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PROFMED



INFORMATION GUIDE **2018**

Applicable 1 January 2018 to 31 December 2018.

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.

Contents

1.	Important contact information.....	3
1.1	General telephone numbers.....	3
1.2	E-mail communication.....	3
1.3	Emergency telephone numbers.....	3
1.4	Facebook, LinkedIn, Profmed app and Twitter.....	3
2.	Management of the Scheme.....	4
3.	Rules.....	4
4.	Scheme benefit options.....	4
5.	Membership.....	5
6.	Termination of membership.....	7
7.	Continuation member.....	8
8.	Contributions.....	8
9.	Pre-authorisation.....	9
10.	Prescribed minimum benefits.....	9
11.	Designated Service Provider Network (DSPN).....	10
12.	Use of medicine.....	11
12.1	DSPN for medication.....	11
12.2	Prescribed acute medication.....	11
12.3	Over-the-counter medication.....	11
12.4	Dispensing cycles.....	11
12.5	Prescribed chronic medication (Life-sustaining medication).....	12
12.6	Reference pricing.....	14
12.7	Maximum Medical Aid Price (MMAP®).....	14
13.	Hospital utilisation management.....	16
14.	Disease management programmes.....	17
14.1	Oncology programme.....	17
14.2	Peritoneal dialysis and haemodialysis programme.....	18
14.3	Transplants.....	18
15.	Endoscopic examinations.....	19
16.	Devices and appliances.....	19
17.	Optical benefit.....	20
18.	Dental benefit.....	20
19.	Contraceptives.....	21
20.	Preventative care.....	21
21.	Trauma and HIV exposure assistance.....	23
22.	Emergency medical transport: Local.....	23
23.	International travel medical assistance.....	24
24.	Claims procedure.....	25
25.	Cover in the SADC Region.....	27
26.	Sabbatical benefit.....	27
27.	Expenses recoverable from a third party.....	28
28.	Exclusions.....	28
29.	Fraud line.....	28
30.	Profmed website.....	28

1. Important contact information

1.1 General telephone numbers

	Within RSA	Outside RSA	Fax
Client Services & 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: - Emergency Medical Assistance - Enquiries	– 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
Profmed Baby	0860 776 363	–	–
Multiply Wellness and Rewards Programme	0861 886 600	–	–
Fraud line (24/7)	0801 113 941	–	0865 222 816
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	claims@profmed.co.za
International Travel Claims	internationalclaims@profmed.co.za
International Travel Enquiries	internationalinfo@profmed.co.za
Pre-authorisation	preauth@profmed.co.za
Fraud line	information@whistleblowing.co.za

1.3 Emergency telephone numbers

	Within and Outside RSA
Emergency medical assistance outside RSA	+27 11 541 1225
Emergency medical assistance within RSA	082 911
Trauma and HIV exposure assistance within RSA	0861 776 363

1.4 Facebook, LinkedIn, Profmed app and Twitter

You can also follow us on:	
	Facebook http://www.facebook.com/Profmed
	LinkedIn http://www.linkedin.com/company/profmed
	Download the Profmed app from your smartphone store
	Twitter https://twitter.com/Profmed_SA

2. Management of the Scheme

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

Vision

To address the healthcare needs of professionals through appropriate benefit design.

