UMVUZO HEALTH MEDICAL SCHEME

ANNEXURE B.2

BENEFITS IN RESPECT OF ULTRA AFFORDABLE OPTION

(APPLICABLE WITH EFFECT FROM 1 JANUARY 2017)

1. The Scheme shall grant benefits as indicated in paragraph 4 of this annexure, for an account for services provided to a member and his registered dependants: Provided that -

   1.1 all the provisions of the Rules are complied with and the account are properly specified in terms of Rule 15;

   1.2 the account is submitted by the member to **UMVUZO HEALTH** on or before the last day of the fourth month following the month in which the service was provided;

   1.3 in the case of a member who submits an account of a foreign provider of service, that member shall be reimbursed the same benefits which would have been applicable if the service was provided in the Republic of South Africa: Provided that the service is in line with adopted managed care principles and funding protocols, qualify for benefits as set out below. The member shall together with the claim and proof of payment, simultaneously submit evidence of the rate of exchange at the time the service concerned was provided;

   1.4 certain contracted services, such as capitation arrangements, do not require the submission of an account as set out in 1.1;

   1.5 all services are pre-authorised; and

   1.6 all benefits, sub-limits included, shall be pro rated in terms of Rule 16.2.

2. The Scheme shall not be compelled to accept an account for payment submitted by a provider of services directly to the Scheme in accordance with an agreement with the Scheme if the account is submitted for the first time after the last day of the fourth month following the month in which the service was rendered. Should this account be accepted for payment, the member concerned shall be entitled to the benefits that would have been payable had

the account been received within the prescribed period, unless inconsistent with any other provision of the Rules.

3. The member shall be liable for any difference between the negotiated tariff and the full amount of the account if services are obtained voluntarily from providers other than designated service providers.

4. Subject to the provisions of the above paragraphs 1 to 3, the exclusions set out in Annexure C, the minimum requirements of the prescribed minimum benefits in a public healthcare facility as contemplated in Regulation 8 to the Act, the following benefits are payable by the Scheme:

BENEFITS
Prescribed Minimum Benefits (PMBs)

The Scheme will provide, in a public healthcare facility or at appointed designated service providers, to all members and dependants with unlimited cover for the prescribed minimum benefits at 100% of the cost as per Scheme managed care treatment and funding guideline.

If a designated service provider is not within reach of a member, an outside service provider can be used subject to authorisation from the managed care organisation. Once the patient is stabilised, the patient can be transferred to a designated service provider. The costs will be covered at 100% of the cost or negotiated tariff.

Primary Care

1. Primary Care

UMVUZO HEALTH uses contracted networks to render primary care services. The Scheme contracts on both a capitation and Fee for Service basis to render the following services:

1.1 100% of the preferred provider tariff for out of hospital consultations, treatments, diagnostic examinations, small procedures and injections as per the contractual agreement and PMB's. The first 8 visits per beneficiary are un-authorised where-after a beneficiary must select a single provider.

1.2 The services referred to in subparagraph 1.1 above includes: Network service point visits, acute and chronic medication as per provider formulary, black and white x-rays, pathology tests, soft tissue

ultrasounds according to provider protocols. Self-medication benefit limited to 3 events per year, maximum of R80 per event. 24 hour medical advice line. Maternal ultrasound limited to two per pregnancy.

1.3 Prescribed medicine

1.3.1 100% of the preferred provider tariff for acute and listed chronic condition medicines which are listed on the fixed formulary as per provider contract. Medicine must be obtained via the preferred provider channels and networks.

1.3.2 Members will be liable for the difference between the formulary product and the own choice product except for PMB's.

1.4 Pathology and Radiology

Subject to PMB's, 100% of the preferred provider tariff for out of hospital pathology and basic radiology provided by the preferred provider as per provider protocol and list of covered codes.

1.5 Dental Services

100% of the preferred provider tariff for essential dentistry as per protocol and list of covered codes.

Dental benefits are limited to procedures as per agreed list of codes in the rooms contracted preferred providers as set out above. No dental procedure under general anaesthesia or conscious sedation will be funded.

1.6 Optical services

1.6.1 100% of the preferred provider tariff for one consultation/refraction test per registered beneficiary per year and one pair of glasses per registered beneficiary every second year, provided by the preferred provider and from a specified range of frames and lenses.

