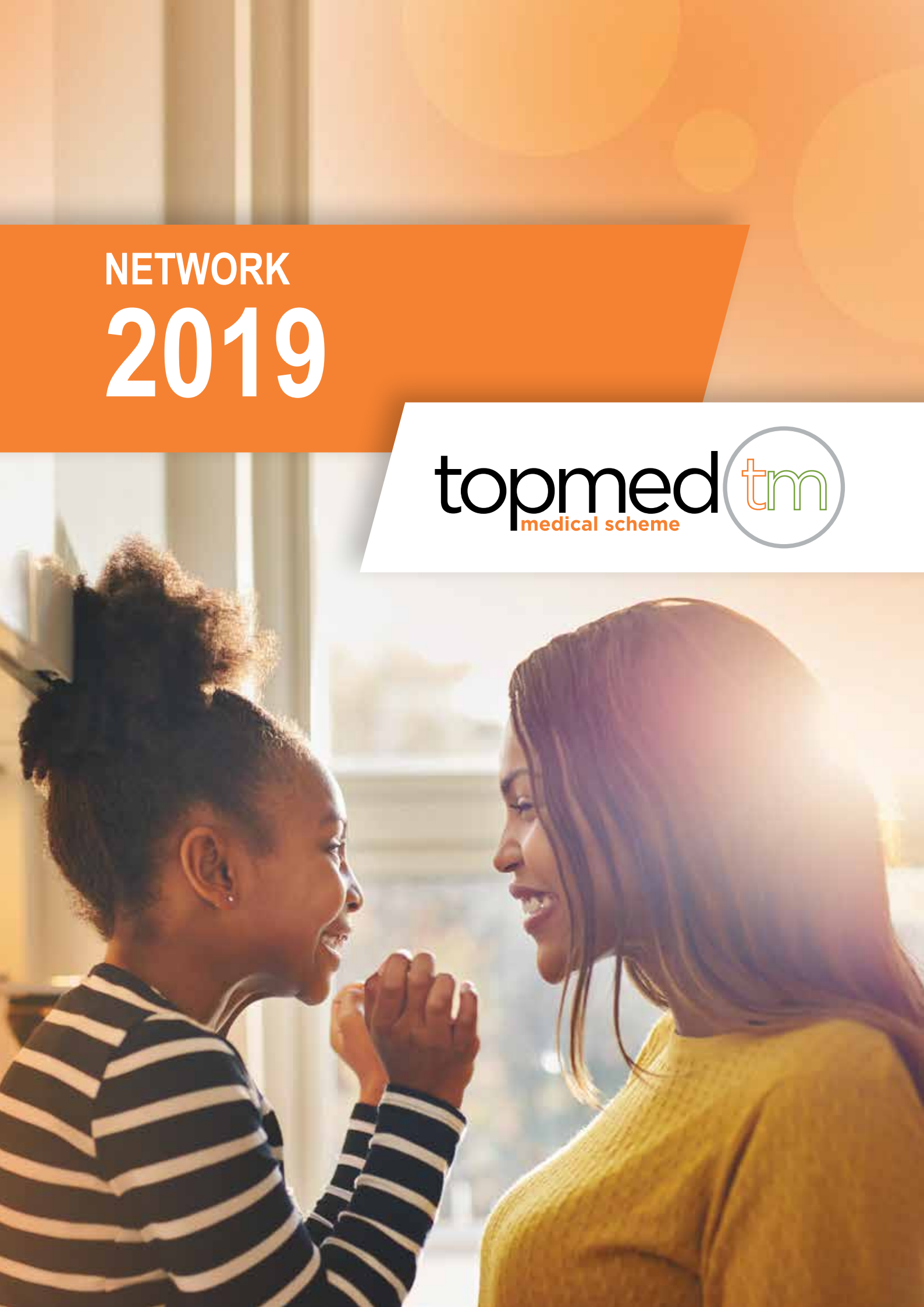
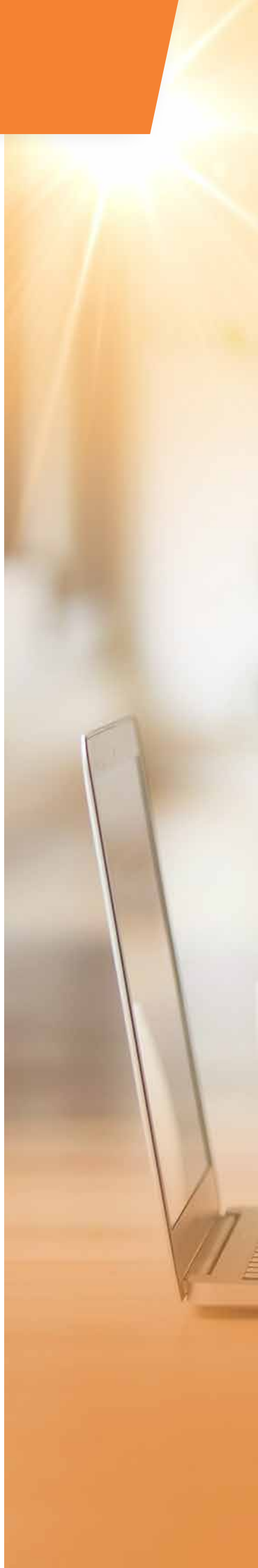
# NETWORK 2019

