Membership

Who qualifies as a dependant of a member?

- Spouse or partner of the Principal member
- Children, adopted children, stepchildren and foster children
- Brothers/sisters under 21 years and parents of the principal member, if dependent on the principal member
- for family care and support (a sworn affidavit confirming the relationship to the principal member stating that the family member is dependent on the principal member for care and support.)

How do I add a new dependant to my existing membership?

By completing an Amendment Form, which can be obtained from Topmed's Client Service Department, or from the website under Member Area. If you are part of a company that belongs to Topmed, please send your completed Amendment Form to your HR or Payroll Department, or if you are an individual member you may forward your Amendment Form directly through to Topmed or via your appointed broker. Please call **0860 00 21 58** if you have any enquiries about your application.

What happens in the event of the death of the principal member?

The eldest dependant may continue with the membership as the principal member, with the status of the other dependants remaining unchanged. Membership will commence on the day following that of the principal member's death unless Topmed is informed that the dependants choose to terminate their membership. Bank details should be furnished to Topmed to avoid any interruption in the payment of contributions and access to benefits.

When will Topmed have the right to cancel my membership or that of any of my dependants?

If you or any of your dependants:

- Join another scheme
- Provide false information or fail to disclose material information when applying for membership.
- Provide false information when submitting a claim, submit a fraudulent claim, or intentionally allow a service provider to do so on your behalf
- Allow any other person to use your membership card
- Without a good explanation, neglect to inform Topmed that it has paid for services or supplies that were not delivered or received
- Commit any other fraudulent act
- Fail to pay contributions within the time prescribed
- Fail to repay any advance or debt within the time prescribed

What is a general waiting period?

Topmed may impose a general waiting period of 3 months on all benefits in respect of all new applicants and dependants who:

- Have not belonged to a previous medical scheme for more than 90 days prior to joining Topmed - no benefits are payable during this period, including payment from your Medical Savings Account

or

- Were members of another medical scheme for a period of more than 2 years, and joined Topmed within 90 days of leaving their previous medical scheme - except in respect of any treatment or diagnostic procedures covered within the Prescribed Minimum Benefits (PMB's), where applicable.

What is a condition-specific waiting period?

Topmed may impose a condition specific waiting period of up to 12 months from the inception date of your membership, in respect of any pre-existing condition, in respect of any beneficiaries who:

- Have not belonged to a previous medical scheme for more than 90 days prior to joining Topmed or
- Have belonged to another medical scheme for less than 2 years, and are joining Topmed within 90 days of leaving their previous medical scheme

How are pro rata benefits applied?

Benefits will be applied pro rata in respect of principal members and dependants who join Topmed after 1 January of a particular year. This applies to all benefits that have an annual limit.

What is Non-Disclosure?

There is a LEGAL requirement to tell Topmed (on joining) about any:

- Current conditions and/or treatments
- Previous conditions and/or treatments
- Planned procedures and/or treatments

Failure to disclose can lead to termination of benefits and/or membership so please make sure that you do not leave anything off your application form even if you think it is something small.

When can I cancel my Membership?

Individual Members: As an individual member you may cancel your membership with at least 1 calendar month's written notice to Topmed.

Employer Groups: As a member of a particular employer, your employer may cancel your membership as a group with at least 3 calendar month's written notice to Topmed.

When can I change my option?

You may only change your option once a year effective from the first day of January, after giving Topmed at least 30 days' written notice.

How do I change my option?

By completing an Option Change Form, which can be obtained from Topmed's Client Service Department or from the website under Member Area. Such a change will only be allowed once annually on 1 January of each year.

Premiums

When are my membership contributions payable?

Contributions are payable monthly in advance, on the first day of each month, effective from your inception date.

At what stage does my contribution increase when a minor dependant turns 21?

The increased contribution for an adult dependant becomes due on the first day of the month following that in which your dependant turns 21 unless your dependant is a full time student.

When do increased contributions become due in respect of a new dependant?

The first increased contribution is payable from the first day of the month in which your dependant is added.