1.6.2 Spectacles (bifocals or single vision), are granted if the qualifications are met.

1.6.3 Sunglasses and contact lenses are not covered. Tinted lenses and contact lens solutions are excluded.

2. Specialists out of hospital

Subject to PMB's

2.1 Subject to pre-authorisation, every family is entitled to specialist visits out of hospital to the limit of 3 visits per family per year where clinically necessary and as per protocol. All referrals and services will be through the Secondary Referral Centre (SRC) and its contracted specialists and other providers. Services and procedures will be covered by the Secondary Referral Centre at 100% of the NHRPL or the negotiated tariff. Services authorised retrospectively will be subjected to a R250 levy per incident. Specialist consultations must be referred by a network GP together with a referral letter.

2.2 These visits must be referrals via the preferred provider primary care network and must be pre-authorised as such. Specialists excluded from this benefit are pathologists, maxillo-facial surgeons, orthodontist, dental technician, periodontist, oral pathologist, dental therapist, community dentistry, radiologists, dentists and opticians. Dermatologists, psychiatrists and plastic surgeons will be limited to one visit per family per year where clinically indicated. Gynaecological visits in the case of a member being pregnant will be limited to three visits per member per family per pregnancy and subject to the limit in 2.1. All appointments and referrals must be coordinated by phoning the number indicated on the membership card. Referrals will be authorised as per protocol.

2.3 Services contractually arranged under capitation will not be funded from this benefit, e.g. optometry. Services covered by the Secondary Referral Centre are defined per code in the provider agreement.

2.4 Services covered in this benefit include consultation and special investigations as pre-authorised (as per protocol) and procedures (as per protocol) relating to out of hospital visits for acute and chronic conditions (including CDL conditions) provided any such episodes of care requiring specialist consultation is unrelated to and does not require any hospital or day theatre admission. All special

investigations, including pathology, must be done via the Secondary Referral Centre. No benefits will be paid for services obtained without pre-authorisation or through other mechanisms, except for PMB's.

2.5 All referral authorisations are based on clinical managed care guidelines and criteria, and will only be considered where the case has been fully worked out by the primary care provider. Onward referrals and follow-up or repeat visits count as a visit each and therefore require pre-authorisation. Emergencies will be allocated on a clinical priority basis.

2.6 Acute medication prescribed by the Secondary Referral Centre's approved specialist provider will be covered and must be in accordance with treatment guidelines. Chronic medication will only be covered as set out under CDL conditions. Any chronic condition approved by the Scheme other than a CDL condition, will be subject to the same principles as they apply to the CDL conditions. Chronic medication will be funded as a combination of medications included in the Scheme's agreement with primary care providers plus CDL drugs on the chronic specialist formulary. All medication must be obtained via the preferred provider channels and networks as specified by the Scheme from time to time.

2.7 Pathology scans and radiology investigations requested by specialists must be pre-authorised and are subject to the limits as set out in 3.2.6 and 3.2.10 and clinical protocols.

2.8 Chronic Disease List (CDL) prescribed minimum benefits

2.8.1 The conditions listed as CDL conditions in the Medical Schemes Act will be covered 100% by the Scheme for medical and pharmacological management at cost;

2.8.2 CDL services may be included in capitation agreements;

2.8.3 The funding is based on Scheme protocols and CDL formulary;

2.8.4 Services that do not form part of the protocols or the formulary are not funded as CDL and will

be considered for payment as non CDL treatment subject to the Rules;

2.8.5 Member or provider own choice medication or services outside the protocols and formularies may be paid for by the member, and claimed from the Scheme, up to the level of the benefits as defined within the protocols and formularies, and where this is regarded as absolutely clinically necessary;

2.8.6 Services and medication will only be funded at designated service providers as communicated to members from time to time. Exceptions will only be considered where services-

2.8.6.1 constitute a medical emergency as reviewed by the Scheme;

2.8.6.2 were involuntarily obtained from a non designated service provider; or

2.8.6.3 were pre-authorised.

2.8.7 Non-compliant members will only be funded in accordance with the applicable funding level based on the Scheme funding guideline.

2.9 Supplementary benefits

Subject to PMB's

Every family is entitled to R1 400 out of hospital benefits per year subject to pre-authorisation. Services will be covered at 100% of the NHRPL or the negotiated tariff. The following services will qualify for this benefit as per protocol:-

2.9.1 Occupational therapy;
2.9.2 Podiatry;
2.9.3 Dieticians;
2.9.4 Psychology;
2.9.5 Speech therapy and Audiology; and
2.9.6 Physiotherapy.

