COMPREHENSIVE
2019

topmed tm
medical scheme

content

abbreviations

AT	Agreed Tariff
CDL	Chronic Disease List
DSP	Designated Service Provider
TRP	Topmed Reference Price (generic & therapeutic substitution)
PAR	Pre-authorisation reference number
PAT	Pharmacy Advised Therapy
PMB	Prescribed Minimum Benefit
TT	Topmed Tariff is the rate that is applicable for the payment of benefits, including the National Health Reference Price List Rate or amended rate as published by Topmed or its agent from time to time
TTO	To Take Out

Scheme Policies and Protocols Apply Throughout

Disclaimer:

- *This is only a summary of the benefits and contributions. In the case of an error or dispute, the registered Rules will prevail. Effective from 1/1/2019*
- *Benefits subject to Council for Medical Schemes approval*

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medical scheme

WE KNOW YOU BETTER

At Topmed we have a number of unique benefits that will help you stretch your day to day benefits giving you more value and reassurance that your health really matters to us. This guide will inform you of the unique benefits available to you and your family.

students are rewarded

Young and growing minds are rewarded with a cheaper premium. We understand that studying and working doesn't always go hand in hand so to help our young minds stay healthy we have reduced their premiums as a helping hand. Dependants who are studying between the ages of 21 and 24 are rewarded with child rates.

wellness nurses

Just for being a Topmed member we have allocated a Wellness Nurse to you to keep track of your health journey. Your Wellness Nurse will be available to you when you need any health advice or a helping hand with managing your health needs.

Topmed's Wellness Nurses have your health and wellness needs at heart. Our aim is to transition your level of wellness to that of a higher level keeping your health optimal for a healthy life, the Topmed way. Our Nurses will guide you in the right direction in working with your basket of benefits from your chosen option and ensuring that your benefits are utilised effectively…consider your Wellness Nurse your wellness coach, let us guide you to the best version of you!

Our Nurses can assist you with:

- Identifying possible health risks through your claims history
- Assisting you with chronic registrations
- Provide education and counselling on your chronic conditions and assist you with accessing and utilising your treatment plan
- Assist you in managing your chronic condition to ensure optimal control
- Supporting you through a wellness transition
- Providing guidance through your wellness journey utilising your wellness benefits

Our Nurses are here for you, we know you better.

the more the merrier

At Topmed we know that looking after a big family can be expensive when it comes to Medical expenses. In order to assist our bigger families and to ensure that everyone can be covered we have limited the number of children that are charged a premium, we only charge to a maximum of 3 children and the rest are on us. Now the whole family can have cover.

corporate care

Healthy employees are happy employees! Topmed have a corporate offering for our employer groups with the goal to keep productivity flowing. Healthy employees are proven to be productive, so why not let Topmed do this for you. Topmed provides employment groups with a Wellness Nurse dedicated to your company to keep production at its peak with face to face interactions through on-site visits. Education, advice, assistance, counselling, queries, health risk assessments - we are here for your employees to help them manage their health without taking time off. We help them to help you.

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 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

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.

PLEASE 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.

TopBaby
topmed maternity programme

pregnancy care for mother and baby

At Topmed we understand that pregnancy is a very special time in your life and we want to ensure that you get the best care possible. With our TopBaby Maternity Programme not only are all your essential medical benefits covered but you get the added support of our in-house midwives who will contact you on a regular basis to offer advice, support and encouragement, and you will be continuously monitored throughout your pregnancy. (Refer to the option tables for benefits)

To enjoy this benefit, you are required to register on the programme when you are between 12 and 20 weeks in your pregnancy.

As a member of TopBaby you have the following benefits are available to you:

- Antenatal Consultations – 12 visits with your Gynaecologist, GP or Midwife payable at Topmed tariff.
- Scans – 2 2D scans payable at Topmed tariff
- Antenatal Classes – Prenatal classes with a registered nurse payable at Topmed tariff.
- Prenatal Vitamins – Access to a variety of prenatal vitamins as per the Topmed formulary.
- Immunisations – Covered for the first 6 years as per the Department of Health Protocols payable at Topmed tariff.
- Paediatrician Consultations – 2 consultations for the first year payable at Topmed tariff.

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
- GP, Gynaecologist or registered Midwife's name and surname
- GP, Gynaecologist or registered Midwife's practice number
- Expected date of delivery

oncology (cancer management)

It is important that prior to commencing active treatment for cancer, you are registered on the Oncology Disease Management Programme.

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 forward a treatment plan and the histology results to the Scheme's Oncology Department on auths@topmedms.co.za.
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 the 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.

