UMVUZO HEALTH MEDICAL SCHEME

ANNEXURE B.4

BENEFITS IN RESPECT OF EXTREME OPTION

(APPLICABLE WITH EFFECT FROM 1 JANUARY 2026)

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, 4 and 6.7 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. General Practitioners and Specialists out of hospital

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 and Specialists out of hospital

1.1.1 General Practitioners

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

Additional services that are available on the Umvuzo Digital Platform can be accessed and authorized via the Platform.

1.1.2 Specialists

Up to 150% of the NHRPL or preferred provider tariff limited to benefits available from the Family benefit. Services include out of hospital consultations, treatments, small procedures and injections/material supplied at doctors' rooms.

1.2 Acute medication

100% of the Scheme's negotiated price for acute medication limited to benefits available from the Family benefit and Scheme protocols. The above are subject to the reimbursement limit, extended acute formulary and Reference Pricing.

Acute medication on the restricted acute formulary are not subject to available funds in the Family benefit.

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 R3 330 per beneficiary per year with a maximum of R285 per event, subject to the reimbursement limit and Reference Pricing.

1.4 Dental Services

1.4.1 100% of the NHRPL or preferred provider tariff limited to benefits available from the Family benefit for dentistry consisting of consultations, fillings, crowns and bridges, clearings, preventative-and fluoride treatment as per Scheme protocols and funding guidelines.

1.4.2 Specialised dentistry

100% of the NHRPL limited to R15 700 per beneficiary for orthodontic, prosthodontic and periodontic treatment.

1.4.3 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 beneficiaries 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 every 24 months

1.5.1 Network provider: -

- 1 consultation per beneficiary; and
- Frame limited to R1 840; and
- 100% of the costs of clear lenses (single vision OR bifocal OR multifocal); OR
- Contact lenses limited to R2 500.

1.5.2 Non-network provider: -

- 1 consultation per beneficiary limited to R420; and
- Frame limited to R1 472; and
- Single vision lenses limited to R450 per pair; OR
- Bifocal vision lenses limited to R970 per pair; OR
- Multifocal vision lenses limited to R1 700 per pair; OR
- Contact lenses limited to R2 500.

Sunglasses and contact lens solutions are not covered.

2. Pathology and radiology out of hospital

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

Out of hospital pathology and radiology outside the basic pathology and radiology benefit will be limited to R17 400 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 by the Scheme for medical and pharmacological management 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 member up to the level of benefits as defined within the protocols, formularies, Reference Pricing and where this is regarded as clinically necessary.

4. Supplementary benefits

Every family is entitled to R14 900 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 Homoeopaths;
4.2 Registered nurse visits limited to R200 per visit;
4.3 Occupational therapy;
4.4 Podiatry;
4.5 Dieticians;
4.6 Psychology;
4.7 Speech therapy and Audiology;
4.8 Social-and Community workers; and
4.9 Physiotherapy, Chiropractors and Biokinetics.

5. In-patient and related cover

5.1 General Practitioners and Specialists in hospital

5.1.1 General Practitioners and Specialists in hospital

5.1.1.1 General Practitioners

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.

5.1.1.2 Specialists

Up to 150% 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.

5.1.2 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 Single Exit Price (SEP) 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.

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 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 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.

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 (Excluding appliances)**

100% of the cost of medical and surgical accessories at preferred providers 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, including delivery systems and 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 R68 300 for stents;
5.2.4.2 Major musculoskeletal prosthesis (spinal procedures and related materials) limited to R41 200;
5.2.4.3 Functional items and recuperative prosthesis (K-wires, plates, screw, lenses, hearing aids, slings, artificial and biological ligaments) limited to R24 300; and
5.2.4.4 Joint replacements (not due to acute trauma) in accordance with funding guidelines, limited to R68 300.

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

5.3 Scans (Including MRI, CAT and RT scans)

Limited to 3 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.

5.4 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.

5.5 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.

5.6 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.

5.7 Pathology, Radiology and Medical Technology

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

5.8 **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.

6. Additional benefits

6.1 Orthopaedic, surgical and medical appliances

100% of the cost, with a maximum of R15 500 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: -

6.1.1 Back-, leg-, arm- and neck supports;
6.1.2 Crutches;
6.1.3 Surgical footwear post-surgery (Excluding health footwear);
6.1.4 Elastic stockings;
6.1.5 Diabetic-and stoma aids continually essential for the medical treatment of the patient; and
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 designated 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	R14 220
(ii)	Per spouse/adult dependant	R11 460
(iii)	Per child dependant	R 5 700

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 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 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.

6.6 Yandisa umvuzo benefit

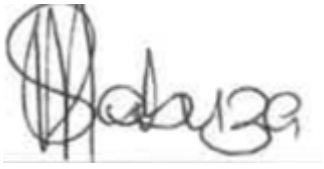
A pre-authorised benefit extender for specific items (not services) that can extend cover for certain items under exceptional circumstances. Factors taken into account in the granting of this benefit will include but is not limited to clinical, functional and financial factors and intended purpose. This is not a gap cover and excludes primary care benefits and any other service. The benefit is limited to R50 000 per family per year.

6.7 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.

S I G N A T U R E S:

SS Mokoena
CHAIRPERSON



SS Mabuza
TRUSTEE

HB van Zyl
PRINCIPAL OFFICER
19/09/2025