Applicable 1 January 2012 to 31 December 2012. 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 in English will apply.
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# Important contact information

<table>
<thead>
<tr>
<th>Service</th>
<th>Within RSA</th>
<th>Outside RSA</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Services &amp; Claims (no faxed claims)</td>
<td>0860 679 200</td>
<td>+27 12 679 4144</td>
<td>+27 12 679 4411</td>
</tr>
<tr>
<td>Chronic Disease &amp; Medication Authorisations</td>
<td>0800 132 345</td>
<td>+27 11 770 6000</td>
<td>–</td>
</tr>
<tr>
<td>Hospital &amp; Specialised Radiology Authorisations</td>
<td>0860 776 363</td>
<td>+27 12 679 4145</td>
<td>+27 12 679 4438</td>
</tr>
<tr>
<td>Emergency Transport Service within RSA and SADC Region</td>
<td>0861 776 363</td>
<td>+27 11 541 1225</td>
<td>–</td>
</tr>
<tr>
<td>International Travel Medical Assistance</td>
<td>011 541 1225</td>
<td>+27 11 541 1225</td>
<td>–</td>
</tr>
<tr>
<td>Disease Management Authorisations</td>
<td>0860 776 363</td>
<td>+27 12 679 4145</td>
<td>+27 12 679 4438</td>
</tr>
<tr>
<td>Dental Authorisations</td>
<td>0860 679 200</td>
<td>+27 12 679 4144</td>
<td>+27 12 679 4411</td>
</tr>
<tr>
<td>Post-trauma Counselling</td>
<td>0800 611 298</td>
<td>+27 11 459 2218</td>
<td>–</td>
</tr>
<tr>
<td>Post-trauma HIV Exposure Assistance:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office hours</td>
<td>0860 906 090</td>
<td>+27 11 251 9400</td>
<td>–</td>
</tr>
<tr>
<td>After hours</td>
<td>071 786 4520</td>
<td>+27 71 786 4520</td>
<td>–</td>
</tr>
<tr>
<td>Multiply Wellness Programme: Information and Momentous Baby</td>
<td>0861 886 600</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Website</td>
<td></td>
<td></td>
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<tr>
<td><a href="http://www.profmed.co.za">www.profmed.co.za</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postal address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Bag X1031 Lyttelton 0140</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You can also follow us on:

- Facebook: [http://www.facebook.com/Profmed](http://www.facebook.com/Profmed)
- Linked-In: [http://www.linkedin.com/company/profmed](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. Each trustee must be a member 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 options**

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

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ProPinnacle</td>
<td>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).</td>
</tr>
<tr>
<td>ProSecure Plus</td>
<td>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 Premium Tariff rates (300% of Profmed Tariff).</td>
</tr>
<tr>
<td>ProSecure</td>
<td>Comprehensive cover in-hospital, and chronic and day-to-day medical expenses, and cover over and above the prescribed minimum benefits.</td>
</tr>
<tr>
<td>ProActive Plus</td>
<td>Comprehensive in-hospital benefits, and cover for prescribed minimum benefits. In-hospital GP and specialist costs covered at Profmed Premium Tariff rates (300% of Profmed Tariff).</td>
</tr>
<tr>
<td>ProActive</td>
<td>Comprehensive in-hospital benefits, and cover for prescribed minimum benefits.</td>
</tr>
</tbody>
</table>

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 both the Benefits and Downloads pages, or by calling Client Services on 0860 679 200.

5. **Membership**

**Who qualifies?**

Graduate professionals with a four-year or post-graduate university degree or students in at least their fourth academic year of study in a field that will qualify them to provide a professional service are eligible.

No person may belong to more than one scheme at a 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 educational institution;
- Your child who is dependent on you because of mental or physical disability or similar cause;
- Your child under the age of 21 years who does not receive a regular income more than the social pension;
Students and children who are 21 years of age or older

Children who have turned 21 years are regarded as adult dependants, unless they are studying full-time at a recognised academic institution. A member must submit annual proof of registration for a dependant who has turned 21 years of age, but who is still studying full-time at an educational institution, in order for that dependant to be regarded as a child dependant.

