UMVUZO HEALTH MEDICAL SCHEME

ANNEXURE B.5

BENEFITS IN RESPECT OF ACTIVATOR OPTION

(APPLICABLE WITH EFFECT FROM 1 JANUARY 2025)

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, 3 and 5.8 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 Practitioner

100% of the NHRPL or preferred provider tariff limited to benefits available from the Day-to-day 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.

1.2 Acute medication

100% of the Scheme's negotiated price for acute medication limited to benefits available from the Day-to-day 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 Day-to-day 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 R1 700 per beneficiary per year with a maximum of R190 per event. The above are subject to the reimbursement limit and Reference Pricing.

1.4 Dental services limited to R5 400 per beneficiary per year

100% of the NHRPL or preferred provider tariff limited to 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, is excluded from benefits. No dental procedure under general anaesthesia or conscious sedation will be funded.

1.5 Optical services every 24 months

1.5.1 Network provider: -

- 1 consultation per beneficiary; and
- Frame limited to R1 250; and
- 100% of the costs of clear lenses (single vision OR bifocal OR multifocal); OR
- Contact lenses limited to R2 025.

1.5.2 Non-network provider: -

- 1 consultation per beneficiary limited to R400; and
- Frame limited to R1 000; and
- Single vision lenses limited to R430 per pair; OR
- Bifocal vision lenses limited to R920 per pair; OR
- Multifocal vision lenses limited to R1 620 per pair; OR
- Contact lenses limited to R2 025.

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

1.6 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 R7 500 per family per year as per Scheme protocols and funding guidelines.

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 12 visits 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 contracted providers. Services and procedures will be covered up to 125% of the NHRPL or the preferred provider negotiated tariff. Services where a retrospective authorisation is granted at the Scheme's discretion, 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 must be pre-authorised. Providers excluded from this benefit are pathologists, maxillo-facial surgeons, orthodontist, dental technician, periodontist, oral pathologist, dental therapist, community dentistry, dentists, radiologists, dentists and opticians. Dermatologists, psychiatrists and plastic surgeons will be limited to one visit per family per year. 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 and radiology, must be authorised by calling the Authorisation Centre and are 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.

2.6 Acute medication prescribed by the specialist provider will be covered in accordance with treatment guidelines and as per benefit communicated as part of pre-authorisation. 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. 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 4.3, authorised benefit packages 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.

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

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

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

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, 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.

3. Supplementary benefits

Every family is entitled to R9 500 out of hospital benefits per year. 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: -

3.1 Homoeopaths;
3.2 Registered nurse visits limited to R170 per visit and R84 for dispensed medicines/consumables;
3.3 Occupational therapy;
3.4 Podiatry;
3.5 Dieticians;
3.6 Psychology;
3.7 Speech therapy and Audiology;
3.8 Social-and Community workers; and
3.9 Physiotherapy, Chiropractors and Biokinetics.

4. In-patient and related cover

4.1 General Practitioners and Specialists in hospital

4.1.1 General Practitioners and Specialists

4.1.1.1 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.

4.1.1.2 Specialists

Up to 125% 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.

4.1.2 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 in line with medicine benefits stipulations. 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.

4.2 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 patients' health.

The obtaining of a retrospective authorisation number will be subject to a levy of R1000 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 pre-authorised. 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 a verified Prescribed Minimum Benefit condition 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.

4.2.1 **Private hospitals & Day Clinics: Non-Designated Service Providers**

No benefits.

4.2.2 **Private hospitals & Day Clinics: Designated Service 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.

4.2.3 **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.

4.2.4 **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, and is divided into the following subcategories: -

4.2.4.1 Vascular prosthesis (valve replacement, pacemakers, stents and grafts, related materials used) limited to R45 000 for stents;

4.2.4.2 Major musculoskeletal prosthesis (spinal procedures and related materials) limited to R28 000;

4.2.4.3 Functional items and recuperative prosthesis (K-wires, plates, screw, lenses and slings) limited to R15 000; and

4.2.4.4 Joint replacements (not due to acute trauma) in accordance with funding guidelines, is limited to R47 000.

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.

4.3 Scans (Including MRI, CAT and RT scans)

Limited to 2 scan 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.

4.4 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.

4.5 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.

4.6 HIV

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.

4.7 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.

4.8 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.

4.9 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.

5. Additional benefits

5.1 Orthopaedic, surgical and medical appliances

100% of the cost, with a maximum of R12 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: -

5.1.1 Back-, leg-, arm- and neck supports;
5.1.2 Crutches;
5.1.3 Surgical footwear post-surgery (Excluding health footwear);
5.1.4 Elastic stockings;

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

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

5.1 Private ambulance cover

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

5.3 Emergency visit subject to the Day-to-day benefit

An incident for these purposes is defined as a condition not requiring hospitalisation or specialist intervention but a clinically validated consultation and/or a procedure room intervention and/or medication. Emergency services may be obtained from any registered emergency facility and excludes facility fees. The member must obtain pre-authorisation for the visit by phoning the number indicated on the membership card.

5.4 Day-to-day benefit

Services will be covered at 100% of the NHRPL or negotiated tariff. The benefits will be for Primary care as per 1 and 5.3 above and are limited to a maximum per family per year made up as follows: -

(i)	Per principal member	R5 160
(ii)	Per spouse/adult dependant	R3 480
(iii)	Per child dependant	R2 400

5.5 Managed Care Plans

Managed Care Plans are 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.

5.6 Terminal and Wound care

The costs for all services related to wound care or 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.

5.7 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.

5.8 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.

S I G N A T U R E S:

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20/09/2024