2024 MEMBER GUIDE

JOIN SAMWUMED

2024 BENEFITS

Affordable Quality Health Care.

SILA- (We are still here) for Municipality Workers nationally.
We have been serving and inspiring members to live healthy lives since 1952.

Samwumed @SAMWUMEDhealth Samwumed

SAMWUMED
Real Heritage. Real People. Real Health Care.

ABOUT SAMWUMED

The South African Municipal Workers Union National Medical Scheme (SAMWUMED) is a fully funded, national, accredited and self-administered medical aid scheme which covers approximately 74 000 lives throughout South Africa.

We welcome and cover all South African municipality employees irrespective of gender, colour and affiliation. Our Scheme is financially healthy with reserve levels remain above 70% exceeding the required statutory threshold of 25%.

VISION

Your family's scheme of choice committed to quality healthcare through service excellence, accessible and affordable health care and an accountable administration.

MISSION

Providing quality, accessible and affordable community-based health care to our members through:

- Empowering and supporting communities to embrace healthy living
- Member-centric, efficient service delivery, and innovative processes
- Preservation of good relationships with all our stakeholders; and
- Ensuring financial sustainability whilst committing to the principle of non-profit

VALUES

- Member centric
- Integrity
- Discipline
- Responsibility
- Accountability
- Value of self
- Ubuntu

Disclaimer: This Member Guide is prepared and distributed for purposes of providing you with essential information to help you select the best benefit option for you and your family. The Guide does not supersede the Scheme Rules. Kindly familiarise yourself with your chosen benefit option and note where pre-authorisations, motivations and or letters of referral are required to access benefits.

REPORT FRAUD, WASTE AND MEDICAL AID ABUSE

Medical aid fraud in all its forms can contribute directly and indirectly to a rise of medical aid costs including your membership contributions.

You have the power to help **STOP** fraud by not being involved in fraudulent activities and reporting those who are involved in fraud.

SAMWUMED has many channels available to you to report fraud. They are listed below:

Contact number - 082 450 9539
Use the dedicated contact number to report fraudulent activities regarding your medical aid.

SMS or WhatsApp number: 082 450 9539
Send your report via SMS line from anywhere in South Africa, costs do apply or via WhatsApp.

Email to fraudreport@qforensic.co.za
Send an email of your report privately to Qhubeka Forensic Services.

REPORTS CAN BE MADE ANONYMOUSLY OR IN CONFIDENCE.

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CONTENTS

GLOSSARY OF TERMS USED IN THIS GUIDE

- **BENEFIT LIMIT**
  The maximum amount that the member or dependent is entitled to for a specific benefit category, considering the Scheme Rules and Scheme Tariff paid for services or appliances.

- **CO-PAYMENT**
  The part of the account that a member pays in situations where the benefit does not cover the relevant health service, or when the provider charges fees that are higher than the Scheme Tariff.

- **OVERALL ANNUAL LIMIT (OAL)**
  The limit that every member and their dependents cannot exceed during each benefit year.

- **DEPENDANT**
  A spouse or partner; child or parent who is dependent on the member for care or support.

- **PBPA**
  Per Beneficiary Per Annum.

- **DESIGNATED SERVICE PROVIDER (DSP)**
  The service provider that the Scheme has chosen to provide certain medical care for PMBs.

- **EXCLUSIONS**
  Any treatment, medications, appliances or similar that are not covered in terms of the Rules of the Scheme.

- **FORMULARY**
  A list of medicines

- **ICD-10 CODE**
  The International Classification of Diseases (ICD), - 10. A system that organises diseases and the complications connected to these diseases according to specific categories.

- **MEDICAL SCHEMES ACT**
  The law that governs all medical schemes in South Africa.

- **PRE-AUTHORISATION**
  The prior approval of scheduled surgeries and procedures. Whenever hospitalisation is required (ER, triage, scans and casualty ward) this must be confirmed with the Scheme's Managed Care partner/s. Please also note that there are certain day-to-day benefits that require pre-authorisation.

- **PRE-EXISTING MEDICAL CONDITION**
  A medical condition or illness that already exists at the time a member or their dependant joins the Scheme.

- **PRESCRIBED MINIMUM BENEFITS (PMBs)**
  A list of conditions, specified in the Medical Schemes Act 131 of 1998, for which all members are entitled to treatment.

- **PRESCRIBED CYCLES**
  The number of times a member is allowed to access certain benefits during a specific benefit year(s).

- **PREFERRED PROVIDER**

  A provider that the Scheme has negotiated favourable rates with and that can be used as an alternative to a DSP in the event of an emergency. A Preferred Provider may also be used if a DSP is not within reasonable travelling distance or does not offer the treatment or services required.

- **PRO-RATED BENEFITS**
  Benefits allocated to a member based on the number of contributions they have paid. This applies to members who join after 31st of March of the benefit year. The Scheme shall apply a pro-rated benefit, based on the following criteria: - April – June - 75 percent of benefit limits, July - September – 50 percent of benefit limit and October -December – 25 percent of benefit limit

- **SCHEME TARIFF**
  The rate according to which the Scheme pays for claims.

- **SUB-LIMIT**
  Forms part of a broader benefit category.

- **WAITING PERIOD**

  A period during which members will not be covered even though they are paying contributions.

- **CMS**
  Council for Medical Schemes

- **POPIA**
  This is the Protection of Personal Information Act

- **SOUTH AFRICAN TRIAGE SCALE (SATS)**
  Triage undifferentiated acute care patients presented to healthcare facilities, such as Emergency Rooms (ERs)

- **TRIAGE EARLY WARNING SCORE (TEWS)**
  Triage undifferentiated acute care patients presented to healthcare facilities, such as Emergency Rooms (ERs)

- **ER**
  The Emergency Room

- **FP**
  Family Practitioner also known as General Practitioner (GP)

REASONS WHY WE ARE THE BEST MEDICAL AID FOR YOU

If you are already a member of SAMWUMED, we assure you that you have made the right decision in joining and staying with our Scheme. That is why SAMWUMED provides HIGH-VALUE and HIGH-QUALITY medical benefits for all our members at Affordable Contributions.

There are many good reasons to Join and Stay with SAMWUMED including

- Financially Healthy: We have high reserve levels, which is way above the required 25% by Council of Medical Schemes (CMS).
- Access to private healthcare services.
- We pay claims.
- We have improved our Call Centre by introducing a self-service call centre solution for you to easily access your information such as: Available Benefits, Statements, Tax Certificate etc.
- We have created a Mobile App that allows you easy access to your e-membership card, benefits, real-time claims, statements etc.
- Cover for PMB and NON-PMB Chronic Conditions including 3 additional and 5 additional on Option A and Option B respectively. See Medication page for further details.
- Lowest non-healthcare costs.
- No charge for replacement of membership cards.
- We have a national footprint of dedicated Sales Consultants who are there to service our members.
- We register eligible family members.

2024 CONTRIBUTION & MEMBER ELIGIBILITY

New SAMWUMED Mobile App

Yes! Yes!

You can now update your own **CONTACT DETAILS** using the SAMWUMED Mobile App.You don't need to call the Contact Centre.

2024 Contributions - Option A

The subsidy amounts differ from employer to employer. Members are encouraged to inquire with their Human Resource for their municipality subsidies.

100% Contribution

SALARY BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R4 020	1 585,00	1 585,00	559,00
R4 021 - R6 490	1 872,00	1 872,00	657,00
R6 491 - R9 990	2 383,00	2 383,00	832,00
R9 991+	2 617,00	2 617,00	923,00

Member 40%

SALARY BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R4 020	634,00	634,00	223,60
R4 021 - R6 490	748,80	748,80	262,80
R6 491 - R9 990	953,20	953,20	332,80
R9 991+	1 046,80	1 046,80	369,20

Company 60%

SALARY BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R4 020	951,00	951,00	335,40
R4 021 - R6 490	1 123,20	1 123,20	394,20
R6 491 - R9 990	1 429,80	1 429,80	499,20
R9 991+	1 570,20	1 570,20	553,80

MEMBER + SPOUSE	MEMBER + SPOUSE + 1 CHILD	MEMBER + SPOUSE + 2 CHILDREN	MEMBER + SPOUSE + 3 CHILDREN
3 170,00	3 729,00	4 288,00	4 847,00
3 744,00	4 401,00	5 058,00	5 715,00
4 766,00	5 598,00	6 430,00	7 262,00
5 234,00	6 157,00	7 080,00	8 003,00

MEMBER + SPOUSE	MEMBER + SPOUSE + 1 CHILD	MEMBER + SPOUSE + 2 CHILDREN	MEMBER + SPOUSE + 3 CHILDREN
1 268,00	1 491,60	1 715,20	1 938,80
1 497,60	1 760,40	2 023,20	2 286,00
1 906,40	2 239,20	2 572,00	2 904,80
2 093,60	2 462,80	2 832,00	3 201,20

MEMBER + SPOUSE	MEMBER + SPOUSE + 1 CHILD	MEMBER + SPOUSE + 2 CHILDREN	MEMBER + SPOUSE + 3 CHILDREN
1 902,00	2 237,40	2 572,80	2 908,20
2 246,40	2 640,60	3 034,80	3 429,00
2 859,60	3 358,80	3 858,00	4 357,20
3 140,40	3 694,20	4 248,00	4 801,80

2024 Contributions - Option B

The subsidy amounts differ from employer to employer. Members are encouraged to inquire with their Human Resource for their municipality subsidies.