BENEFIT OVERVIEW	
Pre-Authorisation and Treatment Plan	Yes
Cancer Treatment (Case Managed)	Limited to R628 848 pb per 12 month cycle, thereafter 20% co-payment
Speciality Medicines and biologicals	Sub-limit applicable
Surgery for your cancer	Pre-authorisation - part of Hospital Management
Bone marrow of stem cell transplantation	Benefit paid at 100% of TT subject to oncology limit
Donor searches	No benefit
PET Scans	One per annum for staging, thereafter clinical appropriateness
Bone Density Scans	One per annum if on aromatase inhibitors
Overall Limit	No

hiv / aids programme

At Topmed, we have been covering HIV/AIDS as a real benefit, including the provision of anti-retroviral treatment, (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 Wellness Nurses, together with a dedicated HIV/AIDS Programme Co-ordinator, 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
- 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
- Hospice care

If you or any of your beneficiaries are affected by HIV or AIDS, please contact the HIV Programme Co-ordinator 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: 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.

diabetes management programme

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

Our Programme:

- Identifies patients with diabetes and their co-morbidities.
- 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.

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 Nurses, and is designed to significantly improve the treatment and compliance of our members.

Benefits of the programme:

- Telephonic confidential support from qualified Psychiatric 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.

DISEASE MANAGEMENT

Disease Management is a holistic approach that focuses on the patient's disease or condition. Intervention takes place by means of patient counselling and education, behaviour modification, therapeutic guidelines, incentives and case management.

INTERNATIONAL BUSINESS & LEISURE TRAVEL INSURANCE

We are still watching over you while you are away.
Foreign claims are limited to medical expenses only as provided by the Scheme's policy, limited to R10 million per family per year, subject to authorisation and applicable conditions. Maximum of 90 days cover. Travel must be declared before departure.

EXTENDED MAJOR MEDICAL BENEFIT

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

This unique benefit allows members access to extended rehabilitation benefits for 5 major events, as outlined below, which are funded from the Major Medical Benefits portion and not from day-to-day benefits.

	BENEFITS
Post Total Hip Replacement Effective mobilisation after a hip replacement is always difficult yet critical to the success of this procedure.	8 physiotherapy sessions within 3 months after being discharged from the hospital. Once per annum (per hip)
Post Total Knee Replacement As with a hip replacement, effective mobilisation after a knee replacement is always difficult and at times painful, yet critical to the success of this procedure.	8 physiotherapy sessions within 3 months after being discharged from the hospital. Once per annum (per knee)
Heart Attack (Myocardial Infarction) A heart attack is caused by a blockage in the arteries supplying your heart muscle.	Subject to Case Management and must be prescribed by the treating cardiologist/physician
Post Crime Trauma This benefit is aimed at supporting you when you have been exposed to a traumatic crime-related incident. To access this benefit, you need to report the event at your nearest Police Station and obtain a Police Reference Number (MR Number).	**In the event of:** • a hijacking or attempted hijacking • attempted murder • assault or attempted assault, including sexual assault • robbery (including armed robbery) or attempted robbery Combined total of 12 consultations within 6 months post-event with a Psychologist, Psychiatrist or Social Worker
Stroke (Cerebro-vascular accident) A stroke occurs when the blood supply to the brain tissue is compromised - either by a blockage of a blood vessel or a brain haemorrhage.	Case Managed. Comprehensive rehabilitation programme including therapy from a multi-disciplinary team 3 months post-event (acute) with a Physiotherapist, Occupational Therapist and Speech Therapist

WELLNESS BENEFIT

Topmed's Wellness Benefits allows you access to certain preventative screening tests which are payable from Topmed's Major Medical Benefit, thus extending your day-to-day benefits.

Payable at 100% of Topmed Tariff

SCREENING BENEFIT (HEALTH ASSESSMENT)	AGE BAND	FREQUENCY
BMI	All adult beneficiaries	1 every year
Blood sugar test (finger prick)		
Blood pressure test		
Cholesterol test (finger prick)		

IMMUNISATION PROGRAMME	AGE BAND	FREQUENCY
Influenza Vaccination	All	1 every year
Baby Immunisation	Covered for the first 6 years of life	According to the Dept of Health protocols
Tetanus	All	As required
Pneumococcal	Beneficiaries aged 60 years and older, high risk individuals	1 every year