What happens if my contributions fall into arrears?

If your contributions are not paid to Topmed within 3 days from the date on which they are due, the payment of benefits in terms of your membership will be suspended until such time as all arrear contributions are received. If contributions are more than 7 days in arrears, membership may be terminated immediately without further notice.

Benefits

How does the Extended/Threshold Cover work? (Applicable to Comprehensive, Executive & Family options)

A threshold is a set value to be reached before claims for day-to-day medical expenses are paid by Topmed. Claims for day-to-day expenses are processed and will accumulate towards reaching this threshold. This includes claims paid from your Yearly Limit and Medical Savings Account or paid from your own pocket. The value accumulated to your threshold is based on the Topmed Tariff (TT), and not necessarily the amount that you have paid. Once your accumulated claims reach the threshold value (and you have exhausted your Yearly Limit or Medical Savings Account), further day-to-day claims will be paid by Topmed as per the benefits stipulated in your Benefit Guide. You may use your Yearly Limit / Medical Savings Account to pay for day-to-day medical expenses incurred before your threshold is reached, or pay from your own pocket should your Yearly Limit / Medical Savings Account be exhausted.

As noted above only the applicable percentage of the benefit amount, i.e. the Topmed Tariff and not the cost, will accumulate towards the threshold, even if the cost is paid from your Yearly Limit / Medical Savings Account. Certain claims will NOT accumulate towards the threshold, even if paid from your Yearly Limit / Medical Savings Account.

It is important to remember to continue to submit your claims to Topmed for accumulation to threshold, even if it is during the period when claims are paid from your own pocket.

If a benefit limit applies before Threshold, how will it affect my benefits after Threshold?

For all benefits that have limits, these limits apply before and after the threshold is reached. This means that if for example, there is a limit of R5 000 on your acute medicines benefit and you utilise the full amount before reaching your threshold, i.e. during the period when you pay your claims from your Yearly Limit / Medical Savings Account, or your own pocket, you will have NO BENEFITS for acute medicines **after** reaching your threshold, i.e. during the period when Topmed starts paying day-to-day claims.

How will my threshold be affected if I join on a date other than 1 January?

The total threshold amount is calculated on a pro rata basis, but will not decrease to less than 50% of what the amount would have been for 12 months.

How will my threshold be affected if I add a dependant to or remove a dependant from my membership?

Your threshold will be adjusted accordingly.

How will my threshold be affected if my dependant turns 21 during the year?

If your dependant's status changes to an adult dependant during a year, your threshold will be adjusted accordingly.

Medical Savings Account (Applicable to Executive, Family, Savings and Active Saver options)

How does a Medical Savings Account work?

Your Medical Savings Account is designed to cover your day-to-day expenses. It works like this:

- You contribute a fixed monthly amount
- The total annual amount is available in advance for medical expenses

What happens to my savings balance at the end of the year?

Any positive balance will be carried over to your Medical Savings Account for the following year.

What happens to my savings balance if I change to an option that doesn't have a Medical Savings Account, or decide to leave Topmed?

Any positive balance will be refunded to you after four and a half months. However, should you leave Topmed to join another medical scheme with a Medical Savings Account, any credit balance will be transferred to your new medical scheme as per the Medical Schemes Act.

What happens to the debits accrued on the savings balance of a member who leaves Topmed?

Should there be a negative balance, you will be responsible for refunding the amount to Topmed within 30 days of notification.

What happens to my savings balance if I pass away?

Any positive balance will be paid out to your estate after four and a half months if your dependants decide not to continue as members of Topmed.

What is a Yearly Limit?

A Yearly Limit is a portion of your monthly contribution which is set aside to pay for day-to-day benefits before you have reached your annual threshold level. It is similar to a Medical Savings Account in that it is used to fund

day- to-day benefits.

What can I use my Yearly Limit for?

Refer to your Benefit Booklet for details of claims that can be funded from your Yearly Limit.

What happens to my Yearly Limit if I leave the Scheme or change to a benefit option that does not have a Yearly Limit?

