restless, or even violent. Your tolerance level is low, your temper short, and everything and everyone gets on your nerves.
- Loss of energy. Feeling fatigued, sluggish, and physically drained. Your whole body may feel heavy, and even small tasks are exhausting or take longer to complete.
- Self-loathing. Strong feelings of worthlessness or guilt. You harshly criticize yourself for perceived faults and mistakes.
- Reckless behavior. You engage in escapist behavior such as substance abuse, compulsive gambling, reckless driving, or dangerous sports.
- Concentration problems. Trouble focusing, making decisions, or remembering things.
- Unexplained aches and pains. An increase in physical complaints such as headaches, back pain, aching muscles, and stomach pain.

This could be a sign that you are suffering from Depression, proper management leads to dramatic health improvements. At TopMed our comprehensive Mental Wellness programme is run by qualified Psychiatric Nursing Sisters, and is designed to significantly improve the treatment and compliance of our members.

Benefits of the programme:

- Telephonic confidential support from qualified nurses
- Detailed assessment of your personal risk factors and assistance with registering for benefits to help you to manage your symptoms
- Referral to specialists if necessary
- Reduced admissions to hospital and better out of hospital treatment

How do you register?

- Contact us on 0860 00 21 58
- Ask your doctor to contact us

If you have had an admission to hospital or are taking medicines for depression, one of our nurses may also contact you to invite you to join. You will need to give your doctor permission to share information with us as the benefits are subject to specific clinical criteria. This is to make sure that we are helping members who need it the most.

Ambulance Services ER24

ER24 provides TopMed Medical Scheme members with Emergency Medical Services throughout South Africa as well as in Lesotho and Swaziland. ER24 has approximately 250 rapid response vehicles and ambulances stationed at bases around the country and this national network includes Basic, Intermediate and Advanced Life Support Emergency Services. Together with additional quality-controlled contracted service providers, ER24's national footprint ensures prompt response of the most appropriate team of paramedics at all times.

In order to ensure efficient and effective call-taking and call-handling, ER24 uses one national number **084 124** operated through a high-tech emergency Contact Centre, 24 hours a day. ER24's clinical staff are all highly specialised in emergency care and include friendly and helpful professional nurses and paramedics who are supported by the ER24 Chief Medical Officer. Daily transfer of scheme data allows providers to confirm member status after-hours.

Why should I call ER24?

ER24 is TopMed's Preferred Provider for any ambulance services. If services are not rendered by (or through the intervention of) ER24, benefits will be limited to a specified maximum (please refer to the Benefit Booklet for details).

What to do in the event of a medical emergency:

- Always call 084 124.
- If someone is calling on your behalf, tell them to call 084 124.

Medical Information and Assistance Hotline

ER24 medical personnel, including paramedics, nurses and doctors, will be available 24 hours a day to provide general medical information and advice. This is an advisory and information service, as a telephonic conversation does not permit an accurate diagnosis:

- Members are encouraged to utilise this 24 hour cost-saving service.
- Our doctors and nurses use medical data base algorithms and protocols to advise members on healthcare solutions.
- Members can first seek advice as to:
- Urgency of attention needed - dispatch ambulance, go to hospital, go to doctor, go to pharmacy for OTC meds, self-medicate from home.
- Doctor and facility referral for scheme benefit DSP's e.g. networks, GP's, hospitals and pharmacies.
- Generic medication advice.

Crisis Counselling and Referral Hotline

In addition to our medical information and assistance line, all TopMed Medical Scheme members have access to telephonic Trauma Counselling where trained counsellors will provide assistance with, inter alia, the following:

- Poison advice
- Suicide hotline
- Substance abuse
- Domestic and child abuse
- Rape counselling and referral to Rape Centres
- Bereavement counselling
- Hijacking
- HIV/Aids information and counselling

Claims Queries

For any claims enquiries, you can phone **0861 084 124** or e-mail **claims@er24.co.za**

Optical Benefits

TopMed has partnered with Preferred Provider Negotiators (PPN) for the administration of the Optical benefits on the following options:

TopMed Comprehensive
TopMed Executive
TopMed Family

PPN will provide the following services for members on the above options:

- Benefit confirmations
- Claims receipt and processing
- Claims payment to members and providers

PPN has 20 years' experience in the field of optometry benefits management and has over 2500 contracted providers (90% of all registered optometrist) that will afford TopMed the best pricing for clear spectacle lenses. By consulting at a PPN provider, members can save up to 70% on clear lenses.

