gems
Government Employees Medical Scheme

Your GEMS 2020
Dental Provider Guide

With **GEMS**
AFFORDABLE means **RICH** in benefits.

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01 Introduction

GEMS ensures that members have access to cost-effective, quality dental healthcare. The Scheme relies on you, as a valued dental provider, to ensure all members' expectations are realised.

This guide will assist you with the 2020 GEMS dentistry benefits and the Scheme's dental managed care rules. These include time and age rules, general principles and exclusions. The guide also stipulates how the rules are applied to various dental procedures and the specific application to the different GEMS options, namely Tanzanite One, Beryl, Ruby, Emerald Value, Emerald and Onyx.

NOTE: Should you have any queries on benefits, rules, exclusions, pre-authorisation or your patient's Scheme option, please contact **0860 436 777** or **enquiries@gems.gov.za**.

GEMS Dental Network

Since high-quality clinical and administrative services is a team effort between the Scheme and healthcare providers, GEMS invites you to become an integral part of this team by joining the GEMS Dental Network and Friends of GEMS. For details and assistance on joining the growing network, please contact **0860 436 777** or **enquiries@gems.gov.za**.

Pre-authorisation, pre-notification and patient registration

Patient registration

During the patient's first visit to your practice, a once-off dental charting and full oral examination in association with code 8101 (as per normal prescribed guidelines for charging of code 8101) needs to be performed and then submitted to GEMS.

The 'Dental report for patient registration' form for benefit applications should be completed and sent to the Scheme. This facilitates centralised capturing of the patient's existing oral health status to ensure proper and appropriate dental managed care and risk management in accordance with internationally recognised standards. It also allows the Scheme to compile an actual and dynamic epidemiologic database of its patient population for future benefit and budgetary planning.

Pre-authorisation and/or a treatment plan

This is required for certain dental procedures as indicated in the procedure schedules in this guide pertaining to each option. They include certain specialised and surgical procedures, orthodontics, periodontal treatment and any procedures to be performed in an operating theatre or under conscious sedation.

Where pre-authorisation is required for periodontal treatment, the 'Periodontal pre-authorisation' form should be completed and forwarded to the Scheme.

Where pre-authorisation and/or treatment plans are required, the standard 'Patient registration, pre-notification and pre-authorisation' form should be completed. It is necessary to complete only the applicable sections - for instance, it is not necessary to complete the charting section with each request, and it can be used until the completion of a treatment plan.

NOTE: The 'Dental report for patient registration' and 'Dental report for periodontal pre-authorisation' forms are available at **www.gems.gov.za**. Email the completed forms to **enquiries@gems.gov.za** or fax to **0861 00 4367**.

02 Tanzanite One and Beryl: General administration, benefits and procedures covered

Tanzanite One and Beryl - summarised benefit specifications and specific rules

Benefit specifications	Tanzanite One	Beryl
Essential dentistry	Approved services/codes are covered at 100% of the agreed tariff subject to availability of funds	Approved services/codes are covered at 100% of the agreed tariff subject to availability of funds
GEMS Dental Network provider	Services must be provided by a GEMS Dental Network provider only	Services must be provided by a GEMS Dental Network provider only
Out-of-network visit	One emergency out-of-network visit per beneficiary per year	One emergency out-of-network visit per beneficiary per year
Emergency dentistry	• Emergency pain and sepsis treatment only • Codes covered – 8132, 8201 and 8307 • Pulpotomy (code 8307) applies only on primary teeth • Any additional treatment requires funding by patient • One event per beneficiary per benefit year allowed for emergency dentistry	• Emergency pain and sepsis treatment only • Codes covered – 8132, 8201 and 8307 • Pulpotomy (code 8307) applies only on primary teeth • Any additional treatment requires funding by patient • One event per beneficiary per benefit year allowed for emergency dentistry
Examinations and preventive treatment	Two consultation/examination and preventive treatment episodes per beneficiary per benefit year	Two consultation/examination and preventive treatment episodes per beneficiary per benefit year
Restorative treatment	• Limited to four restorations per beneficiary per year • Posterior resin fillings paid at the same rand value as amalgam fillings	• Limited to four restorations per beneficiary per year • Pre-authorisation needed for more than four fillings
Specialised dentistry benefit	No specialised dentistry benefit – limited to PMBs	• Specialised dentistry services (periodontal treatment, partial metal frame dentures and maxillofacial treatment) limited to R3 612 per beneficiary per year • All dentures and specialised dentistry subject to pre-authorisation

Benefit specifications	Tanzanite One	Beryl
Maxillofacial surgery	Subject to an annual sub-limit of R23 088 per family	Subject to an annual sub-limit of R23 088 per family
General anaesthesia and sedation	Subject to Scheme rules, relevant managed care protocols and pre-authorisation	Subject to Scheme rules, relevant managed care protocols and pre-authorisation
Hospital network	Hospitalisation subject to use of state or network hospital, failing which the Scheme shall not be liable for the first R12 000 of the other facility's bill	Any hospital, subject to PMB
Radiology	All services subject to an approved list of tariff codes, managed care protocols and processes	All services subject to an approved list of tariff codes, managed care protocols and processes

Charting: Please note that as part of code 8101, a once-off patient charting and oral examination will be required for each beneficiary visiting your practice for the first time. The charting is to be submitted to the Scheme on the 'Dental report for registration, pre-notification and pre-authorisation' form.

