

WOOLTRU HEALTHCARE FUND

COMPREHENSIVE OPTION

SCHEDULE OF BENEFITS

With effect from 1 January 2026

With due regard to PMBs

1. OPTIONS

When a Member joins the Fund he must select the Option that he wishes to join. If the Member has selected the Comprehensive Option, then the Fund will provide to the Member and his Dependants the benefits as detailed in this schedule.

2. PRIMARY HEALTHCARE BENEFITS

The Fund will provide primary healthcare benefits as contained in this Annexure.

3. BENEFITS FOR HOSPITALISATION AND OTHER MAJOR MEDICAL SERVICES

Notwithstanding any other provisions in these Rules, the Fund will provide Members and their Dependants with cover for hospitalisation and other major medical services as contained in this Annexure.

3.1 Annual Major Medical Expenses

Notwithstanding any provisions to the contrary, as contained in the schedule below, all

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benefits in respect of hospitalisation and other major medical services will be unlimited at 300% of the Agreed Tariff, unless otherwise specified, subject to pre-authorisation via the Managed Health Care Organisation protocols.

3.2 Pre-authorisation

Pre-authorisation must be obtained at least 2 working days before admission to hospital. In emergency cases the Managed Health Care Organisation must be notified of the event within 24 hours of admission to the hospital or on the first working day following such emergency admission.

No benefits will be granted for hospitalisation, treatments and associated clinical procedures if the Managed Health Care Organisation has denied authorisation.

In respect of any hospitalisation for which pre-authorisation has not been obtained, or pre-authorisation has been obtained later than as stipulated above members will be subject to the difference between WHFT and actual costs charged for all other associated costs.

4. HEALTHCARE BENEFITS PROVIDED OUTSIDE SOUTHERN AFRICA

No benefits for healthcare services rendered outside of the borders of South Africa will apply to any Member that has taken up permanent residence outside of the borders of South Africa.

Members that have taken up permanent residence outside of the borders of South Africa still qualify for benefits under the Rules of the Fund if treated in South Africa.

Members that have not taken up permanent residence outside the borders of South Africa may still submit claims for healthcare services rendered outside the borders of South Africa and these will be subject to the same benefits, sub-limits and exclusions that apply to the relevant healthcare services in South Africa in terms of the Rules of the Fund, provided that:

- a) Benefits are limited to emergency services only;

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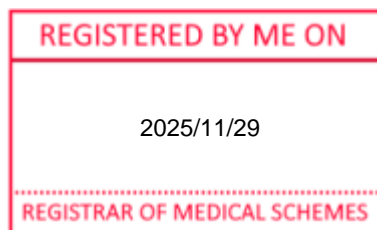
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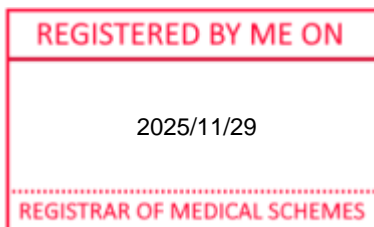
REGISTRAR OF MEDICAL SCHEMES

- b) Limited to 90 days travel outside of South Africa per annum;
- c) Return flight ticket to be supplied with submission of the claim/s;
- d) The benefit entitlement will not exceed the rate and applicable tariff for the equivalent healthcare service in South Africa;
- e) Where the cost of the claim is lower than the applicable tariff, benefits will be paid at cost;
- f) Medicine claims will be paid at cost, limited to the amount payable in terms of relevant South African medicine pricing legislation;
- g) Members must pay the healthcare provider directly and then submit a claim to the Fund for reimbursement consideration;
- h) Claims will be refunded in South African Rands, to the Member's South African bank account at the rate of the WHFT only;
- i) No benefit will be provided in respect of ambulance or other emergency transportation outside South Africa;
- j) No benefit will be provided where costs for healthcare services incurred outside South Africa are claimable from a travel insurance or a similar insurance policy taken out by, or on behalf of, the Beneficiary; and
- k) Claims will only be considered by the Fund, if submitted in English and if drafted by a recognised provider of medical services in the country where services were provided.