EARLY DETECTION TESTS	AGE BAND	FREQUENCY
General physical examination (at a GP) Tariff: 0190/0191/0192	Adults 30-59 years	1 medical examination every 3 years
	Adults 60-69 years	1 medical examination every 2 years
	Adults 70 years & older	1 medical examination every year
Pap smear Consultation Tariff: 0190/0191/0192	Females 15 years & older	1 every year
Pathology Test Tariff: 4566/4559		
Prostate Specific Antigen (PSA) Test (Pathologist) Tariff: 4519	Males 40-49 years	1 every 5 years
	Males 50-59 years	1 every 3 years
	Males 60-69 years	1 every 2 years
	Males 70 yrs & older	1 every year
Free Prostate Specific Antigen (Free PSA) Only if PSA is raised (Pathologist) Tariff: 4524	Males 40-49 years	1 every 5 years
	Males 50-59 years	1 every 3 years
	Males 60-69 years	1 every 2 years
	Males 70 years & older	1 every year
Only if finger prick is raised above 6mmol/L LDL - Tariff: 4026	All adult beneficiaries	1 every year
Basic total -Tariff: 4027		
HDL - Tariff: 4028		
Triglyceride - Tariff: 4147		
Lipogram - Tariff: 4025		
Only if finger prick is raised above 11mmol/L Blood sugar - Quantitative Tariff: 4057	All adult beneficiaries	1 every year
HIV Elisa Test Tariff: 3932	Beneficiaries 15 years and older	1 every year
Mammogram (Includes Sonar) Tariff: 34100/34101	Females 40 years and older	1 every 2 years
Bone Densitometry Tariff: 3604/50120/58531	Beneficiaries 50 years and older	1 every 3 years
Glaucoma test Tariff: 3002 /11202/ 11212 /3014	Beneficiaries 40-49 years	1 every 2 years
	Beneficiaries 50+ years	1 every year

OUR DESIGNATED SERVICE PROVIDER (DSP) NETWORKS

CHOSEN BY US TO ENSURE BEST USE OF YOUR BENEFITS

A Designated Service Provider (DSP) is a healthcare provider (doctor, pharmacist, hospital, etc) that has been chosen by your Scheme for the diagnosis, treatment or care of PMB conditions. A network is a defined group of providers (hospital groups, general practitioners, specialists, pharmacies, etc).

When a Scheme enters into a DSP Network agreement with providers, the providers commit to an agreed tariff and /or agree to the provision of services delivered according to Scheme protocols and formularies. The implementation of these networks is therefore to assist the Scheme in managing the costs of providing benefits, particularly within the context of managing PMBs, given the lack of any pricing guidelines in respect of provider fees.

Treatment of PMB conditions at a DSP will be covered in full by Topmed when delivered according to the Scheme protocols and formularies.If you choose not to use the DSP selected by Topmed, you may have to pay a portion of the bill as a co-payment. This could either be a percentage co-payment or the difference between the DSP's tariff and that charged by the provider you went to.

Topmed utilises DSP Networks in various ways, depending on your option and the particular benefit structure.

Pharmacy Network

Topmed currently has over a 1,000 pharmacies that form part of the Pharmacy Network which includes the major retail pharmacy groups (Clicks and Dischem), as well as various courier pharmacies such as Pharmacy Direct and Clicks Direct Medicines.

Should you obtain your PMB medication from a non-network provider you will receive a 70% benefit. If you are unsure of whether your pharmacy is on the network you may check by downloading the Pharmacy Network List from our website, www.topmed.co.za. If your pharmacy is not on the network and they would like to join they may contact us, and provided that they are willing to agree to the contractual terms, they may be added to our network.

Specialist Network

Topmed has a Specialist Network across all options in respect of in-hospital PMB benefits as well as CDL treatment plan benefits. Topmed will always pay your in-hospital costs at the Topmed tariff applicable to your option (for eg. 200% of TT if you're on the Executive Option). However, should you choose to use a provider that is not part of the DSP Network you may be liable to pay the difference between the Topmed Tariff and what your provider charges.

To assist you in this process, you will be advised upfront at the point of authorisation whether your provider is on the Network, giving you an opportunity to engage with your provider prior to being hospitalised or receiving treatment. Should you want to know whether your provider is a Network Specialist, visit our website: www.topmed.co.za or call Client Services on 0860 0021 58.

Please note that the Networks are updated on a regular basis, so before obtaining treatment, take the time to access the information on the website as noted above.

Members are required to make use of DSPs or Preferred Providers for specific benefits according to this table.
The details of the providers included in each of these networks are available on the website, www.topmed.co.za, or by calling Client Services on 0860 00 21 58.