100% Contribution

SALARY BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R5 970	2 639,00	2 639,00	926,00
R5 971 - R8 240	3 193,00	3 193,00	1 121,00
R8 241 - R15 240	3 272,00	3 272,00	1 150,00
R15 241+	3 618,00	3 618,00	1 192,00

Member 40%

SALARY BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R5 970	1 055,60	1 055,60	370,40
R5 971 - R8 240	1 277,20	1 277,20	448,40
R8 241 - R15 240	1 308,80	1 308,80	460,00
R15 241+	1 447,20	1 447,20	476,80

Company 60%

SALARY BAND	PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 - R5 970	1 583,40	1 583,40	555,60
R5 971 - R8 240	1 915,80	1 915,80	672,60
R8 241 - R15 240	1 963,20	1 963,20	690,00
R15 241+	2 170,80	2 170,80	715,20

MEMBER + SPOUSE	MEMBER + SPOUSE + 1 CHILD	MEMBER + SPOUSE + 2 CHILDREN	MEMBER + SPOUSE + 3 CHILDREN
5 278,00	6 204,00	7 130,00	8 056,00
6 386,00	7 507,00	8 628,00	9 749,00
6 544,00	7 694,00	8 844,00	9 994,00
7 236,00	8 428,00	9 620,00	10 812,00

MEMBER + SPOUSE	MEMBER + SPOUSE + 1 CHILD	MEMBER + SPOUSE + 2 CHILDREN	MEMBER + SPOUSE + 3 CHILDREN
2 111,20	2 481,60	2 852,00	3 222,40
2 554,40	3 002,80	3 451,20	3 899,60
2 617,60	3 077,60	3 537,60	3 997,60
2 894,40	3 371,20	3 848,00	4 324,80

MEMBER + SPOUSE	MEMBER + SPOUSE + 1 CHILD	MEMBER + SPOUSE + 2 CHILDREN	MEMBER + SPOUSE + 3 CHILDREN
3 166,80	3 722,40	4 278,00	4 833,60
3 831,60	4 504,20	5 176,80	5 849,40
3 926,40	4 616,40	5 306,40	5 996,40
4 341,60	5 056,80	5 772,00	6 487,20

MEMBER ELIGIBILITY

SAMWUMED'S PREMIUMS AND MEMBERSHIP DEPARTMENT IS RESPONSIBLE FOR ALL ASPECTS OF MEMBERSHIP AND THE COLLECTION OF CONTRIBUTIONS.

All local government employees have the opportunity to change their medical aid options during the Freedom of Association period (also known as the "window period") from October until the end of November each year. Members who wish to make this change must notify the Scheme in writing by submitting an Option change form via their Human Resource Department by no later than 15 December of the same year. All benefit option changes must be confirmed by January each year.

Section 7 of the South African Local Government Bargain Council's Main Collective Agreement states that "medical scheme members may make an election regarding movement from one accredited medical scheme to another accredited medical scheme on an annual basis before 01 January".

MOVEMENT BETWEEN SCHEMES DURING THE YEAR IS NOT ALLOWED.

Membership application and dependant registration forms make provision for the disclosure of pre-existing health conditions. Failure to provide the appropriate information to the Scheme could lead to the termination of your or your dependant's membership. Single principal members are issued with one membership card and families receive two cards. The Scheme does not charge members for replacement of lost or stolen cards.

It is important that the Scheme has the correct identity numbers for members and dependants. Without it, you might not be able to use your benefits. Please contact the Scheme to ensure that we have your correct telephone numbers, address, and details of your dependants. **If your information changes during the year, it is important to let the Scheme know by contacting 0860 104 117 or send us an email to memberupdates@samwumed.org**

ALL INFORMATION THAT YOU DISCLOSE TO THE SCHEME IS CONSIDERED CONFIDENTIAL. THE SCHEME ADHERES TO THE POPIA ACT.
You should be mindful not to disclose information such as your membership number or hand over tax or membership certificates/cards to any third party.

WHAT DOCUMENTS DO I NEED TO BECOME A MEMBER?

No matter which benefit option you take, SAMWUMED Medical Aid offers cover in full and as stipulated by Scheme Rules, for the diagnosis, treatment and care of an extensive range of medical conditions.

It's simple to become a member of SAMWUMED

Step 1:
Request and complete an APPLICATION FORM from our Sales & Servicing or Broker Consultants,and at our website www.samwumed.org or via your HR office.

Step 2:
Submit your application with photocopies of SOUTH AFRICAN IDENTITY and supporting documents.

Step 3:
You will receive an SMS from SAMWUMED to confirm receipt of your application.

Step 4:
You will receive your SAMWUMED **WELCOME PACK** which includes your

- Membership Guide and
- Membership Card.

CHECKLIST:

What documents do I need to become a member?

South African ID Book/Card.

A sworn affidavit proving financial dependency for children over the age of 21. A spouse/ partner need to provide a marriage certificate or a sworn affidavit .

Legal documents of adopted/foster children.

Previous membership certificate.

Confirmation of banking details.

Salary slip.

NO LATE JOINING FEE PENALTIES: You do not pay late joiner fees when you join us.
WAITING PERIOD: General waiting period of up to one (1) month apply. Condition specific waiting periods of up to 12 months apply.

For more information members may contact the Membership Department via email at memberupdates@samwumed.org

REGISTERING DEPENDANTS

- To register a dependant, a Dependant Registration form must be completed and submitted to the Scheme via your Human Resource Department along with the required documentation such as copies of birth certificates when registering children; affidavits and marriage certificates for spouses and partners; proof of study and/or affidavits proving dependency for dependants over the age of 21.

- The Dependant Registration form makes provision for the disclosure of pre-existing conditions that prospective dependants might have. Depending on the severity of the condition(s), certain waiting periods may be considered by the Scheme before dependants can claim benefits.

- Failure to disclose these pre-existing conditions could limit or exclude a dependant from claiming benefits, according to provision 11.5 of the Scheme Rules, which states that "The Board may, in its absolute discretion, exclude from benefits or terminate the membership of a member or dependant whom the Board finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making a material misrepresentation or non-disclosure of factual information or who, in the opinion of the Board, is guilty of misconduct that would either compromise the achievement of the aims and objects of the Scheme or bring the Scheme into disrepute. In such event, he or she may be required by the Board to refund to the Scheme any sum which, but for his or her abuse of the benefits or privileges of the Scheme, would not have been disbursed on his or her behalf."

CHILD DEPENDANTS

- A child dependant is someone up to the age of 21 but not older than 25 years. Student dependants must be attending a recognised educational institution and be without a regular income. To register a child dependant, a birth certificate, identity document, or affidavit (where the child's surname is not the same as the main member's) is required. Proof of study or medical report must be submitted for child dependants who are students or mentally/physically disabled.

- Grandchildren can be registered, provided that the member is responsible for their care and financial support. An affidavit confirming this dependency is required and this is subject to an annual review.

BIRTH OF A CHILD

- Members must notify the Scheme within 30 days of the birth of a child to qualify for immediate benefits. The birth certificate must be submitted along with the Dependant Registration form. A three-months waiting period will be imposed if the registration is not completed within this time.

REGISTERING DEPENDANTS

ADULT DEPENDANTS

- Adult dependants are 21 years and older and can be a spouse or partner. Spouses who are registered within 30 days of marriage will qualify for benefits immediately. A marriage certificate or affidavit must be submitted with the registration form.

  A three-month waiting period will be imposed if the registration is not completed within this time.

  Dependants over the age of 21, who are not spouses or partners, but are dependent on the main member for care and financial support, can be registered as adult dependants. An affidavit proving this dependency is required.

If you have any questions regarding membership or you want to update your details, please contact them using the below email addresses and contact number: -

Member Updates

Member/ dependant changes (member maintenance such as personal information change, contact details, dependant addition, dependant termination, outstanding documents (membership related), general membership queries (tax / membership certificate requests, card requests) etc.)

E: memberupdates@samwumed.org

New Member Application Form

E: newapps@samwumed.org

Member Terminations

E: resignations@samwumed.org

Option Changes

E: optionchanges@samwumed.org

Alternatively, you may contact us on our share call number 0860 104 117 or visit our web chats on our website at www. samwumed.org

EXCLUSIONS

WHAT DOES THE SCHEME NOT PAY FOR?

Exclusions: Any treatment, medications, appliances or similar that are not covered in terms of the Rules of the Scheme is regarded as an exclusion.

Refer to Annexure C, Scheme Rules.

***Download our Scheme Rules at www.samwumed.org, under member zone.**

SAMWUMED REFERRAL LIST

A referral authorisation will be required for all out of hospital specialist visits and other allied healthcare providers as per Scheme's referral list.***Download our Referral List from our website: www.samwumed.org**

BENEFITS

We have two benefit plans:

Option A and Option B, have been designed to provide for your healthcare needs.

BENEFITS HIGHLIGHTS 2024

OVERALL BENEFITS IMPROVEMENTS

Increase on all Scheme Benefit.

Family Practitioners Network – encourage better quality of service of our members.

Medication Improvements

Improvement on Over The Counter (OTC) medication for **Option A R2 220.00** per family per year (included with dispensed or acute medication limit) and for **Option B R3 220.00** per family per year (included with dispensed or acute medication limit).

Formulary Improvements

Option A We have added additional Chronic Medication to cover:

- Depression, GORD and Gout

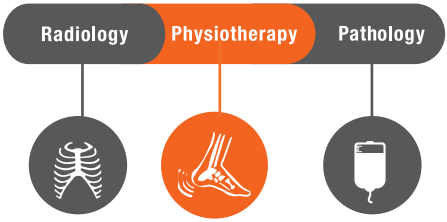
Option B We have improved the Formulary List (Medication List). We have added additional Chronic to cover:

- Eczema, Depression, GORD, Gout and Menopause

Overall annual benefits improvements

Overall Annual Benefits increase for Option A is **R 961 500.00** per family per year and for Option B is **R1 921 000.00** per family per year.