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/she 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	Offers unlimited in-hospital cover in private wards, and comprehensive chronic and day-to-day cover. In- and out-of-hospital GP and specialist costs, i.e. consultations, as well as procedures, are covered at Profmed Premium Tariff rates (300% of Profmed Tariff). Dentists' consultations and procedures are covered at the Profmed Dental Tariff (135% of the Profmed Tariff).
ProSecure Plus	Provides unlimited in-hospital cover and private wards 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, i.e. consultations, as well as procedures, covered at Profmed Plus Tariff rates (200% of Profmed Tariff). Out-of-hospital GP and specialists costs, i.e. consultations, as well as procedures, covered at Profmed Specific Tariff rates (120% of Profmed Tariff for procedures; consultations R439 for GPs and R665 for specialists). Dentists' consultations and procedures are covered at the Profmed Dental Tariff (135% of the Profmed Tariff).
ProSecure	Provides unlimited in-hospital cover as well as chronic and day-to-day medical expenses cover, over and above the prescribed minimum benefits. In- and out-of-hospital GP and specialist costs, i.e. consultations, as well as procedures, covered at Profmed Specific Tariff rates (120% of Profmed Tariff for procedures; consultations R439 for GPs and R665 for specialists). Dentists' consultations and procedures are covered at the Profmed Dental Tariff (135% of the Profmed Tariff).
ProActive Plus	Provides unlimited in-hospital benefits, day-to-day dentistry and GP benefits and cover for prescribed minimum benefits. In-hospital GP and specialist costs, i.e. consultations, as well as procedures, covered at Profmed Plus Tariff rates (200% of Profmed Tariff). Out-of-hospital GP consultations are covered at Profmed Specific Tariff rates (R439 for GPs) and non-hospital procedures in a doctor's rooms are covered at the Profmed Specific Tariff. Dentists' consultations and procedures are covered at the Profmed Dental Tariff (135% of the Profmed Tariff).
ProActive	Offers unlimited in-hospital benefits, day-to-day dentistry benefits and cover for prescribed minimum benefits. In-hospital GP and specialist costs, i.e. consultations, as well as procedures, covered at Profmed Specific Tariff rates (120% of Profmed Tariff). Dentists' consultations and procedures are covered at the Profmed Dental Tariff (135% of the Profmed Tariff).

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:
- 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 28 years who is a student at an academic institution and dependent on you;
- Your child, irrespective of age, who is dependent on you because of mental or physical disability.

Child dependants and students

Children who are younger than 21 years of age are regarded as child dependants for the purposes of calculating contributions. These dependants will be defaulted to adult dependants, effective the last day of the month following their 21st birthday.

Dependants who are studying and who are younger than 28 years are regarded as child dependants for the purposes of calculating contributions. Thereafter, the membership of these dependants will be defaulted to adult dependants and the contributions will be increased accordingly, effective the first day of the month following their 28th birthday. Proof of study must be submitted to the Scheme annually until your dependant turns 28 years.

Children who are dependent on the principal member for family care and support as a result of mental or physical disability are regarded as child dependants until they turn 21 years. Thereafter, the status of such dependants will be defaulted to that of adult dependants and their contributions increased accordingly. Proof of dependence, together with a sworn affidavit to this effect and a medical report from an independent medical practitioner confirming the nature and extent of the mental or physical disability, must be provided annually to the Scheme from the time the child turns 21 years of age.

Please note:

- Proof of registration at an academic institution must be submitted at the beginning of each academic year, for that year.
- Proof of dependence must be submitted annually for child dependants who are 21 years of age or older.
- In all instances, the relevant proof must be provided to the Scheme annually by no later than end-February.
- It is the responsibility of the Member to submit proof of study and dependence by end February, failing which contributions will be amended accordingly, with effect from 1 March.

Application for adding of dependant(s)

To add a new beneficiary to your membership, the "Adding a Dependant" application form must be completed and e-mailed to the Profmed Membership department at newbusiness@profmed.co.za or faxed to 012 679 4411. Application forms can be obtained under Downloads on the website or by calling Client Services on 0860 679 200.

Special dependants

The member's parents with regard to whom the member is responsible for family care and support will be regarded as special dependants. Special dependants are classified as adult dependants for the purpose of calculating contributions. 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/s from the South African Revenue Service (SARS) and copies of three months' recent bank statements must be provided. The Scheme may request additional information as required.

Newborn

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

Adopted children

The application for the registration of adopted children must be accompanied by proof of birth and/or ID document, proof of adoption, and a certified copy of a passport if the child is born 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.

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

- Registration of a new dependant;
- Resignation of a dependant;
- Change in your address, contact details, e-mail address or any other relevant personal details;
- Change in your bank details. Bank details may not be updated on the website, only in writing by e-mail, fax or posted letter; and/or
- Change in status of a child or 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, whichever are applicable. 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 or all 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 a useful tool to assist you in calculating your contributions.