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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# 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.

## 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.

## 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.

## 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.

# 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 PMB |
| Speciality Medicines and biologicals | No benefit |
| Surgery for your cancer | Limited to PMB |
| Bone marrow of stem cell transplantation | Limited to PMB |
| Donor searches | No benefit |
| PET Scans | Limited to PMB |
| Bone Density Scans | Limited to PMB |
| Overall Limit | Limited to PMB |

# 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.

# 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 | Yes |
| Specialist Consults and Services (PMB) | Yes |
| PMB CDLs - Treatment & Diagnostics | Yes |
| PMB CDLs - Medication | Yes |
| Day to Day Benefits | Yes |
| 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) | Limited to PMB |
| 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 | Limited to PMB |
| Orthopaedic Prostheses and Appliances. (Subject to failed conservative treatment & Risk Management) | |
| Spinal fixation devices (max 2 levels unless motivated) | Limited to PMB |
| Fixation devices – non spinal | |
| Bone Lengthening devices | |
| Implantable devices, disc prosthesis, Kyphoplasty | |
| Neuro Stimulators and Deep Brain Stimulators | |
| Internal Sphincters and stimulators | |
| Unspecified/Unlisted above | |

# 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.

# chronic disease list

Please refer to the table below for chronic condition cover on all options. Please note that these are only applicable whilst your Chronic Medicine Benefit Limits are available

| **25** PMB Conditions |
|---|
| Addison's Disease |
| Asthma |
| Bronchiectasis |
| Cardiomyopathy |
| Chronic Renal Failure |
| Cardiac Failure |
| Chronic Obstructive Pulmonary Disorder (COPD) |
| - Emphysema |
| Coronary Artery Disease |
| - Ischaemic Heart Disease |
| Crohn's Disease |
| Diabetes Insipidus |
| Diabetes Mellitus (Type I and II) |
| Dysrhythmias |
| - Ventricular Tachycardia |
| - Arterial Fibrilation Flutter |
| Epilepsy |
| Glaucoma |
| Haemophilia |
| Hyperlipidaemia |
| Hypothyroidism |
| Hypertension |
| Multiple Sclerosis |
| Parkinson's Disease |
| Psychiatric Disorders |
| - Bipolar Mood Disorder |
| - Schizophrenia |
| Rheumatoid Arthritis |
| Systemic Lupus Erythematosis |
| Ulcerative Colitis |

# TOPMED NETWORK

The Network option is an exceptionally affordable medical aid option designed to cover the Primary Care Needs of the younger family. Cover is through a defined network of providers. To make it even more affordable, contributions are income based.

## KEY CONSIDERATIONS

### hospitalisation

- Exclusions apply
- Admission via Network GP and/or Specialist
- All Hospital and In Hospital Specialist claims must be submitted to: P.O. Box 1462, Durban, 4000 or claims@topmedms.co.za

**Ambulance / ER24 (084 124)**

**In Hospital Procedures and Consults**
Subject to using the Network Specialists
Limited to PMB

**X-Rays**
Limited to PMB

**Blood Tests**
Limited to PMB

**In-Hospital Benefit at DSP Network Hospitals and Day Clinics**
(Pre-authorisation is required)

**Call Topmed on 0860 00 21 58 for Hospital Authorisation**

| 2019 PREMIUMS | CONTRIBUTION | | |
|---|---|---|---|
| **Income** | Principal member | Adult dependant | Student/Minor dependant |
| **< R1 000** | 381 | 381 | 381 |
| **R1 001 to R11 000** | 1 530 | 1 530 | 428 |
| **> R11 000** | 2 068 | 2 068 | 554 |

## day-to day benefits

**Out-of-Hospital Specialist Benefit**
(Limited to R1 584 per family and subject to referral from a Network GP to a Network Specialist.)