Benefit Category	Does a DSP/Preferred Provider apply to the benefits listed below?
Hospitalisation	No
Specialist Consults and Services (PMB)	Yes
PMB CDLs - Treatment & Diagnostics	Yes
PMB CDLs - Medication	Yes
Day to Day Benefits	No
Optical	Yes
Ambulance and Emergency Services	Yes

prosthesis benefit

Internal Medical/Surgical Prostheses and Appliances

Internal Medical and Surgical Accessories - (including all components such as pins, rods, screws, plates, nails, fixation material or similar items forming an integral and necessary part of the device so implanted and shall be charged, where applicable, as a single unit) which are implanted during an operation into the body as an internal supporting mechanism and/or which for functional medical reasons are implanted as a prosthesis to replace parts of the body - Subject to pre-authorisation and Scheme negotiated price (Paid from Major Medical Benefits).

Cardiac/Vascular Prostheses and Appliances	
Stents (Cardiac Peripheral and Aortic)	100% of Cost up to R66 600 per beneficiary per year unless obtained at a Scheme DSP or in accordance with PMB Protocol.
Valves	
Pace Makers	
Implantable Defibrillators	
Joint Prostheses (maximum of one joint per beneficiary per year). Subject to failed conservative treatment and Risk Management.	
Hip, Knee, Shoulder or Elbow only	Up to R56 580 per beneficiary per year
Orthopaedic Prostheses and Appliances. (Subject to failed conservative treatment & Risk Management)	
Spinal fixation devices (max 2 levels unless motivated)	100% of Scheme Negotiated price up to R66 600 per beneficiary per year unless obtained at a scheme DSP or in accordance with PMB Protocol
Fixation devices – non spinal	
Bone Lengthening devices	
Implantable devices, disc prosthesis, Kyphoplasty	100% of Scheme Negotiated price up to R66 600 per beneficiary per year unless obtained at a scheme DSP or in accordance with PMB Protocol
Neuro Stimulators and Deep Brain Stimulators	Up to R39 960 per beneficiary per year
Internal Sphincters and stimulators	Up to R64 020 per beneficiary per year
Unspecified/Unlisted above	Up to R17 100 per procedure per year

chronic medicine benefit

The Chronic Medicine Benefit is a benefit that covers medicine for a specified list of conditions according to your option. 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 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.

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 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 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.

TOPMED COMPREHENSIVE

Topmed Comprehensive is for those with considerable healthcare needs. It offers Unlimited Private Hospital cover at up to 300% of the Topmed Tarriff (TT). Fully Comprehensive Out of Hospital cover is unlimited after Threshold and includes Unlimited Chronic benefits.

KEY CONSIDERATIONS

co-payments & 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 as listed below.

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.

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.

Co-Payments & Deductibles
MRI/CT Scans (in and out of hospital): R2 750 Scopes (in hospital): R2 750 Dentistry (in hospital): R1 800 Impacted wisdom teeth: R1 200

designated service provider (dsp) networks

Members are required to make use of DSPs or Preferred Providers for specific benefits according to the table on page 11.
The details of the providers included in each of these networks are available on the website, www.topmed.co.za, or by calling Client Services on 0860 00 21 58.

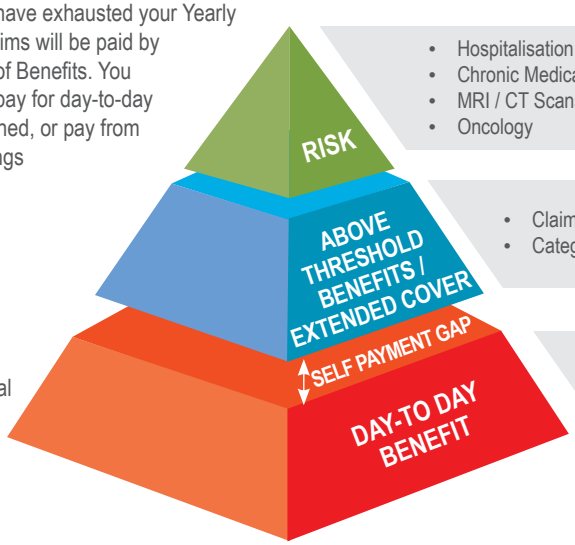
exclusions

Refer to the list of exclusions on page 23.

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.



- Hospitalisation
- Chronic Medication
- MRI / CT Scans
- Oncology

- Claims pay at 100% of TT
- Category limits apply before and after threshold

- Claims accumulate at 100% of TT.
- Claims pay at cost
- Certain claims do not accumulate