Health status

Proof of health must be provided by a member when joining the Scheme by completing the medical questionnaire on the application form or online application on the Profmed website. The Scheme has the right to request any additional medical information for any applicant and his/her dependants.

Consequences of non-disclosure

When completing the medical 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. If specific medical conditions are subject to a waiting period, the benefit date for those conditions will be delayed for the period of the waiting period imposed.

A general waiting period of three (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 90 days. For purposes of applying waiting periods, 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/conditions will be applicable if you did not previously belong to a medical scheme, or if you were a member of a 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 90 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 purposes of calculating waiting periods and late joiner penalties. (See section 8 on page 8 for further details of late joiner penalties).

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 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 six 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. On resignation from the Scheme, benefits are not pro-rated.

Membership card

The aim of the membership card is to serve as identification when obtaining medical services from a service provider, and provides valuable information to facilitate efficient processing of claims. You can access your electronic membership card by downloading the Profmed app from your Smartphone store.

Profmed app

The Profmed app provides members with an electronic membership card, which can also be e-mailed or faxed to your healthcare service provider. For your convenience, the Profmed app can be downloaded by you and all your registered dependants. This will ensure that your entire family has access to valuable functions and Scheme information at their fingertips. All features are sophisticated but easy to use. You can download the Profmed app from your smartphone store.

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 (e.g. 00, 01, etc.);
- Names and beneficiary numbers of all dependants;
- The identity number of the member and all his/her dependants; and
- Benefit date of the principal member and all his/her dependants.

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 written notice of cancellation from you;
- If you resign from your employer, where membership was a condition of employment, and you do not intend to retain your membership of Profmed;
- In the event of your death;
- When Profmed receives written notice of cancellation from the company/employer group where you are employed;

- 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 amounts 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. The membership of all beneficiaries registered on the Scheme will be terminated accordingly.
- Employer groups may terminate their participation with the Scheme on giving three calendar months' written notice.

7. Continuation member

A continuation member is a member or beneficiary whose membership of the Scheme continues either after the death of the principal member or when the principal member retires from the service of a company or employer group that was a corporate member of Profmed.

In the event of the death of the principal member, the membership of his/her dependants will continue 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 or dependants to inform Profmed should they not want to continue membership. This must take place within three months of the death of the principal member.

When a principal member retires, he/she and all his/her beneficiaries registered on the Scheme at the time of retirement remain members of the Scheme, irrespective of whether or not the principal member is eligible to be a member of Profmed.

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 contributions specific to 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 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 due on the 1st of each month and must reach the Scheme no later than the 3rd of each month. Example: The contributions for January are payable by 3 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. This is also applicable to members whose contributions are paid over to the Scheme by their employer and who are part of an employer group.

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 or e-mail proof to contributions@profmed.co.za, for the attention of Contributions.

Change in contributions

If a dependant is added, increased contributions shall be due and benefits shall accrue from the Admission date with the Scheme, provided that all conditions have been fulfilled.

If a dependant is resigned, the contributions will decrease in the month following the date of the resignation, provided the resignation is received by the 1st of the month, giving one calendar month's notice. If the resignation is received after the beginning of the month, the resignation will only be effective at the end of the next month and the contributions will be adjusted the month thereafter.

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 benefit limits or restrictions 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 processed by the Scheme, 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 Disease Treatment Pairs (DTPs) and a group of 26 chronic conditions, as listed in Annexure A of the Medical Schemes Act. The Act obliges schemes from 1 January 2000 to provide minimum benefits for these conditions.

