

# SAMWUM+ED

Real Heritage. Real People. Real Health Care.

## 2020 MEMBER GUIDE



**SAMWUMED** provides **high VALUE** medical aid benefits for Municipality Workers at **Affordable contributions!**

# MISSION STATEMENT



We commit ourselves to service excellence by providing the **most affordable, member friendly, accessible and accountable scheme and administration.**

# VISION



- To be the **leading medical scheme** in the local government sector.
- To provide access to appropriate health benefits in an equitable and affordable manner to all members. To ensure healthy and satisfied members through education and efficient administration in a member friendly environment.
- Commitment to the **principle of non-profit** and to remain sustainable.
- To be one of the **most desired organisations to work for** in South Africa.
- To promote a **clean, healthy and sustainable environment.**

## 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. It is not a full guide to the Scheme Rules and Benefits and does not supersede the Scheme Rules. All contributions and benefit options presented in the 2020 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.



Save Water...Save Life

[www.samwumed.org](http://www.samwumed.org)

**SAMWUM+ED**  
Real Heritage. Real People. Real Health Care.

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# 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, taking into account the Scheme Rules and Scheme Tariff paid for goods, 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.

- **DEPENDANT:**

A spouse or partner, child or parent who is dependent on the member for care and 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.

- **OVERALL ANNUAL LIMIT (OAL):**

The limit that every member and their dependants cannot exceed during each benefit year.

- **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 and Managed Care. 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 March of the benefit year.

- **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)**

Council for Medical Schemes.

- **Late joiner fees**

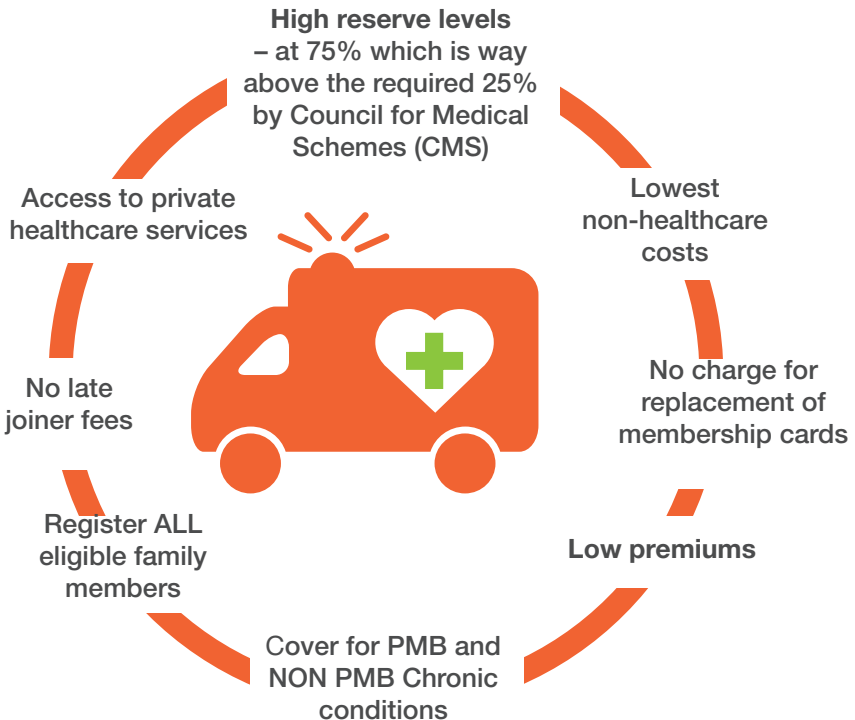
A Late Joiner Penalty/ fee can be imposed on members over the age of 35.

# 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.

If you are still looking for a medical aid cover, we hope the below information will assist you in making the best decision of your life in joining Our SAMWUMED.

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





# BENEFIT HIGHLIGHTS 2020

## Overall Benefits Improvements



Increase on all Scheme Benefit  
General Practitioners - Improvements



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

## Medication Improvements

Improvement on medication  
benefits, specifically **Acute** eg.  
**2019 R10150 on Option B, in 2020**  
you will receive up to **R11020** in  
rand value.

Improvement and increase  
on **Over The Counter**  
on both Options.

## Formulary Improvements



**Overall Hospital Benefit R790 500** per family  
per year on Option A and **Option B**  
**R1 581 000.00** per  
family per year

## Separate In and Out of hospital benefit for the following:



In other words if you are admitted into hospital the above benefits do not get touched!

# 2020 INCOME BANDS

WE HAVE COLLAPSED  
THE BANDS FROM

**6 to 4**



Lower bands on **Option A** were identified to be the highest claimers, thus contributed to the high claims ratio.

We have thus pulled back from the **0%** increase as per previous years.

The income bands for **2020** are as follows:

## 2020 Option A

## 2020 Option B

Income band	2020 Income Band Limits	Income band	2020 Income Band Limits
1	R 0 - R3,900	1	R 0 - R5,800
2	R 3,901 - R6,300	2	R 5,801 - R 8,000
3	R 6,301 - R9,700	3	R 8,001 - R 14,800
4	R 9,701 +	4	R 14,801 +

# BENEFITS CAN BE GROUPED INTO TWO CATEGORIES:

## BENEFITS CAN BE GROUPED INTO:

- **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** 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 the PMBs:

## THE CHRONIC DISEASE LIST (CDL)

specifies medication and treatment for the 26 chronic conditions that are covered in this section of the PMBs:

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



**NOTE: IF YOU HAVE ANY QUESTIONS PLEASE CONTACT OUR CONTACT CENTRE ON 0860 104 117.**

or visit [www.samwumed.org](http://www.samwumed.org) for a chat with one of our qualified Agents