In–hospital and out- of-hospital benefit improvements



Cancer Benefits

We have improved our Cancer Benefits by shortening the number of years for mammograms (breast cancer scans) from every three years to every two years for female beneficiaries from age 45 – 70.

We introduced HPV vaccine to fight the HPV virus which can cause cancers later in life, to our preventative care benefits for female beneficiaries between the age of 9 and 14 years.

Baby Bags

As part of our Maternity Programme, new mothers who have registered on our Maternity Programme and have given birth from the period of January 2023 will be eligible to receive
a baby bag with baby essentials and educational materials for all new-born babies.

BENEFITS CAN BE GROUPED INTO TWO CATEGORIES

DAY-TO DAY BENEFITS

That you can access outside of hospital such as doctor and specialist consultations and visits, dental procedures, medication and optical care. Each benefit category is subject to limits as specified in the Scheme Rules. These benefits allow you and your family to access a wide range of healthcare services.

HOSPITAL BASED CARE BENEFITS

includes hospitalisation and the treatment of Prescribed Minimum Benefit (PMB) conditions. The hospitalisation benefit makes provision for in-hospital admission or transfers to rehabilitation and step-down facilities.

The Chronic Disease List (CDL) specifies medication and treatment for the 26 chronic conditions that are covered in this section of PMBs.

26 CHRONIC MEDICAL CONDITIONS

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy
- Chronic obstructive pulmonary disorder
- Chronic renal disorder
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus types 1&2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- HIV
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- Ulcerative colitis

NOTE: IF YOU HAVE ANY QUESTIONS PLEASE CONTACT OUR CONTACT CENTRE ON 0860 104 117 or visit **www.samwumed.org** for a chat with one of our qualified Agents

DOCTORS BENEFITS

GP & Specialist Consultations,
Visits and Procedures

Members and their dependents on **Option A** and **Option B** are covered for treatments by GPs, either at the GPs' rooms or the members' home. They, along with their dependents are also covered for Emergency treatment and procedures.

2024 Benefits Option A

GP consultations, Specialists visits and procedures.

Benefit limit available **R7 119** per beneficiary per year.

Member Only	Member + 1	Member + 2	Member + 3
R4 383	R7 119	R9 657	R12 042

GP & Specialist, and minor Procedures
Pre Authorisation may be required for certain procedures.

2024 Benefits Option B

GP consultations, Specialists visits.

Benefit limit available **R7 910** per beneficiary per year.

Member Only	Member + 1	Member + 2	Member + 3
R4 870	R7 910	R10 730	R13 380

GP & Specialist, and minor Procedures
R9 880 Per family per year.
Subject to Pre Authorisation.

Conditions

- The benefits are subject to the Scheme's network of doctors and the appointment of a family practitioner.
- To see the list of Scheme networks, visit **www.samwumed.org.**
- GP referral authorisation required for specialist consultations, visits and procedures.

MEDICATION BENEFITS

The Scheme covers beneficiaries for the following medication benefits:

Prescribed
A drug or medicine that legally requires a letter or prescription from a Medical Practitioner for a pharmacy or any place that dispenses medicine to make it available to the member and or his or her dependents.

Acute
This is medicines that have been issued by the GP but not added to a member's repeat prescription records. For the member to get additional medicines, they require a visit to their GP for a review before it is added onto their repeat prescription.

Dispensed
Dispensing refers to the process of preparing and giving medicine to a named person on the basis of a prescription.

Over-the-counter medicine
This is medicine that may be sold at pharmacies or other shops without a doctor's prescription.

Over and above these medications, the Scheme also covers the **26 Chronic Disease List conditions, as prescribed by Law.**

SAMWUMED covers medication for 26 PMB Chronic illnesses and five (5) additional (Non-PMB) illnesses.

Option A

We have added additional Chronic Medication to cover:

Depression, GORD & Gout.

Option B

We have improved the Formulary List (Medication List) We have added additional Chronic Medication to cover:

Eczema, Depression, GORD, Gout & Menopause.

MEDICATION BENEFITS

2024 Benefits Option A

Benefit limit available **R3 810** per beneficiary per year.

Member Only
R2 230

Member + 1
R3 810

Member + 2
R5 270

Member + 3
R6 980

Medication is subject to the Scheme's formulary list (medicine list).

Over the Counter Limit:
R2 220 Per family per year. Included with dispensed or acute medication limit.

Over the Counter Sub Limit:
R190 Per beneficiary per day.

2024 Benefits Option B

Benefit limit available **R5 730** Per beneficiary per year.

Member Only
R4 350

Member + 1
R5 730

Member + 2
R8 760

Member + 3
R11 540

Medication is subject to the Scheme's formulary list (medicine list).

Over the Counter Limit:
R3 220 Per family per year. Included with dispensed or acute medication limit.

Over the Counter Sub Limit:
R230 Per beneficiary per day..

Conditions

- Members will pay 25% co-payment (payment by the member of a portion of the cost incurred) if they use a pharmacy that is not on the Scheme's list of service providers or if they use out-of-formulary medication or medicines that are outside of those recommended by the Scheme. The member can download the list of Pharmacies from our website: www.samwumed.org
- To access Chronic medication, your treating doctor will need to call **0860 33 33 87** to register your Chronic Medication.

HOSPITAL BENEFITS

2024 Benefits Option A

HOSPITALISATION BENEFITS

In-patient: R961 280 Per family per year.

Maternity: Caesarean section and Normal delivery

- **Caesarean Section:** R31 260 Per family per year, unless PMB.
- **Normal delivery:** Unlimited.
- Scheme rules and protocol apply.

Organ Transplant: In and Out of Hospital

- **Out of Hospital:** Subject to Overall Annual Limit.
- **In-Hospital:** Included with In-patient limit.

Renal Dialysi:

- Included with In-Patient benefit PMB Only.

Blood Transfusion

- Included with In-Patient benefit

Oncology

- **Out of Hospital:** Non PMB subject to R243 000
- **In-Hospital:** Subject to Annual Limit.

Alternative to Hospitalisation

- Private Nursing, Frail Care, Hospice & Step Down Facilities Included with In-patient benefits.

Conditions

The conditions to access the benefits are the following:

- Members will need a pre-authorisation or approval before hospitalisation (1 business day before admission or on the first working day after an emergency hospital admission. Failure to do so, will result in a **R1000** co-payment).
- Members are required to be hospitalised and treated at Scheme network hospitals (DSP) or pay 25% co-payment.
- Scheme rules and PMB protocols apply.

HOSPITAL BENEFITS

2024 Benefits Option B

HOSPITALISATION BENEFITS

In-patient: **R1 920 980** Per family per year.

Maternity: Caesarean section and Normal delivery

- **Caesarean Section:** **R33 440** Per family per year, unless PMB.
- **Normal delivery:** Unlimited.
- Scheme rules and protocol apply.

Organ Transplant: In and Out of Hospital

- In & Out hospital.
- Subject to Annual Limit & Scheme Networks.

Renal Dialysis:

- Included with In-Patient benefit.

Blood Transfusion

- Included with In-Patient benefit

Oncology

- **Out of Hospital:** Non PMB subject to **R365 400**
- **In-Hospital:** Incuded with In-patient benefit

Alternative to Hospitalisation

- Private Nursing, Frail Care, Hospice & Step Down Facilities Included with In-patient benefits.

Conditions

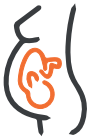
The conditions to access the benefits are the following:

- Members will need a pre-authorisation or approval before hospitalisation (1 business day before admission or on the first working day after an emergency hospital admission. Failure to do so, will result in a **R1000** co-payment).
- Members are required to be hospitalised and treated at Scheme network hospitals (DSP) or pay 25% co-payment.
- Scheme rules and PMB protocols apply.

2024 MATERNITY BENEFITS

Option A & Option B

2024 Option A and Option B MATERNITY BENEFITS



SAMWUMED's Maternity Programme helps expecting moms to receive the help they need to take better care of themselves and their unborn baby by taking advantage of a wide range of maternity preventative care and early detection benefits.

Ultrasounds

Frequency: 100% of Scheme rate. Limited to three ultrasounds for maternity.

Conditions: Limited to 3 screenings per beneficiary per year for **Option B** and 2 screenings per beneficiary per year for **Option A.**

HIV Screening

Frequency: Screen of first test per maternity event. Within 1st trimester (first three months)
Conditions: Limited to one per beneficiary per year.

Ante Natal Consultations

Frequency: 8 Ante-Natal consultations per maternity event.

Conditions: Limited to 8 Ante-Natal consultations per maternity.

Pap Smear

Frequency: (6 weeks post partum) one per beneficiary per year.

Conditions: Limited to one per beneficiary per year.

Vitamins

Folic Acid and Iron Supplements.

Conditions: Limited to first 3 months of pregnancy.

Baby essentials

Baby bag with baby essentials for new born

OPTOMETRY BENEFITS

SAMWUMED members on both **Option A** and **Option B** qualify for optical (eye) cover.

OPTICAL

Option A

Members are covered for eye tests, frames and lenses.

- No contact lenses benefit on **Option A.**

Option B

Members are covered for eye tests, frames, lenses as well as contact lenses.

Conditions

The following conditions apply for members accessing the optical benefits:

- A visit to an ophthalmologist (treatment of disorders and diseases of the eye) requires a referral from GP.
- Exclusions apply, including but not limited to repairs.

  Option B - Frames and contact lenses cannot be taken at the same time. Benefits apply to either or but not both.
- Two year benefit cycle applies for frames and lenses.
- One eye test consultation per beneficiary per year is allowed.
- Access to benefits is subject to family limit.

OPTOMETRY BENEFITS

2024 Benefits Option A

R8 070 per family subject to prescribed cycles.