The prescribed minimum benefits provide cover for specific treatments and services as would have been provided 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 obliged to fund the cost of the diagnosis, the procedures and consultations (Ps + Cs) relevant to the management of a condition, and medication of the specified list of 26 chronic conditions. This specified list is referred to as the “Chronic Disease List” (CDL). These conditions are covered in terms of the PMB legislation. These 26 conditions are covered on all Profmed 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 healthcare service provider (DSP) or network of healthcare service providers (DSPN) contracted by the Scheme to provide diagnosis, services, treatment, medicine or facilities to members in terms of both prescribed minimum benefits (PMBs) and non-PMBs.

Who are the Scheme’s DSPNs?

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

- Alcohol and drug rehabilitation: SANCA
- Cataract surgery: Ophthalmic Management Group (now Ophthalmic Risk Management (ORM))
- Chronic dialysis: National Renal Care, Life Healthcare
- Domiciliary (home) oxygen: Ecomed Medical cc
- Emergency medical transport (within RSA): Netcare 911
- Endoscopic examinations: Netcare, Life Healthcare, Clinix, National Hospital Network (NHN) and Mediclinic
- Medication: Profmed Pharmacy Network (see www.medikredit.net)
- Oncology – PET scans: Bloch & Partners at Morningside Clinic (applies to greater Johannesburg region only)
- Oncology – Radiation therapy: Participating Netcare facilities
- Optical: Opticlear
- Physical rehabilitation: Life Healthcare
- Preventative care – Pathology: Ampath, Lancet Laboratories and Pathcare
- Psychiatric hospitalisation: Participating National Hospital Network (NHN) facilities and Life Healthcare
- Trauma counselling and HIV post-exposure assistance: Lifesense

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 and non-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 thereafter, 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. The Scheme can also ensure that members receive the most appropriate treatment to facilitate better outcomes.

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 dispensing fees than those reimbursed by Profmed. Profmed members are in the fortunate position that Profmed reimburses pharmacies at a higher rate than prescribed. The PPN is an open enrolment network and any pharmacy that agrees to charge the Profmed rate 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, e.g. tonsillitis, or medication for conditions not listed or recognised by the Scheme as chronic conditions, e.g. ADD/ADHD. MMAP® (refer to section 12.7 on page 14 for more information on MMAP®) applies on all options. Medication that you take home 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 upfront and claim the amount from Profmed by submitting the account and receipt to the Scheme. 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 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. Please refer to section 19 on page 21, for more information on the dispensing cycles for contraceptives. In the event that you require chronic medicine or contraceptives before the next dispensing cycle begins, please contact the Scheme to make appropriate arrangements for you to have access to the medication, without having to pay out of your pocket.

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 more than 90 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 Table 1 (page 10), Tables 2, 3 and 4 (page 13).

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 formularies.
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 authorisation 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 10) and the non-CDL conditions listed in Tables 2, 3 and 4 (page 13). Oncology adjunctive treatment is paid from risk and not from the member's Chronic Medication benefit.

Cover for these conditions is available on the following options:

- Members on the ProPinnacle option are covered for the conditions listed in Table 1, Table 2 (56 conditions in total), and Table 4, plus relevant DTP conditions.
- Members on the ProSecure Plus and ProSecure options are covered for the conditions listed in Table 1, Table 3 (38 conditions in total) and Table 4, 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) and Table 4, plus relevant DTP conditions.

Table 2: Other non-CDL conditions | Available ONLY on ProPinnacle option

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

Table 3: Other non-CDL conditions | Available ONLY on ProSecure Plus and ProSecure options

1. Allergic Rhinitis – in patients with asthma	7. Osteoporosis
2. Alzheimer’s Disease	8. Paraplegia & Quadriplegia
3. Ankylosing Spondylitis	9. Pituitary Adenomas/Hyperfunction of Pituitary Gland
4. Benign Prostatic Hypertrophy	10. Psoriatic Arthritis
5. Major Depressive Disorder	11. Pulmonary Interstitial Fibrosis
6. Obsessive Compulsive Disorders	12. Valvular Heart Disease

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 has been registered with Swift OnLine™.