# 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 as a means to better manage quality health outcomes which would ultimately result in lower medical aid premiums. Our amazing Programmes includes the following screenings:

SCREENING TEST CONDITIONS	2020
<b>Blood Pressure</b>	<b>Up to one screening Per beneficiary per year</b>
<b>Type II diabetes</b> <ul style="list-style-type: none"> <li>• Adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg or BMI in the overweight or obese ranges.</li> </ul>	<b>Up to one screening Per beneficiary per year</b>
<b>Total Blood</b>	<b>Up to one screening</b>
<b>Cholesterol</b> <ul style="list-style-type: none"> <li>• All beneficiaries</li> <li>• Persons with a family history of hypercholesterolemia, heart attacks and cholesterol problems</li> <li>• Full lipogram for all adults at least once from age 20 and annually for high risk member</li> </ul>	<b>Per beneficiary per year</b>
<b>Mammogram</b> <ul style="list-style-type: none"> <li>• Breast Cancer</li> <li>• females over the age of 40</li> <li>• If any family history had/ has breast cancer start annually at 35 years of age</li> <li>• If normal previously: do every 2 years, if clinical examination normal and self-examination is done</li> </ul>	<b>Up to one screening Per beneficiary per year</b>  <b>every three years</b>
<b>Bone Density test</b> <ul style="list-style-type: none"> <li>• Screening for all females from menopausal age</li> </ul>	<b>Up to one Per beneficiary per year</b>
<b>Screening for prostate cancer</b> <ul style="list-style-type: none"> <li>• (45-70 years)</li> </ul>	<b>Up to one Per beneficiary per year</b>

**SCREENING TEST CONDITIONS**

2020

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<b>HIV</b>	<ul style="list-style-type: none"><li>• All ages</li></ul>	<b>One test Per beneficiary per year</b>
<b>Cervical Cancer (Pap Smear)</b>	<ul style="list-style-type: none"><li>• Initiate screening at age 25 or at diagnosis of HIV positivity</li><li>• End screening at age 65 or after hysterectomy</li><li>• End screening only after previous negative tests, never end if HIV positive</li><li>• HPV tests to be repeated every 5 years if HIV negative or unknown and annually if HIV positive</li><li>• Cytology tests to be repeated every 3 years if HIV negative or unknown or annually if HIV positive</li></ul>	<b>One every three years</b>  <b>Up to one Per beneficiary per year</b>
<b>TSH screening</b>	<ul style="list-style-type: none"><li>• Congenital hyperthyroidism</li><li>• Less than 1 month old</li></ul>	<b>Once-off for hyperthyroidism in new-borns</b>
<b>Pneumococcal vaccine</b>	<ul style="list-style-type: none"><li>• Up to one vaccination per beneficiary over 65 and beneficiaries aged 2-64 who are immune compromised</li></ul>	<b>One vaccination Per beneficiary per lifetime</b>

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## 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), 2
- Acute gastroenteritis: vomiting and diarrhoea, 2
- Upper and lower respiratory tract infections, 3
- Oral and topical candidiasis: thrush/fungal or yeast infections, 2
- Helminthic infestation: worms, 2
- Headache, 4
- Bacterial conjunctivitis: eye infection, 2
- Urinary tract infection (acute uncomplicated cystitis), 1
- Urticarial: skin rashes, insect bites and stings, 2
- Treatment of wounds and/or infections of the skin/subcutaneous tissues (excl. post- operative wound care), 1

**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.







- **The overall annual benefit limits are as follows:**

OPTION	LIMIT
Option A	R 790,500 per family per annum
Option B	R1 581,000 per family per annum



- **Membership categories:**

- Member only = M0 
- Member plus 1 dependant = M1 
- Member plus 2 dependants = M2 
- Member plus 3 or more dependants = M3+ 

- **A member/beneficiary will be required to obtain a referral number from his PFP for a specialist consultation. The following exceptions are applicable:**

- 1 (one) Urologist consultation/ visit for male beneficiaries
- Gynaecological consultation/ visit for female beneficiaries
- Children under the age of 2 (two) years, for paediatric visits / consultations
- Alternative healthcare practitioners
- Dental practitioners, technologists and therapists
- Maternity benefits - Ante natal visits and consultations
- Oncologists, haematologists and credentialed medical practitioners during pre, active and/ or post active treatment periods
- Ophthalmologist
- Optometrists
- Pathologists
- Psychiatrists, psychometrists, psychologists and registered counsellors
- Radiologists

# **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.

## **GENERAL BENEFITS AND LIMITS**

### **LIMITATION AND RESTRICTION OF BENEFITS**

- 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.
- 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.
- 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.



## BENEFITS & CONTRIBUTIONS

WE HAVE TWO BENEFIT PLANS, **OPTION A** AND **OPTION B**, HAVE BEEN CAREFULLY DESIGNED TO PROVIDE FOR YOUR HEALTHCARE NEEDS.

# Doctor Benefits











## 2020 Benefits Option A

GP & Specialist Consultations, Visits & Procedures

### Option A Specifications











GP Consultations + Procedures

Specialist Consultations + Procedures

<b>Member Only</b> R3 320 Benefit Available		—		R4101
<b>Member + 1</b> R4 430 Benefit Available		—		R6101
<b>Member + 2</b> R5 530 Benefit Available		—		R8010
<b>Member + 3</b> R6 640 Benefit Available		—		R10010
<b>Benefit limit is</b> R3 320 per beneficiary per year		—		R4850

## 2020 Benefits Option B

GP & Specialist, Visits amounts are below & minor procedures, where no auths are required, have a different amount of **R8130** per family per year.

