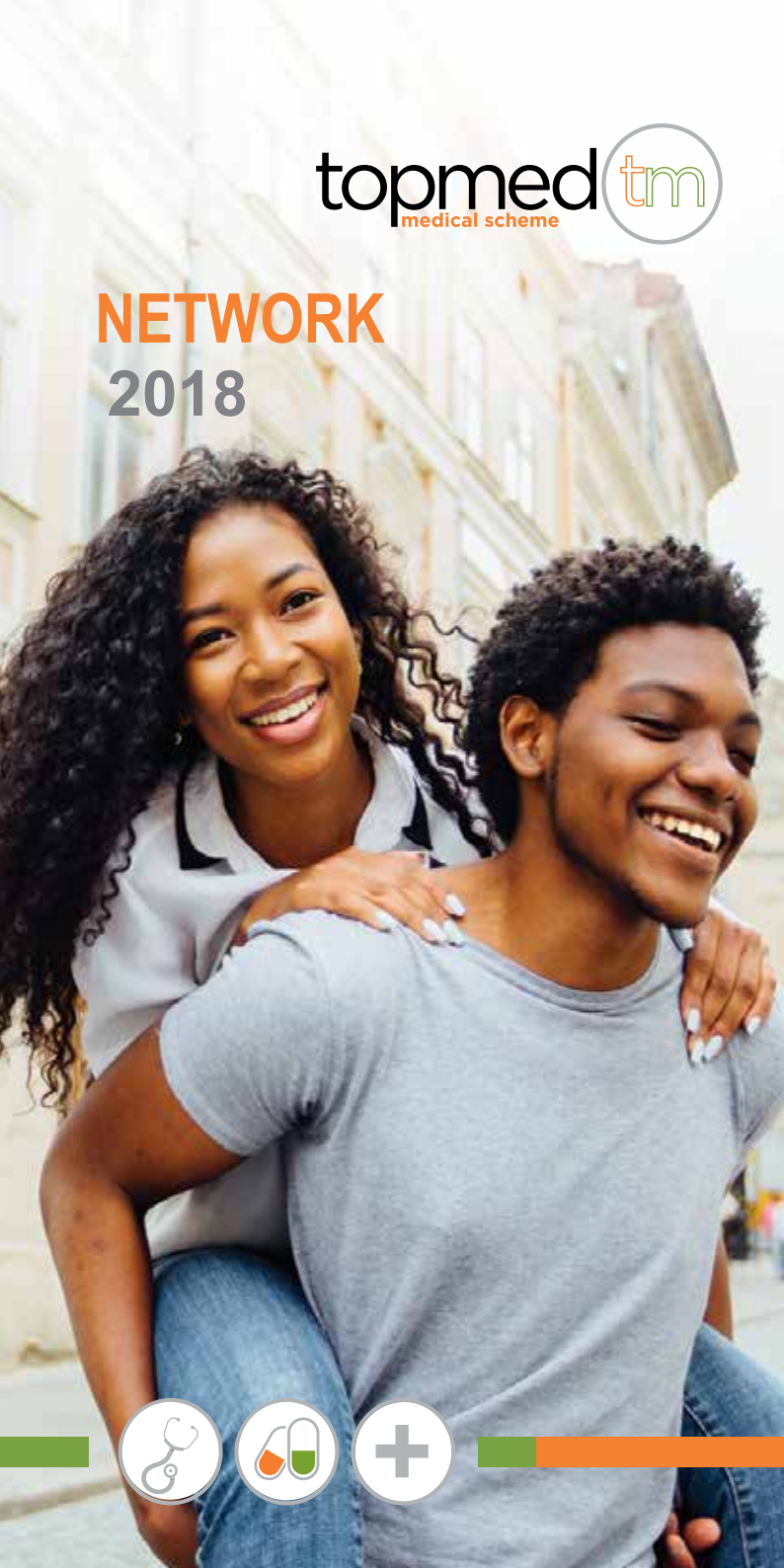
topmed tm
medical scheme

NETWORK
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

IN HOSPITAL BENEFITS

Pre-authorisation (PAR) is required in respect of hospitalisation and the associated clinical procedures before treatment starts. In case of emergency, within the next two business days, otherwise no benefit is allowed.