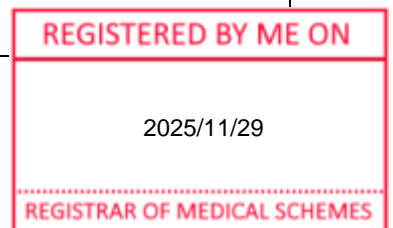


5. ANNUAL BENEFIT SCHEDULES

DAY TO DAY BENEFITS	
<p>Sub-limits apply to certain benefits as specified below.</p> <p>Pro-rata allocation of benefits will apply in respect of Beneficiaries joining the Fund during the year.</p> <p>PMB conditions will be paid at the DSP tariff where a DSP is used. A valid PMB claim will not be paid from the MSA.</p> <p>Medical Savings Account (MSA)</p> <p>Member = R10 896</p> <p>Adult Dependant = R10 896</p> <p>Child Dependant = R3 624</p>	
<p>Professional Services Benefit</p> <p>50% of any non-PMB out-of-hospital claims for:</p> <ul style="list-style-type: none"> • Gynaecologists • Paediatricians • Psychiatrists • Psychologists • Physiotherapists <p>The balance of the claim, will be deducted from member's MSA</p>	<p>Paid at 100% of WTHF tariff.</p> <p>Subject to the following limits:</p> <p>Member = R11 200 Adult Dependant = R10 900 Child Dependant = R3 800</p>
<p>General Practitioner</p> <p>Out of hospital</p>	<p>300% of WHFT.</p> <p>Benefit subject to MSA.</p>



DAY TO DAY BENEFITS	
<p>Specialist</p> <p>Out of hospital</p>	<p>Non-DSP Specialist: 300% of WHFT.</p> <p>DSP Specialist: 100% of Agreed Tariff.</p> <p>Benefit subject to MSA.</p>
<p>Registered Private Nurse Practitioners</p> <p>The costs of consultations, and treatment in the absence of a nursing pre-authorisation, e.g. baby clinic and treatment for primary healthcare services (including the cost of vaccinations and injection material administered by the practitioner)</p>	<p>300% of WHFT.</p> <p>Benefit subject to MSA.</p>
<p>Associated Health and Auxiliary Services</p> <p>(Chiropractor, Homeopath, Naturopath, Clinical psychologist, Speech therapist, Audiologist Occupational Therapist, Podiatrist, Orthotist, Dietician, Biokineticist, Social Workers used for psycho-therapy and Physiotherapist)</p>	<p>300% of WHFT.</p> <p>Benefit subject to MSA.</p> <p>No benefit for vocational guidance, child guidance, marriage guidance, school therapy or attendance at remedial education schools or clinics.</p>
<p>Prescribed Acute Medicine</p> <p>(Medicine used for treatment of diseases or conditions that require a short course of medicine treatment)</p>	<p>100% of Single Exit Price plus Agreed dispensing fee.</p> <p>Benefit subject to MSA.</p>
<p>Over the Counter Medicine</p>	<p>100% of Single Exit Price plus Agreed dispensing fee.</p> <p>Benefit subject to MSA.</p>







DAY TO DAY BENEFITS	
Basic Dentistry (Scale and polish, consultations, fillings, extractions, plastic dentures and other procedures by dental practitioners)	300% of WHFT. Benefit subject to MSA.
Specialised Dentistry (Crowns, bridges, orthodontic treatment and dentures)	300% of WHFT. Benefit subject to MSA.
Optical Benefits (Eye Tests, Frames, Lenses, Contact Lenses)	300% of WHFT. Benefit subject to MSA. No benefit for sunglasses.
Maternity Benefits (Pre-and- Post natal Care, including sonar's, ante natal consultation and post-natal consultation)	300% of WHFT. Benefit subject to MSA.
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Pathology, Radiology & Ultrasounds	300% of WHFT. Benefit subject to MSA. Benefit subject to MSA, unless performed as part of a hospital admission.
Emergency visits/ outpatients	300% of WHFT. Benefit subject to MSA.



MAJOR MEDICAL EXPENSES

Sub-limits apply to certain benefits as specified below.

Pro-rata allocation of benefits will apply in respect of Beneficiaries joining the Fund during the year.