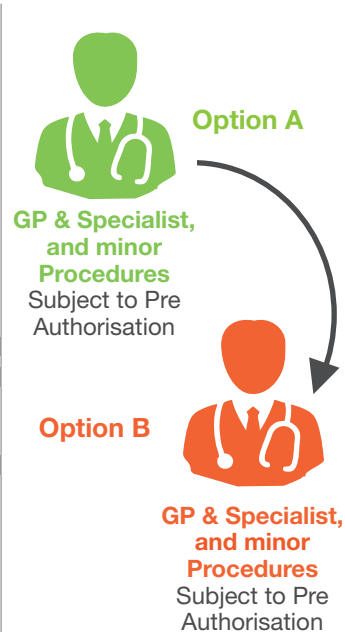
<b>Member Only</b> R4 010 Benefit Available		—	
<b>Member + 1</b> R6 500 Benefit Available		—	
<b>Member + 2</b> R8 830 Benefit Available		—	
<b>Member + 3</b> R11000 Benefit Available		—	
<b>Benefit limit is</b> R4010 per beneficiary per year		—	

### GP & SPECIALIST CONSULTATIONS, VISITS AND PROCEDURES

#### Condition

- The Emergency Treatment sub-limit is included in GP Consultations, visits and procedures limit. Option A amount R1240
- Aside from GP Consultations, Visits and Procedures, Members under both Options receive additional benefits in the form of Specialists **Visits and Consultations and Tests**.
- The benefits are subject to the Scheme's network of doctors.

Visit our website [www.samwumed.org](http://www.samwumed.org)

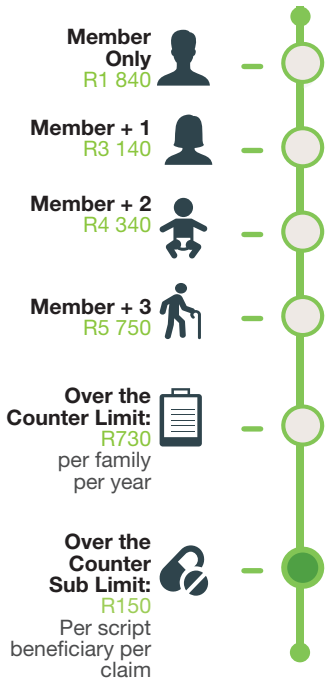




# Medication Benefits

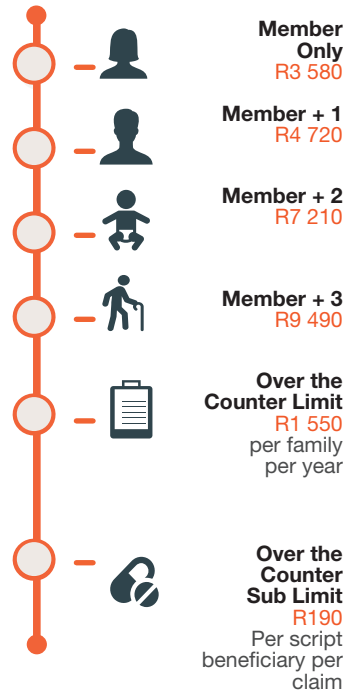
## 2020 Benefits Option A

\*Per beneficiary per year: R3140



## 2020 Benefits Option B

\*Per beneficiary per year: R4720



### MEDICATION

The Scheme covers members on both Option A and Option B and their dependents for various types of medication, including prescribed, dispensed for acute; or a chronic condition including over the counter medicines.

**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).

**Dispensed** (Dispensing refers to the process of preparing and giving medicine to anamed person on the basis of a prescription).

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

#### Over-the-counter medicine

(This is medicine that may be sold at pharmacies without a doctor's prescription).

## Medication benefits continued

### HIGHLIGHTS

#### Option A

We still have additional Chronic Medication to cover:-

**Depression, GORD & Gout**

#### Option B

- We still have additional Chronic Medication to cover:- **Depression, Eczema, GORD, Gout & Menopause**