3. In-patient and related cover

3.1 General Practitioners and Specialists in hospital

3.1.1 100% of the NHRPL or the negotiated tariff for surgical procedures and operations,

anaesthesia for surgical procedures and operations, visits, treatments, diagnostic examinations and non-surgical procedures, in hospital or unattached theatre units. All services must conform to the authorisation process and benefits.

3.1.2 Benefits in respect of medicine obtained on the prescription of a medical practitioner, dentist or legally authorised person and administered during a stay in a hospital or nursing home, will be paid at 100% of cost or negotiated tariff. Benefits in respect of medication obtained on discharge from hospital or day theatre after an authorised admission will be funded to a maximum of seven days supply of acute or chronic medication. Chronic medication as per prescription must be pre-approved and will be formulary and protocol driven. Such medication must be obtained on the prescription of a registered medical practitioner involved in the in-patient treatment of the patient. The medication will be funded at 100% of Single Exit Price (SEP) or negotiated tariff.

3.2 Hospital admission limited to R200 000 per beneficiary per year

No benefits will be granted for hospitalisation if an authorisation number is not obtained before admission. Authorisation is obtained by calling the authorisation phone number supplied to all members. In the case of a proven, life threatening emergency, admission will automatically be granted for an initial period of 24 hours. An emergency for these purposes is defined as the sudden onset of a clinical condition of such severity that the lack of immediate medical attention on an in-patient admission level, will lead to serious and/or permanent damage to the patients health.

Except for PMB`s, the obtaining of a retrospective authorisation number will be subject to a levy of R1 000 per admission for services obtained from a designated service provider, save for the arrangement regarding emergency admissions. Retrospective authorisation will be based on the Scheme's clinical protocols and the utilisation of a designated service provider and will only be granted where an admission was deemed clinically necessary and to the extent of benefits had it been a pre-

authorisation. Prescribed minimum benefits will be covered at least to the funding level of care in a public health care facility (UPFS tariff codes and benefits will be used in calculating funding) as required by the Medical Schemes Act of 1998. In cases of involuntary admission for prescribed minimum benefits to a non-designated facility, the Scheme will fund all costs on the same basis as when the admission took place in a designated service provider facility.

3.2.1 **Private hospitals & Day Clinics: Non-preferred providers**

No benefits.

3.2.2 **Private hospitals & Day Clinics: Preferred providers**

Accommodation, consultation, services, operating theatre, medicine, material and hospital apparatus as pre-authorised and to the total amount and/or Length of Stay authorised per case and paid at 100% of the NHRPL or negotiated tariff. Accommodation in an intensive-and high care ward will be limited to 9 days per person per year where after the benefits will be calculated according to that of a general ward. Pre-authorised admissions will be funded in accordance with the authorised length of stay, rand amount, sub-limits, and levels of care or any combination of the above.

3.2.3 **Provincial hospitals**

Accommodation, consultation, services, operating theatre, medicine, material and hospital apparatus as pre-authorised and to the total amount and/or Length of Stay authorised per case and paid at 100% of the UPFS or negotiated tariff. Accommodation in an intensive-and high care ward will be limited to 9 days per person per year whereafter the benefits will be calculated according to that of a general ward. Pre-authorised admissions will be funded in accordance with the authorised length of stay, rand amount, sub-limits, and levels of care or any combination of the above.

3.2.4 **Internal medical and surgical prosthesis (Excluding appliances)**

100% of the cost of medical and surgical accessories placed in the body as a supporting mechanism during an operation and/or which for functional medical reasons are implanted as prosthesis to replace parts of the body, subject to the limit. The maximum limit per family per year is R34 350 and is divided into the following subcategories:-

3.2.4.1 Vascular prosthesis (valve replacement, pacemakers, stents and grafts, related materials used) limited to R20 450 for stents, excluding drug eluting stents;

3.2.4.2 Major musculoskeletal prosthesis (spinal procedures and related materials) limited to R13 850;

3.2.4.3 Functional and recuperative prosthesis (K-wires, plates, screw, lenses, slings, artificial and biological ligaments) limited to R6 950; and

3.2.4.4 Joint replacements (not due to acute trauma) is limited to R22 500.

Provided however, that benefits shall only be granted if pre-authorised by the Scheme. See Annexure C for exclusions.