Tanzanite One and Beryl – specific rules for dentures

Benefit specifications	Tanzanite One	Beryl
Dentures	• Plastic dentures subject to pre-authorisation. • One set* of plastic dentures allowed per beneficiary per 48-month benefit cycle • No benefit for metal frame dentures • Plastic dentures limited to the approved 2020 Scheme tariff • Only members and beneficiaries over the age of 21 qualify for this benefit	• All dentures (plastic and metal frame) subject to pre-authorisation • One set* of plastic dentures allowed per beneficiary per 48-month benefit cycle • Partial metal frame denture available once per beneficiary in a five-year period • Metal frame denture is covered from the specialised dentistry limit of R3 612 per beneficiary per year • Plastic dentures limited to the approved 2020 Scheme tariff • Only members and beneficiaries over the age of 21 qualify for this benefit

**A set of dentures is defined as follows:*

- Complete upper or lower dentures (not two upper or two lower)
- Partial upper or lower denture (not two partial upper or two partial lower)

The following table details the reimbursement codes for dentures:

- When claiming via electronic data interchange (EDI), use individual nine codes for dental laboratories. Laboratory invoices to be retained by the practice for possible auditing.
- When submitting paper claims use, individual nine codes for dental laboratories and submit the dental laboratory invoice with the paper invoice.
- No claim will be accepted without the professional fee and laboratory codes submitted together or being matched if a laboratory performs self-billing.

Denture codes funded	Denture codes not funded
8231 (complete dentures – maxillary and mandibular) 8232 (complete dentures – maxillary or mandibular) 8233 (partial – one tooth) to 8241 (partial denture – nine or more teeth)	8658 (interim complete denture)
8269 (repair of a denture or other intraoral appliance)	8659 (interim partial denture)
8271 (add tooth to existing partial denture)	8661 (diagnostic dentures)
8273 (impression to repair or modify a denture, or other removable intraoral appliances)	8244 (immediate upper denture)
8259 (rebase complete or partial denture - laboratory)	8245 (immediate lower denture)
8263 (reline complete or partial denture - intraoral)	On the Tanzanite One option: 8281, 8663, 8279 (metal base codes) not funded
Individual nine laboratory codes	8099 (dental laboratory service)

Note: No additional cover if dentures are lost due to negligence. A motivation is required for the replacement of dentures. Please direct all motivations to the GEMS call centre on **0860 436 777** or **enquiries@gems.gov.za**.

Tanzanite One and Beryl - approved service codes and table of benefits

Code	Code Description	Limitations	Covered: Tanzanite One	Covered: Beryl
8101	Consultation	Two per beneficiary per year	Yes	Yes
8104	Examination for a specific problem not requiring full mouth examination	Two per beneficiary per year	Yes	Yes
8107	Intraoral radiographs, per film	Maximum of two per beneficiary per year	Yes	Yes
8112	Bitewings	Maximum of four per beneficiary per year	Yes	Yes
8115	Panoramic x-ray	Benefit from the age of six – maximum one every three years	Yes	Yes
8155	Polishing – complete dentition	Two per beneficiary per 12 months; cannot be charged with 8159 in same year	Yes	Yes
8159	Scaling and polishing	Two per beneficiary per 12 months; only over the age of 10	Yes	Yes
8161	Topical application of fluoride (children)	From the ages of three to 11; once per beneficiary per 12 months	Yes	Yes
8162	Topical application of fluoride (adults)	From the ages of 12 to 16. Once per beneficiary per 12 months	Yes	Yes
8163	Fissure sealant, per tooth	Patient younger than 14; maximum of two per quadrant on posterior permanent teeth only	Yes	Yes
8341	Amalgam one surface	Any four amalgam fillings per beneficiary per year, limited to four restorations	Yes	Yes
8342	Amalgam two surfaces			
8343	Amalgam three surfaces			
8344	Amalgam four and more surfaces			
8351	Resin restoration, one surface anterior	Any four resin fillings per beneficiary per year (anterior), limited to four restorations	Yes	Yes
8354	Resin restoration, four and more surfaces			
8367	Resin restoration, one surface posterior	Any four resin fillings per beneficiary per year (posterior), limited to four restorations	Yes, but to the same rand value as surfaces amalgam filling	Yes
8368	Resin restoration, two surfaces posterior			
8369	Resin restoration, three surfaces posterior			
8370	Resin restoration, four and more surfaces			
8307	Amputation of pulp (pulpotomy)	Only on primary teeth	Yes	Yes
8132	Root canal therapy – gross pulpal debridement	Once per beneficiary per 12 months. One event per beneficiary per benefit year allowed for emergency dentistry.	Yes	Yes
8201	Extraction, single tooth. Code 8201 is charged for the first extraction in a quadrant	Any four non-surgical extractions per beneficiary per year, only if clinically indicated	Yes	Yes
8202	Extraction, each additional tooth Code 8202 is charged for each additional extraction in the same quadrant	Any four non-surgical extractions per beneficiary per year apply (in association with code 8201)	Yes	Yes
8937	Surgical removal of tooth*	Maximum of two removals - pre-authorisation necessary for more than two	Yes, from the age of 12	Yes, from the age of 12

Tanzanite One and Beryl - approved service codes and table of benefits *(continued)*

