2014

PROFMED INFORMATION GUIDE

Applicable 1 January 2014 to 31 December 2014.
This guide is a means of assisting members to better understand the benefits offered by the Scheme. In the case of a dispute, the official rules will apply.

Healthcare for Professionals

PROFMED

Contents

1. Important contact information

1.1 General telephone numbers

	Within RSA	Outside RSA	Fax
Client Services & Claims (no faxed claims)	0860 679 200	+27 12 679 4144	+27 12 679 4411
Chronic Disease & Medication Authorisations (treating doctor and pharmacists only)	0800 132 345	+27 11 770 6000	–
Hospital & Specialised Radiology Authorisations	0860 776 363	+27 12 679 4145	+27 12 679 4438
International Travel Medical Assistance (to activate cover)	0860 679 200	+27 11 541 1225	–
Disease Management Authorisations	0860 776 363	+27 12 679 4145	+27 12 679 4438
Dental Authorisations	0860 679 200	+27 12 679 4144	+27 12 679 4411
Multiply Wellness Programme and Momentous Baby	0861 886 600	–	–
Website: www.profmed.co.za			
Postal address: Private Bag X1031 Lyttelton 0140			

1.2 E-mail communication

	Within and Outside RSA
Client Services & General	info@profmed.co.za
Claims (no faxed claims)	claims@profmed.co.za

1.3 Emergency telephone number

	Within and Outside RSA
Emergency medical transport within RSA & SADC Region	**+27 11 541 1225**
Medical assistance while travelling internationally	
Assistance for trauma and HIV exposure	

1.4 Facebook and Linked-In

You can also follow us on:
Facebook http://www.facebook.com/Profmed
Linked-In http://www.linkedin.com/company/profmed

2. Management of the Scheme

Profmed is a restricted scheme managed by the Board of Trustees. Five of the trustees are elected by members and five are appointed by the Board of Trustees. Trustees must be members of the Scheme. The Board must annually, at the first meeting after the annual general meeting, elect a chairman and vice-chairman from among its ranks.

Vision

To address the healthcare needs of professionals through appropriate benefits.

3. Rules

The rules will assist you to understand your Scheme and to make the best use of your benefits, thereby avoiding disappointment. The payment of contributions is regarded as the member's recognition that he is bound by the rules of the Scheme and any amendments made thereto.

4. Scheme benefit options

Profmed offers five excellent options from which members can choose, depending on their individual needs and financial position:

ProPinnacle	Comprehensive in-hospital cover in private wards, and comprehensive chronic and day-to-day cover. GP and specialist costs covered at Profmed Premium Tariff rates (300% of Profmed Tariff).
ProSecure Plus	Comprehensive cover in-hospital and private ward rates for maternity (post-delivery). Chronic and day-to-day medical expenses and cover over and above the prescribed minimum benefits. In-hospital GP and specialist costs covered at Profmed Plus Tariff rates (200% of Profmed Tariff).
ProSecure	Comprehensive cover in-hospital, and chronic and day-to-day medical expenses, and cover over and above the prescribed minimum benefits.
ProActive Plus	Comprehensive in-hospital benefits, and cover for prescribed minimum benefits. In-hospital GP and specialist costs covered at Profmed Plus Tariff rates (200% of Profmed Tariff).
ProActive	Comprehensive in-hospital benefits, and cover for prescribed minimum benefits.

For more detailed information on the benefits offered on each option, please consult the Schedule of Benefits, which is available at www.profmed.co.za on the Downloads page, or by calling Client Services on 0860 679 200.

5. Membership

Who qualifies?

Membership is exclusively for post-graduate professionals. If you have a degree and/or qualification of four years or more from a university or technical university, or two three-year degrees, or a three-year degree with a post-graduate qualification of not less than one year, you are eligible for Profmed.

No person may belong to more than one scheme at the same time.

Who qualifies as a dependant?

The following members of your family will qualify, if they are not members or dependants of any other medical scheme:

- Your spouse to whom you are married in terms of any law or custom;
- Your life partner with whom you have a serious relationship similar to a marriage and based on objective criteria such as mutual dependence and a shared and joint household, irrespective of the gender of the parties;
- Your own, step or legally adopted children under the age of 21 years who are dependent on you;
- Your child under the age of 26 years who is a full-time student at an academic institution;
- Your child who is dependent on you because of mental or physical disability;
- Your child under the age of 21 years for whom you are responsible for family care and support.

Students and children who are 21 years of age or older

Children who have turned 21 years are regarded as adult dependants for the purposes of calculating contributions, unless they are studying full-time at a recognised academic institution. Members must submit annual proof of registration for a dependant who has turned 21 years of age and who is still studying full-time at an academic institution, in order for that dependant's contributions to be regarded as child dependant rates. Proof of full-time study must reach the Scheme by end-February.

Contributions for child dependants will automatically be changed to those of adult dependants if:

- a child dependant turns 21 years of age;
- a student dependant turns 26 years of age;
- annual proof of full-time study is not received by the Scheme for student dependants by end-February.

In the above instances, the child's or student's child dependant status will change to that of adult dependant on the first day of the month following the child's/student's 21st or 26th birthday, whichever is applicable.

Please note:

- Proof of registration at an academic institution must be submitted at the beginning of each academic year for that ensuing year.
- Proof of dependence must be submitted annually for a child or other dependants who are 21 years of age or older.

Application for adding of dependant(s)

The "Adding Dependant" application form must be completed and e-mailed to Profmed's New Business Division at newbusiness@profmed.co.za or faxed to 012 679 4424. Application forms can be obtained from your broker or by calling Client Services on 0860 679 200. An application form will be faxed or e-mailed to you. Application forms can also be obtained from the website at www.profmed.co.za under Downloads.

Special dependants

The member's parents with regard to whom he/she is responsible for family care and maintenance will be regarded as special dependants. Special dependants are classified as adult dependants. A sworn affidavit confirming that the special dependant is dependent on the financial care of the member must accompany the application, together with a tax directive in respect of the special dependant from the SA Revenue Service (SARS) and copies of three months recent bank statements.

Newborn and adopted children

The registration of newborn and adopted children must take place within 30 days after the birth of a child or the date on which a child is legally adopted. The application must be accompanied by a birth certificate and/or proof of adoption, and a certified copy of a passport if the child is born or adopted outside South Africa.

What happens when your particulars change?

Inform Profmed in writing within 30 days by e-mail to info@profmed.co.za or to fax number 012 679 4411. If you are registered on the website, these changes can also be made online at www.profmed.co.za. Correspondence can be posted to Private Bag X1031, Lyttelton, 0140.

Let the Scheme know if any of the following needs attention:

- Registration of new dependants;
- Resignation of dependants who no longer qualify for membership or as child dependants;
- Your address or personal details change;
- Your bank details change. Bank details may not be updated on the website, only in writing by e-mail, fax or posted letter.
- Change in status of a student dependant.

No changes will be implemented retrospectively.

Please remember to state your name, surname and membership number on your communication and ensure that certified copies of birth, adoption, marriage or death certificates are included. A certified copy of passports in the case of non-South African residents is required. A copy of this communication should also be sent to your employer if they are paying a part of your contribution. Please call Client Services to find out how your contributions and benefits will be affected by any changes in your membership status. The Contribution Calculator on the website is also a useful tool to assist you in calculating your contributions.

Health status

The Scheme has the right to request a health certificate for any applicant and his/her dependants. Proof of health is provided by a member when completing the health questionnaire on the signed application form or when submitting an application online on the Profmed website.

Consequences of non-disclosure

When completing the health questionnaire it is important to list all surgery and procedures, illnesses, conditions and symptoms. Failure to do so could result in claims being rejected or membership being terminated.

How soon can you claim after you have joined the Scheme?

From the benefit date stipulated on your membership card, unless specified services are subject to a waiting period.

A general waiting period of 3 months will usually be applicable if you were not previously a member of a medical scheme, or if you were a member of a registered medical scheme for more than two years and the change of medical scheme was not as a result of a change of your employment, or if the period between the termination of your membership of your previous scheme and joining Profmed is more than ninety days. A registered medical scheme is a scheme registered in South Africa in terms of the Medical Schemes Act.

A 12-month condition-specific waiting period for pre-existing illnesses will be applicable if you did not previously belong to a medical scheme, or if you were a member of a registered medical scheme for less than two years and the change of medical scheme was not as a result of a change of employment, or if the period between the termination of your membership of the previous scheme and joining Profmed was more than ninety days.

