UMVUZO HEALTH MEDICAL SCHEME

ANNEXURE B.1

BENEFITS IN RESPECT OF STANDARD OPTION

(APPLICABLE WITH EFFECT FROM 1 JANUARY 2024)

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, 2.9 and 4.8 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

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 verified prescribed minimum benefits at 100% of the NHRPL or negotiated tariff or Reference price list as per Scheme managed care treatment and funding guidelines.

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 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

Subject to PMB's

The Scheme promotes access to primary care and related services through it's preferred Umvuzo Digital Platform which guides beneficiaries towards appropriate and reasonable levels of care.

1.1 General Practitioners

100% of the NHRPL or preferred provider tariff for out of hospital consultations, treatments, diagnostic

examinations, small procedures and injections as per the contractual agreement and PMB's. Ten visits per beneficiary are un-authorised but managed, thereafter additional services can be accessed and authorised via the Umvuzo Digital Platform.

1.2 Acute medication

100% of the Scheme's negotiated price for acute medication, subject to the reimbursement limit, formulary and Reference Pricing. Members will be liable for the difference between the formulary product and own choice product.

1.3 Over-the-counter medication

Self-medication limited to R850 per beneficiary per year with a maximum of R160 per event, subject to the reimbursement limit and Reference Pricing.

1.4 Dental services limited to R4 400 per beneficiary per year

100% of the NHRPL or preferred provider tariff for benefits available from the Dental limit consisting of consultations, fillings, simple extractions, crowns and bridges, clearings, preventative- and fluoride treatment as per Scheme protocols and funding guidelines.

Specialised dentistry, including orthodontic treatment, are excluded from benefits. No dental procedure under general anaesthesia will be funded, provided that the Scheme, at its sole discretion, may make a once off exception per treatment protocol for children under 12 years of age 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.

1.5 Optical Services

1.5.1 100% of the NHRPL or preferred provider tariff for one eye examination per beneficiary every 24 months.

1.5.2 Frames and lenses are limited to R3 000 per beneficiary every 24 months as per Scheme protocols and funding guidelines.

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

1.6 Pathology and Radiology

100% of the NHRPL or preferred provider tariff for out of hospital pathology and basic radiology as per Scheme protocols and funding guidelines. Maternal ultrasound is limited to two per pregnancy.

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 10 visits per family per year where clinically necessary and as per protocol. All referrals and services will be through the Authorisation Centre and it's contracted specialists and other providers. Services and procedures will be covered at 100% of the NHRPL or the preferred provider negotiated tariff. Services authorised retrospectively will be subjected to a R250 levy per incident. Specialist consultations must be referred by a General Practitioner together with a referral letter.

2.2 These visits must be pre-authorised. Specialists excluded from this benefit are pathologists, maxillo-facial surgeon's orthodontist, dental technicians, periodontist, oral pathologist, dental therapist, community dentists, radiologists, dentists and opticians. Dermatologists, psychiatrists and plastic surgeons will be limited to one visit per family per year where clinically indicated. 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.

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 pre-

authorised by calling the Authorisation Centre and is subject to available limits. No benefits will be paid for services obtained without pre-authorisation or through other mechanisms.

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 specialist provider will be covered 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. The above are subject to the reimbursement limit and Reference Pricing.

2.7 Scan investigations requested by specialists must be pre-authorised and are subject to the limit as set out in 3.3 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 by the Scheme for medical and pharmacological management at designated providers.

2.8.2 The following chronic conditions will also be covered for benefits as per Scheme protocol for the diseases themselves (once diagnosed) and does not included cover for related possible complications: -

2.8.2.1 Severe acne
2.8.2.2 Severe eczema
2.8.2.3 Endometriosis

2.8.2.4 Anaemia
2.8.2.5 Gastro Oesophageal Reflux Disease
2.8.2.6 Sjogren disease

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

2.8.4 The funding is based on Scheme protocols, CDL formulary and Reference Pricing.

2.8.5 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.