<p>Hospitalisation</p> <p>Provincial/State and Private Hospitals</p>	<p>Subject to pre-authorisation.</p> <p>100% of Uniform Patient Fee Schedule or Cost or Agreed Tariff, whichever is applicable at the rate for a general ward & theatre, intensive care units, high care wards, ward and theatre drugs, dressings and materials.</p>
<p>Unattached Theatre Units</p> <p>(Registered with the Department of Health)</p>	<p>300% of WHFT or Agreed Tariff including theatre, drugs, dressings, materials and recovery bed.</p>
<p>Robotic Assisted Laparoscopic Prostatectomy</p>	<p>100% of WHFT.</p> <p>Subject to pre-authorisation and clinical motivation.</p> <p>Performed at an accredited Hospital.</p> <p>Benefit limit R171 700 per qualifying Beneficiary per annum, for hospital and equipment.</p>
<p>Procedures performed at Out-of-Hospital</p> <p>(Departments or Emergency Rooms of Provincial, State or Private Hospitals)</p>	<p>300% of the Uniform Patient Fee Schedule, WHFT or Agreed Tariff in respect of the facility charge, theatres, drugs, dressings, materials, and the recovery bed where the facilities are used to perform a procedure.</p> <p>Subject to pre-authorisation.</p>
<p>To Take Out Medicine</p> <p>(Medicine on discharge from hospital)</p>	<p>Limited to 7 days, except for Immunosuppressant drugs dispensed by the hospital for use after discharge (see Organ Transplants).</p>

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MAJOR MEDICAL EXPENSES

Maternity Benefits: Confinements	Benefit	Limited To
	<p>Vaginal delivery</p> <p>Caesarean Section</p> <p>Two Ultrasounds (12 and 24 weeks)</p> <p>Ward Rate</p> <p>Pathology</p> <p>(Additional maternity pathology paid for by the Fund. Tariff code in brackets)</p>	<p>100% of Agreed Tariff.</p> <p>100% of Agreed Tariff if motivated by a DSP Specialist.</p> <p>100% of Agreed Tariff.</p> <p>General ward rates, subject to the following:</p> <ul style="list-style-type: none"> • Normal delivery - 3 days; and • Caesarean section - 4 days. <p>100% of Agreed Tariff</p> <ul style="list-style-type: none"> • Full Blood Count (3755) • Blood Grouping (3764) • Rhesus Antigen (3765) • Urine Culture (3893) • HIV Elisa or other screening Test (3932) • Rubella Antibody (3948) • VDRL (3949) • Glucose Strip Test (4050) • Urine Analysis Dipstick (4188) • HIV Antibody Rapid Test (4614)
<p>All consultations relating to these benefits are paid from MSA.</p> <p>The services of a midwife during and after confinement, provided that hospital services have not been used and subject to pre-authorisation, are available in lieu of hospitalisation subject to the WHFT.</p>		

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General Practitioner services (Consultations, operations and procedures)	300% of WHFT. Subject to pre-authorisation.
Specialist services (Consultations, operations and procedures)	Non-DSP Specialist: 300% of WHFT. DSP Specialist: 100% of Agreed Tariff. Subject to pre-authorisation.
Pathology	300% of WHFT.
Emergency room visits resulting in hospitalisation	Authorisation must be obtained within 24 hours of admission into hospital or by the following working day.
Radiology (Including MRI, CT scans, Computer Tomography & Radio-Isotope Studies, Ultrasounds and Bone Density Scans (DEXA))	300% of WHFT. Subject to the MSA, unless performed as part of a hospital admission. Subject to pre-authorisation and Managed Health Care protocols.
Maxillo-facial	300% of WHFT. Subject to pre-authorisation and Managed Health Care protocols.
Blood Transfusions (Cost of transfusion and transport i.e. materials, apparatus and operator's fees)	300% of WHFT.
Ambulance Services (Transport to nearest hospital or emergency inter-hospital transfers)	100% of Agreed Tariff. Unlimited if the DSP is used and subject to pre-authorisation by the DSP within 72 hours of the transport occurring. Unauthorised use of an ambulance, for a non-emergency will not be covered by the Fund.