Therefore, your chronic **condition** must be registered first in order for your chronic **medication** to be authorised. The 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 is required to register your chronic condition, including the condition's ICD-10 code and severity status, 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 at www.medikredit.net to do a medicine search, 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 at www.medikredit.net. The search facility can be accessed from the Profmed website via the Benefits pages. 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 medicines or classes of medicines 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 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; and
2. make use of a pharmacy in Profmed's 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 granted for a limited 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 and 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 reimbursement rate approved by the Scheme.

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. The medical practitioner 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 details, 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 denied authorisation after discussion with your doctor, you may claim it from your acute medicine benefit or pay 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 in real-time. When the pharmacist dispenses medication, the system automatically accesses the relevant 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 see 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 transfer 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 transfer 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 for an elective procedure, it is the member's responsibility to obtain authorisation by calling 0860 776 363. 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, authorisation must be obtained on the first working day after admission. If, for any reason, you are not able to request the authorisation yourself, one of your family members or the healthcare provider 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 diagnostic procedure, i.e. the ICD-10 code and procedure code;
- 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, initials, surname and telephone number).

Always ask your doctor for a full description of the:

- Reason for admission;
- Associated medical diagnosis; and
- The procedure to be done as well as the procedure code.

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.

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

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 laparoscopic procedures covered?

Laparoscopic 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 or declined.

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 according to 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

What treatment is covered from the oncology benefit?

Profmed's oncology benefit includes radiation therapy and/or chemotherapy, radiology and pathology to counteract the cancer and adjunct treatment, as well as 180 days of oncology-related consultations, medicine, procedures and investigations for post-treatment monitoring and surveillance, subject to Profmed protocols, costings and PMB legislation. Certain radiology is subject to the use of the DSPN. Co-payment applies for voluntary use of a non-DSP. See section 11 (page 10) for more information on the DSPN. Benefits are subject to the limits on each option. Once the benefit limit has been reached, only PMB's are funded thereafter.

The purpose of the oncology programme is to:

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

How to register on the programme

Once you have been diagnosed, and prior to commencement with treatment, contact 0861 767 205. A trained and qualified advisor will explain the benefits available to you and request you to obtain a treatment plan from your oncologist. The treatment plan must be faxed to 012 679 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.

The following treatment and procedures will be paid from the oncology benefit, subject to the limits per option, provided claims are submitted with the correct ICD-10 codes to match the authorisation:

- Chemotherapy;
- Radiation therapy: 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;
- A co-payment applies to Biologics and other specified drugs, per the Oncology Biologics and other Specified Drugs List (available at www.profmed.co.za);
- Radiology, including MRI, CT and PET scans. PET scans subject to use of the DSPN in JHB region; and
- 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 – Radiation therapy

In order to avoid co-payments, it is necessary to make use of the DSPN contracted to provide services for radiation therapy. The DSPN 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.

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.

Do I get one authorisation number for my total treatment?

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

What number must I call?

For authorisation in respect of hospitalisation, radiation therapy and chemotherapy in a doctor's rooms, during hospitalisation and on an outpatient basis at the hospital, as well as radiation therapy, MRI, CT and PET scans, call 0861 767 205.

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 and Life Healthcare.

What does this benefit cover?

- Chronic haemodialysis;
- Approved blood tests, e.g. pre- and post-dialysis renal function tests; and
- 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 member who is a donor 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-authorization. General anaesthetic will only be covered in exceptional circumstances and will be subject to protocols.

Gastrosopies, 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; namely:

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-authorization 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 last 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-authorization 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:

- | | |
|--------------------------------------|----------------|
| • Orthopaedic braces out of hospital | • 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:

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

If you are not sure whether an item is covered, refer to Annexure C of the rules of the Scheme, available for download at www.profmed.co.za, 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 the last 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 dentistry benefits. Members across all options have access to an in-hospital and out-of-hospital dentistry benefit.