### CONDITIONS

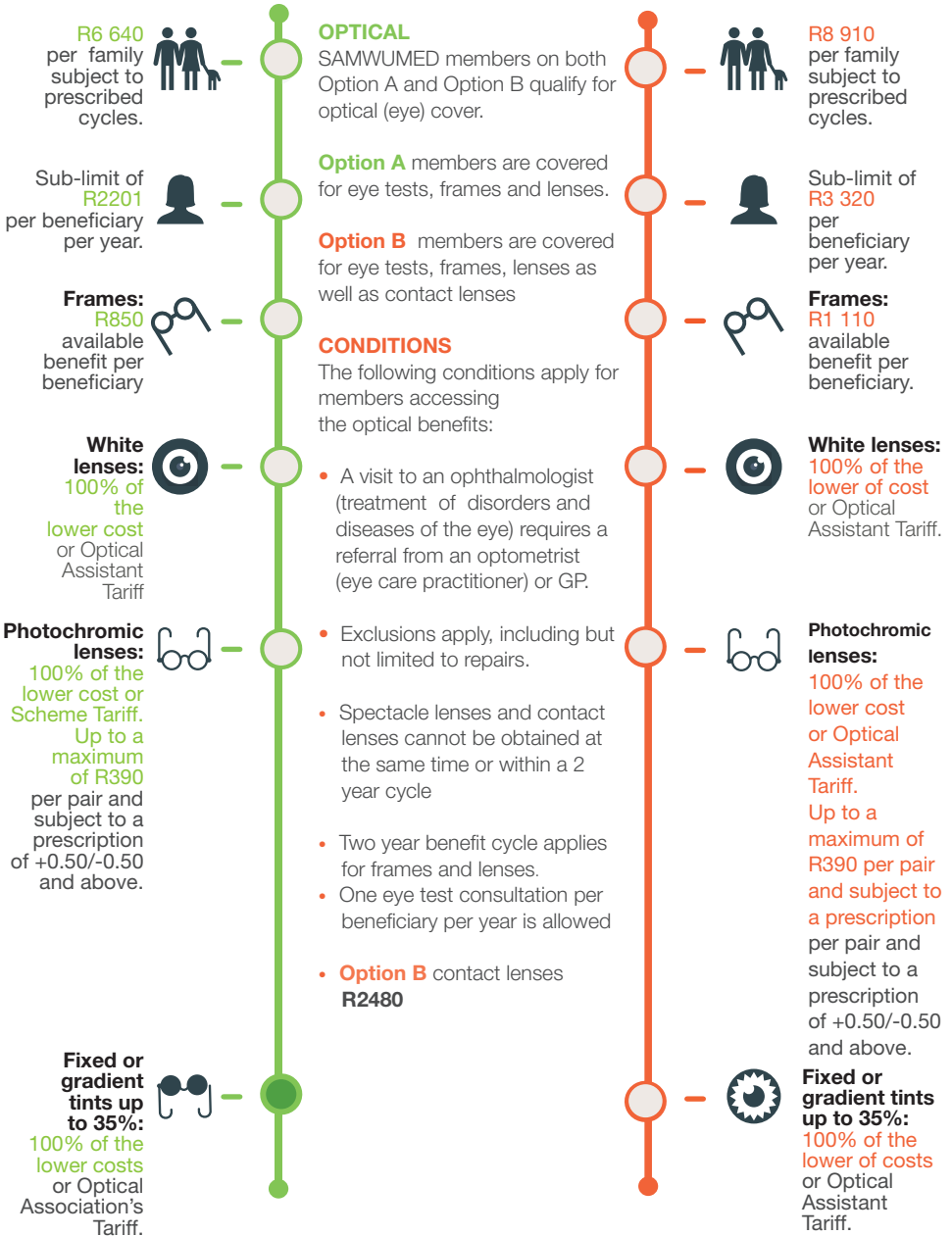
- Members will pay 25% co-payment (payment by the member of a portion of the cost incurred) if they use a pharmacy that is not on the Scheme's list of service providers or if they use out-of-formulary medication or medicines that are outside of those recommended by the Scheme.
- To access Chronic medication,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



# Optometry Benefits

## 2020 Benefits Option A

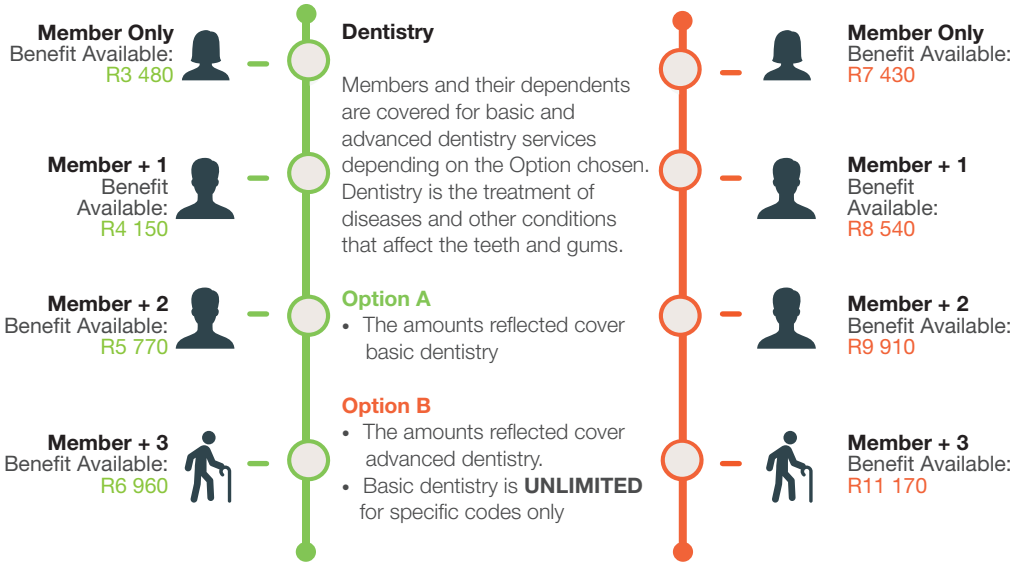
## 2020 Benefits Option B



# Dentistry Benefits

## 2020 Benefits Option A

## 2020 Benefits Option B



### Basic Dentistry

Benefits include: accessing the dental benefits:

- 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); and
- Denture repairs (a removable plate or frame holding one or more artificial teeth).

### Advanced Dentistry benefits include:

- Orthodontists, crowns, bridge-work and any other anaesthetic procedure
  - \*Motivation, referrals and quotes required