**Doctor Visits**
Consultations - Limited to 2 GP consultations pbpa (excluding CDL treatment plan consultations and emergency GP visits) Additional consultations subject to clinical protocol and PAR

**X-Rays Basic Only** - as per a formulary list.
Must be requested by the Network GP.

**Blood Test Basic Only** - as per a formulary list.
Must be requested by the Network GP.

**Basic Dentistry**
Primary Extractions
Fillings, Sepsis, Flouride Treatment, Cleaning.
One set of plastic dentures every 24 months (Subject to Network protocols and use of a Network Dentist)

**Medication**
Prescribed by the Network GP and dispensed by the Network GP or pharmacy.
Acute Medication to be obtained from your Network doctor.
PAT limited to R228 per year max of R76 per event (max. of 3 events per year).
Approved Chronic Medication prescribed by your Network provider and obtained or delivered by a Network pharmacy.

**Optical**
1 consultation per beneficiary per annum.
1 pair single/bi-focal white lenses every 24 months -
Subject to Network protocols and use of a Network Provider.

**Your Network GP is the key to your day-to-day benefits.**
**All services to be obtained via the Network of Providers**

**For any queries call Topmed on 0860 00 21 58 or e-mail info@topmedms.co.za**

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| IN HOSPITAL BENEFITS | |
|---|---|
| Note: Hospitalisation is limited to PMB only. Subject to referral from a Network GP and/or Specialist<br><br>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. | |
| **HOSPITALISATION** | |
| Accommodation, theatre, medicine, material and hospital apparatus used during hospitalisation. | **Limited to PMB only**<br>DSP Hospital - 100% of AT<br>Non DSP Hospital - 75% of AT<br>(Involuntary use of Non DSP Hospital / Day Clinic for PMB's - 100% of AT) |
| **Treatment of Immunocompromise and Opportunistic Infections** irrespective of cause | 100% of TT<br>Limited to R49 404 per family per year |
| **Psychiatric Hospitalisation** (PAR required) | Benefits and treatment provided through Case Management Programme limited to PMB |
| **TTO** (Medicine received on discharge from hospital) | No benefit |
| **MEDICAL PRACTITIONERS** (during authorised hospital treatment) | |
| Admission via Network GP or Specialist | 100% of TT |
| Admission via a non-network GP or Specialist | 70% of TT |
| Associated clinical procedures | 100% of TT (70% of TT for non-network GP or Specialist)<br><br>(Deductibles, specific limits and exclusions apply to certain procedures) |
| **RADIOLOGY AND PATHOLOGY** (during authorised hospital treatment) Radiology and pathology) | |
| MRI scans, CT scans, radioisotope studies (PAR required) | Limited to PMB only |
| **AUXILIARY SERVICES** (during authorised hospital treatment)<br>No referral required from a medical practitioner for auxiliary services, except in respect of external medical and surgical accessories. | |
| Blood transfusions | 100% of Cost |
| Internal medical and surgical accessories | Limited to PMB only |
| Physiotherapy, speech therapy, occupational therapy, social workers and dieticians | Limited to PMB only |
| Clinical and Medical Technologists | Limited to PMB only |
| **DENTISTRY** | |
| No Benefit | |
| **SCOPES** (PAR required) | |
| Gastroscopies and Colonoscopies | Limited to PMB only |
| **OTHER BENEFITS** | |
| **CONFINEMENTS** | |
| Benefits as described in respect of medical practitioners and hospitalisation. Benefits are limited to 1 confinement per family per year in a DSP Network Hospital | |
| Benefits are also allowed in respect of:<br>• Home births provided a registered service provider assists with the birth<br>• Pregnancy tests and family planning (excluding contraceptives) if provided by the Primary Healthcare Provider<br>• Pre and postnatal care, including 1 first trimester sonar scan if provided by the Primary Healthcare Provider. | |
| **DISEASE MANAGEMENT / CASE MANAGEMENT**<br>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. | |
| Organ transplants and kidney dialysis (PAR required) | Benefits and treatment through Case Management Programme limited to PMB |
| Oncology | Benefits and treatment through Oncology Case Management Programme limited to PMB |
| **AMBULANCE SERVICES**<br>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.<br>Limited to PMB only |
| **CHRONIC PMB MEDICATION** | |
| Subject to registration and approval according to the Chronic Medicine Formulary<br>Medication to be supplied by Network Provider as arranged with the beneficiary or supplier | |
| **OPTION SPECIFIC EXCLUSIONS** | |
| Injuries sustained during participation in a strike, picketing or riot, or during a physical struggle | |