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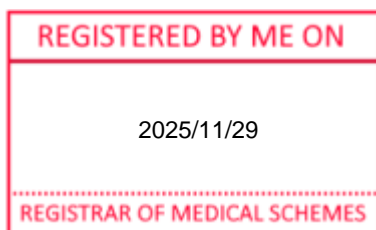
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<p>Medical and Surgical Appliances</p> <p>(Crutches, moonboots, orthotics etc.)</p>	<p>300% of WHFT.</p> <p>Subject to clinical motivation and pre-authorisation.</p> <p>Subject to available MSA where approval is not obtained.</p> <p>If associated to a hospital admission, this will be subject to Major Medical Expenses.</p>
<p>External Protheses and Appliances</p> <p><i>This benefit is issued on a 24-month benefit cycle that runs from date of service.</i></p>	<p>300% of WHFT.</p> <p>Subject to written motivation which must be received 72 hours before the request for pre-authorisation and approval.</p> <p>Benefits are subject to terms, conditions and Managed Health Care protocols.</p> <p>Subject to available MSA where approval is not obtained.</p> <p>Limited to R89 400 per Beneficiary every two years with the following sub-limits:</p> <ul style="list-style-type: none"> • CPAP machine: R32 760 per Beneficiary (full sleep study results, motivation and quote required), <i>every 2 years</i> • Wheelchair: R27 300 per Beneficiary (motivation and quote required), <i>every 3 years</i> • Hearing Aids: R43 680 per Beneficiary (full audiology report, motivation and quote required), <i>every 2 years</i> • Colostomy kits: As prescribed by treating Doctor, <i>annually</i>



<p>Private Nursing</p>	<p>100% of WHFT.</p> <p>Subject to clinical motivation, pre-authorisation and case management.</p> <p>These services must be provided by a registered and approved service provider.</p> <p>A limit of R6 460 per Beneficiary per month applies, limited to 6 months per annum.</p>
<p>Auxiliary Services in hospital</p> <p>(Clinical Psychologist, Speech Therapist, Dietician, Social Worker used for psychotherapy, Biokineticist, Occupational Therapist, Physiotherapist)</p>	<p>100% of WHFT.</p> <p>Benefits only payable if the services are directly related to an authorised admission.</p> <p>Post-operative auxiliary services may be approved and benefit granted on condition such services commence within 6 weeks after the hospital admission.</p> <p>Subject to clinical motivation and preauthorisation.</p> <p>No benefit for Audiologist, Podiatrist, Orthotists, Vocational Guidance, Child Guidance, Marriage Guidance, School Therapy or attendance at remedial education schools or clinics.</p>
<p>Procedures performed in doctor's rooms as per Annexure E (and listed below)</p> <p>Endoscopic Procedures:</p> <ul style="list-style-type: none"> • Gastroscopy • Oesophagoscopy • Sigmoidoscopy • Colonoscopy <p>Examinations performed by an ophthalmologist:</p> <ul style="list-style-type: none"> • Treatment of retina and choroids by cryotherapy • Pan retinal photocoagulation • Laser capsulotomy • Laser trabeculoplasty • Laser apparatus 	<p>300% of WHFT.</p> <p>No co-payment applies if performed in doctor's rooms.</p> <p>A co-payment of R2 920 will apply should any of the procedures, as per Annexure E (as listed), be performed in hospital, without an approved clinical indication and Fund approval.</p> <p>Anaesthetic costs related to these procedures will be limited to local or regional anaesthetic. General anaesthetic costs are not covered.</p> <p>Pathology costs related to these procedures will be covered from Major Medical Expenses.</p>

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Refractive Surgery	<p>100% of WHFT.</p> <p>LASIK surgery is subject to guidelines for refractive surgery for medical reasons.</p> <p>A motivation is required which must include the refractive error.</p> <p>Subject to pre-authorisation.</p>
Specialised Dentistry, limited to Dental Implants and impacted wisdom teeth only	<p>100% of WHFT.</p> <p>Limited to R26 380 per Beneficiary per annum.</p> <p>Subject to pre-authorisation.</p>
Basic Dentistry – procedures in hospital	<p>300% of WHFT.</p> <p>Limited to removal of teeth and multiple fillings for children seven (7) years and younger.</p> <p>Conscious sedation may be considered but is subject to pre-approval.</p> <p>Anaesthetist will be paid from the Major Medical Expenses if approved.</p> <p>The Dentist will be paid from the MSA.</p> <p>Subject to pre-authorisation.</p>
Psychiatric Treatment in hospital or a registered facility OR Outpatient treatment in lieu of hospitalisation	<p>300% of WHFT.</p> <p>Limited to 21 days per Beneficiary per annum.</p> <p>1 Psychiatric or Psychology consultation post admission within 6 weeks post discharge.</p> <p>Subject to pre-authorisation.</p>