Members have access to the following dentistry benefits:

	ProPinnacle	ProSecure Plus and ProSecure	ProActive Plus and ProActive hospital option
Conservative and advanced dentistry (out-of-hospital)	R6 469 per beneficiary Maximum R12 938 per family	R5 507 per beneficiary Maximum R11 100 per family	R555 per beneficiary Maximum R1 586 per family
	+		
Orthognathic surgery (in-hospital)	R33 824 per family	–	–
	+		
Hospitalisation and anaesthetists	Unlimited*	Unlimited*	Unlimited*
	+		
Extensive conservative dentistry in hospital for children younger than 8 years	Unlimited*	Unlimited*	Unlimited*

*Subject to pre-authorisation and protocols.

Conservative and advanced dentistry in the dentist's chair includes:

• Consultations	• Filling of teeth
• Extraction of teeth	• Plastic dentures
• Preventative dental care	• Root canal treatment
• Crowns	• Surgery (excluding functional orthognathic surgery)
• Orthodontic treatment	• Dental implants
• Periodontics	• Bridges

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 on all options are subject to protocols and authorisation and only specific procedures are covered in hospital. 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 younger than 8 years (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 cost of dental laboratory work (in- and out-of-hospital) cannot be claimed under pathology or consultation fees, but will be deducted from the available day-to-day dentistry benefit.

Orthodontic treatment

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

Pre-authorisation

All dental treatment in hospital must be pre-authorised prior to commencement. 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. Contraceptives

This benefit is funded at 100% Single Exit Price and dispensing fee at DSPN rate, subject to a benefit limit per beneficiary per annum, and is paid from risk, not from the member's day-to-day benefits. This benefit covers oral contraceptives and patches, the injection, implants and also includes intra-uterine devices. Contraceptives used for any other purpose than contraception will be funded from the available day-to-day benefit. Dispensing cycles apply, i.e. repeat scripts may only be obtained after 20 days from the last dispensing date.

Dispensing cycles are as follows:

- Oral and patches: every 20 days;
- Injections: 3 to 6-month cycle; and
- Intra-uterine devices and implants: 3 to 5-year cycle.

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, pathology, radiology and vaccinations. One consultation is paid from the Preventative Care benefit, thereafter will be subject to the available day-to-day benefits. 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.

All relevant diagnostic procedures and tests are paid from the risk benefit in terms of the rules and protocols.

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.

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 who 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 012 679 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 - 12 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 compromised or who have relevant chronic diseases.

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

Consultations for preventative care

One consultation is paid from the Preventative Care benefit, but only when it is necessary for the diagnostic testing, e.g. Papsmear, PSA testing, to be done by a medical practitioner or where interpretation of the results of the diagnostic test must be done by a medical practitioner. Thereafter, consultations will be subject to the available day-to-day benefits.

Where services, such as immunisation, can be obtained from a retail pharmacy clinic or directly from a radiology or pathology practice, for example, for mammography, cholesterol blood tests, etc., such services will be funded from the member's day-to-day benefits, if available.

Designated Service Provider (DSP)

We have contracted with all pathology groups to provide pathology services to Profmed members in respect of this benefit. 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 any co-payment, which will be deducted from the member's day-to-day limit. Members on the ProActive Plus and ProActive options will be liable for the full amount.

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.

21. Trauma and HIV exposure assistance

What is covered?

In the event that you are a victim of crime, you and any beneficiaries 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 beneficiaries 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, Lifesense, to avoid co-payments. Claims are not deducted from members' benefit limits, but are paid from Scheme risk.

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 0861 776 363 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 medical transport: Local

Profmed has partnered with Netcare 911 as the Designated Service Provider (DSP) to provide emergency medical assistance to members within South Africa.

In all instances where Profmed members require emergency medical transport within South Africa, it is of vital importance that the Netcare 911 emergency number is contacted to access such services. Rest assured that if your circumstances warrant emergency transport, an appropriate form of transportation will be despatched to you and the full account will be settled by Profmed with no capped limits.

In the event where a member voluntarily makes use of a DSP other than Netcare 911, a 20% co-payment will apply. Also, services for non-medically justifiable cases will not be funded. To ensure you receive the correct treatment timeously and without delay, with no co-payments, it is important to contact 082 911 for assistance.