# NETWORK - SUMMARY OF BENEFITS

| DAY-TO-DAY BENEFIT | |
|---|---|
| **MEDICAL PRACTITIONERS** | |
| **Network GP** | Basic primary care including specified minor trauma treatment. Limited to 2 GP consultations pbpa (excluding CDL treatment plan consultations and emergency GP visits). Additional consultations subject to clinical protocols and PAR. |
| **Maternity (GP)** | Pre and Postnatal Care limited to the supervision of uncomplicated pregnancy up to Week 20 including 1 first trimester scan |
| **General Practioners** (Out of Network) - Emergencies Only | Limited to 3 visits per family per year to a maximum of R1 308 per family per year<br>No benefit for facility fees<br>Only emergencies and after hours services<br>**The member will be required to pay for the services and submit the claim for reimbursement** |
| **Emergency GP Visits** | Unlimited outpatient or emergency visits at a **public hospital** subject to criteria and definition of an emergency medical condition |
| **Specialist** (out of hospital)<br>Subject to pre-authorisation and referral from a Network GP to a Network specialist. | 100% of AT<br>Limited to R1 584 per family<br>Any radiology or pathology called for by the Network Specialist will also be paid from this benefit |
| **MEDICATION** | |
| **Acute Medication**<br>(Subject to the acute medicine formulary) | As dispensed by a Network General Practitioner or pharmacy according to the acute medicine formulary |
| **PAT Medication**<br>(Over the counter medicine) | R228 per family per year subject to a maximum of R76 per script<br>100% of TT (TRP and formulary applies) |
| **DENTISTRY** (services rendered by a Network Provider) | |
| Basic Dentistry | Subject to protocols, consultations, primary extractions, fillings, scaling and polishing<br>1 set of plastic dentures per family per 24 month cycle limited to beneficiaries over the age of 21 |
| Specialised Dentistry | Root canal treatment, crowns and other advanced dentistry are not covered |
| **OPTICAL** | |
| Services rendered by a Network Provider<br>Benefit is available per beneficiary per 24 months subject to protocols | 1 optical test per beneficiary<br>1 pair of white standard monofocal, bifocal lenses or multifocal lenses to the limit of bifocal lenses in a standard frame from a selection **OR** contact lenses to the value of R588<br>A benefit of R150 will be paid toward frames selected from outside of the Network provider range |
| **AUXILIARY SERVICES** (not during hospitalisation) | |
| External medical and surgical appliances | Limited to PMB only |
| Physiotherapy, speech therapy, occupational therapy (not during hospitalisation), podiatry, orthoptic treatment, audiometry, hearing-aid acoustics, biokinetics, dieticians and consultations with chiropractors, osteopaths, homeopaths, naturopaths, herbalists and social workers | No benefit |
| Clinical and Medical technologist | No benefit |
| **RADIOLOGY AND PATHOLOGY** | |
| **Radiology** (must be referred by a Network GP) | Basic x-rays as requested by your Network General Practitioner and subject to protocols |
| **Pathology** (must be referred by a Network GP) | Basic blood tests as requested by your Network General Practitioner and subject to protocols |
| **CLINICAL PSYCHOLOGY** | |
| No benefit | |
| **PSYCHIATRY** | |
| Limited to PMB only | |
| **PREVENTATIVE CARE (BABY IMMUNISATIONS)** | |
| Immunisations are paid according to the standard practices of the Department of Health when and where available. Benefits include education, information and guidance received from the Primary Healthcare Provider | |
| **REPRODUCTIVE HEALTH** | |
| Pregnancy tests and family planning sessions (excluding contraceptives) and pre-natal care and 1 sonar per pregnancy during the first trimester are covered if provided by Primary Healthcare Provider | |
| **HIV/AIDS** | |
| Subject to authorisation from the Primary Healthcare Provider and clinical protocols. Benefits and treatment provided through Case Management Programme. Limited to PMB. | |
| **PRESCRIBED MINIMUM BENEFITS (PMB's)** | |
| Prescribed Minimum Benefits (PMB's) will be covered by Topmed both in the Public Healthcare System or through 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. Please note that only your Primary Healthcare Provider may authorise and provide for your chronic medication and the medical treatment in respect of your PMB Chronic Conditions and HIV/AIDS treatment. 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 75% of TT for hospitalisation. Once any applicable limits are reached Topmed will continue to pay for your PMB's as per the above criteria. | |

# NETWORK OPTION FAQ'S

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

### Who are the Primary Healthcare Providers on Topmed?
Topmed has appointed a countrywide network of doctors, dentists and optometrists to render primary healthcare services to members on the Network option.