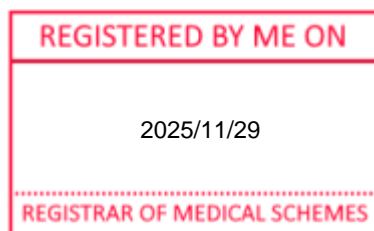
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<p>Oncology, Radiotherapy & Chemotherapy in and out of hospital</p> <p>(Medication/chemicals, related radiology, including MRI and CT scans and pathology)</p>	<p>Limited to PMBs only.</p> <p>Subject to pre-authorisation and registration on the Oncology Risk Management Programme.</p> <p>A detailed clinical motivation and treatment plan is required from the treating specialist.</p> <p>South African Oncology Consortium (SAOC) clinical guidelines apply as reference.</p> <p>Standard and/or State of the Art level of care treatment up to R546 000 per Family per annum. Continued benefits for PMB level of care treatment thereafter.</p> <p>Specialised oncology medication: 30% of cost payable per cycle subject to the oncology benefit limit and qualifying clinical criteria.</p>
<p>Chronic Medication</p> <p>PMB - 26 CDL conditions</p> <p>(Medicines which have been classified to be used for treatment of chronic illnesses as determined by the Fund)</p>	<p>Subject to pre-authorisation.</p> <p>Benefits as per Annexure F.</p>
<p>Chronic Medication</p> <p>Non-PMB</p>	<p>R36 980 per Beneficiary per annum.</p> <p>Subject to pre-authorisation.</p>
<p>Speciality Chronic Medication</p> <p>(excluding Oncology medication)</p>	<p>Subject to pre-authorisation.</p> <p>Authorised medication limited to R199 300 per Beneficiary per annum.</p>



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MAJOR MEDICAL EXPENSES

PREVENTATIVE TESTS	TEST	TARIFF CODE	LIMITED TO
	Mammogram	34100 and 3605	One per female (over 40 years) every two years or clinically indicated by family history.
	Bone Density Scans (DEXA)		One per female (over 65 years) every two years.
	Standard pap smear or liquid-based cytology	4566 or 4559	One per adult female per annum.
	Flu Vaccine		One per Beneficiary per annum.
	Pneumococcal Vaccine		One per lifetime for Beneficiaries over the age of 65 or for High-Risk individuals that are registered for Chronic Disease programme for applicable illnesses.
	HIV test (Pathologist or finger prick)	3932	One per Beneficiary per annum.
	Glaucoma screening	3014	One screening per adult (over 40 years) every two years.
	HPV Vaccine	NAPPI Code: 710020 (Ceravix) NAPPI Code: 710429 (Gardasil)	All female Beneficiaries between the ages of 9 and 13 years.
Prostate-specific antigen (PSA) testing	4519 or 4524	Limited to men aged: <ul style="list-style-type: none"> • 40 to 49 - Once every 5 years • 50 to 59 - Once every 3 years • 60 to 69 - Once every 2 years • 70 and older - Once per annum 	

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MAJOR MEDICAL EXPENSES		
Colorectal cancer screening: Faecal occult blood test/Faecal immune-chemical test	4351 or 4352	One per Beneficiary per annum. Subject to the following criteria: <ul style="list-style-type: none"> Beneficiaries 50 years and older or with family history.
Health Risk Assessment (Body Mass Index, Blood Pressure, finger prick Cholesterol and Blood Sugar tests)		One screening per adult per annum. To be performed at a suitable pharmacy.
<ul style="list-style-type: none"> The cost of the test will not be deducted from the MSA. Should the Health Risk Assessment be performed in the Doctors rooms, the consultation fee will be paid from the MSA. 		

HIV/AIDS
Sub-limits apply to certain benefits as specified below
Pro-rata allocation of benefits will apply in respect of Beneficiaries joining the Fund during the year
<p>HIV/AIDS 100% of Cost, subject to Prescribed Minimum Benefits as per Annexure G.</p> <p>All pathology related treatment (as per the Fund protocols and care plans) will not be deducted from the members MSA.</p> <p>HIV Counselling and testing (HCT): The Fund will allow a benefit of R370 per Beneficiary per annum as a testing fee for General Practitioners.</p> <p>Circumcision for uninfected male adults and male newborns will be paid at 100% of the WHTF rate, subject to MSA.</p>
STATUTORY PRESCRIBED MINIMUM BENEFITS AS PER ANNEXURE G

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