Please display your Profmed/Netcare 911 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 displayed on your Profmed membership card, or in the Profmed app, which provides you with convenient electronic access to contact numbers. It also has a convenient one-touch function to assist you to call an ambulance.

How to obtain assistance and authorisation

- In emergencies where the member/patient is able to communicate, simply dial **082 911**. The consultant receiving the call will guide you further.
- In an emergency where someone else calls an ambulance service other than Profmed's designated service provider, Netcare 911, e.g. where the member/patient is unconscious, Netcare 911 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 Netcare 911 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 082 911 to obtain authorisation for the ambulance transfer.

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

As countries in the SADC region are outside of South Africa, International SOS attends to requests for emergency medical assistance from countries in this 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 countries 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, should it be clinically necessary.

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

23. International travel medical assistance

Who is covered?

All beneficiaries who are registered on the Scheme are covered under this benefit. This benefit covers members in South Africa while travelling outside the borders of South Africa and members who reside in the SADC Region, when travelling outside the borders of their country of residence. SADC Region members may not access this benefit when travelling to South Africa as they will have access to their standard benefits while in South Africa. SADC Region refers to a group of countries in southern Africa, i.e. Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania (including Zanzibar), Zambia and Zimbabwe.

This benefit is managed by International SOS, who provides assistance to members while travelling.

What is covered?

Members on all options are covered up to the limit of R6 million per beneficiary, per journey for a travel period of not longer than 90 days, with no exclusions imposed on age or pre-existing medical conditions. However, members in a general waiting period will not be entitled to any benefits during this period and members in a condition-specific waiting period will not be entitled to benefits relating to that condition during this period.

Members on the ProActive Plus and ProActive options are not covered for out-of-hospital expenses. Members on the ProPinnacle, ProSecure Plus and ProSecure options are entitled to out-of-hospital cover while travelling internationally, provided such cover is offered on their benefit option, but out-of-hospital expenses are subject to an excess of R1 100. All medical expenses while travelling, whether in-hospital or out-of-hospital, are funded from the R6 million limit.

How to access cover

Members are not required to activate cover prior to departure. Members requiring medical assistance outside the borders of South Africa should call International SOS on the international emergency number +27 11 541 1225. If 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 nearest centre of medical excellence or to repatriate you to South Africa, provided that you are fit to travel.

How to request an extended supply of medication

Members who are registered for chronic medication and travelling outside the borders of South Africa can apply for an extended supply of chronic medication for a period of up to three months. You need to apply at least seven working days prior to departure. To request your extended supply of medication, contact us on 0860 679 200 or send an e-mail to info@profmed.co.za. Please remember to provide us with your member number, name and surname of the beneficiary, the name of the medication, the amount of medication required as well as the expected purchase date.

Embassy letter for visa requirements

If you require an Embassy letter, you can request it directly from the Profmed app. The app can be downloaded from your Smartphone store. Alternatively, Client Services can be reached on 0860 679 200 or at internationalinfo@profmed.co.za, Mondays to Fridays between 07:30 and 18:00, and Saturdays between 08:00 and 12:00, excluding public holidays. Please request your letter at least 7 days prior to departure.

How to avoid a co-payment

If you want to avoid a co-payment, it is important that you contact International SOS prior to receiving in- or out-of-hospital treatment. To access treatment while travelling, call +27 11 541 1225. All claims will be assessed in terms of the Scheme rules and International SOS's protocols. Co-payments may apply if the member/patient does not contact International SOS prior to obtaining treatment.

If you require cover for longer than 90 days or should you require additional travel insurance, contact your travel agent prior to departure.

How to submit a claim

Claims paid for personally must be submitted with the following documentation:

- Copy of identity document of the member and claimant/patient;
- Fully completed international travel claim form;
- Proof of travel, i.e. passport, airline ticket, etc.; and
- Medical report from the attending doctor.

Claims must be submitted within four months from the date of treatment. Please note that claims will not be processed if all the required documentation is not submitted. Co-payments could apply if International SOS was not contacted for assistance at the time of the medical incident/event or if treatment is contrary to the Scheme rules and International SOS's protocols.