R2 680 Per beneficiary per year.

Frames: R1 030
Per beneficiary every 2 years.

White lenses:
100% of the lower cost.
- Covered at 100% Scheme rates.

Eye Test:
Covered at **100% Scheme rates,** limited to one per beneficiary per year.

Photochromic lenses:
100% of the lower cost or Scheme Rates.
Up to a maximum of R470 per pair and subject to a prescription of
+0.50/-0.50 and above.
Fixed or gradient tints up to 35%.

2024 Benefits Option B

R10 840 per family subject to prescribed cycles.

R4 030 Per beneficiary per year.

Frames: R1 340
Per beneficiary every 2 years.

Contact lenses:
R3 000 Per beneficiary every 2 years. Frames and contact lenses cannot be obtained at the same time.

White lenses:
100% of the lower cost.
- Covered at 100% Scheme rates.

Eye Test:
Covered at **100% Scheme rates,** limited to one per beneficiary per year.

Photochromic lenses:
100% of the lower cost or Scheme Rates.
100% of the lower cost or Scheme Rates. Up to a maximum of **R470** per pair and subject to a prescription of +0.50/-0.50 and above.
Fixed or gradient tints up to 35%.

The two year benefit cycle applies for frames, lenses and contact lenses on anniversary date, on both Options respectively.

DENTISTRY BENEFITS

Basic Dentistry

Members and their dependents are covered for basic and advanced dentistry services depending on the option chosen. Dentistry is the treatment of diseases and other conditions that affect the teeth and gums.

Option A

- The amount reflected covers basic dentistry.
- No benefit for advanced dentistry on this Option.

Option B

- The amount reflected covers both basic and advanced dentistry.

2024 Benefits Option A

Member Only R4 230

Member + 1 R5 040

Member + 2 R7 010

Member + 3 R8 450

2024 Benefits Option B

Member Only R9 030

Member + 1 R10 370

Member + 2 R12 050

Member + 3 R13 580

Basic Dentistry benefits include:

- Fillings.
- Root canal treatments (dental treatment for removing infection from inside a tooth and protecting a tooth from future infections).
- Scaling (which refers to deep cleaning of teeth that reaches below the gum line to remove plaque build-up).
- Polishing.
- Extractions (removal of teeth).
- Fissure sealants (treatment aimed at preventing tooth decay).
- Denture repairs (a removable plate or frame holding one or more artificial teeth).
- Dentistry is subject to quantity protocols.

Advanced Dentistry benefits include:

- Orthodontists, crowns, bridge-work, inlays, root canal, treatment by periodontists, prosthodontists, dental technicians and any other anaesthetic procedure.

*Motivation, referrals and quotes required.

CONDITIONS

Members have to claim according to the Scheme's approved cycles outlined below:

- **Full dentures** - Every three years.
- **Partial dentures** - Every two years.

RADIOLOGY

SAMWUMED offers its members general and specialised radiology benefits. In both cases in and out-of-hospital cover is provided.

2024 Benefits Option A

General out of hospital
R2 790
Per family per year.

Specialised in and out of Hospital
R10 890
Per family per year.

2024 Benefits Option B

General out of hospital
R11 140
Per family per year.

Specialised in and out of Hospital
R16 790
Per family per year.

CONDITIONS

- Protocols apply for specialised in and out-of-hospital benefits.
- General in Hospital **Unlimited**, based on clinical protocols.
- Subject to Pre – Authorisation

**The general Radiology benefit has a separate In and Out of Hospital benefit.*

PATHOLOGY BENEFITS

SAMWUMED members are covered for both in and out of hospital pathology treatment (diagnosis of diseases based on the laboratory analysis of bodily fluids such as blood and urine, as well as tissues).

2024 Benefits Option A

Benefit available **R5 500**
Per family per year.
Subject to Scheme Network.

2024 Benefits Option B

Benefit available **R11 140**
Per family per year.
Subject to Scheme Network.

*This benefit has a separate In and Out of hospital benefit.
*Pathology In hospital = Unlimited.
*Subjected to clinical protocols.

APPLIANCES BENEFITS

Members and their dependents are covered for medical and surgical appliances including crutches, walking aids and blood pressure monitors, etc. This benefit is basically more to help patients with movement challenges.

2024 Benefits Option A

Member Only
R3 390

Member+1
R4 800

Member+2
R6 090

2024 Benefits Option B

Member Only
R7 490 per family per year.

CONDITIONS

Members can enjoy this benefit subject to the following conditions:

- They have to submit a motivation, complete with costs for pre-authorisation or approval by the Scheme.
- Members have to be within their benefit limits and cycles in order to qualify.
- The Scheme (or contracted managed care company on behalf of the Scheme) may from time to time partner with other parties or centres of excellence in order to ensure cost effective and appropriate care.
- Members have to submit a motivation, Quotations from at least three (3) service providers are required. and referral letter for certain appliances.

  Some appliances requires a member to be registered for a chronic condition in order to obtain the appliance.

PROSTHESES BENEFITS

SAMWUMED provides cover for both internal and external prostheses. These are artificial body parts such as legs, arms and eyes.

2024 Benefits Option A

Internal
R32 790 Per family per year.

External
R16 850 Per family per year.

2024 Benefits Option B

Internal
R33 440 Per family per year.

External
R19 670 Per family per year.

CONDITIONS

- Included with in-hospital benefit.
- Quotations from at least three (3) service providers are required.
- Scheme networks applies for hip and knee replacements. **R10 000** co-payment will apply for out-of-network voluntary use.

AUXILLARY BENEFITS

The Scheme allows members to be able to access or receive services from:

Occupational therapists

A health care professional who is trained to treat injured, ill, or disabled patients through therapeutic use of everyday activities. The patients develop, recover, improve, as well as maintain the skills needed for daily living and working.

Audiologists

A health care professional who is trained to evaluate hearing loss and related disorders, including balance (vestibular) disorders and tinnitus (ringing in the ears) and to rehabilitate individuals with hearing loss and related disorders.

Speech therapists

A health care professional who is trained to assist patients with speech and language problems to speak more clearly.

Dieticians

A health care professional who is trained to assist patients with expert advice on diet and nutrition.

2024 Benefits Option A

Subject to sub-limit of **R2 700**
Per family per year.
Included in GP and Specialist consultations and procedures.

2024 Benefits Option B

R5 580
Per family per year.

CONDITIONS

- Members will require a referral from a GP to access the benefits.
- The limit applies for in and out of hospital.

PHYSIOTHERAPY & BIOKINETICS BENEFITS

The Scheme offers both out-of-hospital and in-hospital physiotherapy benefits (treatment of sprains, back pain, arthritis, strains, reduced mobility, etc).

2024 Benefits Option A

Out of Hospital
R2 500 Per family per year.

2024 Benefits Option B

Out of Hospital
R5 580 Per family per year.

Out of Hospital
Sub limit of
R2 290 Per beneficiary per year.

CONDITIONS

- In-hospital on both options.
- For in hospital Two (2) sessions only, thereafter motivation is required.

This benefit has a separate In and Out of hospital benefit

MENTAL HEALTH & SUBSTANCE DEPENDENCY

SAMWUMED covers its members for mental health and substance dependency (drug abuse), including hospitalisation. The benefits apply to consultations or visits as well as procedures.

HOSPITALISATION

Benefits for mental health and substance dependency include hospitalisation.

- A referral from a specialist is required for mental health hospitalisation.
- PMB conditions apply.

2024 Benefits Option A

Benefit available

R3 000 Per family per year. Subject to clinical and PMB protocols.

- Requires registration on the Mental Health Programme, subject to clinical criteria.

2024 Benefits Option B

Benefit available

R5 000 Per family per year. Subject to clinical and PMB protocols.

- Requires registration on the Mental Health Programme, subject to clinical criteria.

REHABILITATION FOR SUBSTANCE ABUSE

- Unlimited, subject to PMB conditions, protocols and Scheme DSP.

CONDITIONS

Out of Hospital:

- GP referral required for all practitioners under this benefit.

In-Hospital:

- Benefits are subject to the Scheme's network.
- Enrollment into a Mental Health Programme at private Hospital Network.
- Drug & Alcohol rehab standalone benefit (Scheme covers for up to 21 days per beneficiary, per year).
- PMB conditions apply.
- Subject to the relevant managed healthcare programme and to its prior authorisation.
- Co-payment of 25% will apply for the voluntary use of a non-network

INFERTILITY BENEFITS

Members are covered for infertility, commonly known as the inability by women or men of child bearing age to conceive children.

Conditions

- PMB conditions apply.
- Limited to PMB only for **Option A** and **Option B.**

ALTERNATIVE HEALTHCARE

Our Scheme not only covers members for visits or consultations with General Practitioners (GPs), it also covers them for alternative healthcare services.

Members are allowed to consult healthcare practitioners listed below for treatments:

- Podiatrist (refers to the medical care and treatment of the human foot).
- Homeopath (which is the treatment of ailments through the use of natural medicine).
- Chiropractor (refers to the treatment of misaligned joints).
- Naturopath (Healthcare providers who use natural therapies to support and stimulate healing).

2024 Benefits Option A

R2 690
Per family per year.

This benefit is included in GP/Specialist consultations, visits and procedures limit.

2024 Benefits Option B

R4 110
Per family per year.

This benefit is included in GP/Specialist consultations and visits limit.

Conditions

- The practitioners have to be registered with the Health Professions Council of SA or Allied Health Professionals Council of South Africa.
- This benefit excludes Alternative Healthcare Medicine.
- This benefit excludes X-rays performed by chiropractors.