To locate your nearest Network provider, please log onto www.topmed.co.za or use Topmed's Mobile Application which can be downloaded from Google Play or the AppStore.

### What are my benefits at a Network General Practitioner?
In his treatment, the Network GP may:
- Provide you with acute medication according to a medicine list
- Register you for chronic medication for a specific condition and according to a medicine list
- Perform some minor surgical procedures in the rooms
- Call for listed blood tests and x-rays
- Offer pre and post-natal care including one ultrasound scan in the first trimester per pregnancy.

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

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

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

### Do I and my dependants have to visit the same Network-contracted GP?
No, each of you can choose the Network GP that is nearest to you. It is important that once you choose a GP that you are comfortable with, that you continue to consult with your chosen GP only. This is the best way for your health to be managed effectively.

### What must I do in an after hours emergency or if I am on holiday and not close to the Network Provider I selected?
- Your benefits make provision for after hours emergencies or visits outside of the Network. This benefit is limited  You have the following options:
  - » You may visit any GP close to you
  - » Alternatively, you may go to an emergency room at the nearest private or public hospital.
- Please note that you will have to pay upfront for these services obtained outside of the Network.
- You may, however, claim back the costs from Topmed subject to the benefit limit and Topmed rates.

### Will I have to pay when visiting Network providers?
No, as long as your contributions have been paid. However, sometimes you may require medication, blood tests or x-rays that are not covered under your Network option. Your GP will inform you when you require such treatment and you will have to pay for these yourself.

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

### What Specialist Benefits are provided?

- The Specialist benefit is limited (refer to the Network Benefits on page 30).
- Specialist services are subject to referral by a Network GP to a Network Specialist and obtaining a pre-authorisation.
- Any radiology or pathology called for by the Network Specialist will also be paid from this benefit.

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

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

Hospital benefits are limited to PMB's only. If you and/or any of your dependants have to be admitted to hospital, you must obtain an authorisation (PAR) by contacting 0860 00 21 58. Topmed will pay the cost of your hospitalisation, and the costs of the treatment you receive whilst in hospital at 100% of the agreed tariff if you were referred by the Network GP or Specialist and your admission is in respect of a PMB diagnosis. If your provider is not a Network Provider, Topmed will pay 70% of the TT, and you will be required to pay the balance to your provider.

**PLEASE NOTE: Hospitalisation is limited to PMB only**

### What must I do in case of an emergency?

If in an emergency you are unable to obtain authorisation prior to being rushed to hospital, for example in the case of an accident, you and/or your family have two working days from the time that you are admitted to inform Topmed that you are in hospital.

### How are my claims paid?

- Services rendered at Network providers:
  - The provider will send the account directly to Topmed.
- Services rendered at a Specialist (out-of-hospital):
  - This account must be submitted to Topmed.
- Services rendered at a hospital:
  - Submit hospital-related claims to Topmed.

**PLEASE NOTE: All claims must reach Topmed for payment within 4 months from the end of the month in which treatment was rendered. After these 4 months, the claims become stale and will no longer be paid by Topmed.**

### Are benefits allowed in respect of foreign claims?

No.

### Is HIV/AIDS covered?

Yes. The HIV/Aids Programme assists members living with HIV/Aids to access quality care and to make optimal use of the benefits available to them. The programme will include the necessary pathology tests, anti-retroviral medication (if required), doctor's consultations, information, counselling and advice.

To access these benefits call 0860 448 2273 to register on the programme. This is a fully confidential line.

### Are dialysis and organ transplants covered?

These condition are covered subject to Prescribed Minimum Benefits (the minimum benefits Topmed is compelled to offer in terms of the Medical Schemes Act, 1998).

### Are benefits paid for confinements?

Yes, but benefits are limited to one confinement per family per year and the mother must obtain pre-authorisation for the admission, within 24 - 48 hours of the admission.

