topmed tm
medical scheme

LIMITED

2018

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

CONTACT DETAILS

Client Services, Pre-authorisation Case Management and Disease Management Programmes	Tel: 0860 00 21 58
International	087 740 2899 (for calls outside SA)
Email	info@topmedms.co.za
Fax	086 762 4050
Website	www.topmed.co.za
Membership	membership@topmedms.co.za
Claims	claims@topmedms.co.za
Postal Address	PO Box 1462, Durban, 4000
Queries	info@topmedms.co.za

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 1/1/2018***
- ***Benefits subject to Council for Medical Schemes approval***

MAJOR MEDICAL BENEFITS

Topmed Limited is a traditional design option with specific benefit limits reimbursed on an 80% basis for doctors and health care providers and a sliding scale co-payment for hospital accounts.
Other than the hospital account, members must first pay and then submit claims on a claim form. This includes claims for all associated providers and treatment received whilst in hospital.

HOSPITAL BENEFITS

Overall Annual Limit (OAL) R1 million per beneficiary per year
All benefits are subject to Scheme Rules and Managed Care Protocols
Sub-limits and co-payments apply as per Scheme Rules

Admission to Public Hospital Facility (PAR required)	Unlimited
Admission to Private Hospital Facility (PAR required) **DSP Network applies**	Up to the Overall Annual Limit at 100% of Cost at a DSP Hospital and 75% of TT at a non DSP Hospital and thereafter unlimited through Public Hospital facilities. Individual benefit limits apply
Co-payment applies to the Hospital Account at Private Hospital Facilities	50% of the first R5 220 per incident for the members account thereafter 10% of the remainder, up to a maximum co-payment of R11 280
All accounts other than a Hospital Account	20% co-payment and individual benefit limits apply

In Hospital – Pre-Authorisation Required	
Admission to General Ward	Subject to OAL
Intensive Care	Subject to OAL
Procedures, doctors and specialist in hospital	Subject to OAL (PMB DSP applies)
Psychiatric Admission	Maximum 21 days per family per year
Sub-acute facilities, Hospice, Nursing services and Rehabilitation	Maximum 21 days per beneficiary per year
Prostheses	Maximum R33 504 per family per year
Surgical, electronic and nuclear appliances	R5 556 per beneficiary per year
Treatment of immunocompromise and opportunistic infections	R46 872 per family per annum

In Hospital – Pre-Authorisation Required	
Cancer treatment	Subject to OAL
Dialysis including hospital fee	Subject to OAL
Pathology whilst admitted	Subject to OAL
Radiology whilst admitted	Subject to OAL
Auxiliary services whilst admitted (Physiotherapy, Clinical technologists, Medical technologists, Speech Therapy, Occupational Therapy, Dieticians and Social workers)	Subject to OAL
Blood transfusion	Subject to OAL
TTO medication	Maximum of 7 days supply
Casualty and Day case procedures	Subject to OAL
Investigations e.g. gastroscopy	Subject to OAL

MATERNITY PROGRAMME / CONFINEMENTS

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:
2 Ante-natal consultations and 2 Scans per beneficiary per pregnancy (the costs of 3D-scans are limited to the cost of a 2D-scan)

DAY-TO-DAY BENEFITS

Day-to-day benefits are subject to specific benefit limits and are reimbursed on an 80% basis. Members must first pay and then submit claims on a claim form. This includes claims for all associated providers and treatment received whilst in hospital.

Radiology, Pathology and Histology	Maximum of R5 088 per family per year.
CT and MRI scans	3 scans per family per year to a maximum of R15 852
Nursing Services and Hospice	21 days per beneficiary per year
Medical Appliances	Max R5 364 per beneficiary per year
Optical Benefit (per beneficiary per year) Multifocals need clinical motivation	Test alone – R468 Single vision (incl. test) – R924 Bifocal (incl. test) – R1 380 Multifocal (incl. test) – R1 848
General Dentistry	Max R5 040 per family per year
Specialised Dentistry	Max R8 028 per family per year
Hearing Aids	Max R12 828 per beneficiary in a 24 month period
Acute Medication	Max R7 860 per family per year (TRP and formulary applies)
Chronic Medication	Max R11 508 per family per year - thereafter PMB's unlimited (DSP, TRP and formulary applies)
Physiotherapy, Chiropractor and Biokineticist	Max R3 024 per family per year for all services
Audiologist, Dietician, Occupational Therapist, Speech Therapist, Social Worker	Max R2 400 per family per year for all services
General Practitioners and Specialists (Out Patient) - PMB DSP applies	Max R7 080 per family per year for all services
General Practitioners and Specialists (Out Patient) for CDL - PMB DSP applies	Subject to Scheme protocols and DSP
Chiropodist, Homeopath, Naturopath, Osteopath, Podiatrist, and Orthoptist	Max R2 400 per family per year for all services
Clinical Psychologist and Psychiatrist	Max R4 488 per family per year for all services

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) Non-preferred Provider	100% of AT 100% of TT limited to R2 328 per family 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

PRESCRIBED MINIMUM BENEFITS (PMB)

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, 75% of TT for hospitalisation 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.

WELLNESS BENEFIT

Members must first pay and then submit claims on a claim form with the exception of the Mammogram and Bone Densitometry tests which will be paid to the Provider directly.

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

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

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)		

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

EARLY DETECTION TESTS	AGE BAND	FREQUENCY
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

Please note:
Except in the case of PMBs, any consultations and costs not specifically stated above but related to the above tests will be paid from your day-to-day benefits.

CHRONIC CONDITION DISEASE LIST

PRESCRIBED MINIMUM BENEFIT - CHRONIC CONDITION DISEASE LIST

- 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

DESIGNATED SERVICE PROVIDER (DSP) NETWORKS

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 DirectMedicines.

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 Mediscor (who manage the network on our behalf), 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.

Hospital Network

Topmed's Hospital Network includes over 280 hospitals, sub-acute facilities and day clinics spread geographically across South Africa. The majority of these facilities are Life Healthcare or Mediclinic facilities however in certain areas, where Life Healthcare or Mediclinic do not have a facility, NHN facilities have been included. For a detailed list of the facilities included in the Hospital Network please log onto the website, www.topmed.co.za. If you do not have access to the website, please call our Client Services department on 0860 00 21 58 and we will gladly assist you in finding the closest facility to you.

In order for your hospital account to be paid in full (at 100% of the AT), it is important to note that you must make use of a network hospital for any planned or non-emergency admissions. Planned or non-emergency admissions at hospitals outside of the network will only be at paid at 75% of the AT. To avoid unnecessary co-payments on your hospital accounts, please ensure that you confirm before being admitted whether your hospital is included in the network.

Members are required to make use of DSPs or Preferred Providers for specific benefits according to the table below. 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	No
Optical	No
Ambulance and Emergency Services	Yes

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).

CONTRIBUTIONS			
All incomes	Principal Member	Adult dependant	Student / Minor dependant
CONTRIBUTIONS	**R2 267**	**R990**	**R416**

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