SAMWUMED CARES WELLNESS PROGRAMME

Apart from ensuring our members do not find themselves in hospitals, the SAMWUMED Cares Wellness Programme and early detection benefit provides members with an opportunity to take ownership of their own health. Our amazing Programmes includes the following screenings:

SCREENING TEST	AGE	2024 BENEFIT
Blood Pressure	18 yrs and older	Up to one screening, per beneficiary per year
Type II Diabetes	18 yrs and older	Up to one screening, per beneficiary per year
Total Blood Cholesterol	From age 20	Up to one test for all adults at least once and every year for high risk members
Papanicolaou (Pap) Test	18 yrs and older	Up to one screening per beneficiary per year within a 2 year cycle
Chlamydia Screening	18 yrs and older	Up to one screening per beneficiary per year within a 2 year cycle
Folic Acid	Childbearing age	Up to 1 per month for the first 3 months of pregnancy
Faecal Occult Blood Test	50 yrs and older	Up to one screening per beneficiary per year
Mammogram	Over the age of 45 until the age of 70	Up to one screening per female beneficiary every two years
Bone Density Test	65 yrs to 70 yrs	Up to one test for male beneficiaries aged 70 years and older and one test for female beneficiaries aged 65 years and older per annum
HIV	All ages	One test per beneficiary per year
Cytology		One test per beneficiary, every three years

SAMWUMED CARES WELLNESS PROGRAMME

SCREENING TEST	AGE	2024 BENEFIT
TSH Screening	Less than 1 month old	Once-off for hyperthyroidism in new-borns
Flu Vaccine		Up to one vaccination per beneficiary per year
HPV Test		Up to one test per female beneficiary every five years
Child Immunisation		As per Immunisations prescribed by the South African Expanded Immunisation Programme
Pneumococcal Vaccine	2 yrs to 65 yrs	Up to one vaccination per beneficiary 65 years and older and for beneficiaries aged 2 to 64 years who are at risk of serious pneumococcal disease per lifetime
HPV Vaccine	Females 9 yrs to 14 yrs	Up to one vaccination per female beneficiary per annum. Vaccination includes 2 doses administered over 6 months in the same benefit year
Pertussis (Whooping Cough) Booster	7 yrs to 64 yrs	Up to one vaccination per beneficiary. Beneficiaries are eligible for the booster dose every 10 years
Health Risk Assessment	All beneficiaries	Up to one assessment per beneficiary per year
Hearing Test	Newborns	One hearing test per new-born baby administered by an audiologist
Prostate Antigen Test	45 yrs to 70 yrs	Up to one test per annum per male beneficiary

ADDITIONAL VALUE

SAMWUMED PRIMARY HEALTHCARE BENEFIT PROGRAMME

This unique benefit offers SAMWUMED members peace of mind should a member deplete his/her annual medicine benefit. In partnership with our pharmacy network, SAMWUMED has created a formulary (a specific list of most cost effective medicines) available over the counter for the 10 most common ailments:

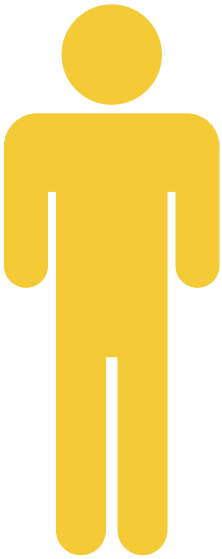
Stomach pain, heartburn, indigestion (including reflux), (Option A x 2, Option B x 3)

Acute gastroenteritis: vomiting and diarrhoea, (Option A x2, Option B x 3

Upper and lower respiratory tract infections, (Option A x3, Option B x 4)

Oral and topical candidiasis: thrush/fungal or yeastinfections (Option Ax 2, Option Bx 3)

Helminthic infestation: worms, (Option A x2, Option B x 2)



Headache, (Option A x 4, Option B x 6)

Bacterial conjunctivitis: eye infection, 2 (Option A x 2 Option B x 2)

Urinary tract infection (acute uncomplicated cystitis), (Option A x1, Option B x 2)

Urticarial: skin rashes, insect bites and stings, (Option A x2, Option B x 2

Treatment of wounds and/or infections of then skin/ subcutaneous tissues (excl. post- operative wound care), (Option A x 1, Option B x 2)

Subject to Scheme tariffs, members can access these from an approved pharmacist without paying extra money.

ENTITLEMENT TO BENEFITS

Beneficiaries are entitled to benefits as shown in Annexure B of the Scheme Rules, subject to the monetary limits and implementation restrictions set out herein, to the exclusions referred to in Annexure C of the Rules, to the general limitation and restriction of benefits set out in Annexure D of the Rules and to the procedural and other requirements set out in the Main Rules.

CHARGING OF BENEFITS, LIMITS

(INCLUDING OVERALL ANNUAL LIMITS),AND MEMBERSHIP CATEGORIES

The section headed **"SAMWUMED Option benefits available"** shows the extent to which the relevant benefit is limited annually or sub-limited in monetary or other terms. When that limit is reached no further benefits are available in the category.

The section headed **"Benefits"** shows how the cost of a valid claim shall be determined for the purpose of reimbursing the member or the supplier and the share of such cost that the Scheme will bear. The balance of the share of costs to make up 100% thereof shall be the member's responsibility, except for Prescribed Minimum Benefits.

ADDITIONAL VALUE

THE OVERALL ANNUAL BENEFIT LIMITS ARE AS FOLLOWS

Option A

LIMIT: R 961 500
per family per annum

Option B

LIMIT: R1 921 000
per family per annum

This simply means for any benefit utilisation during each annual cycle, the funds are deducted from the above available amounts, subject to the option a member belongs to.

PRESCRIBED MINIMUM BENEFITS ("PMB")

Prescribed Minimum Benefits as shown in Annexure A of the General Regulations, made in terms of the Medical Schemes Act 131 of 1998, override all benefits and limits indicated in this Annexure.

The Prescribed Minimum Benefits are available in conjunction with the Scheme's contracted managed health care programmes, which include the application of treatment protocols, medicine formularies, pre-authorisation and case management. These measures have been implemented to ensure appropriate and effective delivery of Prescribed Minimum Benefits. See Annexure D - paragraph 7 for a full explanation.

In cases of an illness of a protracted nature, the Scheme shall have the right to insist upon a member or dependant of a member consulting any particular specialist, the Scheme may nominate in consultation with the attending provider.

GENERAL BENEFITS AND LIMITS

Limitation and restriction of benefits

- The Scheme may require a second opinion in respect of proposed health care service(s) which may result in a claim for benefits and for that purpose the relevant beneficiary shall consult a dental or medical provider nominated by the Scheme and at the cost of the Scheme. In the event that the second opinion proposes different health care service(s) to the first, the Scheme may in its discretion require that the second opinion proposals be followed, unless in terms of the managed health care programme.
- In cases where a specialist is consulted without the recommendation of a Family Practitioner, the benefit allowed by the Scheme may, at its discretion, be limited to the amount that would have been paid to the Family Practitioner for the same service.
- Unless otherwise decided by the Scheme, benefits in respect of medicines obtained on a prescription are limited to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.
- If the Scheme or its managed health care programme contracted service supplier has funding guidelines or protocols in respect of covered services and supplies, beneficiaries will only qualify for benefits in respect of those services and supplies with reference to the available funding guidelines and protocols with due regard to the provision of Regulation 15(H) and 15(I).
- If the Scheme does not have funding guidelines or protocols in respect of benefits for services and supplies referred to in Annexure B, beneficiaries will only qualify for benefits in respect of those services and supplies if the Scheme or its managed health care programme contracted service supplier acknowledges them as medically necessary, and then subject to such conditions as the Scheme or its managed health care programme contracted service supplier may impose.

"MEDICALLY NECESSARY" REFERS TO HEALTH SERVICES OR SUPPLIES THAT MEET ALL THE FOLLOWING REQUIREMENTS:

- They are required to restore normal function of an affected limb, organ, or system;
- no alternative exists that has a better outcome, is more cost-effective, or has a lower risk;

- they are accepted by the relevant service provider as optimal and necessary for the specific condition, and at an appropriate level to render safe and adequate care;
- they are not rendered or provided for the convenience of the relevant beneficiary or service provider;
- outcome studies are available and acceptable to the Scheme in respect of such services or supplies;
- they are not rendered or provided because of personal choice or preference of the relevant beneficiary or service provider, while other medically appropriate, more cost-effective alternatives exist.

- The Scheme reserves the right not to pay for any new medical technology or, investigational procedures, interventions, new drugs or medicine as applied in clinical medicine, including new indications for existing medicines or technologies, unless the following clinical data relating to the above have been presented to and accepted by the Medical Advisory Committee and such data demonstrating their:
  - therapeutic role in clinical medicine;
  - cost-efficiency and affordability;
  - value relative to existing services or supplies;
  - role in drug therapy as established by the Schemes' managed health care programme contracted service supplier.
- In the event that:
  - the treatment of an extended chronic sickness condition becomes necessary;
  - a disease or a condition (including pregnancy) requires specialised or intensive treatment;
  - the treatment of any disease or condition becomes of a protracted nature or requires extended medicine and such treatment is given in or by a non-designated service provider or a preferred provider, the case may be evaluated in terms of the relevant managed health care programme and, having regard to the aforementioned diseases or conditions in question, the Scheme may require or advise:
  - the transfer as arranged by the Scheme of that beneficiary to designated service provider where appropriate care is available, with due regard to Regulation 8(3)(c);
  - the application of a limited drug formulary;
  - both such transfer and restricted drug formulary;

  in order to conserve or maximise efficient utilisation of available benefits.