Code	Code Description	Limitations	Covered: Tanzanite One	Covered: Beryl
8213	Surgical removal of residual roots, first tooth - per tooth*	Maximum of one procedure - more than one requires clinical motivation	Yes, from the age of 12	Yes, from the age of 12
8214	Surgical removal of residual roots, second and subsequent teeth's roots*	Maximum of one procedure - more than one requires clinical motivation	Yes, from the age of 12	Yes, from the age of 12
8941	Surgical removal of impacted tooth – first tooth*	Pre-authorisation required for in-hospital	Yes	Yes
8943	Surgical removal of impacted tooth – second tooth*	Pre-authorisation required for in-hospital	Yes	Yes
8945	Surgical removal of impacted tooth – third and subsequent teeth*	Pre-authorisation required for in-hospital	Yes	Yes
8220	Sutures	Limited to once a year in association with surgical extractions and/or impactions	Yes	Yes
8935	Treatment of septic socket		Yes	Yes
8109	Infection control/barrier techniques. Code 8109 includes provision by dentist of new rubber gloves, masks etc for each patient	Two per visit	Yes	Yes
8110	Sterilised instrumentation	One per visit	Yes	Yes
8145	Local anaesthetic	One per visit	Yes	Yes
8231	Complete dentures - maxillary and mandibular	• One set of plastic dentures allowed per beneficiary per 48 months • Pre-authorisation necessary • Only members and beneficiaries over the age of 21 • Only plastic dentures for the Tanzanite One options • Beryl: Metal framework every five years	Yes	Yes
8232	Complete dentures – maxillary or mandibular		Yes	Yes
8233	Partial denture (resin base) – one tooth		Yes	Yes
8234	Partial denture (resin base) – two teeth		Yes	Yes
8235	Partial denture (resin base) -three teeth		Yes	Yes
8236	Partial denture (resin base) – four teeth		Yes	Yes
8237	Partial denture (resin base) – five teeth		Yes	Yes
8238	Partial denture (resin base) – six teeth		Yes	Yes
8239	Partial denture (resin base) seven teeth		Yes	Yes
8240	Partial denture (resin base) -eight teeth		Yes	Yes
8241	Partial denture (resin base) – nine teeth and more		Yes	Yes
8259	Rebase complete or partial dentures (laboratory)	Rebase allowed only once every two years	Yes	Yes
8269	Repair denture	Cannot be completed with six months of fitting a new denture	Yes	Yes
8263	Reline complete or partial dentures (chair side)	Reline allowed only once every two years	Yes	Yes
8271	Add tooth to existing partial dentures	Cannot be completed within six months of fitting a new denture	Yes	Yes
8273	Impression to repair/addition	Cannot be completed within six months of fitting a new denture	Yes	Yes

03 Ruby, Emerald Value, Emerald and Onyx: General administration, benefits and procedures covered

Ruby, Emerald Value, Emerald and Onyx - shared dental sublimit

Ruby	Emerald Value and Emerald	Onyx
Shared dental sub-limit of R3 548 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry	Shared dental sub-limit of R5 454 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry	Shared dental sub-limit of R9 730 per beneficiary per year for in-hospital dentistry professional fees and all out-of-hospital dentistry

Ruby, Emerald Value, Emerald and Onyx - summarised benefits covered

Provider limitations	Services not limited to GEMS Dental Network providers
Conservative and restorative dentistry (including plastic dentures)	100% of Scheme rate subject to available funds
Specialised dentistry (including metal base partial dentures)	• No pre-authorisation required for partial metal base dentures • Pre-authorisation required for all other specialised dentistry procedures • Excludes osseo-integrated implants, all implant-related procedures and orthognathic surgery • Excludes orthodontic treatment on patients older than 21
General anaesthesia and conscious sedation	• Subject to pre-authorisation, and managed care protocols and processes • Applicable only to beneficiaries younger than six, severe trauma and impacted teeth • Impacted third molars: 200% of Scheme rate payable for removal under conscious sedation in doctor's rooms • Anaesthetists required to obtain a separate authorisation for dental-related conscious sedation procedures

Charting: As part of code 8101, a once-off patient charting and oral examination will be required for each beneficiary visiting your practice for the first time. The charting is to be submitted to the Scheme on the 'Dental report for registration, pre-notification and pre-authorisation' form.

Please ensure that pre-authorisations are performed before starting treatment where indicated e.g. specialised dentistry, orthodontic treatment, in-hospital (theatre) and conscious sedation-associated treatment.

Ruby, Emerald Value, Emerald and Onyx – general rules

General principles:

- All dental procedures are covered by the rules applicable per specific Scheme option.
- All specialised dentistry and in-hospital dentistry are subject to pre-authorisation before start of treatment except in an emergency where retrospective authorisation should be obtained within 72 working hours after the event.
- An authorisation granted is not a guarantee of payment – payment remains strictly subject to availability of funds.
- Confirmation of benefits is not a guarantee of payment – payment remains strictly subject to availability of funds.
- Hospital authorisations are valid for a one month and all other authorisations are valid for three months.
- Where the dental treatment plan changes, authorisations must be updated before submitting the claim.