Note: Hospitalisation is limited to PMB only. Subject to referral from a Network GP and/or Specialist

Benefits for hip and knee replacements for hospitalisation and associated Providers will only be covered in the event of trauma

Accommodation, theatre, medicine, material and hospital apparatus used during hospitalisation.	**Limited to PMB only** DSP Hospital - 100% of AT Non DSP Hospital - 75% of AT (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 Limited to R46 872 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) (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)	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

CONFINEMENTS

PAR required

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:

- Home births provided a registered service provider assists with the birth
- Pregnancy tests and family planning (excluding contraceptives) if provided by the Primary Healthcare Provider
- Pre and postnatal care, including 1 first trimester sonar scan if provided by the Primary Healthcare Provider.

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.	
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 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 subject to overall annual limit

SECONDARY FACILITIES
Step-down nursing, hospice & rehabilitation
Benefits and treatment provided through Case Management Programme limited to PMB

CHRONIC PMB MEDICATION
Subject to registration and approval according to the Chronic Medicine Formulary
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

DAY-TO-DAY BENEFITS

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 236 per family per year No benefit for facility fees Only emergencies and after hours services **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) Subject to pre-authorisation and referral from a Network GP to a Network specialist.	100% of AT Limited to R1 500 per family Any radiology or pathology called for by the Network Specialist will also be paid from this benefit
ACUTE MEDICATION (Subject to the acute medicine formulary)	As dispensed by a Network General Practitioner or pharmacy according to the acute medicine formulary
PAT MEDICATION (Over the counter medicine)	R216 per family per year subject to a maximum of R72 per script 100% of TT (TRP and formulary applies)
DENTISTRY (services rendered by a Network Provider) Basic Dentistry Specialised Dentistry	 Subject to protocols, consultations, primary extractions, fillings, scaling and polishing 1 set of plastic dentures per family per 24 month cycle limited to beneficiaries over the age of 21 Root canal treatment, crowns and other advanced dentistry are not covered
OPTICAL (services rendered by a Network Provider) (Benefit is available per beneficiary per 24 months subject to protocols)	1 optical test per beneficiary 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 R555 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
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 (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
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 Health-care 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.

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)	PMB Only
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	PMB Only
Orthopaedic Prostheses and Appliances (Subject to failed conservative treatment & Risk Management)	
Spinal fixation devices (max 2 levels unless motivated)	PMB Only
Fixation devices – non spinal	
Bone Lengthening devices	
Implantable devices, disc prosthesis, Kyphoplasty	PMB Only
Neuro Stimulators and Deep Brain Stimulators	PMB Only
Internal Sphincters and stimulators	PMB Only
Unspecified/Unlisted above	PMB Only

OPERATION OF TOPMED NETWORK

What is a Primary Healthcare Provider?

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

Who is the Primary Healthcare Provider on Topmed?

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

To locate your nearest Network provider, please log onto www.topmed.co.za for the information and details of the Network doctors.

What are my benefits at a Network General Practitioner?

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

What is acute medication?

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

What do I do if I have a chronic condition?

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

What other benefits do I have?

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

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

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

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

Your benefits make provision for after hours emergencies or visits outside of the network. This benefit is limited.

You have the following options:

- You may visit any Network-contracted or non-Network GP close to you
- Alternatively, you may go to an emergency room at the nearest private or public hospital.
- Please note that you will have to pay upfront for the service obtained outside of the network.
- You may, however, claim back the costs from Topmed subject to the benefit limit and Topmed rates.

Will I have to pay when visiting Network providers?

No, as long as your contributions have been paid. 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. Any radiology or pathology called for by the Network Specialist will also be paid from this benefit. Should you require treatment/consultation from a Specialist you would be required to obtain an authorisation first before you consult with the Specialist. Follow these steps to obtain authorisation:

- Your Network GP would need to complete the Specialist referral form. This form is available on the Topmed website www.topmed.co.za.
- The completed Specialist referral form can be emailed to referrals@topmedms.co.za or fax to 086 762 4050
- Topmed will ensure that the referral is given to a contracted Network Specialist.
- Once authorised the member will be informed of the authorisation number. Please take your Specialist referral form with the authorisation number quoted on the form to the Specialist.