2.8.6 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 benefits as defined within the protocols, formularies, Reference Pricing and where this is regarded as clinically necessary.

2.9 Supplementary benefits

Every family is entitled to R7 400 out of hospital benefits per year. 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 Homoeopaths;
2.9.2 Registered nurse visits limited to R163 per visit and R80 for dispensed medicines/consumables;
2.9.3 Occupational therapy;
2.9.4 Podiatry;
2.9.5 Dieticians;
2.9.6 Psychology;
2.9.7 Speech therapy and Audiology;
2.9.8 Social-and Community workers; and
2.9.9 Physiotherapy, Chiropractors and Biokinetics.

3. In-patient and related cover

3.1 General Practitioners and Specialists in hospital

3.1.1 100% 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. Additional services, including supplementary services must be pre-authorised.

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 the NHRPL 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 Single Exit Price (SEP) or negotiated tariff.

3.2 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 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.

The obtaining of a retrospective authorisation number will be subject to a levy of R1 000 per admission for service 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. 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. 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, and is divided into the following subcategories: -

3.2.4.1 Vascular prosthesis (valve replacement, pacemakers, stents and grafts, related materials used) limited to R37 000 for stents;

3.2.4.2 Major musculoskeletal prosthesis spinal procedures and related materials) limited to R24 900;

3.2.4.3 Functional items and recuperative prosthesis (K-wires, plates, screws, lenses and slings) limited to R12 200; and

3.2.4.4 Joint replacements (not due to acute trauma) in accordance with funding guidelines, limited to R41 600.

Provided however, that benefits shall only be granted if pre-authorised by the Scheme. Eyes and similar prosthesis are excluded from this benefit. See Annexure C for exclusions.

3.3 Scans (Including MRI, CAT and RT scans)

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.

3.4 Oncology

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.

3.5 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.

3.6 HIV

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.

3.7 Pathology, Radiology and Medical Technology

100% of the NHRPL or negotiated tariff for pathology, radiology, non-oncology radiotherapy, and medical technology, investigations (i.e. mammogram), subject to pre-authorisation.

3.8 Mental Health Institutions

Subject to PMB's only, hospital based management up to 3 weeks per year, or outpatient psychotherapy of up to 15 contacts per year, as pre-authorised.

3.9 Endovascular, Laparoscopic and Arthroscopic equipment

Where endovascular, laparoscopic or arthroscopic procedures are pre-authorised in accordance with Scheme Funding Guidelines, a rand amount limit will apply for the various procedures in relation to equipment and items utilised as part of the pre-authorisation basket of care and subject to prevailing preferred provider agreements.

4. Additional benefits

4.1 Orthopaedic, surgical and medical appliances

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

4.1.1 Back-, leg-, arm- and neck supports;
4.1.2 Crutches;
4.1.3 Surgical footwear post-surgery (Excluding health footwear);
4.1.4 Elastic stockings;

4.1.5 Diabetic-and stoma aids continually essential for the medical treatment of the patient;

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

4.2 Private ambulance cover

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

4.3 After hour incidents

Five after hour visits per family per year for incidents that occur at times when the General Practitioner 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.

4.4 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.

4.5 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.

4.6 Terminal and Wound care

The costs for all services related to wound care and care for a terminal condition that do not conform to acute admission or services based on Scheme protocols, will be limited to R8 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.

4.7 Yandisa umvuzo benefit

A pre-authorised benefit extender for specific items that can extend cover under exceptional circumstances for an existing benefit or where such a benefit has been depleted. Factors taken into account in the granting of this benefit will include but Is not limited to clinical, functional and financial factors and intended purpose. The benefit is limited to R50 000 per family per year.

4.8 Umvuzo Digital Platform

Beneficiaries have unlimited access to a customised Umvuzo Digital Platform. This platform provides simplified access to basic medical care. Benefits include but are not limited to health assessments, symptom checker, screening and other forms of digital primary care.

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