Orthodontic treatment:

- Benefits applicable only to beneficiaries under 21.
- Authorisation and a treatment plan apply and benefits subject to prior evaluation according to the ICON criteria – Index of Complexity, Outcome and Treatment Need.
- Once approved, an initial amount will be payable and the balance in increments subject to availability of funds.
- Approved treatment plans are valid for one year.
- Should a case be transferred to another provider, only the balance due as per original treatment plan is covered.
- Orthodontic exclusions: Refer to 'General exclusions and restrictions'.
- When relocating or seeking second opinions, kindly request records from the first service provider to avoid overexposure to radiation.

Hospitalisation

- Covered only for patients under the age of six, impacted teeth and severe trauma as per Scheme rules.
- No other procedures apply.
- Subject to pre-authorisation.
- Children under the age of six:
  - Considered only where no other options are available.
  - All procedures necessary to be completed in one theatre-associated event.
  - Only necessary restorative and surgical (e.g. extractions) procedures may be performed. No preventive treatment (polish, fluoride treatment, fissure sealants) will be covered in theatre.
- Emerald Value option: A co-payment of up to R12 000 may be levied should you not use a GEMS network hospital.

Table of benefits: Ruby, Emerald Value, Emerald and Onyx

	Ruby	Emerald Value and Emerald	Onyx
Dental consultation yearly check-up	Two annual consultations per beneficiary, one every six months	Two annual consultations per beneficiary, one every six months	Two annual consultations per beneficiary, one every six months
Diagnostics	8107: Diagnosis and treatment procedures where necessary	8107: Diagnosis and treatment procedures where necessary	8107: Diagnosis and treatment procedures where necessary
	8108: Benefit from the age of six - one every 24 months	8108: Benefit from the age of six - one every 24 months	8108: Benefit from the age of six - one every 24 months
	8112: Maximum of four per 12 months	8112: Maximum of four per 12 months	8112: Maximum of four per 12 months
	8115: Benefit from the age of six – maximum one every 36 months	8115: Benefit from the age of six – maximum one every 36 months	8115: Benefit from the age of six – maximum one every 36 months
	8116, 8114: For orthodontic treatment only, benefit subject to pre-authorisation	8116, 8114: For orthodontic treatment only, benefit subject to pre-authorisation	8116, 8114: For orthodontic treatment only, benefit subject to pre-authorisation
Infection control	8109: Infection control/barrier techniques - twice per visit	8109: Infection control/barrier techniques - twice per visit	8109: Infection control/barrier techniques - twice per visit
	8110: Sterilised instrumentation - once per visit	8110: Sterilised instrumentation - once per visit	8110: Sterilised instrumentation - once per visit
Preventive dentistry	Scale and polish 8159: Once every six months – from the age of 10 only	Scale and polish 8159: Once every six months – from the age of 10 only	Scale and polish 8159: Once every six months – from the age of 10 only
	Polish 8155: Once every six months	Polish 8155: Once every six months	Polish 8155: Once every six months
	Fluoride treatment: 8161 paid once every six months under the age of 12	Fluoride treatment: 8161 paid once every six months under the age of 12	Fluoride treatment: 8161 paid once every six months under the age of 12
	Fluoride treatment: 8162 paid once every six months from the ages of 12 to 16	Fluoride treatment: 8162 paid once every six months from the ages of 12 to 16	Fluoride treatment: 8162 paid once every six months from the ages of 12 to 16
	Dental sealant: Maximum two per quadrant and once every two years per tooth – no benefit if tooth already in mouth for more than four years and for those over 18	Dental sealant: Maximum two per quadrant and once every two years per tooth – no benefit if tooth already in mouth for more than four years and for those over 18	Dental sealant: Maximum two per quadrant and once every two years per tooth – no benefit if tooth already in mouth for more than four years and for those over 18
Restorations/ fillings	Benefits available where clinically indicated – once per tooth per year	Benefits available where clinically indicated – once per tooth per year	Benefits available where clinically indicated – once per tooth per year
Dentures	One set of full, or full upper or full lower, or partial upper and/or partial lower plastic dentures every four years; relines, rebase, soft base every two years; metal framework every five years	One set of full, or full upper or full lower, or partial upper and/or partial lower plastic dentures every four years; relines, rebase, soft base every two years; metal framework every five years	One set of full, or full upper or full lower, or partial upper and/or partial lower plastic dentures every four years; relines, rebase, soft base every two years; metal framework every five years
Endodontic (root canal) treatment	Pre-authorisation necessary for patients under 14	Pre-authorisation necessary for patients under 14	Pre-authorisation necessary for patients under 14
	Note: 8132 not allowed on same day as root treatment. Maximum of three treatment-associated periapical x-rays allowed (thereafter, pre-authorisation necessary)	Note: 8132 not allowed on same day as root treatment. Maximum of three treatment-associated periapical x-rays allowed (thereafter, pre-authorisation necessary)	Note: 8132 not allowed on same day as root treatment. Maximum of three treatment associated periapical x-rays allowed (thereafter, pre-authorisation necessary)