PRESCRIBED MINIMUM BENEFITS ("PMB")

- In the event that a decision has been taken in terms of the paragraph above, the following conditions shall apply:
    - in respect of Prescribed Minimum Benefits, no benefit limit shall apply provided treatment is given in or by a designated service provider. If for any reason the beneficiary involuntarily receives treatment in or by a non-designated service provider, no co-payment applies;
    - in respect of non-Prescribed Minimum Benefit conditions, if the Scheme or its managed health care programme contracted service supplier should determine that any annual

      benefit limits, as set out in Annexure B, and available to the beneficiary receiving such treatment, are likely to be exceeded in the course of the year, the beneficiary may be advised to move to a designated service provider or to accept a limited drug formulary, or both, in order to conserve available benefits.
- In such designated service provider any costs incurred over and above the limit stipulated in Annexure B (excluding Prescribed Minimum Benefit conditions), shall be the member's responsibility. The member may elect on behalf of himself or his beneficiary, to remain in the private hospital, or remain on the full drug formulary available, or both, in which event the Scheme shall pay up to the benefit limit stipulated in Annexure B, where after the member shall be responsible for payment, direct to the private hospital, for any further treatment in such hospital, or for payment direct to the supplier for further medicine.
- The Scheme (or its managed health care programme contracted service supplier on behalf of the Scheme) may from time to time contract with or credential specific provider groups (networks) or centres of excellence as determined by the Scheme in order to ensure cost effective and appropriate care. The Scheme reserves the right not to fund or partially fund services acquired outside of these networks, provided reasonable steps are taken by the Scheme to ensure access to the network, subject to Prescribed Minimum Benefits.
- The Scheme reserves the right not to pay for procedures performed by non-recognised providers.
- Certain procedures may be associated with a significant learning curve and/or are not taught routinely at local universities and/or require special training and experience, including that aimed at maintenance of expertise, and/or need access to certain infrastructure for quality outcomes, where such procedures have been identified by the Scheme's managed health care programme contracted service supplier. Recognised providers are those who have been acknowledged by meeting minimum training and practice criteria for the safe and effective performance of such procedures. Recognition occurs as a result of a formal application process by interested providers and adjudication of relevant information against competency guidelines by the managed health care programme contracted service supplier and/or appointed credentialing body. Criteria for formal recognition are informed by clinical evidence, clinical guidelines and/or expert opinion.

INFORMATION ON ACCESSING YOUR BENEFITS EFFICIENTLY

GETTING AUTHORISATION FOR YOUR HOSPITAL STAY

- A Managed Care partner has been contracted by the Scheme to ensure that you and your dependents get cost efficient, quality care in hospital. Managed Care offers useful advice, and their team of doctors and nurses will make sure that you are admitted at the appropriate facility at the correct fee. **You must contact Managed Care for pre-authorisation on 0860 33 33 87, at least three (3) working days before a planned procedure or on the first working day after an emergency hospital admission to obtain an authorisation number for your treatment.**

- Authorisation requests for major surgery should be submitted at least thirty (30) days in advance to allow the Scheme to obtain a second opinion to ensure that you and your dependent receive appropriate treatment.

- It is important to note that pre-authorisation is compulsory for hospitalisation and failure to comply could result in a commensurate penalty.

WHY IS PRE-AUTHORISATION NECESSARY?

Pre-authorisation for hospital admissions and certain out-of-hospital care is a key component in managing your access to affordable, appropriate, safe and quality health care. Medscheme's pre-authorisation requests are adjudicated against clinical and funding guidelines as well as set criteria in recognising healthcare providers who are able to perform certain procedures. Once you are pre-approved, the healthcare provider and hospital account will then be paid according to your selected benefit option and available benefits.

WHEN DO YOU NEED TO CONTACT US FOR PRE-AUTHORISATION?

- Any procedure or treatment that clinically requires admission to hospital.
- Specialised radiology in- and out-of-hospital (MRI and CT Scans).
- Oncology Treatment.Renal Dialysis.
- Clinically appropriate home nursing, admission to a step-down facility and rehabilitation.
- Maternity admissions and confinements.

INFORMATION ON ACCESSING YOUR BENEFITS EFFICIENTLY

HOW DO I PRE-AUTHORISE?

Call 0860 33 33 87 (preferably 72 hours before the procedure is performed) and provide the following information when requesting an authorisation:

- membership number
- beneficiary details
- patient's date of birth
- planned date of treatment or admission to hospital
- name and practice number of the doctor who is treating the patient in hospital
- relevant diagnosis and/or procedure codes
- if treatment will be in or out of hospital

WHAT IF I'M DIAGNOSED WITH CANCER?

- Register with the SAMWUMED Oncology Management Programme by calling **0860 33 33 87** or send an e-mail to **cancerinfo@medscheme.co.za.**
- A SAMWUMED Oncology case manager will provide support and guidance that will continue throughout your treatment.
- As soon as you and your team of doctors agree on a treatment plan, ask your doctor to forward it to the SAMWUMED Oncology Management Programme. An Oncology case manager will review the plan, discuss it with your doctor and advise on the outcome of your application.
- You will then receive an authorisation letter for the authorised treatment. If there are certain items that are not covered, you will need to discuss this with your doctor.
- Please ensure that your doctor informs the SAMWUMED Oncology Management Programme of any change in your treatment, as your authorisation will have to be re-assessed and updated accordingly to ensure that your claim(s) are not rejected or paid from the incorrect benefit.

WHAT HAPPENS IN AN EMERGENCY?

Don't worry. In the case of an emergency situation, you or a family member may pre-authorise the admission on the first working day after being admitted.

WHAT IS A PMB?

Prescribed Minimum Benefits (PMB) is a set of defined benefits that ensure you have access to certain minimum health services, regardless of the benefit option you have selected. In accordance with the Medical Scheme's Act, medical schemes have to cover the costs related to these conditions which include:

- Any emergency medical admission
- A limited set of 270 pre-defined medical conditions
- Twenty-six (26) chronic medical conditions

INFORMATION ON ACCESSING YOUR BENEFITS EFFICIENTLY

Your doctor will guide you in determining whether your condition falls into one of the PMB conditions. It is vital that you obtain a pre-authorisation for any PMB condition as your scheme may require you to be referred to a designated service provider so that all associated costs are in line with SAMWUMED's Scheme Rules.

WHAT IS CASE MANAGEMENT AND CARE CO-ORDINATION?

- While you are in hospital, our case managers will ensure that the appropriate length of stay, and level of care is provided at all times and that appropriate discharge planning takes place.
- Medscheme also focuses on care co-ordination to improve the quality of care that you receive while in hospital, and to improve your health status after you are dis- charged. The benefit of this is that, with your consent, we will share information about your condition, well-being and health within the different managed health care departments as well as with your nominated doctor.
- Co-ordinating your care is done through various interventions from pre-admission to eight weeks after you are discharged so that you receive the best health care; reduce your chances of re-admission and encourage you to take responsibility for your own health.
- Through care co-ordination you will receive a pre-admission hospital checklist (de- pending on your type of admission) that will assist you in preparing for hospitalisation and post discharge recovery. You will also be referred to various managed care services and appropriate healthcare providers as and when required.

CHECKING AVAILABLE BENEFITS

You can check your available benefits by logging onto the Scheme's website at www.samwumed.org. We have a new and interactive chat platform where members get to receive customer service from our Call Centre in real time. No more long waits on telephone calls, you simply type your name at the bottom of the chat room and an agent will contact you immediately.

OBTAINING PRE-AUTHORISATION FROM THE CALL CENTRE

The Call Centre can assist you with the pre-authorisation for procedures and tests done in doctors' or any other equipped procedure rooms, advanced dentistry such as orthodontics, crown and bridgework and appliances, for example: wheelchairs, walking frames or neck braces related to hospital admissions.

BENEFITS THAT REQUIRE MOTIVATION AND/OR REFERRAL LETTERS

- Clinical motivation and cost estimates will be requested from your treating doctor or specialist before appliances are approved. Approved appliances would be subject to Scheme's list.
- Clinical motivation is required for all advanced dentistry procedures.
- To access the mental health or substance dependency benefit, clinical motivation will be required after the first two visits for continued sessions.
- Physiotherapy – clinical motivation required after two visits.
- Prostheses – clinical motivation and costing.
- Specialised radiology and radiography.

INFORMATION ON ACCESSING YOUR BENEFITS EFFICIENTLY

WHAT IS COVERED UNDER THE MEDICATION BENEFIT?

The medication benefit provides cover for acute/ prescribed, over the counter and chronic medication and the Primary Healthcare Programme. Chronic medication cover includes the diagnosis, medical management and medication of conditions on the Chronic Disease List (CDL) as provided under PMB legislation. The Scheme has contracted a medicine risk management department to provide a service to members and their registered dependants who need treatment for their chronic conditions which include the following:

- Makes sure that their chronic benefits are allocated accordingly.
- Access to expert advisors who will assess medication/ treatment.
- Useful advice and information regarding various chronic conditions.

HOW TO REGISTER AND OBTAIN MEDICATION FOR A CHRONIC CONDITION:

A chronic condition is a persistent or otherwise long-lasting illness that may be longer than three months or lifelong. SAMWUMED will cover for the diagnosis, treatment and care of 26 chronic conditions (PMBs), and five (5) and three (3) additional chronic (non-PMB) conditions on Option A and Option B respectively such as:

Option A	Option B
Depression, Gout, Gord	Depression, Eczema, Gord, Gout, Menopause

SAMWUMED works with Medscheme to give members the best advice on the use of their chronic medication, as well as to ensure that their chronic benefits are correctly allocated.