Claims can be submitted as follows:

Post:

Private Bag X1031
Lyttelton
Centurion
0140

Email: internationalclaims@profmed.co.za

You can download the International Travel Medical Assistance Benefit Document and International Travel Claim Form from the website. Alternatively, contact us on 0860 679 200 or send an e-mail to internationalinfo@profmed.co.za to request copies of these documents.

24. Claims procedure

Profmed aims to make the claims procedure for its members as user-friendly as possible. In most cases claims are submitted electronically by the service provider, i.e. your doctor, dentist, pharmacist, etc., on your behalf. You must, however, check all claims submitted on your behalf to ensure that the service being claimed for has indeed been rendered to you. For this purpose, check your claims statements e-mailed to you from Profmed. 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 and claims payable to members are reimbursed weekly.

A receipt submitted without the relevant 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. You can also submit your claims via the Profmed app by taking a photograph of the claim, or browsing for the claim saved on your mobile device, and submit.

Alternatively, you can post your accounts to:
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. As scanners have become more sophisticated, members can e-mail scanned claims to claims@profmed.co.za. Claims will be reimbursed to you by means of a direct payment EFT into your bank account. Cheques will not be issued. Claims paid to service providers are paid every second week.

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); and
- 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 the last day of the fourth month from the date of service, it is considered a "stale" claim and will not be paid. Stale claims 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 personal profile from the Profmed website. You must be a registered Profmed website user to access this function.

Once the claims have been processed, you will receive a claims statement, 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;
- Amounts payable by you to the Scheme or service provider (doctor, hospital, etc.) in the event of there being insufficient benefits available or treatment falling outside the Scheme rules and protocols;
- The benefit from which funds were paid; and
- 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 statement.

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 should still receive a copy of the account from the provider and you should use it together with your Profmed claims statement to follow up on the processing of the claim.

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 via EFT. 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.

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, e.g. 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.

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.

25. Cover in the SADC Region

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

Members in the SADC Region travelling across the borders of their country of residence 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 (including Zanzibar), Zambia and Zimbabwe.

26. Sabbatical benefit

Who qualifies?

Any member and his/her dependants who have been registered with Profmed for at least one year and who wish to pursue their career or post-graduate studies overseas, or travel for an extended period abroad, qualify 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. 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 for information on how to access this benefit. Alternatively, e-mail a request to contributions@profmed.co.za, informing the Membership Department that you want to activate your Sabbatical benefit. 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. Expenses recoverable from a third party

Any claim against the Scheme for which compensation can be recovered from a third party, e.g. the Road Accident Fund (RAF) or Workmen's Compensation Fund (WCF), must be reported to the Scheme as soon as possible after the incident or event that gave rise to the claim.

In such circumstances, Profmed will fund the required treatment in terms of the Scheme rules and benefit options, and PMB legislation, but the member will be required to provide an undertaking to Profmed to reimburse to the Scheme any funds recovered by the member from a third party in respect of the claims paid by the Scheme.

28. 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 as well as in other sections of this document.

29. Fraud line

Profmed remains committed to eliminating fraud, corruption and unethical practices and makes use of the services of Whistle Blowers, an independent company to which illegal or suspicious activity can be reported without fear of victimisation. If you wish to report suspicious activity against the Scheme, please call 0801 113 941, send a fax to 0865 222 816 or e-mail information@whistleblowing.co.za. The identity of callers will remain anonymous. The fraud line is available twenty-four hours a day throughout the year, in all eleven official languages.

30. Profmed website

Profmed's website, www.profmed.co.za, is an 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. The "Chat" facility lets stakeholders communicate with us conveniently and in real-time.

Providers will be able to view and track their Profmed members' claims and brokers will have access to certain information on 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.

0860 679 200
+27 12 679 4144 (Outside RSA)
012 679 4411 (No faxed claims)
info@profmed.co.za
claims@profmed.co.za
www.promed.co.za

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