To ensure that your provider belongs to the PPN network, either visit the PPN website www.ppn.co.za or call the PPN call center on 0860 103 529.

PLEASE NOTE:

For TopMed's Comprehensive, Executive and Family Options your optical claims MUST be sent to PPN.

Claims can either be emailed to claims@ppn.co.za or faxed to 041 506 5750.

Maternity Programme

TopMed offers a Maternity Programme on all options **(except the TopMed Network and TopMed Limited Options)**.
To enjoy this benefit you are required to register on the programme when you are between 12 and 20 weeks in your pregnancy.

How to register

Members must phone the TopMed Medical Scheme member Call Centre on **0860 00 21 58**.

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

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

As part of the programme 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.

MATERNITY PROGRAMME BENEFITS	REGISTER BETWEEN 12 AND 20 WEEKS
Antenatal Consultations - Tariff Codes: 190-192	Refer to your Benefit Booklet for benefit limits.
Antenatal Scans - Tariff Codes: 3615/3617/5107	
Antenatal Classes - Tariff Code 88407	
Antenatal Vitamins and Iron Supplements	
Paediatrician Visit	

9. PAYMENT OF CLAIMS

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-10 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.**

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.

How will I know when my claim has been settled?

At the end of each month you will be sent a claims advice. All claims processed during the month will be listed. Should you have any queries on how to read this document, please contact Client Services on 0860 00 21 58.

You can also view your claims on the TopMed website www.topmed.co.za

For security reasons you will need to register a username and password before you can login to view claims. For assistance with logging in, please call Client Services as above.

Claim statements incorporate 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

In addition to your monthly claims statement, subject to TopMed having a valid email address for you, you will also receive an email notification after every claims payment run in which we have paid claims submitted by you or your provider of service.

Different providers have different methods of billing their services. Some providers will submit directly to the Scheme while others may have cash practices and do not deal with the Scheme.

For example, Pharmacies and Hospitals will usually send claims electronically. General Practitioners will usually submit claims directly but it is best to check with your doctor.

Some Specialist run cash practices for consultations in their consulting rooms but will bill directly for hospital procedures. This varies by provider and is not controlled by the Scheme. We therefore recommend that you discuss the method of billing with your doctor or the receptionist at the doctors' room to ensure that you know whether you will need to submit a claim yourself or not.

TopMed Limited: Other than the hospital account, members must first pay and then submit claims on a claim form.

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.

Tariff Payable

Please note that the payment of claims is subject to the NRPL 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, namely:

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.

10. RESOLVING PROBLEMS AND QUERIES

The following table illustrates how to log a telephonic or email query, problem or complaint in the most effective manner.

Call Client Services 0860 00 21 58 for:

- Claims payment and accounts
- Benefits
- Contributions
- New cards
- Underwriting
- Contact details
- Designated Service Provider
- Formularies

Call a Dedicated Professional Nurses 0860 00 21 58 for:

- Health Advice
- HIV
- Maternity Programme
- Ex-Gratia
- Medical Queries
- Protocol for PMB, Chronic Benefit, Investigation and Procedures

For Escalated Queries

Operations Manager
0860 00 21 58

or

Administrator's Chief Operating Officer 0860 00 21 58

Disputes and complaints may also be posted to Queries / Complaints at TopMed, P.O.Box 1462, Durban, 4000 or via email to info@topmedms.co.za. It is important to follow the process depicted above as it will provide you with a response in the shortest possible time.