### CONDITIONS

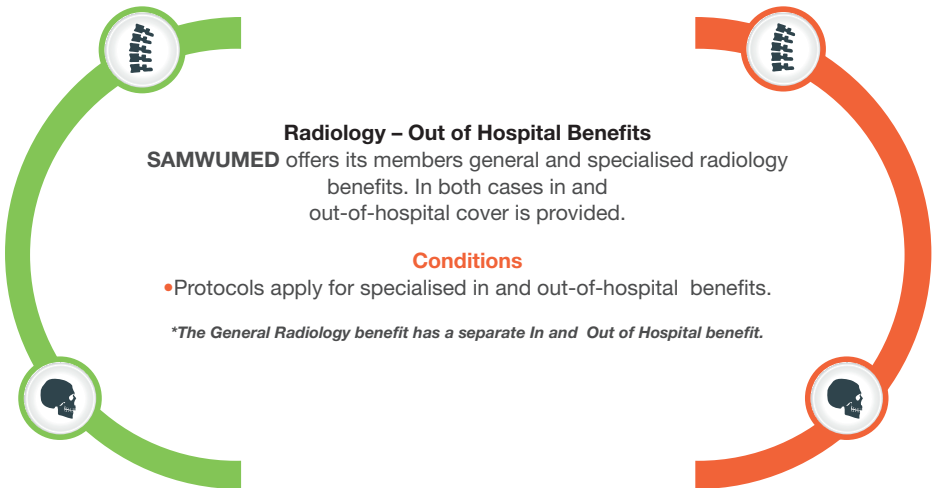
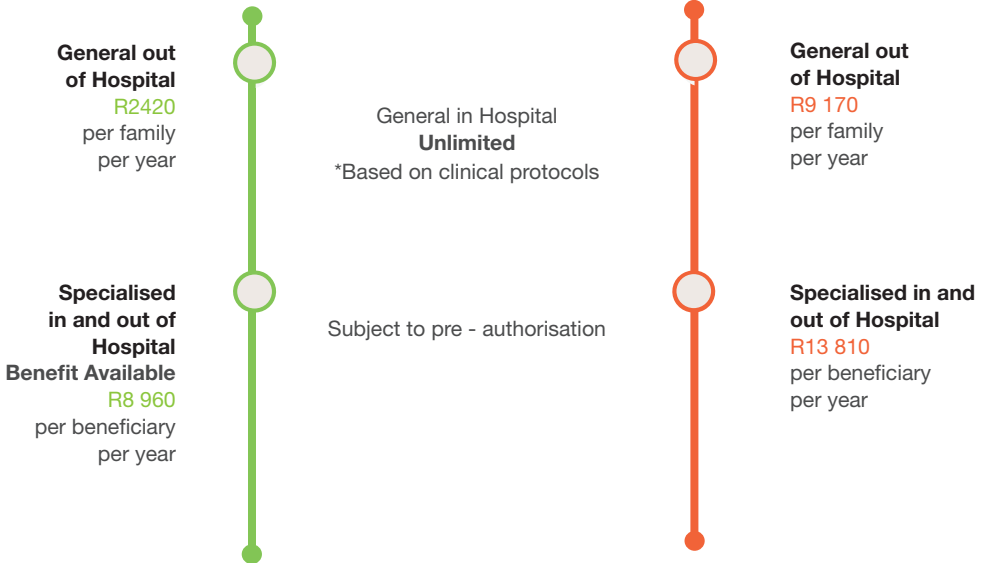
Members have to claim according to the Scheme's approved cycles outlined below:

- Full dentures - Every three years
- Partial dentures - Every two years
- Advanced dentistry not included on **Option A**

# Radiology - Out of Hospital Benefits

## 2020 Benefits Option A

## 2020 Benefits Option B



# Pathology Benefits

---

## 2020 Benefits Option A



### PATHOLOGY BENEFIT

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.)

**Out of Hospital  
Benefit Available**  
R4 530  
per family  
per year

\*The Pathology benefit has a separate In and Out of hospital benefit

\*Pathology In hospital = **Unlimited**

\*Subjected to clinical protocols

## 2020 Benefits Option B



**Out of Hospital  
Benefit Available**  
R9 170  
per family  
per year





# Appliances & Prostheses Benefits

## 2020 Benefits Option A

**Member Only  
Benefit  
Available**  
R2 790



**Member +1  
Benefit  
Available**  
R3 950



**Member +2  
Benefit  
Available**  
R5 010



### Appliances

Members and their dependents are covered for medical and surgical appliances. This benefit is basically more to help patients with movement challenges.

### Condition

- 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.

## 2020 Benefits Option B



**Benefit Available**  
R6 170  
per family per  
year

**Internal**  
R26 980  
per family  
per year  
**Benefit  
Available**



**External**  
R13 860  
per family  
per year



### Prosthesis

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

### Condition

- Included with in-hospital benefit. Quotations from at least three (3) service providers are required.



**Internal**  
R27 510  
per family  
per year

**External**  
R16 180  
per family  
per year

# Ancillary Benefits

## 2020 Benefits Option A

**Subject to sub-limit of R2 220 per family per year**



## 2020 Benefits Option B

**R4 580 per family per year**



### Ancillary 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.

**Speech therapists** (A health care professional who is trained to assist patients with speech and language problems to speak more clearly).

**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.

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

**The above benefits are included with specialist benefit for in or out-of-hospital treatment, and only applies to Option A**

## Physiotherapy & Biokinetics Benefits

**Out of Hospital Benefit Available R2 060 per family per year**



### PHYSIOTHERAPY BENEFIT

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

#### Condition

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



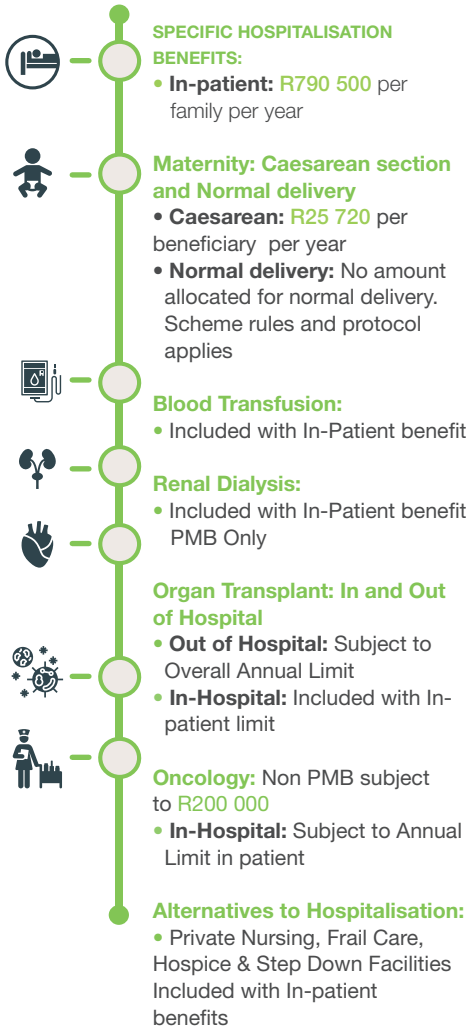
**Out of Hospital Benefit Available R4 580 per family per year**