Please note:

- If you are still serving a waiting period at another scheme, the remainder thereof may be carried over to Profmed.
- Medical schemes not registered in South Africa in terms of the Medical Schemes Act are not recognised as valid medical schemes for underwriting purposes.

What happens if you join or resign from the Scheme during the course of the year?

A benefit year runs from 1 January to 31 December. If you should become a member of the Scheme during the course of the benefit year, i.e. after January, your benefits will be pro-rated. For example, if you join the Scheme halfway through the year (e.g. with 6 months remaining in the benefit year) and the annual maximum for a benefit is R1 000, you will only be entitled to claim half of this, i.e. R500.

Membership Card

The aim of the membership card is to serve as identification when obtaining services from a service provider, and provides valuable information to facilitate efficient processing of claims. A principal member with dependants is provided with two membership cards as proof of membership. Members without dependants are provided with one membership card.

This card must be shown on request by the service provider, e.g. a medical practitioner. In the event of any enquiries in this regard, Client Services can be contacted on 0860 679 200.

Information on the card

The following information appears on the membership card and must be checked by the member for accuracy and completeness:

- Name and beneficiary number of principal member;
- Names of all dependants and beneficiary numbers;
- The identity number of the member and date of birth of all his/her dependants;
- Benefit date of the principal member and all his/her dependants; and
- The gender of all beneficiaries.

Change of benefit options

A member is entitled to change benefit options, subject to the following conditions:

- The change may only be effective from 1 January of any benefit year.
- An application to change options must be made in writing and must be submitted to Profmed by 30 November of the year before the change takes effect.

6. Termination of membership

When will your membership be terminated?

- When Profmed receives one calendar month's written notice of cancellation from you;
- If you resign from your employer, where membership was a condition of service, and you do not intend to retain your membership of Profmed;
- In the event of your death;
- When Profmed receives three calendar months' written notice of cancellation from your employer;
- If Profmed should find that a member and/or his/her dependants have exploited the benefits of the Scheme. The member may also have to repay any amount which the Scheme has paid on his/her behalf;
- If a member fails to pay contributions for two consecutive months;
- When you are no longer a member in terms of any other stipulations of the Scheme.

How must members resign?

Members must give one month's written notice and the reason for the resignation as well as the date of termination, i.e. the last day on which the member will be eligible for benefits.

Dependant

A dependant will no longer be a dependant if the principal member's membership is terminated or if the member notifies the Scheme to terminate membership of a dependant.

7. Continuation member

When the membership of a member is terminated as a result of his/her death, the benefits in respect of such a member's dependants may be continued in terms of the rules of the Scheme, provided that:

- the remaining spouse/partner is registered as the new principal member;
- if there is no spouse/partner, the oldest dependant is registered as the new principal member;
- the contributions are adjusted, depending on the number of remaining beneficiaries;
- the adjusted contributions are paid to Profmed without interruption.

Please note: It is the responsibility of the surviving spouse/dependants to inform Profmed of the decision to continue membership. This must take place within three months of the death of the principal member.

8. Contributions

Calculation

Contributions are calculated according to the total number of beneficiaries (member and all adult and child dependants) registered on the Scheme, and the benefit option chosen by the member.

Late joiner penalty

A contribution loading (late joiner penalty) may be imposed on persons (a member or adult dependant) older than 35 who were not members or dependants of a medical scheme prior to 1 April 2001. This loading also applies to any beneficiary who enjoyed coverage with one or more medical schemes prior to 1 April 2001, with a break in coverage exceeding three months since 1 April 2001. This loading is calculated according to the years without cover after the age of 35, with credit given for years of cover after the age of 21, according to the following scales:

1 - 4 years = 5%
5 - 14 years = 25%
15 - 24 years = 50%
25+ years = 75%.

For purposes of this calculation, medical schemes not registered in South Africa in terms of the Medical Schemes Act are not recognised as valid medical schemes.

Payment of contributions

Contributions are payable monthly in advance and must reach the Scheme before the 1st of each month. Example: The contributions for January are payable by 1 January.

The contributions of members on Persal (government employees), who have a concession according to which contributions are levied retrospectively, are payable before or on the last day of a month, e.g. the contributions for January are received by 31 January.

Contributions must be paid to the Scheme by means of a debit order or electronic transfer (EFT). The bank details are:

Bank: FNB
Branch code: 25 50 05
Name of account holder: Profmed
Account number: 6203 4202 549
Reference number: Your membership number.

Please fax proof of payment to 012 679 4411 for the attention of Finance, or e-mail to contributions@profmed.co.za.

Change of contributions

If another dependant is added, the adjusted contribution must be paid from the first day of the month in which the dependant is registered to receive benefits. Benefits for such a dependant will apply from the benefit date or the date the dependant commenced with the Scheme, provided that all conditions have been fulfilled.

What will happen if you do not provide proof of income?

The Scheme reserves the right to request proof of income at any time. Unless satisfactory proof of income is provided, your contributions will fall into the highest income category, as indicated on the contribution table. The contribution table is contained in the Schedule of Benefits.

9. Pre-authorisation

Why is pre-authorisation necessary?

Pre-authorisation serves five purposes, namely, to:

1. alert the Scheme to any upcoming high-cost claims;
2. allow the Scheme to apply managed care interventions and protocols;
3. limit the risk to the membership by ensuring only clinically necessary and cost-effective treatment is funded;

4. inform members of the limits in respect of the procedure or treatment for which they are requesting authorisation;
5. give members the opportunity to query their benefits in respect of the procedure or treatment being authorised.

Pre-authorisation is based on clinical criteria, not on the availability of benefits and is not a guarantee of payment. Benefits are funded subject to the benefit limits and availability of funds at the time the claim is received by the Scheme for processing, and in accordance with the relevant protocols and Scheme rules. Authorised services or treatment must commence within three months of authorisation. Authorisation does not include the fees charged by the attending medical practitioners. It is the member's responsibility to obtain pre-authorisation, which should be obtained at least seven days prior to the commencement of treatment or services. In cases of after-hours emergencies, authorisation must be obtained the next working day. Reimbursement of services that were authorised is dependent on the availability of funds at the time the Scheme receives the claim. Funds are not reserved when authorisation is granted.

10. Prescribed minimum benefits

What are prescribed minimum benefits?

The prescribed minimum benefits (PMBs) comprise a list of 270 conditions or group of conditions as listed in Annexure A of the Medical Schemes Act. The Act obliged schemes from 1 January 2000 to provide minimum benefits for these conditions. The prescribed minimum benefits provide cover for specific treatments and services as rendered by the State. A list of the 270 conditions is available on the website of the Council for Medical Schemes at www.medicalschemes.com. If you are uncertain of the cover in respect of a specific condition, enquiries may be directed to the Scheme.

Chronic Disease List (CDL)

From 1 January 2004 schemes were also obliged to fund the cost of the diagnosis, the procedures and consultations (Ps + Cs) relevant to the management of the condition, and medication of a specified list of 26 chronic conditions. This list is referred to as the "Chronic Disease List" (CDL). These conditions are covered in terms of the PMB legislation. These conditions are covered on all Profmed's options, but benefits will be more or less restrictive depending on the option the member has chosen.

Table 1: CDL conditions | Available on all options

1.	Addison's Disease	14.	Epilepsy
2.	Asthma	15.	Glaucoma
3.	Bipolar Mood Disorder	16.	Haemophilia
4.	Bronchiectasis	17.	HIV/AIDS
5.	Cardiac Failure	18.	Hyperlipidaemia
6.	Cardiomyopathy Disease	19.	Hypertension
7.	Chronic Obstructive Pulmonary Disorder	20.	Hypothyroidism
8.	Chronic Renal Disease	21.	Multiple Sclerosis
9.	Coronary Artery Disease	22.	Parkinson's Disease
10.	Crohn's Disease	23.	Rheumatoid Arthritis
11.	Diabetes Insipidus	24.	Schizophrenia
12.	Diabetes Mellitus Types 1 and 2	25.	Systemic Lupus Erythematosus
13.	Dysrhythmias	26.	Ulcerative Colitis

11. Designated service provider network (DSPN)

What is a DSPN?