Annual Threshold Limit	Member: R13 740 Adult: R11 304 Child: R3 144
Above Threshold Benefits / Extended Cover	Specific sub-limits apply
Self-payment Gap	Member: R3 396 Adult: R2 544 Child: R852
Day-to-day Benefit	Member: R10 344 Adult: R8 760 Child: R2 292
IN HOSPITAL BENEFITS	
Pre-authorisation (PAR) is required in respect of hospitalisation and the associated clinical procedures before treatment starts. In case of an emergency, within the next two business days, otherwise no benefits are allowed.	
EXTENDED MAJOR MEDICAL BENEFIT	
Post-operative benefits available for the following: • Hip Replacement • Heart Attack • Stroke • Knee Replacement • Post-Crime Trauma	100% of TT (refer to page 9 for more details)
HOSPITALISATION	
Accommodation, theatre, medicine, material and hospital apparatus used during hospitalisation	Unlimited 100% of AT
Treatment of Immunocompromise and Opportunistic Infections irrespective of cause	100% of TT Limited to R49 404 per family per year
Psychiatric Hospitalisation (PAR required)	Benefits and treatment provided through Case Management Programme limited to 21 days per beneficiary per year
TTO (Medicine received on discharge from hospital)	100% of AT (TRP and formulary applies) maximum seven days supply
Specialised Surgery (New Technology) (PAR Required)	Limited to R334 224 per family per year. Managed Care protocols applicable
OUT-PATIENT TREATMENT AT HOSPITAL FACILITIES	
Trauma benefits only	100% of AT for facility fee 300% of TT for treatment delivered on the day of injury
MEDICAL PRACTITIONERS (in hospital)	
General Practitioners	300% of TT
Specialists (PMB DSP applies)	300% of TT
Associated clinical procedures (during authorised hospital treatment)	300% of TT
AUXILIARY SERVICES (during authorised hospital treatment)	
Blood transfusions	100% of Cost
Physiotherapy, speech therapy, occupational therapy, social workers and dieticians	100% of TT
Clinical technologists and medical technologists	100% of TT
Internal medical and surgical accessories (PAR required)	100% of Cost subject to sub-limits as applied per clinical protocols
Stomatherapy	Limited to R21 060 per family per year - PAR required if limit exceeded
DENTISTRY	
	100% of AT from Yearly Limit thereafter Extended Cover at 80% of TT. A co-payment of R1 800 for extractions and fillings for children under 6 years including dental clearance. Dental clearance limited to R28 296 pbpa
IMPACTED WISDOM TEETH (PAR required)	100% of TT subject to R1 200 co-payment
MAXILLO-FACIAL - subject to clinical criteria and limited to jaw fractures, congenital deformities and surgical treatment of pathological conditions	300% of TT
ORTHOGNATHIC SURGERY (PAR required)	100% of TT subject to 20% co-payment
SCOPES (PAR required)	
Gastroscopies and Colonoscopies	100% of TT subject to a R2 750 co-payment per scope. If performed in a day clinic/doctors rooms no co-payment applies

RADIOLOGY AND PATHOLOGY (during authorised hospital treatment)	
Basic radiology and pathology	100% of TT
MRI scans, CT scans, radioisotope studies (PAR required)	100% of TT subject to a R2 750 co-payment per scan
MATERNITY	
Confinement and Elective Ceasarean Section (PAR required prior to birth)	300% of TT
Home Births	Benefits are allowed in respect of home births, if a registered service provider assists with the birth
Neo-natal hospitalisation	Unlimited
MATERNITY PROGRAMME BENEFITS	
To enjoy this benefit you are required to register on the programme when you are between 12 and 20 weeks into your pregnancy. To register call the Call Centre on 0860 00 21 58. **Registration on the programme entitles you to:**	
Antenatal Consultations	300% of TT limited to 12 consultations
Antenatal Classes	300% of TT limited to 12 classes
Antenatal Scans (3D and 4D scans paid at 2D rate)	Limited to 2 2D scans per beneficiary per pregnancy
Paediatrician Consultations	Limited to 2 newborn visits
Prenatal Vitamins	Formulary applies
Baby Immunisations (Subject to Department of Health Protocols)	100% of TT
OTHER BENEFITS	
DISEASE MANAGEMENT / CASE 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. **PAR required for all of the below**	
AIDS and HIV infections	Benefits and treatment provided through Case Management Programme
Organ Transplants	
Kidney Dialysis	
Oncology	Benefits and treatment provided through Oncology Case Management Programme. R628 848 per beneficiary per 12 month cycle thereafter 20% co-payment. Speciality medicines and biologicals sub-limit of R355 944 per family per year with 20% co-payment (accrues to overall oncology limit of R628 848) Herceptin for early stage Breast Cancer no co-payment for 9 week course
AMBULANCE SERVICES 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.	
Preferred Provider ER 24 (084 124)	100% of AT
Non-preferred Provider	100% of TT limited to R2 460 per family per year.
SECONDARY FACILITIES	
Step-down nursing, hospice & rehabilitation	Benefits and treatment provided through Case Management Programme. Benefits for clinical procedures and treatments during a stay in a secondary facility will be limited to R146 712 per beneficiary per year
INTERNATIONAL BUSINESS & LEISURE TRAVEL INSURANCE	
Foreign claims are limited to medical expenses only as provided by the Scheme's policy, limited to R10 million per family per year, subject to authorisation and applicable conditions. Maximum of 90 days cover. Travel must be declared before departure.	
CHRONIC MEDICATION	
26 Chronic Disease List - PMB (TRP and formulary applies)	100% of AT from Yearly Limit at a DSP, thereafter unlimited from Extended Cover at 100% of AT
Non-PMB / Non-formulary / Non-DSP	70% of AT from Yearly Limit thereafter Extended Cover at 80% of TT
Extended Chronic Conditions	Unlimited