**Out of Hospital Sub-limit of R1 880 per beneficiary per year**

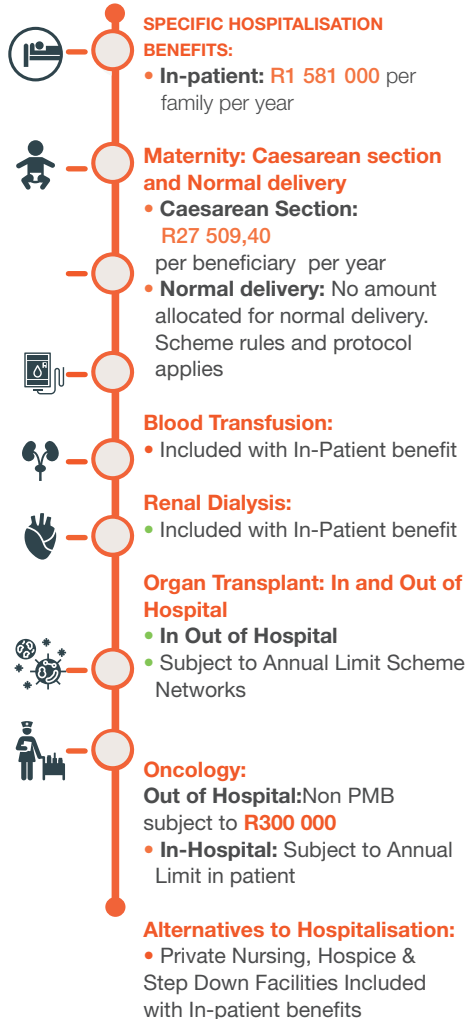
*\*This benefit has a separate In and Out of hospital benefit*

# Hospital Benefits

## 2020 Benefits Option A



## 2020 Benefits Option B



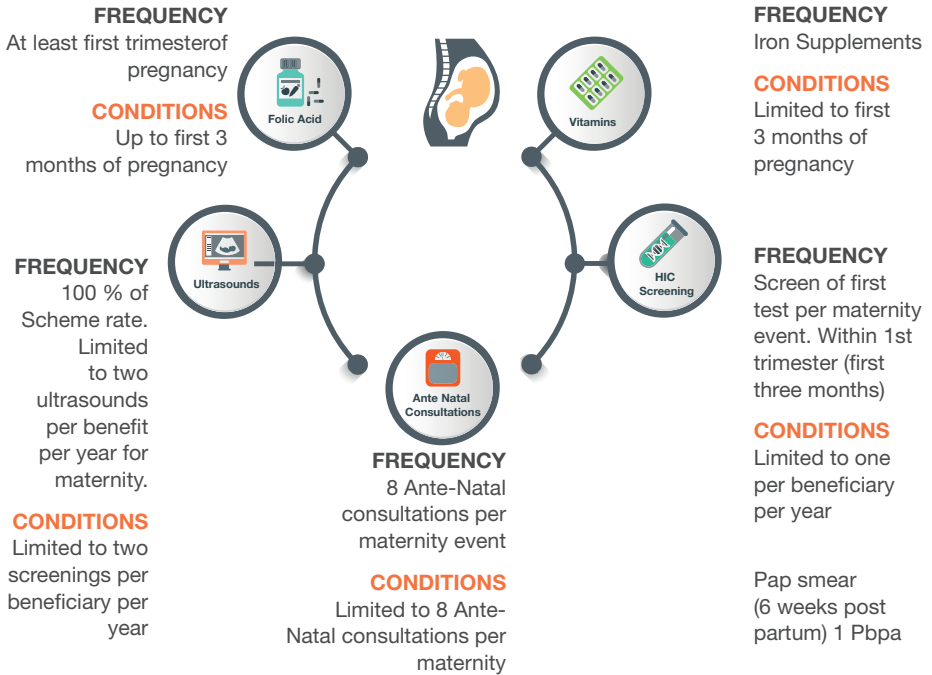
### CONDITIONS

#### The conditions to access the benefits are the following:

- Members will need a pre-authorisation or approval before hospitalisation.(1 business day before admission, as 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.

# Maternity Benefits

## 2020 Maternity Benefits **Option A & Option B**



### MATERNITY BENEFITS

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

### CONDITIONS

Expecting mothers have to register onto the Programme on: **0860 33 3387**

Among information that will be required when registering is: **Practice number of doctor, Hospital practice number for the birth, due date of birth, ICD10 codes and procedure codes.**



## MENTAL HEALTH AND 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 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

### CONDITIONS

#### Out of Hospital


- per beneficiary (if not enrolled in Mental Health Programme)
- 15 PMB & 10 Non PMB covered

#### In- Hospital

- Benefits are subject to the Scheme's network
- Access to in and out of hospital benefit
- Enrolment into a Mental Health Programme at private Hospital Network
- Drug & Alcohol rehab standalone benefit
- PMB conditions apply

## Ambulance Services

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**AMBULANCE SERVICES**


Due to our understanding that sickness can strike anywhere, and at any time, we cover our members for **Road and Air Ambulance Services**

### CONDITIONS

- The Road and Air Ambulance Services can only be provided by Designated Service Providers (service providers selected by the Scheme).
- The benefit is unlimited for emergency assistance only.
- Case management and protocols apply.
- Members have to co-pay or pay a portion of the costs should they decide to use a service provider of their choice and not one designated by the Scheme.
- Members will be held responsible for the full cost of the Road and Air Ambulance Services should it be determined that the costs were incurred unnecessarily and cannot be justified from a medical perspective.