A DSPN is a provider (DSP) or network of providers (DSPN) who are contracted by the Scheme to provide services, treatment, medicine or facilities to members in terms of both prescribed minimum benefits (PMBs) and non-PMB illnesses.

Who are the Scheme's DSPNs?

The providers listed below have been contracted to provide services, as follows:

- Medication: Profmed Pharmacy Network
- Preventative care: Ampath, Lancet Laboratories and Pathcare
- Optical: Opticlear
- Trauma counselling and HIV post-exposure assistance: Lifesense
- Alcohol and drug rehabilitation: SANCA
- Physical rehabilitation: Life Healthcare
- Psychiatric hospitalisation: Participating National Hospital Network (NHN) facilities and Life Healthcare
- Endoscopic examinations: Netcare, Life Healthcare, Clinix, National Hospital Network (NHN) and Mediclinic
- Chronic dialysis: National Renal Care
- Domiciliary (home) oxygen: Ecomed Medical cc
- Oncology - Radiotherapy: Participating Netcare facilities
- Oncology - PET scans: Bloch & Partners at Morningside Clinic (applies to greater Johannesburg region only).

Members will be required to make use of the DSPs to avoid co-payments for the relevant services. Refer to the relevant sections in this Guide on how to access these networks. In instances where there is no DSP, the relevant managed healthcare principles, Scheme protocols, formularies, reference pricing and Scheme rules will apply. Services obtained from a non-DSPN will be reimbursed at the rate negotiated by Profmed with the DSPN.

How do DSPNs affect you?

The Scheme is obliged to cover certain chronic, and other conditions, in terms of the PMB algorithms (treatment protocols) published by the Council for Medical Schemes. This cover is obligatory, even once a member has exhausted the limits on his benefits. You may elect to receive treatment at a provider or facility other than the DSPN, but the Scheme will only be liable for the equivalent of the tariff charged by the DSP and the balance of the cost will be the responsibility of the member.

While a member still has funds available in his/her day-to-day benefits, the Scheme will pay for services or treatment received for PMBs in terms of the rules and protocols of the Scheme and of the option the member has chosen. Once the benefit limits are reached, however, only PMB conditions will be covered at the rate charged by the DSPN.

How do DSPNs benefit members?

The Scheme negotiates discounted rates with DSPNs. When a member makes use of the DSPN, the amount deducted from the member's benefit limit is in accordance with the discounted rate charged by the DSPN, leaving more funds available in the member's benefit limit for other relevant expenses.

12. Use of medicine

12.1 DSPN for medication

The Profmed Pharmacy Network (PPN) has a national footprint across South Africa. The DSPN ensures that you are not charged higher levies than the dispensing fee reimbursed by Profmed. Profmed members are in the fortunate position that Profmed has always reimbursed pharmacies at a higher rate than any other medical scheme. The PPN is an open enrolment network and any pharmacy that agrees to charge the Profmed fee can join.

If your pharmacy is not part of the PPN, ask your pharmacist to call Profmed's pharmacy benefit manager, MediKredit, on 0860 932 273 to join. Members may utilise any pharmacy of their choice, but if that pharmacy is not part of the PPN, you will be liable for any additional levies or co-payments. The list of pharmacies in the network can be found at www.medikredit.net.

12.2 Prescribed acute medication

Acute medication is medication prescribed once for less than one month by a medical practitioner, or is medication for conditions not listed or recognised as chronic conditions by the Scheme, e.g. antibiotics prescribed for tonsillitis. MMAP® applies on all options. Medication that you take with you on discharge from hospital will also be deducted from this benefit.

12.3 Over-the-counter medication

Over-the-counter medication (self-medication) is medication with a "NAPPI" code that can be obtained from a pharmacy without a prescription. The pharmacy will either claim the amount directly from Profmed or the member may pay the pharmacy in cash and claim the amount from Profmed by forwarding the relevant account and receipt. Over-the-counter medication is subject to both the acute medicine limit and the day-to-day limit.

12.4 Dispensing cycles

In line with the legislation, and to limit risk to the Scheme, dispensing cycles apply to the claiming of both acute and chronic medication as well as oral contraceptives. Acute medication scripts may be claimed again after three days from the last dispensing date, and chronic medication after 24 days from the last dispensing date. Oral contraceptives may be claimed 20 days after the last dispensing date.

If you require more than one month's supply of chronic medication

In terms of legislation, medical schemes cannot fund more than one month's supply of medication at a time. Please obtain authorisation from the Scheme if you require more than one month's supply of chronic medication (but not longer than ninety day's supply), e.g. when going on vacation. Contact Client Services on 0860 679 200 for authorisation. Submit your request at least one week prior to departure to ensure timeous authorisation.

12.5 Prescribed chronic medication (Life-sustaining medication)

Chronic medication is medication used for more than a month for the conditions listed in Tables 1 (page 8), 2, 3 and 4 (page 11).

Criteria that qualify for the chronic medicine benefit

1. Although your doctor may define your condition as being chronic, the condition may not fulfil the Scheme criteria to qualify for benefits from the chronic medicine benefit.
2. Access to chronic medication from the chronic benefit is subject to specific clinical criteria and medication formulary.
3. For any listed chronic condition, specific drugs only are funded from the chronic benefit. Drugs not qualifying for the chronic benefit may be considered for funding from the acute medicine benefit.
4. Profmed may limit the treatment covered in accordance with gazetted therapeutic algorithms, and reference pricing, and MMAP® will apply. This will assist you to make optimum use of your benefits.
5. Unregistered drugs and "off-label" usage of drugs will not be funded. Off-label drugs are medicines used for a condition for which they are not specifically registered.
6. Certain PMB high-cost drugs which are not listed in the algorithms will only be covered on the ProPinnacle option, subject to protocols and Scheme rules.
7. It is vital that you are aware of the expiry date of your authorisations and to renew the authorisation timeously. Only the treating doctor or your pharmacist can authorise your chronic condition and medication.
8. If your chronic medication is not authorised before the expiry date, benefits will be paid from the acute medicine benefit, subject to the availability of funds.

Conditions that are covered

Benefits for chronic medication are limited to the CDL conditions listed in Table 1 (page 8) and the non-CDL conditions listed in Tables 2, 3 and 4, below.

Cover for these conditions is available on the following options:

- Members on the ProPinnacle option are covered for the conditions listed in Table 1 and Table 2 (57 conditions in total), plus relevant DTP conditions.
- Members on the ProSecure Plus and ProSecure options are covered for the conditions listed in Table 1 and Table 3 (39 conditions in total), plus relevant DTP conditions.
- Members on the ProActive Plus and ProActive options are only covered for the conditions in Table 1 (26 conditions in total), plus relevant DTP conditions.

Table 2: Other non-CDL conditions			Available ONLY on ProPinnacle option
1.	Allergic Rhinitis – in patients with asthma	17.	Obsessive Compulsive Disorder
2.	Alzheimer's Disease	18.	Oncology Adjunctive Treatment
3.	Ankylosing Spondylitis	19.	Osteoarthritis
4.	Benign Prostatic Hypertrophy	20.	Osteoporosis
5.	Cushing's Disease	21.	Paget's Disease
6.	Cystic Fibrosis	22.	Paraplegia & Quadriplegia
7.	Deep Vein Thrombosis	23.	Peripheral Vascular Disease
8.	Gastro-Oesophageal Reflux Disorder	24.	Pituitary Adenomas/Hyperfunction of Pituitary Gland
9.	Gout	25.	Post-Organ Transplant (non-DTP)
10.	Hypoparathyroidism	26.	Psoriatic Arthritis
11.	Hyperthyroidism	27.	Pulmonary Interstitial Fibrosis
12.	Major Depressive Disorder	28.	Stroke/Cerebrovascular Accident
13.	Malabsorption Syndrome	29.	Systemic Connective Tissue Disorders
14.	Meniere's Disease	30.	Tuberculosis
15.	Motor Neuron Disease	31.	Valvular Heart Disease
16.	Myasthenia Gravis		

Table 3: Other non-CDL conditions			Available ONLY on ProSecure Plus and ProSecure options
1.	Allergic Rhinitis – in patients with asthma	8.	Osteoporosis
2.	Alzheimer's Disease	9.	Paraplegia & Quadriplegia
3.	Ankylosing Spondylitis	10.	Pituitary Adenomas/Hyperfunction of Pituitary Gland
4.	Benign Prostatic Hypertrophy	11.	Psoriatic Arthritis
5.	Major Depressive Disorder	12.	Pulmonary Interstitial Fibrosis
6.	Obsessive Compulsive Disorders	13.	Valvular Heart Disease
7.	Oncology Adjunctive Treatment		

Table 4: PMB conditions	Available on all options
Relevant conditions on the list of the 270 prescribed minimum benefit conditions, e.g. hormone replacement therapy for menopause, immuno-suppressive therapy for post-organ transplants.	