### Important things to remember

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

# 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<br>• Benefits<br>• Contributions<br>• New cards<br>• Underwriting<br>• Contact details<br>• Designated Service Provider<br>• Formularies | • Health Advice<br>• HIV<br>• Maternity Programme<br>• Ex-Gratia<br>• Medical Queries<br>• Protocol for PMB, Chronic Benefit, Investigation and Procedures | Operations Manager<br><br>or<br><br>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:

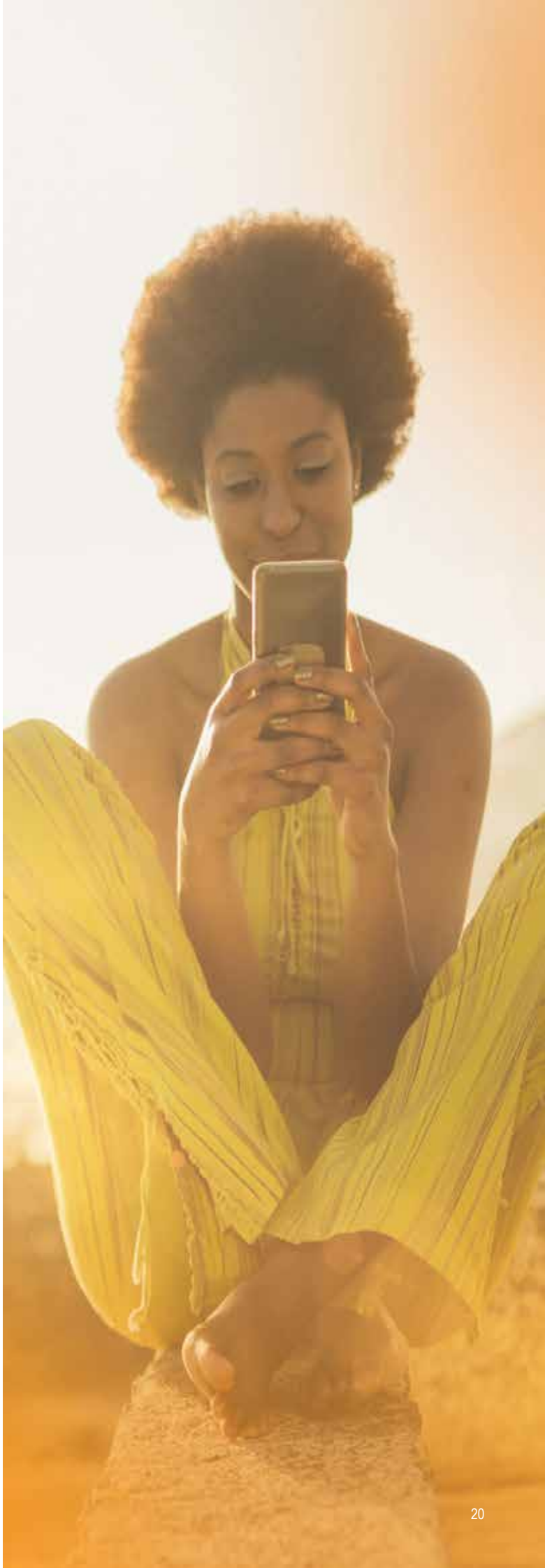
- Ozone therapy
- Orthognathic (jaw corrections) surgery and the related hospital cost (except on the Comprehensive option)
- Snoring appliances
- Cost of Mineral Trioxide
- Cost of prescribed toothpastes, mouthwashes (e.g. Corsodyl) and ointments
- Oral and/or facial image (Digital/conventional)
- Microbiological 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<br>International: 087 740 2899 (for calls outside SA)<br>email: info@topmedms.co.za<br>Fax: 086 762 4050 |
| Hospital Pre-Authorisation | Tel: 0860 00 21 58 |
| Chronic Medication | Tel: 0860 00 21 58<br>Fax: 086 762 4050<br>email: chronic@topmedms.co.za |
| Case Management or Disease Management Programmes | Tel: 0860 00 21 58<br>Fax: 086 762 4050 |
| ER24 (Emergency Assistance)<br>If you need an ambulance or Assistance Hotline<br>For claims enquiries | <br>Tel: 084 124<br>Tel: 0861 084 124 |
| Preferred Provider Negotiators (PPN)<br>Website: | Tel: 0860 10 35 29<br>www.preferredprovider.co.za |
| Mail your claims to | Topmed Medical Scheme<br>PO Box 1462, Durban, 4000<br>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<br>Fax: 012 431 0680<br>email: support@medicalschemes.com<br>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.