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.

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.
- Proof of dependence must be submitted annually for a child or other dependants who have turned 21 years of age.

Application for adding of dependant(s)

A member must complete the “Adding Dependant” application form and send it to Profmed's New Business Division at Private Bag X1031, Lyttelton, 0140. 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 submitted online or obtained off the website at www.profmed.co.za.

Special dependants

The member's parents with regard to whom he is responsible for family care and maintenance will be regarded as special dependants. Special dependants are considered 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 and send the letter to:
Attention: Profmed Member Administration
Private Bag X1031
Lyttelton
0140.

Fax: 012 679 4411
E-mail: info@profmed.co.za

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 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;
- Change in student dependant status.
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.

Health status

The Scheme has the right to request a health certificate for any applicant and his 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.

Please note: It is important to list all operations, illnesses, conditions and symptoms. This will prevent claims from being rejected as a result of non-disclosure.

Consequences of non-disclosure:

- If a member or dependant suffers from a specific illness, Profmed has the right to exclude the applicant and/or dependant from benefits for this specific condition for a period of 12 months.
- If it should be found that a member has submitted false information or has deliberately left out any relevant information during application, the Scheme may correct this in terms of the rules of the Scheme or terminate the member’s membership.

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 registered 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 12-month condition-specific waiting period for pre-existing illnesses will usually 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 transferred 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?

If you should become a member of the Scheme or resign during the course of the benefit year (1 January to 31 December), your benefits will be pro-rated.

For example, if you join the Scheme halfway through the year (e.g. with 6 months remaining) and the annual maximum for a certain benefit is R1 000, you will only be entitled to claim half of this, i.e. R500. If you resign from the Scheme, having been a member, for example, for nine months of the benefit year, your benefits will be pro-rated according to the nine months of membership on the Scheme.

Proof of membership

A principal member with dependants is provided with two membership cards as proof of membership. Members without dependants are provided with one membership card. The aim of the membership card is to serve as identification when obtaining services from a service provider, and also provides valuable information.
This card must be shown on request of the service provider, e.g. a medical practitioner. A fee of R20 per membership card is payable if an additional membership card is requested or if existing membership cards are lost or stolen. 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:
- Benefit date;
- 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 dependants;
- The gender of all beneficiaries; and
- Exclusions.

**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;
- 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 dependants have exploited the benefits of the Scheme. The member may also have to repay any amount which the Scheme has paid on his 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 the member resign?**
A member must give one month’s written notice in which the reason for the resignation is given, as is the date of termination, i.e. the last day of the notice period 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**

**Upon the death of the principal member**
If the membership of a member is terminated as a result of his 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 dependants, and are calculated according to the income of the widower/widow/partner; and
- 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 child and/or adult dependants) registered on the Scheme, and the choice of benefit option.

Contribution loading for persons who join a medical scheme late in life
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 from a date before 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 3rd of each month. Example: The contributions for January are payable by 3 January.

The contributions of members on Persal, 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 the contributions should be adjusted because another dependant has been added, the adjusted contribution must be paid from the first day of the month in which the dependant is registered to receive benefits.

Please note: Benefits for such a dependant will apply from the date on which he has become a dependant, 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.
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 a clinical decision 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.