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DAY TO DAY BENEFITS - OUT OF HOSPITAL	
OUT-PATIENT TREATMENT AT HOSPITAL FACILITIES (Non Trauma)	Subject to day to day benefits
MEDICAL PRACTITIONERS AND SPECIALISTS	
Clinical procedures, visits (PMB DSP applies), material and injection material (excluding medicine) administered in a Provider's consulting room	100% of Cost from Yearly Limit, Self Payment Gap and thereafter 80% of TT from Extended Cover
ACUTE MEDICATION Benefits payable from Yearly Limit, once Yearly Limit is depleted and the Annual Threshold level is reached benefits are payable from Extended Cover at 80% of TT, subject to scheme approval.	
Prescribed Acute Medicine	100% of Cost from Yearly Limit, Self Payment Gap and thereafter 80% of AT from Extended Cover (TRP and formulary applies)
Vitamins and Minerals (does not accrue to threshold)	Member R2 748 Adult R2 268 Child R636
Non-prescribed schedule 1 and 2 medicine (PAT) supplied by a pharmacy (PAT does not accrue to Threshold)	100% of Cost from Yearly Limit, Self Payment Gap and thereafter 80% of AT from Extended Cover (TRP and formulary applies) Max of R180 per script
OPTICAL BENEFITS	
Managed by PPN	100% of Cost from Yearly Limit, Self Payment Gap and thereafter PPN rates from Extended Cover (PPN rates accrue to Threshold) Contact lenses limited to R2 556 per beneficiary per annum No benefit for both spectacles and contact lenses in the same year
DENTISTRY	
General and Specialised (PAR required for Specialised Dentistry)	100% of TT from Yearly Limit, Self Payment Gap and thereafter 80% of TT from Extended Cover limited to R25 380 per family per year.
Orthodontics	Restricted to beneficiaries 18 years and younger and 1 family member at a time

AUXILIARY SERVICES Benefits payable from Yearly Limit, once Yearly Limit is depleted and the Annual Threshold level is reached benefits are payable from Extended Cover at 80% of TT, subject to scheme approval.	
External medical and surgical appliances	100% of Cost from Yearly Limit, Self Payment Gap and thereafter 80% of TT from Extended Cover
Physiotherapy, occupational therapy, speech therapy, social workers and dieticians, podiatry, orthoptic treatment, audiometry, hearing-aid acoustics, biokinetics and consultations with chiropractors, osteopaths, homeopaths, naturopaths and herbalists	
Wheelchairs, Hearing Aids and External Prostheses (PAR required)	
Clinical and Medical Technologist	
RADIOLOGY	
Basic radiology	100% of Cost from Yearly Limit, Self Payment Gap and thereafter 80% of TT from Extended Cover
MRI scans, CT scans, radioisotope studies (PAR required)	100% of TT subject to a R2 750 co-payment per scan
PATHOLOGY	
	100% of Cost from Yearly Limit, Self Payment Gap and thereafter 80% of TT from Extended Cover
CLINICAL PSYCHOLOGY & PSYCHIATRIC TREATMENT	
	100% of Cost from Yearly Limit, Self Payment Gap and thereafter 80% of TT from Extended Cover
REPRODUCTIVE HEALTH	
Oral, injectable and IUD contraceptives	100% of Cost from Yearly Limit, Self Payment Gap and thereafter 80% of TT from Extended Cover (TRP and formulary applies)
PRESCRIBED MINIMUM BENEFITS (PMB's)	
Prescribed Minimum Benefits (PMB's) will be covered by Topmed both in the Public Healthcare System or Topmed's Designated Service Providers (DSP's). The treatment of PMB's includes chronic medication as well as the medical or surgical treatment of your PMB condition. The payment of all your PMB's requires authorisation and is subject to clinical protocols (inclusive of formularies for medicines) and must be obtained from Topmed's DSP's, failing which Topmed will only pay a 70% benefit for medicines and 100% of TT for all other benefits. Once any applicable limits are reached Topmed will continue to pay for your PMB's as per the above criteria	
* Note that all limits apply before and after the Threshold is reached. Benefits are payable from Savings, Self Payment Gap and thereafter from Extended Cover.	