Conditions and medicines excluded from chronic medicine benefits

Excluded medicines include, but are not limited to:

• Botox	• Hypnotics and anxiolytics (sleep & anxiety-related medication)
• Food supplements	• Slimming preparations
• Homeopathic medication	• Eye lubricants
• Vitamins and minerals	• Muscle relaxants
• Laxatives and stool softeners	• Antidiarrhoeals

Excluded conditions include, but are not limited to:

• ADD/ADHD	• Irritable Bowel Syndrome (IBS)
• Acne	• Diverticular disease
• Headaches/migraines	• Dry eye syndrome
• Constipation	• Insomnia

How do you access the chronic medication benefit?

If you are diagnosed with one of the chronic conditions listed in Table 1, 2, 3 or 4, you can only have access to chronic medication once the chronic condition(s) has been registered with Swift OnLine™.

Therefore, your chronic **condition** must be registered first in order for your chronic **medication** to be authorised. A chronic condition only needs to be registered once. This applies to all eligible chronic conditions. If the medication is claimed without an authorisation, the cost will be processed from the acute medicine benefit or rejected if no acute medicine benefit is available.

Who can register your chronic condition?

As detailed clinical information, including the condition's ICD-10 code and severity status, are required to register your chronic condition, the treating doctor or a pharmacist is required to register the chronic condition. This is done telephonically by the treating doctor or your pharmacist by calling 0800 132 345.

Once your condition has been registered, you will have access to the Condition Medicine List (CML). This is a list of drugs appropriate for the treatment of that condition. Refer to the CML on the Profmed website to find out if a co-payment applies to your medication.

The CML includes formulary drugs. These are drugs that are available to all patients with a specified condition to which no reference price (co-payment) applies, provided they are claimed in appropriate quantities.

Reference pricing and MMAP® may apply to non-formulary drugs for CDL, non-CDL and PMB conditions, in accordance with the option selected by the member.

Where can I obtain the Condition Medicine List (CML)?

The CML is available in search facility format from the Profmed website. Select any benefit option from the Benefits tab and then click on the chronic medication link.

12.6 Reference pricing

Certain products on the Condition Medicine List (CML) have reference pricing applied. Reference pricing is the maximum price for which the Scheme is liable for specific medicine or classes of medicine listed on Profmed's CML. The reference price differs from one option to another and will be most restrictive on the hospital options (ProActive and ProActive Plus) and progressively least restrictive on the more comprehensive options (ProSecure, ProSecure Plus and ProPinnacle). The CML will indicate whether a co-payment applies to your medication as a result of reference pricing or other interventions. Refer to the "Scheme Info" page on the website for more information on reference pricing.

12.7 Maximum Medical Aid Price (MMAP®)

By utilising the MMAP® range of drugs available to you, you will maximise the limits available to you on your chronic, acute and day-to-day benefits. Profmed's pharmacy benefit manager, MediKredit, determines the MMAP® price levels by conducting surveys in the medication market, and is responsible for the implementation of MMAP®. MMAP® is the maximum price the Scheme is prepared to pay for specific categories of medication. This means that if you should choose to receive the MMAP® product, which will be within the permitted limits, Profmed will pay the full price of this product (dispensing fees are paid per the DSPN tariff). If, however, you choose medication that is more expensive than this price, you will be responsible for the price difference.

MMAP® products have been chosen because they have been tested, tried and approved by the Medicines Control Council. Approval is based on evaluation criteria that determine that the product may be regarded as the pharmaceutical equivalent (also known as "generic product") of other popular brands. The composition and effect of the generic products is thus the same, but may differ in price.

To stretch your medicine and day-to-day benefits further and to effect savings on your medical costs, we advise you to:

1. ask the doctor to prescribe generic medication where possible;
2. make use of your pharmacy in the pharmacy network to prescribe medication for minor conditions.

Medication not included on the CML

The CML does not list all medication that may be required to treat a patient's condition. Some medication requires specific pre-authorisation. This authorisation will be limited to a specific period, depending on your prescription and the motivation, which is required from the treating doctor. At the end of the period, a new authorisation needs to be obtained. As detailed clinical information is required to authorise these drugs, the treating doctor is requested to obtain this authorisation from Swift Online™ on 0800 132 345.

Please note: The CML is not a fixed list of products. This list is continuously being revised with regard to new products being registered, products that have been taken off the market, price changes, maximum medical aid prices (MMAP®) that change, and changes to the product registration details.

Certain high-cost chronic medication will only be funded on the ProPinnacle option and at a rate approved by the Scheme. Examples of medication in this category include, but are not limited to Forteo, Immunoglobulins, Pulmozyme and Venofer.

Certain products will only be authorised if prescribed by the appropriate specialist. In exceptional circumstances only, these drugs may be authorised by a non-specialist, who should contact the Swift Online™ pre-authorisation helpdesk on 0800 132 345.

If you require chronic medication, you must follow this procedure:

1. Inform the doctor of the CML when you visit him/her for a condition that requires chronic medication. Your doctor should refer to the CML when he/she prescribes medication for your chronic condition. If it is the first time you are diagnosed with the condition, your doctor will have to register this condition with Swift Online™ on the tollfree number 0800 132 345. The doctor can also call this number to discuss your medication and to obtain telephonic authorisation for medication that does not appear on the CML.
2. Your doctor will then issue a prescription so that you can obtain the medication from a pharmacy. With your doctor's prescription and your Profmed membership card, the pharmacist will submit a claim by means of the MediKredit Healthnet facility, in terms of the Scheme's benefit for chronic medication. Your doctor can also dispense the medication, provided he has a dispensing licence.
   Please note: Only doctors and pharmacists may make use of the Swift OnLine™ number. Members and patients may not use this line, but can obtain further information on existing chronic authorisations from Client Services by calling 0860 679 200.
3. If certain medication is not authorised after discussion with your doctor, you can still obtain it from your pharmacy or from your doctor by claiming it against your acute medicine benefit or by paying for it yourself.

4. MMAP® will apply to certain medication on the CML. Generic equivalents that fall within the maximum medical aid price are available and also appear on the CML. If the doctor should prescribe a product that costs more than the maximum medical aid price, you will be responsible for paying the price difference when you purchase the medication.

Processing of pharmacy claims

Pharmacy claims are processed electronically, online and real-time. When the pharmacist dispenses medication, the system automatically accesses the member's details and benefit information from the Scheme's database and provides the pharmacist with a response from the Scheme immediately. The pharmacist is therefore immediately able to ascertain whether the claim was processed or not, which benefit it was processed from (chronic or acute), and whether the member will be required to pay a co-payment. In the case of repeat scripts, for example for chronic medication, the pharmacist is also able to advise you when your prescription needs to be re-issued or the medication needs to be re-authorised.

On rare occasions, the system interface between the pharmacy, MediKredit (Profmed's pharmacy benefit manager) and Profmed may not be operational. The pharmacy system then goes into "stand-in" mode. In the event of this happening, MediKredit processes claims using the daily data dump of benefit information from Profmed. Pharmacy claims are then processed between the pharmacy and MediKredit to verify member information and benefit availability. As these transactions are not real-time, there are instances in which the information provided on the data dump may be outdated as medical schemes are high-volume transaction businesses. In this instance, the MediKredit system could approve a claim, but once processed by the Scheme, the claim could be rejected due to insufficient benefits or a co-payment may be applicable. In this instance the provider will be short-paid and the member will be responsible for the balance.

13. Hospital utilisation management

Pre-authorisation of hospital admissions

Before a beneficiary can be admitted to hospital, it is the member's responsibility to obtain authorisation by calling 0860 776 363. Elective procedures or treatment can be authorised between 07:30 and 18:00 from Mondays to Fridays, and between 08:00 and 12:00 on Saturdays.

In an emergency, or for after-hours admissions, an authorisation number must be obtained on the first working day after admission. If, for any reason, you are unable to obtain an authorisation number yourself, one of your family members must obtain it on your behalf.