Specialised dentistry			
Crowns and bridges	Pre-authorisation necessary. Benefit once per tooth per four years	Pre-authorisation necessary. Benefit once per tooth per four years	Pre-authorisation necessary. Benefit once per tooth per four years
Orthodontics	Treatment plan necessary – limited to patients under 21	Treatment plan necessary – limited to patients under 21	Treatment plan necessary – limited to patients under 21
Periodontics	Treatment plan necessary	Treatment plan necessary	Treatment plan necessary
Maxillofacial and oral/dental surgery	Pre-authorisation necessary when done in theatre or under conscious sedation; impacted wisdom teeth paid at 200% of rate when performed under conscious sedation in dentist's rooms	Pre-authorisation necessary when done in theatre or under conscious sedation; impacted wisdom teeth paid at 200% of rate when performed under conscious sedation in dentist's rooms	Pre-authorisation necessary when done in theatre or under conscious sedation; impacted wisdom teeth paid at 200% of rate when performed under conscious sedation in dentist's rooms
Dental hospitalisation			
Dental hospitalisation*	For patients under the age of six, bony impactions and severe trauma (PMB). Subject to pre-authorisation, treatment protocols and PMB conditions applying	For patients under the age of 6, bony impactions and severe trauma (PMB). Subject to pre-authorisation, treatment protocols and PMB conditions applying	For patients under the age of six, bony impactions and severe trauma (PMB). Subject to pre-authorisation, treatment protocols and PMB conditions applying

*Emerald Value: Non-network hospital use may attract a co-payment of up to R12 000

04 All GEMS options: General exclusions and restrictions (excludes PMB)

Exclusions

Please refer to the summary of benefits, detailed procedure benefit lists/schedules and general exclusions detailed earlier in this guide pertaining to each Scheme option to ensure compliance with the benefits allowed, exclusions and managed care rules (e.g. pre-authorisation, number of annual events, age rules etc).

Where treatment is performed where an exclusion exists or when the patient's benefits have been exceeded, the patient will have to self-fund – please ensure the 'Patient consent' form for limits exceeded is completed by the patient and kept on file at the practice.

Diagnostic/preventive treatment

- Special report
- Dental testimony
- Microbiological studies
- Caries susceptibility tests
- Diagnostic models covered only in association with orthodontic treatment
- Appointment not kept
- Nutritional counselling
- Tobacco counselling
- Oral hygiene instruction and/or associated visits
- Removal of gross calculus
- Behaviour management
- Cost of toothbrushes, toothpastes and mouthwashes
- Fissure sealants in patients older than 18 or where teeth have been in the mouth for more than four years
- Oral and/or facial image (digital and conventional) covered only where orthodontic treatment applies
- Fluoride treatment for patients older than 16

Fillings, restorations

- Resin bonding for restorations charged separately from the restoration
- Enamel micro-abrasion
- Elective replacement of fillings
- Gold or gold foil restorations

Dentures

- Diagnostic dentures
- Snoring apparatus
- Clasp or rest – cast gold
- Clasp or rest – wrought gold
- Inlay in denture
- Metal base to full dentures
- Metal frames for partial dentures limited to one per jaw and once every five years

Crown and bridge

- Where an underlying periodontal condition (e.g. extensive loss of alveolar bone) compromises an acceptable term prognosis
- Where a lack of remaining tooth structure compromises an acceptable prognosis
- Where enough remaining tooth structure does not justify a crown as the restoration of choice
- On a failed root canal-treated tooth
- For cosmetic reasons
- Allowed once per tooth every four years
- Emergency crowns not placed for immediate protection of injured teeth
- Temporary and provisional crowns, including lab costs
- Pontics on second molars
- On primary teeth or third molars
- Cost of gold, semi-precious metal and platinum foil
- 8570 – computer-generated restoration: Laboratory not allowed with this code (only 8560)

Implants

All implant-related clinical and laboratory associated procedures (includes implant placement, cost of components, restorations/crowns/bridges/dentures/repairs associated with implants)

Endodontic treatment

- On third molars
- On primary teeth
- Emergency root canal treatment charged on the same day as the completed root canal treatment
- Retreatment not covered within two years of initial treatment
- Motivation required for treatment under the age of 14

Orthodontic treatment exclusions

- Retreatment of orthodontic treatment
- Lost appliances not covered
- Lingual orthodontics not covered
- Ceramic brackets not covered
- Refixing of orthodontic brackets not covered
- Retainers limited to one per jaw
- Treatment planning for orthognathic surgery

In-hospital (theatre)

- For patients under the age of six, bony impactions and severe trauma as per Scheme rules - no other procedures apply
- Preventive dental procedures as part of the dental treatment performed on children under the age of six not covered

Inlays and onlays:

- Exclude tooth numbers one to three in all quadrants
- No benefit for gold or precious metal
- Allowed once every four years

Other

- Cosmetic dentistry
- The treatment of any complication related to treatment not funded by the Scheme
- Intramuscular and subcutaneous injections
- All procedures related to bleaching (except internal bleaching on previously endodontically treated teeth)
- PerioChip replacement
- Treatment plan completed (code 8120)
- Cost of mineral trioxide
- Ozone therapy
- Cost of gold, semi-precious metal and platinum foil
- Orthognathic surgery and related hospital costs
- Occlusal adjustment minor (pre-authorisation necessary for major occlusal adjustment)
- Bone regeneration procedures
- Cost of bone regenerative/repair material
- Any laboratory costs where the associated procedure is not covered
- Dental MRI or CAT scans not covered

05 Dental medicine formulary

The GEMS dental medicine formulary is available at www.gems.gov.za.

Medicine may be prescribed:

- According to the GEMS dental medicine formulary
- By an approved GEMS network dentist or dental therapist (within his/her scope)

For Tanzanite One and Beryl options, medicine must be dispensed by approved GEMS network, courier pharmacies or dispensing dentists.