## Infertility Benefits

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**INFERTILITY**

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

## 2020 Benefits Option A

### Benefit Available

R2210

Per Family Per Annum/Year (PFPA)

This benefit is included in GP consultation and visits.



### 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 naturopath** (which is the treatment of ailments through the use of natural medicine).
- **Chiropractor** (refers to the treatment of misaligned joints.)

### Condition

The practitioners have to be registered with the Health Professions Council of SA or Allied Health Professionals Council of South Africa.

## 2020 Benefits Option B

### Benefit Available

R3370

Per family Per Annum/Year (PFPA)

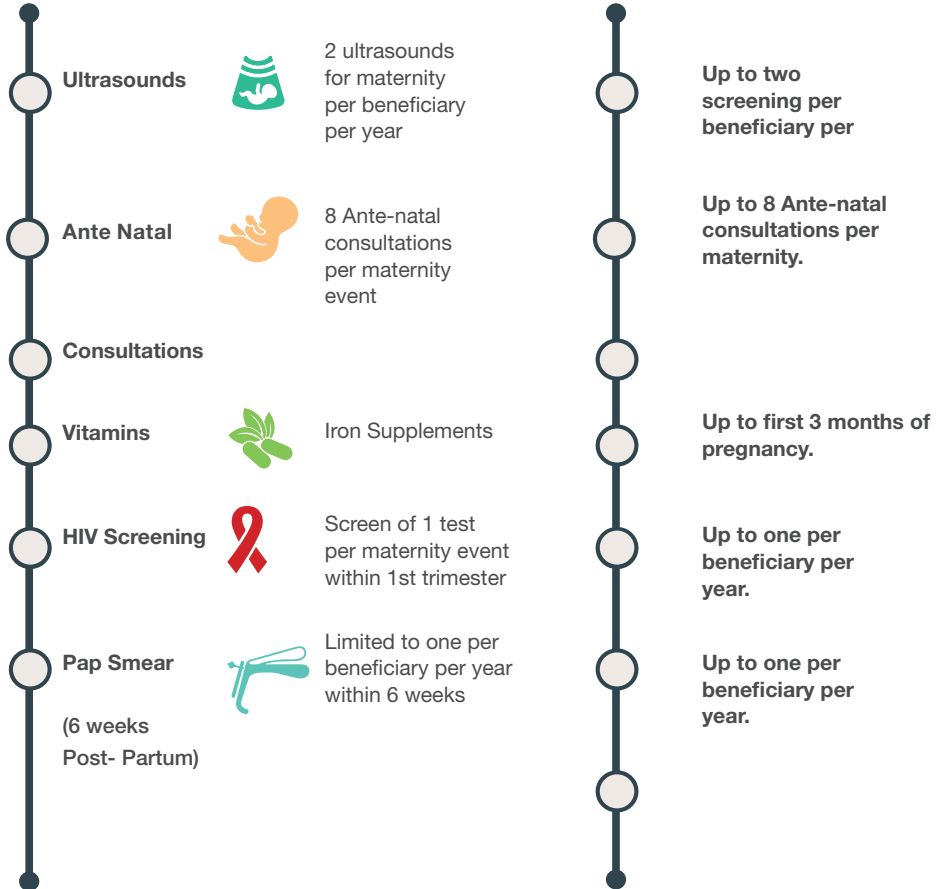
This benefit is included in GP/Specialist consultation limits



# MATERNITY PROGRAMME

Expecting moms can access the SAMWUMED Maternity Programme to help take better care of themselves and their unborn baby by taking advantage of a wide range of maternity and wellness benefits.

**SIMPLY DIAL 0860 333 387 TO REGISTER**





## CHRONIC MEDICINE BENEFITS

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.

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

Your treating doctor will need to call our Managed Care Provider, Medscheme on 0860 33 33 87 to register for your Chronic Medication.



## HOSPITAL CARE

When you need hospital treatment or an operation, SAMWUMED will cover you for approved medical expenses when you are in hospital. The comprehensive hospital benefit cover ensures you are taken care of should you or your loved ones land up in a hospital.

We have partnered with Medscheme as our Hospital and Oncology Benefit Management Service Provider to manage your hospital care.

For all hospital pre-authorisations members can call 0860 33 33 87.



UNLESS AN EMERGENCY, MEMBERS WILL NEED TO CONTACT MEDSCHEME NO LESS THAN 72 HOURS BEFORE THE PROCEDURE TO GET AUTHORISATION FOR THEIR ADMISSION TO HOSPITAL ON 0860 33 33 87



# OUR 2020 CONTRIBUTION INCREASES

The tables below represents 100% contribution. Employees only pay up to 40%. Contributions are paid monthly in arrears.

