UMVUZO HEALTH MEDICAL SCHEME

ANNEXURE B.4

BENEFITS IN RESPECT OF EXTREME OPTION

(APPLICABLE WITH EFFECT FROM 1 JANUARY 2021)

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 except services set out in 1, 2 and 4 below; 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

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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 the public healthcare facility or at appointed designated service providers to all members and dependants with unlimited cover for verified 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.

Payments shall first be processed from the specified limit(s) on the applicable benefit before continued funding in respect of PMB may be assessed.

1. Primary Care and Specialists out of hospital
Subject to PMB's

1.1 100% of the NHRPL or the preferred provider tariff limited to benefits available from the Family benefit. Services include out of hospital consultations (including Homoeopaths), treatments, small procedures and injections/material supplied at doctors' rooms.

1.2 Acute medication

100% of the costs for acute medication limited to benefits available from the Family benefit and

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Scheme protocols. Self-medication limited to R2 350 per beneficiary per year with a maximum of R220 per event, subject to available funds from the Family benefit.

1.3 Dental Services

1.3.1 100% of the NHRPL tariff limited to benefits available from the Family benefit for dentistry consisting of consultations, fillings, clearings, preventative-and fluoride treatment as per Scheme protocols and funding guidelines.

1.3.2 Specialised dentistry

100% of the NHRPL limited to R8 800 per family for orthodontic, prosthodontic and periodontic treatment, metal base dentures, ceramic/laminated inlays, gold inlays (own/natural teeth only), crowns and bridges.

1.3.3 No dental procedure under general anaesthesia will be funded, providing that the Scheme, at its sole discretion, may make a once off exception per treatment protocol for children under the age of 5 years with severe dental problems of such scope and magnitude that the Scheme's medical advisors are satisfied that no other route of treatment is available. In such cases, only conscious sedation will be considered.

1.4 Optical services limited to R3 830 per beneficiary every 24 months

1.4.1 100% of the NHRPL tariff limited to available funds from the Family benefit for spectacles and contact lenses per registered beneficiary as per Scheme protocols and funding guidelines.

1.4.2 Spectacles (bifocal or single vision) are granted if the qualifying norms as per Scheme protocols are met.

Sunglasses and contact lens solutions are not covered.

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2. Pathology and radiology out of hospital

Subject to PMB's, 100% of the NHRPL tariff for out of hospital pathology and basic radiology limited to R13 650 per family per year as per Scheme protocols and funding guidelines.

3. Chronic Disease List (CDL) prescribed minimum benefits

3.1 The chronic conditions listed as CDL conditions in the Medical Schemes Act will be covered 100% by the Scheme for medical and pharmacological management at cost and at designated providers.

3.2 Members will be liable for the difference between the formulary product and the own choice product.

3.3 Subject to available funds in the Family benefit, the following additional conditions will also be covered for benefits as per the Scheme protocol for the diseases themselves (once diagnosed) and does not include cover for related possible complications: -

3.3.1 Severe acne;
3.3.2 Severe eczema;
3.3.3 Endometriosis;
3.3.4 Anemia;
3.3.5 Gastro Oesophageal Reflux Disease;
3.3.6 Sjogren disease;
3.3.7 Celiac disease;
3.3.8 Tay-Sachs disease; and
3.3.9 RP isomerise deficiency.

3.4 CDL services may be included in capitation or other remuneration agreements.

3.5 Members are encouraged to register on the disease management program for the confirmed CDL condition(s). Members will be categorised in accordance with severity and benefits will be allocated and communicated to members.

3.6 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.

3.7 Member or provider own choice medication or services may be paid for by the member and claimed from the Scheme, which will consider refunding the

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member up to the level of benefits as defined within the protocols, and where this is regarded as clinically necessary.

3.8 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: -

3.8.1 were pre-authorised;
3.8.2 constitute a medical emergency as reviewed by the Scheme; or
3.8.3 were involuntarily obtained from a non-designated service provider.