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 cover you for specific treatments and services as rendered by the State. A list of the 270 conditions covered 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, medical management (consultations and procedures) and medication of a specified list of 26 chronic conditions. This list is referred to as the prescribed minimum benefits “Chronic Disease List” (CDL). These conditions are covered in full terms of the Scheme rules if services are rendered according to the Scheme’s benefits, treatment plans and protocols, CDL medication lists, and claimed with the correct diagnostic (ICD-10) codes. 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>
<thead>
<tr>
<th>Table 1: PMB CDL conditions</th>
<th>Available on all options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Addison’s Disease</td>
<td>14. Epilepsy</td>
</tr>
<tr>
<td>2. Asthma</td>
<td>15. Glaucoma</td>
</tr>
<tr>
<td>4. Bronchiectasis</td>
<td>17. HIV/AIDS</td>
</tr>
<tr>
<td>5. Cardiac Failure</td>
<td>18. Hyperlipidaemia</td>
</tr>
<tr>
<td>6. Cardiomyopathy Disease</td>
<td>19. Hypertension</td>
</tr>
<tr>
<td>7. Chronic Obstructive Pulmonary Disease</td>
<td>20. Hypothyroidism</td>
</tr>
<tr>
<td>8. Chronic Renal Disease</td>
<td>21. Multiple Sclerosis</td>
</tr>
<tr>
<td>9. Coronary Artery Disease</td>
<td>22. Parkinson’s Disease</td>
</tr>
<tr>
<td>10. Crohn’s Disease</td>
<td>23. Rheumatoid Arthritis</td>
</tr>
<tr>
<td>12. Diabetes Mellitus Type 1 and 2</td>
<td>25. Systemic Lupus Erythematosus</td>
</tr>
</tbody>
</table>
11. Designated service providers (DSPs)

What is a DSP?
A DSP (or DSP Network – DSPN) is a provider or network of providers 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 is the Scheme’s DSP?
The providers listed below have been contracted to provide services, as follows:
- Acute and chronic medication: Profmed Pharmacy Network
- Preventative care: Ampath, Lancet Laboratories and Pathcare
- Optical: Opticlear
- Post-trauma counselling: ICAS
- Post-trauma HIV assistance: Optipharm
- Alcohol and drug rehabilitation: SANCA
- Psychiatric hospitalisation: Participating National Hospital Network (NHN) facilities
- Endoscopic examinations: Netcare, Life Healthcare and Clinix facilities.

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.

How does a DSP 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. These expenses will only be reimbursed in accordance with the Scheme rules. You may elect to receive treatment at a provider or facility other than the DSP, 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 benefits, the Scheme will pay for services or treatment received 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 DSP.

How does a DSP benefit members?
The Scheme negotiates discounted rates with DSPs. When a member makes use of the DSP, the amount deducted from the member’s benefit limit is in accordance with the discounted rate charged by the DSP, thereby leaving more funds available in the member’s benefit limit for other relevant costs.

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 over and above 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 currently 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. The list of pharmacies in the network can be found at www.profmed.co.za under the “Benefits” tab.
12.2 Prescribed acute medication
Acute medication is medication prescribed once for less than one month by a medical practitioner, or medication for conditions not listed or recognised as chronic conditions by the Scheme. MMAP® applies on all options. Example: Antibiotics prescribed for tonsillitis. Medication that you take with you upon 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 terms of legislation, medical schemes cannot fund more than one month’s supply of medication at a time. In line with the legislation, and to limit risk to the Scheme, dispensing cycles apply to both acute and chronic medication. Acute medication scripts may be renewed after three days from the last dispensing date, and chronic medication after 24 days from the last dispensing date.

If you require more than one month’s supply of chronic medication
Please obtain authorisation from the Scheme if you require more than one month’s supply of chronic medication (but not longer than ninety days), e.g. for vacation.

Contact Client Services on 0860 679 200. You will be requested to complete the required form and to fax the form back to 012 679 4411. 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 and 3 (page 11).

Criteria which qualify for the chronic medicine benefit
1. Although your doctor may define your condition as being chronic, this condition may not fulfil the Scheme criteria for chronic medicine benefits.
2. Access to chronic medication from the chronic benefit is subject to clinical entry criteria and drug utilisation review.
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 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.
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 in order to renew the authorisation timeously.
8. If you do not re-authorise your chronic medication before the expiry date, benefits will be paid from the acute medicine benefit.

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 and 3 (page 11).