2019 COMPREHENSIVE CONRIBUTIONS	Principal member	Adult dependant	Student/Minor dependant
	7 306	6 029	1 715

CONVENIENT,
EASY ACCESS
ANYTIME... ANYWHERE

go digital

Available on the App Store | Google Play

Topmed's self-service facilities on the Website and the Mobile App provide 24 hour access to important information regarding statements, savings balances and more.

REGISTER ONCE:
Use the same username and password to access the Website and the Mobile App

To access your information via the **website:**

1. Go to www.topmed.co.za and click on Login and click Member
2. To register click on New User and complete the details

To access your information on your **mobile device:**

1. To download the Mobile App go to Google Play or the AppStore
2. Search for Topmed Medical Scheme and click Install
3. To register for a username and password click Register

Our online Self-Service functionalities allows you to:

Request a new card
With just a click of a button you can request a new membership card that will be sent to the address on your profile.

Benefits & Savings
Easy to read information on your benefits and savings balances and important information regarding access to benefits.

Request a Document
If you require a copy of your Membership Certificate or Tax Certificate simply select the document that you need, click OK and it will be emailed to you.

Document download
Download or view copies of your claims statements and billing statements.

Update your profile
Update your contact information online and stay up to date with communication regarding your membership.

Find a network doctor
Use your GPS location or home address to find a nearby contracted General Practitioner or Specialist

Submit a claim
Take a photo of your claim or document and submit via the App

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	CALL A DEDICATED WELLNESS NURSE	FOR ESCALATED QUERIES
• Claims payment and accounts • Benefits • Contributions • New cards • Underwriting • Contact details • Designated Service Provider • Formularies	• Health Advice • HIV • Maternity Programme • Ex-Gratia • Medical Queries • Protocol for PMB, Chronic Benefit, Investigation and Procedures	Operations Manager or Administrator's Chief Executive Officer

CONTACT
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

exclusions

GENERAL EXCLUSIONS

The following are General Exclusions and also are applicable to the Medical Savings Accounts:

- Examinations for testing of eyes or vision by somebody other than an eye specialist or registered optometrist, and the cost of any instrument other than spectacles or contact lenses
- Travel costs – which exceed the limits of Rule P of the NHRPL.
- Applicators, toilet preparations and cosmetics
- Holidays for recuperative purposes
- Accommodation in old-age homes and similar institutions, frail care and long-term care
- The difference between TRP and the cost charged for Medicine subject to Regulation 15I (c)
- Non-prescription sunglasses
- Costs rejected by the Scheme, due to them being fraudulent or not clinically indicated or medically necessary, as indicated by the Scheme's clinical auditing company
- The exclusions set out in 4.1, as well as the following General Exclusions apply to Annexures B01 and to the Major Medical Benefits and Threshold Cover (where applicable) in Annexures B02 – B08:
- Substance dependency – unless treatment forms part of a Case Management Programme and PMB's
- Bandages, cotton wool, plasters and other household first-aid items – unless these are supplied during a stay in Hospital
- Examinations for insurance, employment, lawsuits and similar purposes
- Cosmetic and reconstructive surgery, including for protruding ears, according to the Member's or Dependant's own choice, or recommended for psychological reasons only – and any complications resulting from such surgery
- Beauty treatments and beauty preparations and cosmetics
- Examinations and/or treatment where no real or supposed illness exists and/or recommended for psychological reasons only, except for PMB treatment.
- Medicine for erectile dysfunction, except for PMB treatment.
- Artificial insemination and treatment of infertility other than what is stipulated in explanatory note 9 for DTP 902M.
- Marriage therapy
- Birth control, except oral, injectable and IUD contraceptives
- Breathing exercises, pre- and post-natal exercises, group exercises or fitness tests
- Treatment of obesity
- Telephone consultations
- Services of social workers, unless forming part of a Case Management Programme
- Fees for medical reports
- All desensitization treatment and ALCAT allergy tests
- Sclerotherapy treatment, unless a vascular surgeon is responsible for the treatment where it forms part of the surgical removal of vascular veins
- Treatment of kelloids (except in the case of burns or functional impairment, dependent on a PAR).
- Refractive surgery
- Functional reconstruction of palate and uvula (uvulopalatopharyngoplasty)
- Injuries due to professional sports subject to PMB (except on Active Saver option)
- Acupuncture, Aromatherapy and Reflexology
- Treatment forming part of clinical trials or experimental drugs
- All associated costs for elective hip/knee replacements on the Network, Essential and Active Saver options only (unless as a result of immediate trauma requiring emergency PMB treatment).
- Any cost related to the use of modifier 0018 (Modifier for patients with BMI over 35) unless clinically motivated and not charged in conjunction with Rule J.
- Costs related to Surrogacy Agreements, including all pre-natal care, maternal care and confinement.
- Booking and Birthing Fees
- Admissions for diagnostic testing where no diagnostic test results are available at the time when a patient presents for admission into hospital.