Information required for authorisation

a. Your membership number;
b. The full name of the patient being hospitalised;
c. The name of the hospital to which the patient is being admitted;
d. The reason for the hospital admission or the planned diagnostic procedure;
e. The date of admission and the date on which the procedure is scheduled to be carried out;
f. The particulars of the doctor or service provider (practice code number if applicable, initials, surname and telephone number).

Always ask your doctor for a full description of the:

- reason for admission;
- associated medical diagnosis;
- prospective procedures as well as the procedure code he intends to use.

Please note that a pre-authorisation reference number does not guarantee payment. Refer to Pre-Authorisation in this Guide for further information on pre-authorisation.

Once the abovementioned information has been reviewed, you will be provided with an authorisation number, and informed of the number of days that will be covered in hospital. If an authorisation number is obtained only after treatment has started or after a procedure has been carried out, or if no authorisation number has been obtained at all, you may be responsible for a penalty in the form of the payment of the first R2 000 with regard to the treatment or procedure.

Authorisation also applies to pregnancy admissions and maternity deliveries.

In certain instances, you may be requested to submit a motivation for a procedure or to obtain a second opinion. These requests are made under the guidance of a panel of suitably qualified doctors and professionals in an attempt to ensure appropriate use of your benefits and to best utilise the funds of the Scheme to the advantage of the entire membership.

Are laparascopic procedures covered?

Laparascopic procedures will only be reimbursed if pre-authorised pre-operatively and in terms of the protocols, and the particular procedure complies with specific clinical criteria. If authorisation is not obtained, these procedures will be reimbursed at the equivalent rate of the conventional procedure.

What costs are included in the hospital authorisation?

Hospital authorisation covers only the cost of the hospital facilities, e.g. ward fees, materials, theatre fees, medicines (excluding medicine taken home on discharge) as these fees are controlled either by legislation, in the case of medication, or in terms of fees negotiated by Profmed with the various hospitals and hospital groups.

Specialist and GP fees for consultations and procedures and other medical practitioner fees in hospital are not included in the authorisation as the fees for these services differ from provider to provider and can only be reimbursed according to the tariff and benefit available on the option the member has chosen.

Internal surgical devices and external prostheses and appliances are included in the authorisation but are reimbursed only at the benefit available to the member in accordance with the option the member has chosen. Quotes for these items must be submitted to the Scheme.

Radiology and pathology in hospital

It is important to note that hospitalisation is not covered if the admission is for the sole purpose of radiology or pathology investigations. MRI and CT scans and other investigative procedures while in hospital must be pre-authorised.

14. Disease management programmes

These programmes are all subject to the Scheme's management protocols.

14.1 Oncology programme

The purpose of the programme is to:

- co-ordinate and manage the care of the patient throughout the course of the treatment;
- ensure that the patient is put onto a treatment plan;
- ensure that the plan is managed in relation to the benefits available in consultation with your oncologist or treating physician;
- involve the patient during the treatment period;
- promote optimal wellbeing.

How to register on the programme

Prior to commencement on active treatment, contact 0861 767 205 (outside RSA +27 12 679 4142). A trained and qualified advisor will explain the benefits available to you as well as the fact that you will need a treatment plan from your oncologist. The treatment plan must be faxed to +27 12 679 4427 or e-mailed to oncology@profmed.co.za. The plan will be evaluated and, in consultation with your oncologist, a treatment plan specific to your condition will be authorised in accordance with the Scheme's rules and protocols.

What treatment is covered from the oncology benefit?

This will depend on whether the patient is receiving active treatment with chemotherapy or radiotherapy, or is in the non-active phase.

Active treatment

In accordance with the Scheme's protocols, the active treatment period is defined as the period from the date on which the patient first receives treatment with chemotherapy and/or radiotherapy and continues up to ninety days after the last date of active therapy.

While a patient is receiving active treatment, the following treatments and procedures will be paid from the oncology benefit, provided claims are submitted with the correct ICD-10 codes to match the authorisation:

- Chemotherapy
- Radiotherapy: subject to use of DSPN
- Hospitalisation
- Pathology
- Medication, including medication to treat complications of cancer or cancer therapy (oncology adjunctive treatment), subject to oncology programme protocols
- Radiology, including MRI, CT and PET scans. PET scans subject to use of the DSPN
- Consultations by the treating oncologist (in- and out-of-hospital).

Related costs, such as the cost of wigs, stoma bags and breast prostheses, will be covered from the external appliance benefit.

Please note: Medication and procedures not directly related to the oncology treatment, e.g. high blood pressure medication and anti-depressants, etc., will be paid from the relevant chronic or day-to-day benefit.

DSPN - Radiotherapy

In order to avoid co-payments, it is necessary to make use of the DSPN contracted to provide services for radiotherapy. The DSPN for radiotherapy is all participating Netcare facilities.

PET scans (Positron-Emission Tomography)

PET scans are covered subject to pre-authorisation and the use of the DSPN, and are paid strictly in accordance with Profmed protocols. PET scans are funded during active treatment only.

DSPN - PET scans

In order to avoid co-payments, members in the greater Johannesburg region will be required to make use of the DSPN contracted to provide services for this diagnostic treatment. The DSPN for PET scans is Bloch & Partners at Morningside Clinic. Members outside the greater Johannesburg region are not required to use the DSPN.

Non-active treatment

Non-active treatment refers to that period when the patient is no longer receiving chemotherapy or radiotherapy, and commences ninety days after the date of the last active treatment. This includes consultations, investigations and medication.

Medication will be paid from the chronic benefit, and consultations, radiology and pathology (and other related costs) from the relevant day-to-day benefit. All costs are subject to the limits available in the relevant benefit and are dependent on the option the member has chosen.

Do I get one authorisation number for my total treatment?

No – authorisation numbers are issued separately for chemotherapy, radiotherapy, hospitalisation and radiology. An authorisation number must be obtained for each procedure. Blood tests are authorised together with the concomitant chemotherapy or radiotherapy.

What number must I call?

For authorisation in respect of hospitalisation, radiotherapy and chemotherapy in a doctor's rooms, during hospitalisation and on an outpatient basis at the hospital, as well as radiotherapy, MRI, CT and PET scans, call 0861 767 205 (outside RSA +27 12 679 4142).

14.2 Peritoneal dialysis and haemodialysis programme

The comprehensive dialysis management programme ensures that members receive optimal treatment at cost-effective cover. To qualify for benefits, please register on the programme by calling 0860 776 363. You will be requested to submit a treatment plan, which will be authorised in conjunction with your treating physician, according to protocols.

DSPN - Chronic dialysis

In order to avoid co-payments, it is necessary to make use of the DSPN contracted to provide services for chronic dialysis, which is National Renal Care.

What does this benefit cover?

- Chronic haemodialysis
- Approved blood tests, e.g. pre- and post-dialysis renal function tests
- Certain approved investigations related to the condition (subject to the protocols of the programme).

Please note: Claims will be paid according to the benefit option the member has chosen and the use of the DSPN.

14.3 Transplants

What is covered?

Cover for pre-, intra-, and post-operative treatment is available to members. To qualify for benefits, register on the programme by calling 0860 776 363. Submit a treatment plan, including a comprehensive quotation from your attending physician, which will be authorised in conjunction with your doctor, according to protocols.

Post-operative chronic and immuno-suppressant medication will be paid from the chronic benefit and will be paid in accordance with the option the member has chosen. The formularies and protocols of the Scheme will apply. Chronic medication must be authorised by a doctor or pharmacist by calling 0800 132 345.

Donor costs

Benefits for donor costs are only available to a Profmed transplant recipient. The Scheme does not cover the donor costs of a Profmed member who elects to be a donor to a transplant recipient who is not a Profmed member. PMB legislation applies in all instances.

15. Endoscopic examinations

Profmed's DSPN for endoscopic examinations is Netcare, Life Healthcare, Clinix, National Hospital Network (NHN) and Mediclinic. Procedures undertaken at a non-DSPN facility will be reimbursed at the rate negotiated with the DSPN and any balance will be for the account of the member.

Requests for endoscopic procedures to be done under conscious sedation are subject to Profmed protocols and pre-authorisation. General anaesthetic will only be covered in exceptional circumstances and will be subject to protocols.