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 (60 conditions in total);
• Members on the ProSecure Plus and ProSecure options are covered for the conditions listed in Table 1 and Table 3 (40 conditions in total);
• Members on the ProActive Plus and ProActive options are only covered for the conditions in Table 1 (26 conditions in total).
### Table 2: Other non-CDL conditions

<table>
<thead>
<tr>
<th>Available ONLY on ProPinnacle option</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Ankylosing Spondylitis</td>
</tr>
<tr>
<td>5. Cushing's Disease</td>
</tr>
<tr>
<td>6. Cystic Fibrosis</td>
</tr>
<tr>
<td>10. Hypoparathyroidism</td>
</tr>
<tr>
<td>11. Hyperthyroidism</td>
</tr>
<tr>
<td>12. Major Depressive Disorder</td>
</tr>
<tr>
<td>13. Malabsorption Syndrome</td>
</tr>
<tr>
<td>14. Meniere's Disease</td>
</tr>
<tr>
<td>15. Menopause (HRT)</td>
</tr>
<tr>
<td>16. Menopause (Calcium)</td>
</tr>
<tr>
<td>17. Motor Neuron Disease</td>
</tr>
</tbody>
</table>

### Table 3: Other non-CDL Conditions

<table>
<thead>
<tr>
<th>Available ONLY on ProSecure Plus and ProSecure options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Alzheimer's Disease</td>
</tr>
<tr>
<td>4. Major Depressive Disorder</td>
</tr>
<tr>
<td>5. Menopause (HRT)*</td>
</tr>
<tr>
<td>6. Obsessive Compulsive Disorders</td>
</tr>
<tr>
<td>7. Oncology Adjunctive Treatment</td>
</tr>
</tbody>
</table>

*Covered on the ProActive Plus and ProActive options

### 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:

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

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How do you access the chronic medication benefit?
If you are diagnosed with one of the chronic conditions listed in Table 1, 2 or 3, 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.

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

Where can I obtain the Condition Medicine List (CML)?
The CML can be viewed, downloaded or printed from the Profmed website at www.profmed.co.za, from the Downloads page. The list is also available in search facility format by selecting any benefit option from the Benefits page. You can search by condition, medication or the active ingredient in your medication. As the information is not static and is updated throughout the year, the online list is the most effective way of ensuring that the information is as current as possible.

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 ProActive option and least restrictive on the ProPinnacle option. 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®)
Profmed takes savings a step further with the use of the MMAP® or “Maximum Medical Aid Price” concept. 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 (excluding any possible levies that may be applicable). 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 they 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. 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. Give the doctor the CML when you visit him for a condition that requires chronic medication. Your doctor should refer to the CML when he 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™. The doctor can also call the Swift Online™ tollfree number, 0800 132 345, 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 the aid of your doctor’s prescription and your medical scheme 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 and claim for it, 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 through Client Services by calling 0860 679 200.

3. If certain medication is still not authorised after discussion with your doctor, you can still obtain it from your pharmacy or from your doctor by paying for it yourself or by claiming it against your acute medicine benefit.

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.

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 17:00 from Monday to Friday.
In an emergency, or after-hours, 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 will be 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.*

Once the abovementioned information has been checked, you will be provided with an authorisation number, stating 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 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.

**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 disease;
• 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 0866 027 682 (outside RSA +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 during which the patient is receiving 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:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td>Medication, including medication to treat complications of cancer or cancer therapy (subject to oncology programme protocols)</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>Radiology, including MRI, CT and PET scans</td>
</tr>
<tr>
<td>Hospitalisation</td>
<td>Consultations by the treating oncologist (in- and out-of-hospital)</td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
</tr>
</tbody>
</table>

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 will be paid from the appropriate chronic or day-to-day benefit, e.g. high blood pressure medication and anti-depressants, etc.

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.

PET scans (Positron-Emission Tomography)

PET scans are covered subject to pre-authorisation and the benefit limit, and are paid strictly in accordance with Profmed protocols. Due to the high cost of this modality, we recommend that patients negotiate the fees charged by their radiologist. PET scans are funded during active treatment only.
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, both in a doctor’s rooms and 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.