3.2.5 **Orthopaedic, surgical and medical appliances**

100% of the cost, with a maximum of R5 650 per family per financial year on the following items if prescribed by a preferred provider and where these items follow on or form part of the in-patient treatment: Provided however, that benefits shall only be granted if pre-authorised by the Scheme and where in line with managed care guidelines.

3.2.5.1 Back-, leg-, arm- and neck supports post surgery;
3.2.5.2 Crutches post surgery;

3.2.5.3 Surgical footwear (Excluding health footwear) post surgery;

3.2.5.4 Elastic stockings after vascular surgery;

3.2.5.5 Respiratory Oxygen, diabetic-and stoma aids continually essential for the medical treatment of the patient;

3.2.5.6 Specific items deemed clinically vital based solely on the discretion of the Scheme.

3.2.6 **Scans (Including MRI, CAT and RT scans)**

Subject to PMB's, limited to 1 scan per family per year as per scan code list and protocol. All scans must be pre-authorised. All scan referrals must be done via the Secondary Referral Centre. Scans done as part of in-hospital stay will be regarded as part of the scan benefit limit.

3.2.7 **Oncology**

Subject to PMB`s

Members are encouraged to register with the Cancer Management Program. A total treatment plan benefit will be allocated based on Scheme treatment guidelines. Only designated service providers and or public health care facilities will be funded for all treatment at UPFS or negotiated tariffs limited to Tier 1 treatment protocols as followed in the public health care facilities.The Scheme may from time to time set up similar programs for specific diseases with an all-inclusive limit per family per year, where members are encouraged to register for defined treatment plan based benefits.

3.2.8 **Blood transfusion**

100% of the cost of blood transfusions including the cost of the blood, apparatus and the operator's fee. Own blood donated prior to surgery will be funded on the same basis as if transfusion originated from the blood bank, and no additional costs will be funded. Transfusions must be pre-authorised where they are the reason for admission, and must be in accordance with Scheme managed care guidelines.

3.2.9 **HIV**

Subject to PMB's

Members are encouraged to register with the HIV Management Program. A total treatment plan benefit will be allocated based on Scheme treatment guidelines. Only designated service providers and or public health care facilities will be funded for secondary and tertiary care at UPFS or negotiated tariffs. All services must be pre-authorised.

3.2.10 **Pathology, Radiology and Medical Technology**

Subject to PMB's, 100% of the NHRPL or negotiated tariff for pathology, radiology, non-oncology radiotherapy, and medical technology (i.e. mammogram), subject to pre-authorisation. All referrals must be done via the Secondary Referral Centre. Investigations done as part of in-hospital stay, or referred by a specialist out of hospital will be regarded as part of the benefit limit.

4. Additional benefits

4.1 Private ambulance cover

Pre-authorised medical and hospital logistics services, including emergency road and air evacuation as provided by the contracted preferred provider.

4.2 After hour incidents

Three after hour visits per family per year for incidents that occur at times when the contracted primary care network is closed (After-hours, weekends after hours and public holidays). An incident for these purposes is defined as a condition not requiring hospitalisation or specialist intervention but clinically validates a consultation and/or a procedure room intervention and/or medication. All services, materials and medication (generic medication sufficient for three days' use only) must be obtained from the primary service delivery facility. The services may be obtained from any registered medical facility and excludes facility fees. The member must obtain pre-

authorisation for the visit by phoning the number indicated on the membership card.

4.3 **Emergency visit**

Unlimited, provided the episode meets the requirements of an emergency medical condition as indicated herewith: the sudden and, at the time unexpected, onset of a life threatening health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place a person's life in serious jeopardy. Facility fees are excluded. Authorisation for the visit must be obtained within 24 hours by phoning the number indicated on the membership card. Incidents of the severity outlined above warrants inpatient treatment.

4.4 **Managed Care Plans**

Managed Care Plans will be defined benefits for specific diseases or conditions, managed by a contracted organisation. The benefits will only be available to members who applied for such benefits under the Rules.

4.5 Terminal and Wound care

The costs for all services related to care for a terminal condition that do not conform to acute admission or services based on Scheme protocols will be limited to R5 000 per family per year. All such services must be pre-authorised. Inpatient status must be changed from acute to terminal care based on Scheme protocols.

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