YOUR TREATING DOCTOR WILL NEED TO CALL OUR MANAGED CARE PROVIDER, MEDSCHEME ON 0860 333 387 TO REGISTER YOUR CHRONIC MEDICATION. THE REGISTRATION CAN ALSO BE DONE BY SENDING A DOCTORS PRESCRIPTION TO THIS EMAIL: samwumedcmm@medscheme.co.za

SAMWUMED PRIMARY & HEALTHCARE PROGRAMES

PRIMARY HEALTHCARE PROGRAMME

SAMWUMED offers members access to a variety of healthcare treatments under its Primary Healthcare Programme.

The teatments include:

- You can only access the benefit after your acute, prescribed/ dispensed; and over-the- counter (PAT) medicine benefit has been depleted.
- The Scheme's Pharmacy Benefit Partner with a wide range of pharmacy networks across the country.
- Ask your pharmacist for the specific list of medicines that have been allocated to the condition that you need care for and remind them to include the correct ICD-10 code on the account.
- If you are unsure about your medicine benefits, please contact the SAMWUMED Call Centre for advice 0860 104 117.

This benefit provides you with a safety net by granting access to essential medicine benefits to treat ten common ailments every family can experience including but not limited to:

Stomach pain,heartburn, indigestion, including reflux.

Treatment of wounds and or infections of the skin.

Upper and lower respiratory tract infections.

Thrush or fungal or yeast infections.

Urinary tract infection.

Skin rashes, insect bites and stings.

Vomiting and diarrhoea.

Headache.

Eye infection.

Worms.

It is important to note that there are sub-limits for each incident and that a specific list of suitable and cost-efficient medicines has been prepared by the Scheme so that you can obtain these from your pharmacist without paying extra.

Advice for current medical scheme members

If you are already a member of a scheme, read all the material such as options to change plans. Ensure that you understand how the benefit options operate and select according to your healthcare needs and what you can afford. The registered Rules of medical schemes fully disclose detailed information regarding the relevant benefits and contributions. It is essential that you obtain the Rules of the Scheme or a summary thereof to verify all relevant information to enable you to make an informed choice. You can access SAMWUMED's Rules on the website at www.samwumed.org. Some people choose to make use of an agent or broker (intermediary). Remember it is not compulsory to use a broker, but if you do ensure that he/she has been accredited by the CMS and that your selection of a scheme is based on informed consent.

HIV MANAGEMENT PROGRAMME

SAMWUMED offers Members and Beneficiaries with HIV/AIDS complete HIV disease management assistance under its AID for AIDS Programme.

- Medicine to treat HIV, including drugs to prevent mother-to-child transmission.
- Treatment to prevent opportunistic or common infections as a result of HIV. For example, pneumonia and TB.
- Regular monitoring of the disease and response to therapy.
- Regular tests to pick up possible side-effects of the treatment.
- Nurse-Line service which allows a patient to call a nurse whenever the need arises.
- Clinical guidelines and telephonic support for doctors.
- Help in finding a registered counsellor for emotional support.

Registering on the Programme

If you are diagnosed with HIV, your doctor must contact Aid for AIDS to register you on the HIV Management Programme.

Tel: 0860 100 646 or 083 410 9078 | **Fax:** 0800 600 773 | **Email:** afa@afadm.co.za.

MENTAL HEALTH PROGRAMME

Mental illness is a serious illness that can affect a person's thinking, mood and behaviour, as well as how they deal with stress.

The Mental Health Programme is aimed at helping members and dependents to manage their eemotional, psychological and social wellbeing.

It provides support to patients suffering from drug and alcohol abuse and promotes access to the best quality primary mental healthcare that is available.

It provides effective collaboration between family practitioners, psychiatrists and other healthcare professionals.

Members receive direct access to a Care Manager, and an individualised care plan. They also receive relevant education and information on community support groups.

How to access this benefit. To register your mental health condition,simply call 0860 106 155 or email membercare@medscheme.co.za to find out whether you meet the criteria for this programme

CHRONIC MEDICINE MANAGEMENT PROGRAMME

SAMWUMED covers its Members and their dependents for 26 Chronic illnesses.

This Programme is aimed at helping our Members and their dependents who suffer from chronic illnesses to receive their Chronic Medication un-interrupted.

Members and dependents under the Programme have access to a list of pre-approved medicines, referred to as a basket. They are also allowed to change or add new medicine based on the prescription.

Registering on the Programme

To be able to access this benefit, Members and their dependents have to register on the Programme.

Register Telephonically:
Call CMM between 08:30am and 4pm on **0860 33 33 87** and select the chronic option
or

Register on Email:
samwumedcmm@medscheme.co.za.

CANCER DISEASE MANAGEMENT PROGRAMME

This Programme is aimed at helping our members and their dependents suffering from Cancer to get the right treatment to manage their disease and also improve the quality of their lives.

Through the Programme, patients are provided with treatment plans that include **hospitalisation, private nursing** or **hospice services.** Treatment also includes, **MRI scans, CT scans, angiography** and **radiology.**

Registering onto the Cancer or Oncology Programme

Once diagnosed with Cancer, members or dependents have to register onto the Programme where their treatment plans are managed or overseen by the clinical team. All oncology treatment is subject to pre-authorisation and case management. After the treatment plans have been assessed and approved, authorisation is sent to the treating doctor.

Pre-Authorisation

Pre authorisation is the process where the treatment process is approved first before it is provided. This is to ensure that there is value through the planned intervention.

The treating doctor can call **0860 100 572** for patient pre authorisation.

Steps to follow to register on the Programme

After being diagnosed with Cancer, the treating doctor has to contact Medscheme to register the patient. The contact details are: - **Contact number:** 0860 100 572

Email: **cancerinfo@medscheme.co.za**

DBC BACK & NECK REHABILITATION PROGRAMME

The DBC (Documentation Based Care) back and neck rehabilitation programme is a physiotherapy and rehabilitation programme that helps members and dependents who suffer primarily from back and neck problems.

It takes place at specific DBC Centres and consists of up to 12 sessions over a 6 week period. It helps patients to amongst others:

1. Manage severe neck and back pain.
2. Restore the range of motion.
3. Improve muscle endurance.
4. Re-educate patients on the difference between normal physical loading and pain.
5. Restore muscle co-ordination and movement control.
6. Improve general condition.
7. Reduce fears and avoidance behaviour.
8. Tackle the psychological, social and occupational obstacles to return to normal daily living.

Programme Benefits

- The Scheme covers the full cost of the programme, so it won't impact your Day-to-Day benefits.
- An initial assessment is done to determine the level of treatment required.
- A personalised treatment plan for up to 6 weeks, including doctors, physiotherapists and biokineticists.
- Home care plan to maintain results in the long-term.

Programme Benefits

Members can access the programme through various ways. For example:

- If admitted to hospital with back or neck surgery, pain management or specialised radiology.
- If a member is identified as being at risk of a back or neck admission within the next year.
- Referal by a specialist or Family Practitioner.
- A member may also contact the Member Contact Centre on **0860 002 103** should they experience chronic, ongoing back or neck pain.

-

Option A and Option B

Limited to one protocol per beneficiary per annum from the Overall Annual Limit and subject to managed care protocols. Additional protocols may be considered upon receipt of a clinical motivation and subject to managed care protocols.

Conditions

- **Subject to the relevant managed healthcare programme and to its prior authorisation and subject to the Schemes contract with the DSP, (DBC) Documentation Based Care.**
- **Benefits for clinical procedures and treatment during stay in an alternative facility will be subject to the same.**
- **The member will be responsible for a R10 000 co-payment for admissions for Back and Neck surgery if a member voluntarily did not have a DBC assessment or voluntarily did not complete their DBC protocol.**

GoSmokeFree PROGRAMME

ARE YOU STRUGGLING TO STOP SMOKING?

JOIN OUR GoSmokeFree PROGRAMME

SAMWUMED has a programme to help members to stop smoking for their own health.

Programme Benefits

Include:

- Healthcare assessments.
- Help with managing withdrawal symptoms.
- Prevention of backsliding into old habits.
- Improving chances of a successful quit.
- Motivational tool for the quit journey.

SAMWUMED members qualify for up to one course per beneficiary per lifetime.

Please consult with your local pharmacy to confirm if they offer the service.

THE COMPLAINTS PROCESS

WHO CAN COMPLAIN TO THE REGISTRAR'S OFFICE?

- Any beneficiary or any person who is aggrieved with the conduct of a medical scheme can submit a complaint.
- It is however very important to note that a prospective complainant should always first seek to resolve complaints through the complaint's mechanism in place at the respective medical scheme before approaching the Council for assistance.
- You can contact your scheme by phone or writing to the Principal Officer of the Scheme, giving him/her full details of your complaint.
- If you are not satisfied with the response from your Principal Officer, you can ask the matter to be referred to the Disputes Committee of your scheme.
- If you are not satisfied with the decision of the Disputes Committee, you can appeal against the decision within three months of the date of the decision to the Council. The appeal should be in the form of an affidavit directed to the Council.
- Complaints can be submitted by any reasonable means such as a letter, fax, e-mail or by post to Council for Medical Schemes (CMS) on **(086) 673 2466** (fax), **complaints@medical schemes.co.za** (email) or by post to the Council for Medical Schemes Complaints Unit Private Bag X34, Hatfield,0028

Your complaints should be in writing, detailing the following:

- Full names, membership number, benefit option, contact details and full details of the complaint with any documents or information that substantiates the complaint.
- The Council for Medical Scheme's Complaints Adjudication Unit also provides telephonic advice and personal consultations, when necessary.

Who can you complain about?