As the Yearly Limit is considered a Risk Benefit, when you leave the Scheme or change to a option that does not have a Yearly Limit , your Yearly Limit benefit will fall away and the balance remains with the Scheme.

What happens to my Yearly Limit balance at the end of the year?

Any Yearly Limit balance at the end of the year will fall away and you will be allocated a new balance at the beginning of the next year.

What is pre-authorisation (PAR)?

Pre-authorisation (PAR) is the prior approval of any planned admission to a hospital, including an associated treatment or procedure (including dental procedures) performed by a medical practitioner or dentist during hospitalisation.

Please note that a PAR is merely a confirmation that the proposed clinical procedure or treatment is medically necessary and is not a guarantee that benefits will be paid.

When must I apply for a pre-authorisation reference number (PAR)?

Application for a PAR should be made for any procedure requiring a reservation for admission to a hospital or if certain scans or radio-isotope studies are planned. If you are unsure if the procedure requires a PAR, it is recommended that you call the Pre-Authorisation Department for advice on 0860 00 21 58.

Application for a PAR should be made as soon as possible, preferably when admission is confirmed by your doctor. You need not apply for authorisation more than one month in advance.

It is recommended that application be made at least two days ahead of a planned procedure, in case more information is required from your doctor. In the event of an emergency admission to hospital over a weekend or at night, you may apply for a PAR from the Pre-authorisation Department within two working days following the admission or scan.

What must I do in the case of an emergency?

If in an emergency you are unable to obtain pre-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.

What information should I provide when requesting pre-authorisation?

- Membership number and dependant code
- Patient's full name
- Date of admission PLUS the date of the procedure. (This is particularly important, as we do not routinely Authorize pre-operative procedures the day prior to planned surgery - this must be applied for and motivated.)
- Surname and initials of attending doctor or service provider (practice number, if available)
- Telephone number of attending doctor or service provider
- Name of hospital to which the patient will be admitted.
- The reason for the admission to hospital or the planned diagnostic procedure
- Ask your doctor for a full description of:
  - the reason for admission
  - the associated medical diagnosis and the applicable ICD-10 code
  - the planned procedure, as well as the procedural codes and tariffs he/she intends to use

What information must I obtain when calling the Pre-authorisation Department?

- The unique pre-authorisation number
- The initial length of stay in an approved hospital
- The approved codes

What must I do if I stay in hospital longer than the initial length of stay approved by the Pre-authorisation Department?

A family member, your doctor or a hospital staff member must immediately inform the Pre-authorisation Department, and the clinical indications for the extended stay will be evaluated. An extended length of stay must be authorised to qualify for benefits as no retrospective PAR's will be granted.

How will the medicine I receive on discharge from hospital be paid for?

You will qualify for a maximum of seven days' supply. This benefit will be paid from Risk (except for the Network option). The medicine dispensed when you leave the hospital, will always be paid for from Risk to a maximum of seven days' supply. If you have a chronic medicine authorisation, you should obtain your medicine from a DSP retail pharmacy.

How do I apply for Chronic Medicine Benefits?

- Your 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 TRP?

Topmed Reference Price (TRP) sets a maximum reimbursable price for a list of generically similar products with a cost lower than that of the original medicine. It is the maximum price that Topmed is prepared to pay for a medicine with generic alternatives. This means that if you opt to use the original product, and a generic alternative is available, you will have to pay the difference between the price of the chosen original medicine and that of TRP.

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 (see list of chronic conditions on page 24 for details) and your Chronic Limit (where applicable) is exhausted, Topmed will continue to provide a 100% benefit provided you obtain your medicine within the formulary and from the DSP.

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.
- For 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.

What is the deadline for the submission and payment of a claim?

A claim must be submitted within 4 (four) months from the end of the month in which the service was provided, or within (2) two 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?

As soon as a claim has been processed you will receive a confirmation email then at the end of the month you will be sent a detailed 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 mobile app or website www.topmed.co.za.