Key to quantities and limitations

'Consumables' means the medication may be administrated only by a designated service provider (DSP) at the rooms. All injectables are consumables and claims for scripts given to patients to collect from DSP pharmacies will be rejected.

'Max Rx/7 days and 3 Rx/annum' means a script filled to a maximum of seven days' medicine supply and three prescriptions per year may be claimed.

Benefits for medicine are subject to reference pricing lists (MPLs) and exclusion lists (MELs). Should the cost of the item exceed MPL, the patient is liable for payment of the difference in cost. If this is the case please inform the patient that it is for his/her own personal account.

Dental therapists may prescribe as per the latest government gazette published by the Department of Health.

Note: Provider trade names are not listed on formulary, allowing for generic substitution, but applying MPLs and MELs.

Disclaimer

The formulary is reviewed regularly by clinical and pharmaceutical advisers to ensure that it complies with the latest industry norms for the treatment of these conditions. GEMS reserves the right to change medicines on the formulary when important information comes to light that requires it, e.g. new finding on the safety of a drug.

06 Pre-authorisation

In all cases where pre-authorisation is required, as specified earlier and per option in this guide, please complete the relevant sections of the 'Dental report for registration, pre-notification and pre-authorisation' form and submit to the Scheme before starting treatment.

Should you be unsure whether pre-authorisation is required, contact the call centre on **0860 436 777** to prevent rejection of the patient's account by the Scheme.

Orthodontic treatment: Before treatment, submit to the Scheme a pre-authorisation form and treatment plan, which should include the diagnosis and payment quotation for approval. Email **enquiries@gems.gov.za** or fax to **0861 00 4367**.

Periodontal treatment: Complete and submit the 'Periodontal treatment pre-authorisation' form, downloadable from **www.gems.gov.za**.

Note: Tooth charting on the form is not necessary for pre-authorisation or treatment plan (charting needs to be completed only at the patient's first visit to the practice in terms of code 8101).

07 Claim procedures

Required information on claims

- Main member details such as membership number, option, name and contact details
- Patient details, including date of birth, name and identity number
- Provider details, including a valid Board of Healthcare Funders practice number, name and contact details
- Diagnosis and summary of medical procedures performed, medicine dispensed, other items dispensed to patient
- Relevant tariff codes
- Complete list of individual laboratory codes
- Associated costs

Rejection of claims

- If the details are incomplete the claim will be rejected
- The clinical and laboratory codes are to be submitted together, reflecting corresponding service dates, corresponding details of codes used and authorisation numbers for laboratory codes where clinical codes require pre-authorisation
- Self-claiming laboratories may not submit their claim without confirmation with the dental provider that the clinical delivery was completed
- Any other procedures done outside the scope of benefit will not be paid
- All claims from non-network dental providers on Tanzanite One and Beryl options, except emergency consultations (limited to one event per year), will not be funded
- All claims requiring pre-authorisation - if no valid pre-authorisation exists, the claim will be rejected

08 Member verification and validation

Verification on benefits

- Always ensure that available benefit codes and tariff values are verified with the Scheme
- The dental provider is required to verify membership details and confirm the identity of the patient
- The Scheme will not be responsible for payment of services excluded by it or managed care rules
- Members will be liable for claims incurred on benefits falling outside the benefit schedule
- Benefit confirmation via pre-authorisation is required where indicated

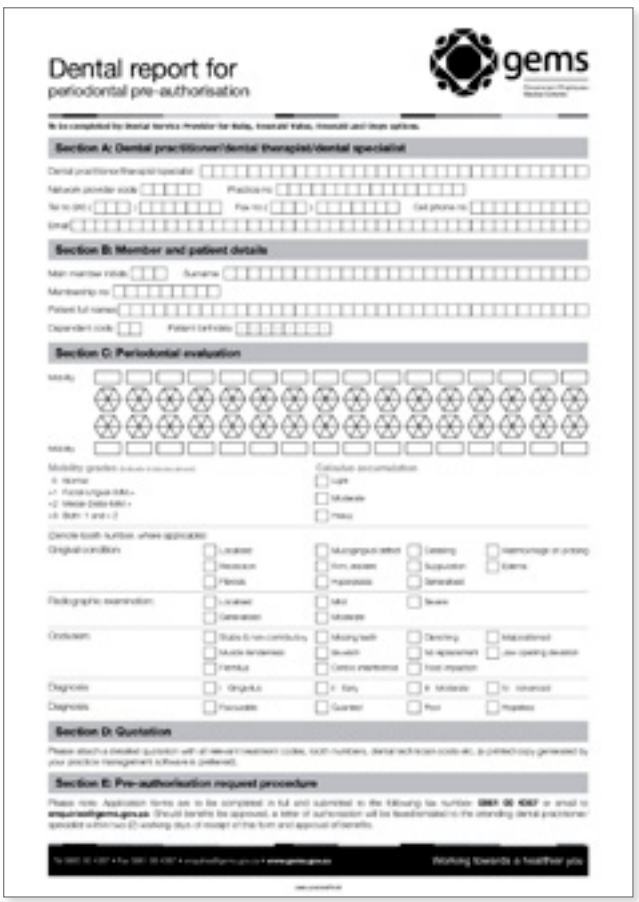
09 Ex Gratia

Application for an Ex Gratia consideration for benefits not covered may be lodged with the Scheme in accordance with Scheme rules

10 Forms

Example: Dental report for registration, pre-notification and pre-authorisation

(Forms are available at www.gems.gov.za. Email the completed form to enquiries@gems.gov.za or fax to 0861 00 4367).