Should you feel that your concerns are not being addressed you may also contact the Principal Officer at principalofficer@topmed.co.za

If your issues are not resolved through the above process, members may also appeal via the Council for Medical Schemes on complaints@medicalschemes.com

11. CO-PAYMENTS AND DEDUCTIBLES

A **CO-PAYMENT** is a specific percentage, rand amount or the difference you would need to pay from your own pocket if your provider charges more than the TopMed Tariff for your option or the benefit specifies a co-payment e.g. MRI and CT Scans, Extended Cover and some medicines.

A co-payment cannot be paid from your Yearly Limit if you are member of the Comprehensive Option and you need to settle this directly with your provider. If you are a member of an option that offers a Medical Savings Account (MSA) you may request to have your co-payments refunded to you from your MSA provided that you have a positive balance.

A **DEDUCTIBLE** is a specific amount that is due for a specific procedure as per the Scheme Rules. The Deductible applies to the hospital account and needs to be paid by the member to the hospital. If the hospital bills the Scheme the full amount, the Scheme will pay the claim less the Deductible which will be recovered from the member by the hospital.

Certain procedures on the Executive, Family, Active Saver and Network options attract a deductible. Please refer to the Benefit Booklet for more details.

Co-Payments and Deductibles do not apply to confirmed Prescribed Minimum Benefits treated at

a Designated Service Provider and as per the Scheme protocols. Medical reports may be required to confirm the diagnosis and protocol as being consistent with the Prescribed Minimum Benefit entitlement.

Avoiding a Tariff Co-Payment on your hospital account

Hospital benefits and certain specified procedures performed in hospital are limited to 100% - 300% of the TopMed Tariff depending on your option. TopMed has negotiated with certain hospital groups to provide services for members at the negotiated TopMed Tariff. These providers are known as Preferred Providers (PP).

Note: A Preferred Provider differs from a Designated Service Provider (DSP) in that TopMed has negotiated a rate for all services at a Preferred Provider whereas a DSP is specifically for PMB services. Services provided at a Preferred Provider may be limited if they exceed sub-limits whereas services at a DSP are unlimited for PMB conditions.

You have the freedom of choice to use any of the hospital groups, depending on your option, but may be liable for a co-payment if you are admitted to a hospital that is NOT one of the Preferred Providers. It is recommended that you check with our Client Services prior to admission to determine whether the hospital you will be using is a Preferred Provider.

TopMed Limited is a traditional design option with specific benefit limits reimbursed on an 80% basis for doctors and health care providers and a sliding scale co-payment for hospital accounts.*

Co-payments applicable to TopMed Limited

Members on the Limited option have co-payments for all claims. Non-hospital claims will have a co-payment of 20%. Private hospital claims will have a co-payment of 50% of the first R4 950 per incident, thereafter 10% of the remainder, up to a maximum co-payment of R10 650.
*With due regard to PMBs.

12. DEFINITIONS

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

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.

Adult
A dependant who is 21 years or older.

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.

Annual Threshold
A Threshold is a set value to be reached before claims for day-to-day medical expenses are covered from Major Medical. All day-to-day claims paid from the member's Yearly Limit / MSA or self-funded, accumulate towards reaching this threshold. Once this threshold limit is reached, further day-to-day claims will be paid by TopMed subject to benefit limits as stipulated in the benefit summary for each option.

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

Beneficiary
Each individual member and dependant.

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.

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.

Chronic Medicine
Medicine that meets all the following requirements:

- prescribed by a medical practitioner for an uninterrupted period of at least three months; and
- for a condition appearing on TopMed's list of approved chronic conditions as amended from time to time; and
- 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.

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

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.

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:

- a spouse/partner; and/or
- a child - including an adopted child, stepchild or foster child; and/or
- the principal member's parents, sisters and brothers; and/or
- any other person approved by TopMed.

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

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.