What Specialist Benefits are provided?

- The Specialist benefit is limited to R1 500 per family
- Specialist services are subject to referral by a Network GP to a Network Specialist and pre-authorisation.
- Any radiology or pathology called for by the Network Specialist will also be paid from this benefit.

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

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

If you and/or any of your dependants have to be admitted to a private or provincial hospital, you must obtain an authorisation (PAR) by contacting 0860 00 21 58.

You would be required to use a DSP Network of Hospitals and Day Clinics for a defined list of procedures.

Should you be admitted in a DSP Hospital or Day Clinic Topmed will pay the cost of your hospitalisation, and the costs of the treatment you received whilst in hospital at 100% of the agreed tariff if you were referred by the Network GP or Network Specialist.

If you are admitted to a Non-DSP Hospital or Day Clinic, Topmed will pay 75% of the agreed tariff and you will be required to pay the balance to the hospital.

Please note if the admitting/treating provider is a Network Provider, Topmed will pay 100% of Topmed tariff. If your provider is not a Network Provider, Topmed will pay 70% of the Topmed tariff, and you will be required to pay the balance to your provider.

Note: The Network option only covers admissions for PMB conditions.

What must I do in case of an emergency?

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

Note: For a detailed breakdown of the information you need to supply and obtain when applying for a PAR, please refer the Member Guide.

How are my claims paid?

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

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

For more information on claims, please refer Payment of Claims in the Member Guide.

When do I have to pay my contributions?

Contributions are payable monthly in advance. If contributions are not paid within 3 days from the date that they are due, your membership will be suspended. If your contributions remain in arrears for more than 14 days, your membership may be cancelled without further notice.

Note: For more information on Contributions, please refer to Contributions the Member Guide.

Are benefits allowed in respect of foreign claims?

No.

Is HIV/AIDS covered?

Yes. The HIV/Aids Programme assists members living with HIV/Aids to access quality care and to make optimal use of the benefits available to them. The programme will include the necessary pathology tests, anti-retroviral medication (if required), doctor's consultations, information, counselling and advice.
To access these benefits you should register on the programme by calling 0860 448 2273. This is a fully confidential line.

Are dialysis and organ transplants covered?

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

Are benefits paid for confinements in a private hospital?

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

Important things to remember

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

IN-HOSPITAL AND SPECIALIST CLAIMS

- 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
- 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

OUT-OF-HOSPITAL / DAY-TO-DAY BENEFIT

Out-of-Hospital Specialist Benefit
(Limited to R1 500 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 R216 per year max of R72 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

Physiotherapy, Speech Therapy and Occupational Therapy
NO BENEFIT

Out-of-Network Emergency visits:
Limited to 3 visits per family to a maximum of R1 236 per family per year. (Member to pay and claim back from Topmed)

HIV / AIDS Registration
0860 448 2273 (subject to clinical protocols)

Specialist
Referral from your Network GP to a Network Specialist. Benefit limited to R1 500 per family per year.

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	Yes
Optical	Yes
Ambulance and Emergency Services	Yes

ONCOLOGY (CANCER MANAGEMENT)

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

Who needs to register?

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

How to register

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

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

	BENEFITS
Pre-Authorisation and Treatment Plan	Yes
Cancer Treatment	PMB treatment
Surgery for your cancer	PMB / Pre-authorisation - Hospital Management
Bone marrow of stem cell transplantation	PMB benefits only
Donor searches	No benefit
PET Scans	PMB
Bone Density Scans	PMB

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

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			
Incomes	Principal Member	Adult dependant	Student/Minor dependant
< R1000	R348	R348	R348
R1001 – R8000	R1 050	R1 050	R380
R8001 – R11000	R1 397	R1 397	R391
> R11000	R1 889	R1 889	R506