Gastroscopies, colonoscopies, sigmoidoscopies and anoscopies will be covered only in a suitably equipped procedure room. Authorisation must be obtained by calling 0860 776 363.

16. Devices and appliances

What am I covered for?

This benefit is divided into two categories:

Category 1 – Internal surgical devices

The use of internal surgical devices requires authorisation. This benefit includes, but is not limited to the following items:

• Cochlear implants	• Implantable cardiac defibrillators
• Internal nerve stimulators	• Artificial sphincters
• Artificial intervertebral discs	• Cardiac stents
• Abdominal aortic stents	• Joint replacements

Benefits are subject to pre-authorisation by calling 0860 776 363 and are paid from the risk benefit, subject to the benefit limit.

Category 2 – External prostheses and appliances

This benefit includes, but is not limited to insulin pumps, hearing aids, stoma bags and domiciliary (home) oxygen therapy, and is subject to the benefit limit. This benefit is not subject to the day-to-day limit.

Hearing aids are only available every 24 months and insulin pumps every 48 months, calculated from the date of service.

Home oxygen is subject to the use of the DSPN. Ecomed Medical cc is the DSPN for home oxygen. In order to avoid co-payments it is necessary to make use of the DSPN.

Pre-authorisation for all external prostheses and appliances is required by calling **0860 776 363**.

The following "Other" prostheses and appliances are subject to a sub-limit, which is subject to the day-to-day limit:

• Neck and back braces fitted in theatre	• Wheel chairs
• Walking frames	• Crutches

Please note: The external prostheses and appliance benefit is not available on the ProActive Plus and ProActive options.

What is not covered?

The most commonly used items not covered are:

• Toilet seat raisers	• Orthopaedic shoe inserts and retail innersoles
• Apnoea monitors	• Safe-hip prostheses
• Nappies for adult use	• APS therapy machines or similar equipment
• Kidney belts	• Medic Alert bands
• Mattresses, waterbeds and special beds and chairs	• Bedpans
• Humidifiers	• Health shoes, e.g. Green Cross
• Repairs of durable goods	• Cushions, sheepskins and waterproof sheets
• Repairs of hearing aids	• Replacement batteries for medical appliances or devices, e.g. hearing aids
• Motorised mobility devices	

If you are not sure whether an item is covered, refer to the list of exclusions included in this Guide and in the Schedule of Benefits, or call Client Services on 0860 679 200.

17. Optical benefit

Profmed's optical benefits are subject to clinical protocols and are applied over a 24-month period calculated from date of service. If members utilise their benefits within Profmed's protocols, members will not be liable for co-payments. Profmed excludes sunglasses and spectacle lens tinting. All optical benefits are subject to the day-to-day limit, and frames and contact lenses are also subject to a benefit sub-limit. Optical benefits are not available to members on the ProActive Plus or ProActive options.

Please note: A limited benefit for refractive surgery is available only on the ProPinnacle option.

18. Dental benefit

Profmed's dental benefits are amongst the richest in the industry. Hospitalisation for dentistry under general anaesthetic that has been authorised is paid from risk and not from the member's day-to-day benefits. The in-hospital and out-of-hospital dental benefits are not combined, which means members have access to three levels of dental benefits, depending on your benefit option:

- Hospitalisation for dentistry (excluding dentist's fees) – paid from risk;
- Out-of-hospital conservative dentistry – no benefit limit and subject to the overall annual day-to-day limit; and
- Out-of-hospital advanced dentistry – subject to the benefit limit and not subject to the overall annual day-to-day limit.

Members on the ProPinnacle option have access to benefits for orthognathic surgery.

Conservative dentistry in the dentist's chair includes:

• Consultations	• Filling of teeth
• Extraction of teeth	• Plastic dentures
• Preventative dental care	• Root canal treatment

Advanced dentistry includes:

• Crowns	• Surgery (excluding functional orthognathic surgery)
• Orthodontic treatment	• Dental implants
• Periodontics	• Bridges

The limit on advanced dentistry is option-specific. The sub-limit is not subject to the day-to-day limit. Advanced dentistry in hospital will be approved in specific cases only.

Dentistry in hospital

It is generally accepted in the medical scheme industry that dentistry is considered to be an out-of-hospital benefit and is not covered in-hospital on hospital-only options. Profmed is, therefore, unique in that dentistry in hospital is covered on Profmed's two hospital options, ProActive Plus and ProActive. In-hospital procedures are subject to protocols and authorisation and only specific procedures are covered in hospital. Basic dentistry has no sub-limit but is subject to the day-to-day limit. Basic dentistry in hospital on the ProActive and ProActive Plus options will be approved in specific cases only, namely, extensive conservative dental treatment in children 8 years and younger (24-month benefit), and permanent tooth impaction removal.

Functional orthognathic surgery

This benefit is only available to members on the ProPinnacle option and is subject to a benefit limit. All costs related to the event will accumulate to this limit, including but not limited to the surgeon fee, assistant fee, anaesthetist, hospitalisation, etc. Pre-authorisation must be obtained by calling 0860 776 363.

Dental laboratory services

The costs of dental laboratory work cannot be claimed under pathology or consultation fees, but will be deducted from the relevant dental benefit limit.

Orthodontic treatment

Orthodontic treatment is subject to pre-authorisation. Treatment without pre-authorisation will be excluded from benefits. For more information concerning the treatment plan, please call 0860 679 200. You will be requested to fax the treatment plan to 012 679 4411. Orthodontic treatment is limited to age 18. Benefits are subject to management, and the protocols and rules of the Scheme.

Pre-authorisation

Authorisation must be obtained prior to the commencement of any dental treatment in hospital, whether conservative or advanced dentistry. Call 0860 679 200 to request authorisation. In-hospital dentistry will be subject to strict management and protocols. Please refer to section 9 "Pre-authorisation" in this Guide for more information on authorisation.

19. Oral contraceptives

This benefit is subject to a benefit limit per beneficiary per month and is paid from risk, not from the member's day-to-day benefits. This benefit covers only oral contraceptives or the injection or the patch, but does not cover intra-uterine devices. Oral contraceptives used for any other purpose than contraception will not be funded. Dispensing cycles apply, i.e. repeat scripts may only be obtained after 20 days from the last dispensing date.

20. Preventative care

As part of our commitment to your wellbeing, this benefit encourages the early detection of the most frequently diagnosed high-risk diseases. Early treatment reduces the risk of complications and is more likely to secure a better prognosis for the patient. This benefit provides cover for specified consultations, pathology, radiology and vaccinations. Beneficiaries with condition-specific

waiting periods relevant to this benefit do not qualify to receive cover under this benefit for the duration of the waiting period.

This benefit provides cover for the following vaccines:

• Influenza	• Child immunisations
• Human papilloma virus	• Pneumococcal

Testing is covered for the following:

• Breast cancer	• Prostate cancer
• Cervical cancer	• Cardiac disease
• Late onset diabetes	

Who qualifies for this benefit?

- **Mammography for breast cancer** is available to women who are 40 years or older. Women who are younger than 40 and are pre-disposed to breast cancer also qualify but a motivation from your doctor must be submitted to the Scheme. Contact 0860 776 363. You will be requested to submit a motivation, which must be faxed to 0866 092 245 (outside RSA +27 12 679 4438).
- **Prostate Specific Antigen (PSA) testing for prostate cancer** is available to men who are 40 years or older.
- **Pap smears for cervical cancer** are available to women who are 18 years or older. Profmed also funds liquid-based cytology tests, which is the latest development in screening for cervical cancer. This test is funded at the same rate as the conventional Pap smear.
- **Fasting blood tests (cholesterol) for cardiac disease** are available to men and women who are 40 years or older. The patient will be required to fast prior to the blood test.
- **Fasting blood sugar test for late onset diabetes** is available to men and women who are 40 years or older. The patient will be required to fast prior to the blood test.
- **Influenza vaccine** is available to beneficiaries of all ages.
- **Human papilloma virus (HPV) vaccine** is available to females 9 – 27 years of age. The benefit covers the initial vaccine and follow-up boosters.
- **Child immunisation vaccines** are available to children 0 – 6 years old, per the Department of Health's immunisation schedule.
- **Pneumococcal vaccine** is available to adults 65 years and older, as well as to patients of all ages who are respiratory- or immuno-compromised.

Pre-authorisation is not required, except in the case of mammography for women under 40 years of age.