EXCLUSIONS APPLICABLE TO BASIC AND SPECIALISED DENTISTRY

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

- Ozone therapy
- Orthognathic (jaw corrections) surgery and the related hospital cost (except on the Comprehensive option)
- Snoring appliances
- Cost of Mineral Trioxide
- Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments
- Oral and/or facial image (Digital/conventional)
- Microbiological studies
- Caries susceptibility test
- Pulp test
- Occlusion analysis mounted
- Pantographic recording
- Electrognathographic recording without/with computer analysis
- Polishing – complete dentition
- Removal of gross calculus
- Topical application of fluoride - adult
- Nutritional and Tobacco counselling
- Resin crown – anterior – anterior primary tooth (direct)
- Gold foil class I-V
- Inlays/Onlays
- Crown ¾ cast metal/porcelain/ceramic
- Provisional crown
- Veneers
- Prefabricated metal or resin crown
- Re-burnishing and polishing of restorations – complete dentition.
- Carve restoration to accommodate existing clasp or rest
- Pedicle flapped graft
- Cost of bone regenerative/repair material
- Interim, partial or complete denture
- Diagnostic denture
- Locks and milled rest
- Precision attachment
- Metal base to complete denture
- Remount crown or bridge for prosthetics
- Altered cast technique
- Additive partial denture
- Connector bar – implant supported
- Clasp or rest – stainless steel
- Stress breaker
- Coping Metal
- Ortho Tx-fixed lingual orthodontics
- Therapeutic drug injection
- Bleaching
- Special report
- Appointment not kept/30min
- Sedative filling
- Behaviour management
- Implants and all associated costs (except on the Comprehensive option)
- General anaesthetic for beneficiaries from 7 years of age

EXCLUSIONS APPLICABLE TO OPTICAL BENEFITS

- Adjustment of frames
- Fitting of contact lenses
- Coloured /tinted contact lenses
- Sunglasses or tinted lenses
- Contact lens solutions
- Hard coating and other extras

EXCLUSIONS APPLICABLE TO ACUTE MEDICATION

- Patent, patent preparations and household remedies (unless listed on the Essential Drug List and part of PMB level care).
- Patent food-stuffs, including baby food and special formulae (unless listed on the Essential Drug List and part of PMB level care).
- Tonics, nutritional supplements, multi-vitamin preparations and vitamin combinations, except for prenatal, lactation and pediatric use (except on the Comprehensive, and Active Saver options) (unless listed on the Essential Drug List and part of PMB level care or clinically appropriate to correct a vitamin or mineral defficiency).
- Slimming preparations
- Birth control preparations, except oral and injectable contraceptives and IUD's
- Anti-smoking preparations
- Surgical appliances and devices unless based on EBM protocols
- Medicine used specifically to treat alcoholism, except if used as part of a beneficiary's rehabilitation treatment at a recognised facility
- The purchase of oxygen delivery systems
- Aphrodisiacs
- Anabolic steroids
- Sunscreens and tanning agents including emollients and moisturisers
- Cosmetic preparations, soaps, shampoos and other topical applications medicated or otherwise except for the treatment of lice, scabies, and other parasitic and fungal infections
- Single or combined mineral preparations, except for calcium preparations with 300mg or more of elemental calcium used for the prevention and treatment of osteoporosis and potassium when used in conjunction with a diuretic (except on the Comprehensive, and Active Saver options) (unless listed on the Essential Drug List and part of PMB level care).
- Contact lens preparations
- Preparations not easily classified
- Stimulant laxatives
- Treatment of erectile dysfunction, e.g. Sildenafil and/or similar remedies
- Injection material, unless prescribed and part of a PMB treatment plan.
- Biological Drugs unless part of a Disease Management Programme and subject to Clinical Protocols and subject to Regulation 15H (c) and 15I (c).

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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 email: chronic@topmedms.co.za
Case Management or Disease Management Programmes	Tel: 0860 00 21 58 Fax: 086 762 4050
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
Council for Medical Schemes	Tel: 012 431 0500 Fax: 012 431 0680 email: support@medicalschemes.com Website: www.medicalschemes.com

EMERGENCY MEDICAL CARE
ER24
084 124

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.