Dental report for
periodontal pre-authorisation

gems

Section A: Dental practitioner/dental therapist/dental specialist

Section B: Member and patient details

Section C: Periodontal evaluation

Section D: Quotation

Section E: Pre-authorisation request procedure

Section E: Dental practitioner/dental therapist/dental specialist details

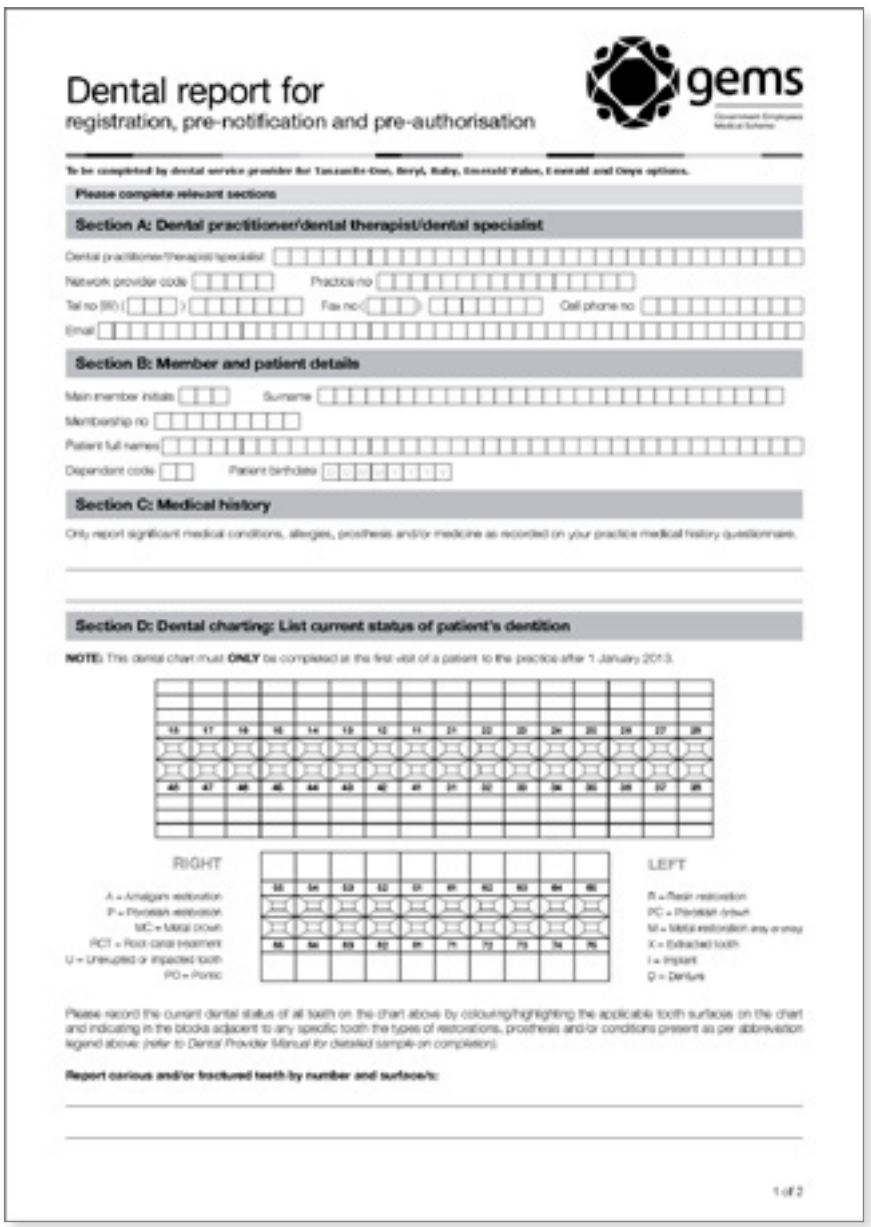
Section F: Intra- and extra-oral examination

Section G: Treatment plan and quotation

Section H: Pre-authorisation and pre-notification request procedure

Example: Dental report for periodontal pre-authorisation

(Forms are available at www.gems.gov.za. Email the completed form to enquiries@gems.gov.za or fax to 0861 00 4367).



Dental report for
registration, pre-notification and pre-authorisation

gems

To be completed by dental service provider for Tanzanite One, Beryl, Ruby, Emerald Value, Emerald and Onyx options.

Please complete relevant sections

Section A: Dental practitioner/dental therapist/dental specialist

Dental practitioner/Therapist/specialist
Network provider code
Practice no
Tel no (BH) ( )
Fax no
Cell phone no
Email

Section B: Member and patient details

Main member initials
Surname
Membership no
Patient full names
Dependent code
Patient birthdate

Section C: Medical history

Only report significant medical conditions, allergies, prostheses and/or medicine as recorded on your practice medical history questionnaire.

Section D: Dental charting: List current status of patient's dentition

NOTE: This dental chart must **ONLY** be completed at the first visit of a patient to the practice after 1 January 2013.