Designated Service Provider (DSP)

The Ampath group, including Drs Du Buisson, Bruinette & Kruger and Drs Bouwer & Partners, Pathcare and Lancet Laboratories, have been contracted to provide pathology services to Profmed members in respect of this benefit, where applicable. Funding is covered in terms of the protocols of the Scheme as indicated in the Schedule of Benefits.

Note: Should a member use the services of a provider other than the DSP, the member will be liable for a co-payment, which will be deducted from the member's day-to-day limit. Members on the ProActive Plus and ProActive options who do not have a day-to-day limit will be required to pay the provider directly.

Where can a DSP practice be located?

Drs Du Buisson, Bruinette & Kruger offer services nationally except in KwaZulu-Natal, and Drs Bouwer & Partners offer services in KwaZulu-Natal. Ask your doctor to provide you with the location of a DSP practice in your area, or access the list of practices via the links for each pathology provider on the Profmed website at www.profmed.co.za under the Links tab.

Follow-up investigations, treatment or consultations resulting from these tests are not paid from this benefit but are funded from the relevant chronic, day-to-day or other benefit in terms of the rules, limits and protocols of the option the member has chosen.

21. Trauma and HIV exposure assistance

What is covered?

In the event that you are a victim of crime, you and any dependants who were victims of such an incident will be entitled to immediate and follow-up trauma counselling. All counselling, whether telephonic or one-on-one visits, is undertaken by a registered psychologist. Where relevant, victims will be accompanied by an appropriate, qualified professional to identity parades and court appearances for emotional support. If the crime exposed you in any way to the possibility of HIV infection, you and/or your dependants will receive PEP (post exposure prophylaxis) treatment and follow-up management. This also applies to healthcare practitioners who are exposed to needle-stick injury. Benefits must be accessed through the DSP to avoid co-payments. Claims are not deducted from members' benefit limits.

How to obtain assistance

The emergency helpline is available 24-hours a day to assist you immediately after a traumatic event. If follow-up counselling is required, the case manager assigned to you will arrange for consultations with a psychologist, appropriately qualified to assist you in dealing with the specific crime or trauma you have experienced. Please call 011 541 1225 for trauma and HIV post-exposure assistance. This benefit is not available to members residing outside South Africa.

Where prophylactic medication is required, it will be immediately despatched to you and you will be informed of the process over the following three to six months in managing and monitoring your HIV risk and treatment.

Follow-up investigations, treatment or consultations resulting from this benefit are not paid from this benefit but are funded from the relevant chronic, day-to-day or other benefit in terms of the rules, limits and protocols of the option the member has chosen.

22. Emergency transport

In all instances where Profmed members require emergency medical transport within South Africa, or within their country of residence in the SADC Region, it is of vital importance that the emergency number is contacted to access such services. Rest assured that if your circumstances warrant emergency transport, on contacting the emergency transport number, an appropriate form of transportation will be despatched to you and the full account will be settled by Profmed with no capped limits.

Please display your Profmed emergency windscreen sticker on your motor vehicle/s to ensure you receive the correct assistance in the event of a motor vehicle accident or other roadside medical emergency. It is also advisable to ensure ready access to the emergency number while in your home. All emergency numbers are also reflected on your Profmed membership card.

How to obtain assistance and authorisation

- In emergencies where the member can communicate, simply dial **0861 776 363**. The consultant receiving the call will guide you further.
- In an emergency where someone else calls an ambulance service other than Profmed's provider, International SOS, e.g. where the member is unconscious, International SOS must be informed within 48 hours after the incident. Please ensure that your family is made aware of this requirement. The account submitted by the ambulance service will be assessed by International SOS and paid in accordance with the protocols of the Scheme.
- In cases of inter-hospital transfers (including emergency transfer from a doctor's room to a hospital), ensure that the doctor or receptionist dials 0861 776 363 to obtain authorisation for the ambulance transfer.

How do I request assistance from countries within the SADC Region?

Please refer to section 25 "Cover in the SADC Region" in this Guide for a list of countries that comprise the SADC Region. From within this region, please call **+27 11 541 1225** for emergency assistance. If the circumstances permit, International SOS will arrange for a suitable, appropriate local emergency transport organisation to assist you or you will be referred to a local suitably equipped and appropriate medical facility. If suitable facilities are not available where you are situated, appropriate emergency transport will be despatched to evacuate you to the closest most appropriate facility.

Important: Please ensure you have the emergency contact number readily available at all times.

23. International travel medical assistance

While travelling outside the borders of their country of residence, members in the RSA and SADC Region have access to international medical cover. This benefit is managed by International SOS.

Members can now travel outside the borders of South Africa, or their country of residence in the SADC Region, with peace of mind knowing that all emergency or unexpected medical expenses will be taken care of. Members requiring medical assistance while travelling must call International SOS on the international emergency number. If the circumstances permit, International SOS will arrange for a suitable, appropriate local emergency transport organisation to assist you or you will be referred to a local suitably equipped and appropriate medical facility. If suitable facilities are not available where you are situated, appropriate emergency transport will be despatched to evacuate you to the closest most appropriate medical facility.

What is covered?

Members on all options are entitled to R3 million cover per beneficiary per journey for journeys not exceeding 90 days, which includes all in- and out-of-hospital claims. Members on the ProActive Plus and ProActive options do not have access to out-of-hospital benefits.

All out-of-hospital claims are subject to a R1 000 excess. Spectacle and contact lens claims are limited to R3 000, subject to the R1 000 excess (co-payment). Elective or anticipated medical expenses incurred while travelling will not be covered.

Members and dependants who are in a 12-month condition-specific waiting period will not receive benefits for that condition while travelling. Members in a 3-month general waiting period are not entitled to international travel cover for the duration of the waiting period.

How do I access cover?

- Before departing on your trip, whether flying, driving or on a sea cruise, please activate your cover by calling **0860 679 200**.
- Enquiries can be e-mailed to profmed@internationalsos.com.
- You will be provided with a policy document, which sets out the terms, conditions and exclusions applicable.
- While travelling, the emergency number to contact is **+27 11 541 1225**.

Important:

- When travelling internationally, ensure you have the international emergency contact number readily available, i.e. **+27 11 541 1225**.
- It is the responsibility of members to ensure they understand the terms, conditions and exclusions applicable to this cover prior to departure from South Africa.

How to claim

All claims in respect of medical expenses incurred are processed through International SOS in South Africa. Most claims are dealt with directly by International SOS, but should you return to South Africa with paper claims in respect of expenses you have incurred personally, these claims, together with the receipts, must be sent to International SOS, P O Box 4561, Halfway House, 1685, together with a completed claim form, which will be e-mailed to you when activating your cover prior to departure.

Additional international travel cover

Members who require optional additional international cover can obtain this cover from ACE Insurance Ltd. Profmed provides emergency international travel medical expenses cover at no cost for the initial R3 million, thereafter ACE offers additional cover at the member's expense. ACE Insurance will issue members with a policy document setting out the terms and conditions of the cover available. For more information on the additional international travel cover contact **0860 679 200.**

24. Claims procedure

Profmed aims to make the claims procedure for its members as user-friendly as possible and in most cases claims are submitted electronically by the service provider, i.e. your doctor, dentist, pharmacist, etc., on your behalf. We must point out, however, that you must check all claims submitted on your behalf to ensure that the service has indeed been rendered to you. For this purpose you must check the statement you receive from Profmed when you have visited a medical practitioner. In this way you will notice if there are any inaccurate claims against your benefits. If there does appear to be a problem, please contact the service provider and enquire about the claim submitted on your behalf. You must then contact Profmed and point out the irregularities. Profmed will ensure that only costs for services you have received are paid out from your benefits.

What if you have paid cash for services?

If you pay cash for services covered by your benefits, you can claim this payment back from Profmed. When making the payment to the provider, please remember to obtain a detailed account and receipt for your payment. Cash claims are paid weekly.

A receipt submitted without the accompanying account can and will not be paid.

No claim form is required. You can simply scan and e-mail your claims to claims@profmed.co.za. Alternatively, you can post your accounts to:
Profmed Claims Department
Private Bag X1031
Lyttelton
0140.

Please check the details on your account (see "What should you check on your claim?" below) and write "Account Paid" on the account.