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

Extended Cover / Above Threshold Benenfit
Cover provided by the Scheme for day to day claims once the Yearly Limit / MSA is depleted, and a set Threshold value is reached. Once this threshold limit is reached, further day-to-day claims will be paid by TopMed subject to benefit limits as stipulated in the Rules.

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:

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

Family
A member and his/her dependants.

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

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

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

Late Joiner
An applicant or the adult dependant of an applicant who, on the Application Date, is 35 years or older but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001.

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

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.

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 on the TopMed Active Saver, Savings, Family and Executive Options.

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

TopMed Reference Price (TRP)
The maximum price that TopMed is prepared to pay for a medicine with generic alternatives. TRP sets a reference price for a list of generically similar products at which these products are reimbursed.

Member
A person who has been registered as a member by TopMed.

Minor
A dependant who is not yet 21 years old.

NRPL List (National Reference Price List)
The tariff and applicable rules for specific services or supplies provided, based on the 2006 NRP List published by the Council for Medical Schemes, with annual inflationary increases.

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

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

Pre-Authorisation Reference Number (PAR)
A number allocated by TopMed's managed healthcare agent, which is required before certain services qualify for benefits.

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.

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

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

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 Yearly Limit/Medical Savings Account is depleted.

Service Date
In the event of:

- hospitalisation - the date of each discharge from a hospital; or termination of membership, whichever takes place first
- any other service or supplies - the date on which the service was rendered or the supplies obtained, whether for the same illness or not.

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.

TopMed Tariff
The rate that is applicable for the payment of benefits, including the NRPL Rate or amended rate as published by TopMed or its agent from time to time.

Threshold
A specified amount, calculated according to family size, to which certain day-to-day claims accumulate when paid from your Medical Savings Account, Yearly Limit or from your own pocket. Once the threshold amount is reached, TopMed will start paying further day-to-day claims according to option specific Protocols and Rules.

Trauma
An acute episode where emergency or trauma has occurred and life-saving treatment is provided until such time as the patient's critical condition has been stabilised. It does not include ongoing medium to long term rehabilitation, chronic medication and treatment of disabilities unless they form part of the Chronic Disease List conditions

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

Yearly Limit
The annual allowance allocated per member for payment of day-to-day benefits until an annual threshold level is reached

13. ABBREVIATONS

CDL Chronic Disease List

TRP TopMed Reference Price

MMAP Maximum Medical Aid Price

AT Agreed Tariff

PAR Pre-authorisation Reference Number

PAT Pharmacist Advised Therapy

PMBs Prescribed Minimum Benefits

TT TopMed Tariff

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.

DSP Designated Service Provider

TopMedtm

Your Plan For A Healthier Life

Contact Details

Client Services	Tel: 0860 00 21 58 International: 087 740 2899 (for calls outside SA) email: info@topmedms.co.za Fax: 086 762 4050
Hospital Pre-Authorisation	Tel: 0860 00 21 58
Chronic Medication	Tel: 0860 00 21 58 Fax: 086 762 4050
Case Management or Disease Management Programmes	Tel: 0860 00 21 58 Fax: 086 762 4050
HIV/Aids Management Programme	Tel: 0860 448 22 73 (0860 HIV CARE) Fax: 086 662 0282
ER24 (Emergency Assistance) If you need an ambulance or Assistance Hotline For claims enquiries	 Tel: 084 124 Tel: 0861 084 124
Preferred Provider Negotiators (PPN) Website:	Tel: 0860 10 35 29 www.preferredprovider.co.za
Mail your claims to	TopMed Medical Scheme PO Box 1462, Durban, 4000 email: claims@topmedms.co.za
To report possible fraud	fraudtipoff@pha.co.za
Website	www.topmed.co.za
CMS- Council for Medical Schemes	Tel: 012 431 0500 Fax: 012 431 0680 email: support@medicalschemes.com Website: www.medicalschemes.com

IMPORTANT NOTE: This guide is a condensed version of the Rules for information purposes only. All benefits are governed by the Rules of the Scheme. In the event of conflict, the Rules take precedence.