The Council for Medical Schemes governs the medical schemes industry and therefore your complaint should be related to your medical scheme. If your complaint is related to any other aspect of the health industry, please visit the relevant websites:

- For complaints against Health Professionals (doctors) and allied health professional such as physiotherapists, occupational therapists etc. – **www.hpcsa.co.za or call 012 338 9300**
- For complaints against Private Hospitals – **www.hasa.co.za or call 011 784 6828**
- For complaints against Nurses – **www.sanc.co.za or call 012 420 1000**
- For complaints against Brokers – **www.faisombud.co.za or call 012 762 5000**
- For complaints in respect of other health insurance products – **www.osti.co.za** (short term insurance ombudsman) or call 012 762 5000 or **www.ombud.co.za** (long term insurance ombudsman) or call 021 657 5000

THE COMPLAINTS PROCESS

Time limits for dealing with complaints

- Our aim is to provide a transparent, equitable, accessible, expeditious as well as a reasonable and procedurally fair dispute resolution process.
- The Registrar's Office will send a written acknowledgement of a complaint within 3 working days of its receipt, providing the name, reference number and contact details of the person who will be dealing with a complaint.
- In terms of Section 47 of the Medical Schemes Act 131 of 1998 a written complaint received in relation to any matter provided for in this Act will be referred to the medical scheme. The medical scheme is obliged to provide a written response to the Registrar's Office within 30 days.
- The Registrar's Office shall within four days of receiving the complaint from the administrator, analyse the complaint and refer a complaint to a medical scheme for
- comments.
  Upon receipt of the response from the medical scheme, the Registrar's Office will analyse the response in order to make a decision or ruling. Decisions/rulings will be made within 120 working days of the date of referral of a complaint and communicated to the parties.

The registrar's ruling and appeal to council

Section 48 of the Act makes provision for any party who is aggrieved with the decision of the Registrar to appeal such a decision.

This appeal is at no cost to either of the parties.

An appeal must be submitted within three months and should be in the form of an affidavit directed to the Council. The operation of the decision shall be suspended pending review of the matter by the Council's Appeals Committee.

The secretariat of the Appeals Committee will inform all parties involved of the date and time of the hearing. This notice should be provided no less than 14 days before the date of the hearing.

The parties may appear before the Committee and tender evidence or submit written arguments or explanations in person or through a representative. The Appeals Committee may after the hearing confirm or vary the decision concerned or rescind it and give another decision they deem to be just.

The section 50 appeal's process

Any party that is aggrieved with the decision of the Appeals Committee may appeal to the Appeal Board. The aggrieved party has 60 days within which to appeal the decision and must submit written arguments or explanation of the grounds of his or her appeal.

The Appeal Board shall determine the date, time and venue for the hearing and all parties will be notified in writing.

The Appeal Board shall be heard in public unless the chairperson decides otherwise.

SCHEME NETWORKS

GUIDE TO HOSPITAL NETWORKS

One of SAMWUMED's principles is to ensure access to quality healthcare services for all its members. To this end, Medscheme has been appointed by the Scheme to identify a hospital network on behalf of SAMWUMED taking into consideration the geographical distribution of members and facilities.

The intention is to negotiate reduced competitive tariffs (fees) as well minimum service standards for our members.

Benefits of a SAMWUMED Hospital Network

The benefits of establishing these networks are to improve access to quality health care and choice of services for members.

Other benefits are:

- Reduced cost of care for SAMWUMED members
- Improving the quality of care
- Ensuring Access to care
- Improving and supporting Broad-Based Economic Empowerment

The Scheme has contracted an **Acute Hospital, a Day Surgery and a Mental Health Facility network.** These will cover members on SAMWUMED **Option A** and **Option B**. The list of the hospital networks are available on the SAMWUMED website.

For any queries you may contact our Contact Centre on 0860 104 117 or engage with us via Web Chat function available on www.samwumed.org where we have qualified agents ready and waiting to assist you.

FREQUENTLY ASKED QUESTIONS (FAQ's)

WHAT IS A CO-PAYMENT?
This is the part of the account that a member might have to pay out of their own pocket where benefits do not cover the treatment or medication received.

WHAT IS THE SCHEME TARIFF?
The rate at which the Scheme pays for health services to service providers on behalf of members. It is based on the National Reference Price List published by the Department of Health.

MUST I GIVE NOTICE TO THE SCHEME IF I WISH TO TERMINATE MEMBERSHIP?
Yes, members must comply with the notice period stipulated in the Rules.

CAN A MINOR BECOME A MEMBER?
Yes, based on the following:

- With the assistance of his/her parents or guardian and provided that the relevant
- contributions are paid.
  Only if minor was a dependant on the medical aid when the main member passed away

CAN I OR MY DEPENDANTS BELONG TO MORE THAN ONE MEDICAL SCHEME AT A TIME?
No, the Medical Schemes Act 131 of 1998 prohibits it. No person shall be a member or dependant of more than one (1) medical scheme.

IS MEMBERSHIP OF A MEDICAL SCHEME AVAILABLE TO ANY PERSON?
Yes, except in a restricted membership scheme, where a particular employer, profession, trade, industry, calling or association has established a scheme exclusively for its employees or members.

MUST MY EMPLOYER SUBSIDISE MY CONTRIBUTIONS TO THE MEDICAL SCHEME?
No, subsidies are conditions of employment, and the Act does not address such conditions.

IF I DO NOT CLAIM FROM MY MEDICAL SCHEME, MAY I RECEIVE A NO-CLAIM BONUS OR REBATE?
No, the Act prohibits the payment of bonuses, rebates or re-funding of a portion of contributions other than in respect of savings accounts in certain circumstances.

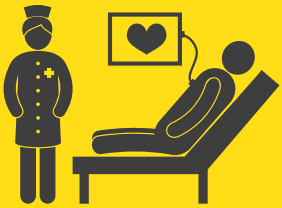
WHAT IS A DESIGNATED SERVICE PROVIDER (DSP)?
A healthcare provider or group of providers that the Scheme has chosen to provide certain medical care for Prescribed Minimum Benefits.

HOW SOON WILL I BE ABLE TO USE MY BENEFITS AFTER REGISTERING AS A MEMBER OF THE SCHEME?
If you were registered in another medical scheme in the past 90 days for at least 2 years, benefits will be activated from the joining date, as soon as your application is successful. Secondly, if you join the scheme with no previous medical scheme membership, the waiting period is one month from the join date and 12 months for pre-existing conditions.

For more Frequently Asked Questions (FAQ's) download them from our website: www.samwumed.org under Member zone tab.

TRIAGE EXPLAINED:

THE TRIAGE IS THE ASSIGNMENT OF DEGREES OF URGENCY TO WOUNDS OR ILLNESSES TO DECIDE THE ORDER OF TREATMENT OF A LARGE NUMBER OF PATIENTS OR CASUALTIES.



The South African Triage Scale (SATS) was developed to triage undifferentiated acute care patients presented to healthcare facilities, such as Emergency Rooms (ERs). To determine the final SATS triage acuity, a Triage Early Warning Score (TEWS), including variables like mobility, heart rate, respiratory rate, systolic blood pressure, temperature, mental status and presence of trauma is calculated. Each score is associated with a SATS colour, namely **green, yellow, orange and red** from lowest to highest acuity respectively with blue being used for patients without signs of life.

The ER facilities generally operate on a cash upfront basis for green and yellow triage cases with orange and red triage cases which follow the normal authorisation process, which does not require upfront payment to be made. For green and yellow triage cases members would need to submit the claim themselves for processing as this is treated as a normal Family Practitioner (FP) consultation, but who often times whose practice operates in a hospital facility.

It is thus important that members do not make routine use of ER facilities, unless indicated or under extreme circumstances, and rather consult with their network FP to avoid having to pay upfront for the consultation at the ER facility.

SAMWUMED
Real Heritage. Real People. Real Health Care.

Contact us

Physical Address: Cnr Trematon &
Lascelles Streets, Athlone, Cape Town
Postal Address: P.O. Box 134, Athlone, 7760

OPERATING HOURS

Contact Centre: 08h30 -16h00, Mon – Fri
Weekends and Public Holidays: Closed

Share call: 0860 104 117
Telephone for the Contact Centre: 021 697 9000

Web chat: Available on our website: www.samwumed.org

Download our Mobile App at Google Play Store,IOS ,Huawei or www.samwumed.org

www.samwumed.org

SAMWUMED

SAMWUMEDHEALTH

SAMWUMED

MEDSCHEME

Hospital Benefit Management: 0860 33 33 87
Email: samwumed.authorisations@medscheme.co.za

Chronic Medicine Management: 0860 33 33 87
Email: samwumedcmm@medscheme.co.za

Oncology Management: 0860 33 33 87
Email: cancerinfo@medscheme.co.za

HIV MANAGEMENT – Aid for Aids (AfA)
Member Enquiries: 0860 100 646
Email: afa@afadm.co.za

FRAUD HOTLINE
Tel: 082 450 9539
Email: fraudreport@qforensic.co.za

COMPLAINTS
Do you have a complaint against SAMWUMED?
Contact Council for Medical Schemes (CMS) on:
Fax: 086 673 2466 Email: complaints@medicalschemes.co.za
or by post
The Council for Medical Schemes Complaints Unit
Private Bag X34
Hatfield
0028

DISCLAIMER:
This Member Guide is prepared and distributed for purposes of providing you with essential information to help you select the best benefit option for you and your family. The Guide does not supersede the Scheme Rules. All contributions and benefit options presented in the 2024 Member Guide are subject to the approval by the Council for Medical Schemes. Kindly familiarise yourself with your chosen benefit option and note where pre-authorisations, motivations and or letters of referral are required to access benefits

Cnr Trematon & Lascelles Streets,
Athlone, Cape Town, 7760

Contact Centre: 0860 104 117
www.samwumed.org

Download our mobile app
on Google Play, Apple App Store or Hauwei App Gallery.
Visit: **www.samwumed.org** for more information and to download.

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or by post
The Council for Medical Schemes Complaints Unit,
Private Bag X34, Hatfield, 0028

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