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

4. Supplementary benefits

Every family is entitled to R11 550 per year for supplementary benefits. Services will be covered at 100% of the NHRPL or the negotiated tariff only. The following services will qualify for this benefit as per protocol: -

4.1 Occupational therapy;
4.2 Podiatry;
4.3 Dieticians;
4.4 Psychology;
4.5 Speech therapy and Audiology; and
4.6 Physiotherapy, Chiropractors and Biokinetics.

5. In-patient and related cover

5.1 General Practitioners and Specialists in hospital

5.1.1 100% of the NHRPL or the preferred provider 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.

5.1.2 Benefits in respect of medicine obtained on the prescription of a medical practitioner, dentist or legally authorised person and administered

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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.

5.1.3 Benefits for any surgical procedure carried out by an ophthalmologist to improve the patient's visual acuity shall be limited to once every 24 months as per Scheme protocols and funding guidelines.

5.2 Hospital admission

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 patient's 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

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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.

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

No benefits.

5.2.2 **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. Pre-authorised admissions will be funded in accordance with the authorised length of stay, Rand amount, sub limits, levels of care or any combinations of the above.

5.2.3 **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. Pre-authorised admissions will be funded in accordance with the authorised length of stay, Rand amount, sub limits, levels of care or any combinations of the above.

5.2.4 **Internal medical and surgical prosthesis (Including hearing aids)**

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 R82 000, including delivery systems and

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devices, and is divided into the following subcategories: -

5.2.4.1 Vascular prosthesis (valve replacement, pacemakers, stents and grafts, related materials used) limited to R53 700 for stents, excluding drug eluting stents;

5.2.4.2 Major musculoskeletal prosthesis (spinal procedures and related materials) limited to R32 300;

5.2.4.3 Functional items and recuperative prosthesis (K-wires, plates, screw, lenses, slings, artificial and biological ligaments) limited to R19 000; and

5.2.4.4 Joint replacements (not due to acute trauma) and below knee basic artificial limbs, both in accordance with funding guidelines, limited to R53 700.

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

5.2.5 **Mental Health Institutions**

Subject to PMB's only, accommodation, consultation, services, medicine, material and hospital apparatus as pre-authorised.

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

Subject to PMB's, limited to 2 scans per family per year as per scan code list and protocol. All scans must be pre-authorised. Scans done as part of in-hospital stay will be regarded as part of the scan benefit limit and need to be pre-authorised.

5.2.7 **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 negotiate tariffs limited to Tier 1 treatment

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protocols as followed in the public health care facilities.

5.2.8 **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.

5.2.9 **HIV**

Subject to PMB's

Members must 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.

5.2.10 **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. 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.

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6. Additional benefits

6.1 Orthopaedic, surgical and medical appliances

100% of the cost, with a maximum of R12 200 per family per financial year on the following items if prescribed by a preferred provider: Provided however, that benefits shall only be granted if pre-authorised by the Scheme and where in line with managed care guidelines.

6.1.1 Back-, leg-, arm- and neck supports post surgery;
6.1.2 Crutches post surgery;
6.1.3 Surgical footwear (Excluding health footwear) post surgery;
6.1.4 Elastic stockings after vascular surgery;
6.1.5 Respiratory Oxygen, diabetic-and stoma aids continually essential for the medical treatment of the patient;
6.1.6 Specific items deemed clinically vital based solely on the discretion of the Scheme.

6.2 Private ambulance cover

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

6.3 Family benefit

Services will be covered at 100% of the NHRPL or negotiated tariff. The benefits will be for Primary care and Specialists as per 1 above and are limited to a maximum per family per year made up as follows: -

(i)	Per principal member	R12 300
(ii)	Per spouse/adult dependant	R 9 900
(iii)	Per child dependant	R 4 860

6.4 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.

6.5 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

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R10 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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SS Mabuza
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