Faxed claims will NOT be accepted. These claims are often illegible, which leads to claims being paid incorrectly, or not at all. It is also difficult to detect any irregular changes made to the original document. Claims will be reimbursed to you by means of a direct payment into your bank account. Cheques will not be issued. Payments are made twice a month.

What should you check on your claim?

Before you submit claims, you must ensure that the account contains the following information:

- Your membership number as it appears on your membership card
- Profmed's name as the medical scheme
- The surname, initials and postal address of the principal member
- A receipt (if you have already paid the account)
- The patient's first name(s) and dependant code as indicated on your membership card
- The name and practice code number of the service provider (doctor, hospital, pharmacy, etc.)
- The date of the service or treatment
- The nature and cost of each service and, where applicable, the tariff code
- The referring doctor's name and practice code number in the case of a specialist's account (where applicable)
- The duration of an operation (where applicable)
- The name, quantity, price and NAPPI code of each item of medication (where applicable)
- The ICD-10 diagnostic code (where applicable).

If your claim does not contain all the necessary information, it will lead to delayed or faulty benefit payments.

You are advised to keep copies of all your accounts, receipts and statements for your own records.

How quickly should you submit claims?

You should submit claims as quickly as possible. If the Scheme receives a claim after four months from the date of service, it is considered a "stale" claim and will not be paid. Accounts that are older than four months from the service date and for which no proof of timeous submission can be provided will not be paid.

How can you keep record of claims processed?

Once you have submitted your claim to the Scheme, you can track the progress of your claim by logging into your profile from the Profmed website. You must be a registered website user to access this function.

Once the claims have been processed, you will receive a claims advice, which indicates the following information:

- Amounts paid by the Scheme and to whom payment was made, i.e. to the member or the service provider;
- Monies owed by you to the Scheme or service provider (doctor, hospital, etc.);
- The benefit from which funds were paid;
- The balance of your benefits for the current year.

Enquire at Client Services about claims you have submitted that do not appear on your claims advice.

What happens if the service provider submits the claim directly to the Scheme?

Many providers of medical services and medication have an electronic link to the Scheme, which enables them to submit claims directly to the Scheme. These are called EDI (electronic data interchange) claims. In such cases you are entitled to receive a copy of the account from the provider and you should use it together with your Profmed claims advice to follow up on the processing of these claims.

How will the Scheme pay out what is due to you?

If the Scheme owes you money, it will be paid into your bank account. Direct payments into your bank account are to your advantage because they are efficient and less risky. Due to fraud, cheque payments will no longer be made. If you are currently not making use of direct payments into your bank account, please provide Profmed with your bank details.

What happens if there are outstanding claims when you resign or in the event of your death?

Claims will be paid out for up to four months after resignation or death, as long as the service date was before the date of resignation or death. Any amount paid by the Scheme that exceeds the benefits to which you are entitled will be recovered from you or your estate, or the payment to suppliers will be cancelled.

Why are accounts not always paid in full (co-payment)?

A co-payment results when there is a difference between the fee charged for a medical service and the benefit paid by the Scheme where the claim amount is higher than the tariff amount. There may also be a co-payment if the permitted maximum benefits have been exhausted.

25. Cover in the SADC Region

Profmed covers members for all benefits offered by the Scheme while members are resident or working in the SADC Region. Claims are paid at South African rates in accordance with the option chosen by the member. Members who submit claims incurred while resident or working in the SADC Region may not claim for the same expenses from the International Travel Medical Assistance benefit.

Members travelling across the borders of their country of residence in the SADC Region should make use of the International Travel Medical Assistance benefit – refer to that section in this Guide for more details.

Countries in the SADC (Southern African Development Community) Region

This region includes Angola, Botswana, Democratic Republic of the Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

26. Sabbatical benefit

Who qualifies?

Any person who has been a member of Profmed for at least one year and who wishes to pursue their career or post-graduate studies overseas, or travel for an extended period abroad, qualifies for this benefit.

What does the benefit offer?

Profmed will terminate the membership of the principal member and his/her dependants during the sabbatical period. On return to South Africa, Profmed will re-activate the membership of the member and his family with a new membership number, without underwriting being applied, provided there has been no significant deterioration in health. Underwriting will, however, apply if the sabbatical period is longer than three years. Members may only access this benefit again after one year of re-activation of cover.

How to access the benefit

Call Client Services on 0860 679 200. The necessary arrangements will be made to accommodate your sabbatical and you will be issued with a letter confirming your arrangement with Profmed. This letter must be submitted to Profmed on your return to South Africa for your membership to be re-activated.

27. Motor vehicle accident claims and expenses recoverable from a third party

Any circumstances for which compensation can be claimed or which may give rise to compensation in terms of the Road Accident Fund, or any expense which is recoverable from a third party, does not qualify for benefits in terms of the Scheme unless the member informs Profmed within a reasonable time after the accident/incident about his/her intention to submit a third-party claim. These claims will then be handled separately from the member's normal Scheme benefits.

Please note: Benefits will not be withheld in this instance, provided the Scheme receives an undertaking from the member that, once the member has received compensation from the relevant responsible third party, such funds will be reimbursed to the Scheme. Claims will be kept on hold until such undertaking is received.

28. Injury on duty

Medical claims arising from an injury on duty are not covered by Profmed. All claims in respect of injuries incurred while on duty must be claimed from the Compensation Commissioner. If it should happen that claims applicable to the injury on duty are inadvertently paid by the Scheme, the Scheme must be informed, after which adjustments will be made to the claims, and the amount will be claimed back from the service provider. It is your or your employer's responsibility to ensure that the medical claims are claimed from the Compensation Commissioner.

29. Exclusions

With the exception of the prescribed minimum benefits and unless specific provision has been made in the rules for benefits, certain treatment, services, appliances and circumstances do not qualify for benefits. These exclusions are enumerated in Annexure C of the Rules, the Schedule of Benefits as well as in other sections of this Information Guide.

30. Fraud line

The Profmed fraud line enables the Scheme to respond to complaints and to investigate any medical scheme claims that may appear suspicious. The fraud line is available twenty-four hours a day.

If you know of any possible fraud directed against the Scheme, call the fraud line on 0860 110 820, or e-mail fraud@profmed.co.za. All contacts will be treated as confidential. The fraud line is a share-call number.

31. Profmed website

Profmed's website, www.profmed.co.za, is an interesting, interactive site for Profmed members, service providers and brokers.

Members can view their claims history, access documents, view and update their personal details and correspond with the Scheme online.

Providers will be able to view and track their Profmed members' claims and brokers will have access to their Profmed clients' profiles.

If you would like to register on the website, click the "Register" link on the Home page and follow the prompts. If you require further information, please contact Client Services on 0860 679 200.

32. The role of medical scheme brokers

Medical schemes make use of brokers (also called "consultants", "advisors" or "intermediaries") to market their scheme to the public.

Profmed is a closed or restricted scheme, which means that only members of the public who comply with certain entry criteria can apply to the Scheme for membership. Brokers play an important role in the sales process. Only an accredited and licensed broker may make application on your behalf to Profmed.

It is important to know that brokers are not employed by the Scheme, but are independent and have a contract with Profmed. Most of the brokers contracted to Profmed also have contracts with other medical schemes.

Brokers function within a highly regulated environment and the Medical Schemes Act determines, among other things, that brokers must adhere to a certain code of conduct. The remuneration received by brokers from schemes for introducing new business is regulated by legislation.

Brokers take the following factors into account when advising clients on a suitable medical scheme:

1. Affordability according to the applicant's budget and possible employer subsidy;
2. A needs analysis of the type of cover required;
3. Legislative implications with regard to waiting periods, exclusions and penalties;
4. The financial position of the Scheme;
5. Administrative capacity and general performance of the Scheme.

Brokers facilitate efficient interaction with the Scheme on behalf of their clients. Clients (members) can expect the following from their broker:

1. An explanation of the nature and extent of benefits which the member's benefit option offers, as well as the contributions being paid;
2. Help with change of benefit options;
3. Assistance and information with regard to procedures;
4. Information about changes in benefit options, benefits or contributions;
5. Assisting with the resolution of problems.

The medical scheme industry is becoming increasingly complex, and by making use of a knowledgeable broker, members should have greater peace of mind. If you are not sure who your broker is, contact Client Services on 0860 679 200. If you wish to use the services of a broker, call 0800 DEGREE (334 733) or e-mail degree@profmed.co.za. A Profmed consultant will put you in touch with a broker in your area.

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