RIGHT

A = Amalgam restoration
P = Porcelain restoration
MC = Metal crown
RCT = Root canal treatment
U = Unerupted or impacted tooth
PO = Pontic

LEFT

R = Resin restoration
PC = Porcelain crown
M = Metal restoration any or may
X = Extracted tooth
I = Implant
D = Denture

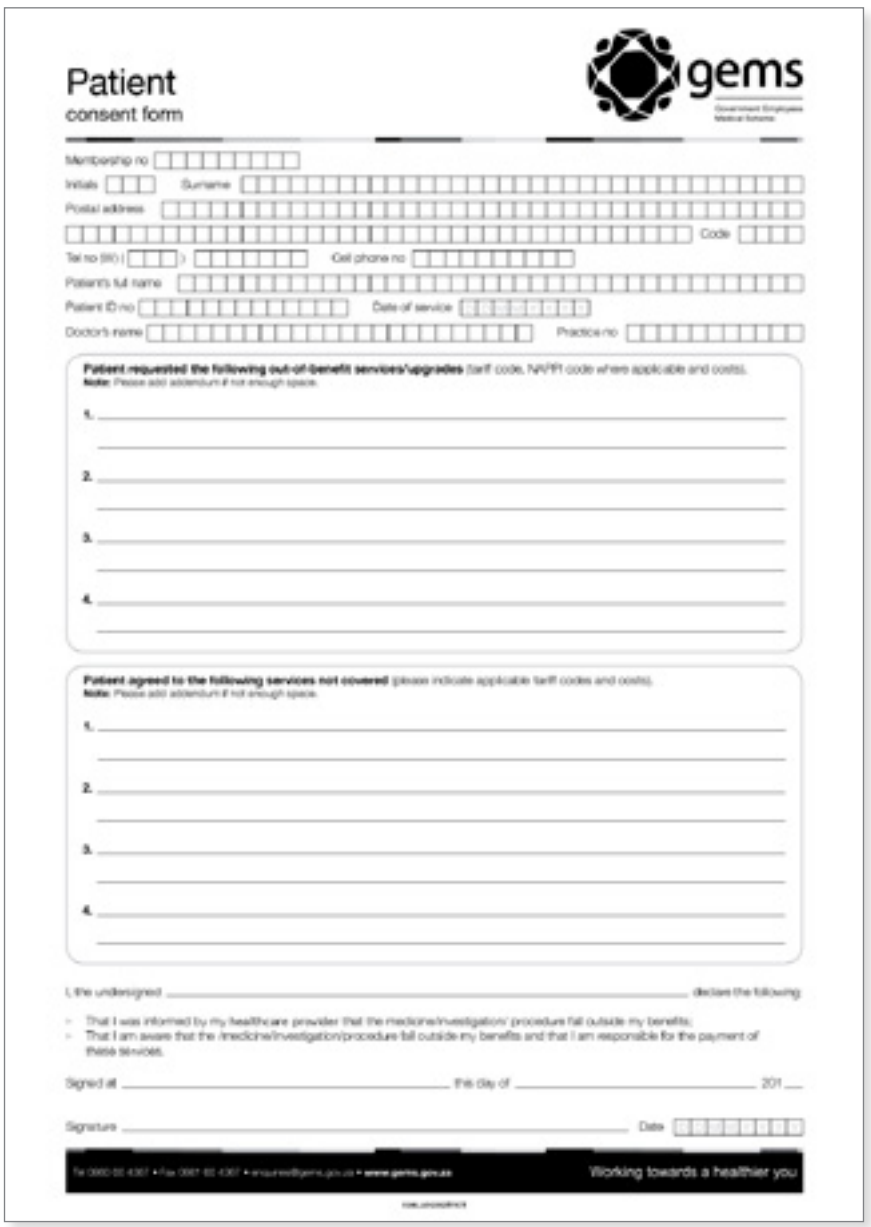
Please record the current dental status of all teeth on the chart above by colouring/highlighting the applicable tooth surface on the chart and indicating in the blocks adjacent to any specific tooth the types of restorations, prosthesis and/or conditions present as per abbreviation legend above: *(refer to Dental Provider Manual for detailed sample on completion).*

Report carious and/or fractured teeth by number and surface/s:

1 of 2

Example: Patient consent form

(Forms are available at www.gems.gov.za. Email the completed form to enquiries@gems.gov.za or fax to 0861 00 4367).



Patient
consent form

gems

Membership no

Initials Surname

Postal address

Code

Tel no (W) ( ) Cell phone no

Patient's full name

Patient ID no Date of service

Doctor's name Practice no

Patient requested the following out-of-benefit services/upgrades (tariff code, NAPPI code where applicable and costs).
Note: Please add addendum if not enough space.

1.

2.

3.

4.

Patient agreed to the following services not covered (please indicate applicable tariff codes and costs).
Note: Please add addendum if not enough space.

1.

2.

3.

4.

I, the undersigned declare the following:

- That I was informed by my healthcare provider that the medicine/investigation/ procedure fall outside my benefits;
- That I am aware that the /medicine/investigation/procedure fall outside my benefits and that I am responsible for the payment of these services.

Signed at this day of 201

Signature Date

Working towards a healthier you

Contact details

GEMS Contact Centre
0860 436 777

Web
www.gems.gov.za

Email
enquiries@gems.gov.za

GEMS Emergency Services
0800 444 367

HIV Aids Helpline
0860 436 736