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.

14.3 Transplants
What is covered?
A patient will be eligible for pre-, intra-, and post-operative cover. 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.

15. Endoscopic examinations
Profmed’s DSP for endoscopic examinations is Netcare, Life Healthcare and Clinix. Procedures undertaken at a non-DSP facility will be reimbursed at the rate negotiated with the DSP and the 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.

The following procedures will be covered only in a suitably equipped procedure room:
• Gastroscopy
• Colonoscopy
• Sigmoidoscopy
• Anoscopy.

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
- Internal nerve stimulators
- Artificial intervertebral discs
- Abdominal aortic stents
- Implantable cardiac defibrillators
- Artificial sphincters
- Cardiac stents
- 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 home oxygen therapy, and is subject to a 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, which are calculated from date of service.

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

The following “other” items are subject to a sub-limit, which is subject to the day-to-day limit:

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

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

What is not covered?

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

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 the Client Service Centre on 0860 679 200.

17. Optical benefit

Profmed’s optical benefits are subject to clinical protocols and are applied over a 24-month period that commences 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

Effective 1 January 2012, in-hospital dental benefits are available to members on the ProActive Plus and ProActive options. These benefits are, however, managed according to strict protocols.

Know your dental benefits

The dental benefit is divided into three categories, namely basic dentistry, advanced dentistry and functional orthognathic surgery.

Basic dentistry in the dentist’s chair includes:

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

Basic dentistry has no sub-limit but is subject to the day-to-day limit. Basic dentistry in hospital will be approved in exceptional cases only.

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 exceptional cases only.

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 appropriate 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 basic 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.
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. The benefit provides cover for specified consultations, pathology and radiology. 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 includes the influenza vaccine, and testing 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, however, funded at the same rate as the conventional Pap smear.

- **Fasting blood tests (cholesterol) for cardiac disease** are available to women who are 50 years or older, and to men 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. The cost of a medical practitioner to administer the vaccine is not covered under this benefit but is funded from the day-to-day benefit, depending on the option chosen by the member. This service can, at certain times of the year, be obtained free of charge from various pharmacy outlets and clinics.

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. The influenza vaccine is not subject to the use of a DSP, but is subject to the benefit sub-limit.

Funding is covered in terms of the protocols and is not deducted from your benefit limits, provided services are rendered 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 I locate a DSP practice?**

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. Post-trauma management

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. 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 DSPs to avoid co-payments. Claims are not deducted from the member’s benefit limits.

How do I obtain trauma counselling 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 psychologist handling your call will arrange for consultations with a psychologist in your area, appropriately qualified to assist you in dealing with the specific crime or trauma you have experienced. The number to call is 0800 611 298 within South Africa or +27 11 459 2218 within the SADC region. Although it is recommended that you contact the helpline as soon as possible after experiencing the trauma, this benefit can still be accessed within 14 days after the event.

How do I obtain HIV exposure assistance?
Should you have been exposed to HIV infection, it is essential that you call Optipharm on the following numbers for assistance:

<table>
<thead>
<tr>
<th></th>
<th>Within RSA</th>
<th>Outside RSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office hours</td>
<td>0860 906 090</td>
<td>+27 11 251 9400</td>
</tr>
<tr>
<td>After hours</td>
<td>071 786 4520</td>
<td>+27 71 786 4520</td>
</tr>
</tbody>
</table>

Prophylactic medication 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 members who are resident or working 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 an emergency. It is also advisable to ensure ready access to the emergency number while in your home and away. All emergency numbers are also reflected on your Profmed membership card.

How to obtain 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 International SOS, e.g. where the member is unconscious and unable to contact International SOS, 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 within the SADC Region?
Please refer to “Foreign Claims” 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 South Africa, members have access to international medical cover. This international cover includes cover in the SADC Region. The cover is provided by International SOS and underwritten by ACE Insurance Limited.

Members can now travel outside the borders of South Africa with peace of mind knowing that all emergency or unexpected medical expenses will be taken care of. Members requiring assistance outside the borders of South Africa should 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 the ProSecure Plus, ProSecure, ProActive Plus and ProActive options are entitled to R5 million cover, while members on the ProPinnacle option are entitled to cover of R10 million. This cover includes:
- emergency or unexpected medical expenses;
- repatriation to South Africa;
- repatriation of mortal remains;
- return flights to South Africa if you missed your original flight due to illness or hospitalisation;
- return flights to South Africa of any unattended minor dependants who would otherwise not be taken care of during the time of your medical incapacity.

Cover is limited to a maximum travel duration of 90 days.

Optional baggage and inconvenience cover may be purchased directly from ACE at the member’s expense. On behalf of its members, Profmed has negotiated preferential rates for this cover with ACE.

**Cover for pre-existing conditions**
ACE Insurance provides R1 million pre-existing condition cover at no additional cost to members, to a maximum of 31 days, and includes cover for cardiac, cardio-vascular and related conditions. If your trip is longer than 31 days, you will be required to buy up cover for any pre-existing conditions. When activating cover, whether your trip is longer or shorter than 31 days, you must advise ACE of any pre-existing conditions.

**How do I access cover?**
- Before departing on your trip, please activate your cover by calling +27 11 541 1225.
- Enquiries can be e-mailed to profmed@internationalsos.com.
- As cover is underwritten by ACE, they will provide you 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.
- Before departing, if you require more information on the international cover available to you, please call ACE on +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.

Exclusions, terms and conditions
Standard insurance industry exclusions are imposed on international medical cover. The exclusions, terms and conditions imposed by ACE are out of Profmed’s control.

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.

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 by the service provider, i.e. your doctor, dentist, physiotherapist, 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 directly from Profmed. Here we refer to certain providers who request upfront or cash payments or who offer a cash discount, which in turn will ensure that your benefits stretch further. When you pay cash, please remember to request a detailed account and a receipt for your payment.

No claim form is required. You simply have to:
1. check the details on your account (see “What should you check on your claim?” below);
2. write “account paid” on the account;
3. post the original account and receipt to:
   Profmed Claims Department
   Private Bag X1031
   Lyttelton
   0140.

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

Claims by fax, e-mail or copies 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.

You will be reimbursed 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 the 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 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 cannot be processed normally – this 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 you submit 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 the claims have been processed, you will receive a payment advice, which indicates the following information:
• Amounts paid by the Scheme and to whom payment has been 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 funds were paid from;
• 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. In such a case you are entitled to receive a copy of the account from the provider and you should use it together with your statement to check 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. **Foreign claims**

The Scheme does not cover elected or anticipated medical expenses incurred outside the borders of the SADC Region. For cover while travelling outside the borders of South Africa, refer to section 23 “International Travel Medical Assistance” in this Guide.

**SADC Region (Southern African Development Community)**

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 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 Region**

This region includes Angola, Botswana, Democratic Republic of 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 extensively abroad, qualifies for this benefit.

**What does the benefit offer?**

Profmed will suspend the membership of the principal member and his dependants during the sabbatical period. Provided the sabbatical period does not exceed three years, Profmed will reinstate the membership of the member and his family without underwriting being applied. Underwriting will, however, apply if the sabbatical period is longer than three years.

**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 reinstated.

27. **Motor vehicle accidents 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 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 during office hours. For your convenience, you will only be responsible for local call costs and the difference will be paid by Profmed.

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

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 or 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 products 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 a very 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 a broker is not employed by the Scheme, but acts as an independent business that has a contract with Profmed to sell its products. 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.

Profmed makes use of brokers to carry out certain functions on its behalf. These functions are mainly aimed at allowing a member’s day-to-day interaction with the Scheme to run as smoothly as possible.

In terms of the abovementioned services, a member can expect the following from his 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, a member should have much more peace of mind. If a member is not sure who his broker is, Client Services may be contacted at 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.