## Option A 2020

Salary Band	Salary Band	Salary Band	Salary Band
R0 - R3 900	R3 901 - R6 300	R6 301- R9 700	R9701+
			
Principal Member 1144,00	Principal Member 1352,00	Principal Member 1720,00	Principal Member 1889,00
Adult Dep 1144,00	Adult Dep 1352,00	Adult Dep 1720,00	Adult Dep 1889,00
Child Dep. 403,00	Child Dep. 474,00	Child Dep. 600,00	Child Dep. 667,00
Member + Spouse 2288,00	Member + Spouse 2704,00	Member + Spouse 3440,00	Member + Spouse 3778,00
Member + Spouse + 1 Child 2691,00	Member + Spouse + 1 Child 3178,00	Member + Spouse + 1 Child 4040,00	Member + Spouse + 1 Child 4445,00
Member + Spouse + 2 Children 3094,00	Member + Spouse + 2 Children 3652,00	Member + Spouse + 2 Children 4640,00	Member + Spouse + 2 Children 5112,00
Member + Spouse + 3 Children 3497,00	Member + Spouse + 3 Children 4126,00	Member + Spouse + 3 Children 5240,00	Member + Spouse + 3 Children 5779,00
Member + 1 child 1547,00	Member + 1 child 1826,00	Member + 1 child 2320,00	Member + 1 child 2556,00
Member + 2 children 1950,00	Member + 2 children 2300,00	Member + 2 children 2920,00	Member + 2 children 3223,00
Member + 3 children 2353,00	Member + 3 children 2774,00	Member + 3 children 3520,00	Member + 3 children 3890,00
Member + 4 children 2756,00	Member + 4 children 3248,00	Member + 4 children 4120,00	Member + 4 children 4557,00

# Option B 2020

## Salary Band R0 - R5 800



Principal Member  
1 897,00

Adult Dep  
1 897,00

Child Dep.  
665,00

Member +  
Spouse  
3794,00

Member +  
Spouse + 1 Child  
4459,00

Member +  
Spouse + 2  
Children  
5124,00

Member +  
Spouse + 3  
Children  
5789,00

Member + 1 child  
2562,00

Member + 2  
children  
3227,00

Member + 3  
children  
3892,00

Member + 4  
children  
4557,00

## Salary Band R5 801 - R8 000



Principal Member  
2 296,00

Adult Dep  
2 296,00

Child Dep.  
806,00

Member +  
Spouse  
4592,00

Member +  
Spouse + 1 Child  
5398,00

Member +  
Spouse + 2  
Children  
6204,00

Member +  
Spouse + 3  
Children  
7010,00

Member + 1 child  
3102,00

Member + 2  
children  
3908,00

Member + 3  
children  
4714,00

Member + 4  
children  
5520,00

## Salary Band R8 001- R14 800



Principal Member  
2 351,00

Adult Dep  
2 351,00

Child Dep.  
826,00

Member +  
Spouse  
4702,00

Member +  
Spouse + 1 Child  
5528,00

Member +  
Spouse + 2  
Children  
6354,00

Member +  
Spouse + 3  
Children  
7180,00

Member + 1 child  
3177,00

Member + 2  
children  
4003,00

Member + 3  
children  
4829,00

Member + 4  
children  
5655,00

## Salary Band R14 801+



Principal Member  
2 600,00

Adult Dep  
2 600,00

Child Dep.  
855,00

Member +  
Spouse  
5200,00

Member +  
Spouse + 1 Child  
6055,00

Member +  
Spouse + 2  
Children  
6910,00

Member +  
Spouse + 3  
Children  
7765,00

Member + 1 child  
3455,00

Member + 2  
children  
4310,00

Member + 3  
children  
5165,00

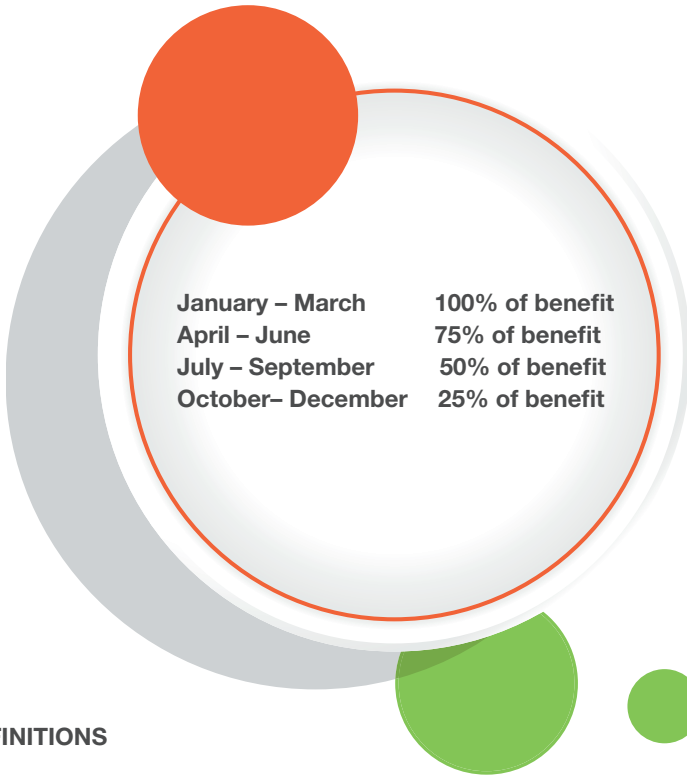
Member + 4  
children  
6020,00

## How to calculate your contribution as per your employment contract

- 1) Establish your income before deductions to establish your Income Band
- 2) Sum the values in the respective columns for the Principal Member and Beneficiaries
- 3) Multiply the total by your contribution percentage as per your Employment Contract

# MONTHLY CONTRIBUTIONS

Your medical aid contribution is generally paid for, from two sources: your employer's subsidy and your portion of your monthly salary. Your employer deducts contributions from your salary each month and pays it over to the Scheme. Contributions are calculated according to income and family size and are paid monthly in arrears. The Scheme does not have access to your salary. The Scheme will advise you in cases where incorrect contributions are received or if your employer has not paid the correct amount to the Scheme. If a member joins after 31 March, you will be subject to pro-rated benefits. This means that you will only be entitled to benefits according to the contributions that you have made:



## DEFINITIONS

- **Salary column:** this reflects the monthly salary before tax or other deductions.
- **Principal column:** this column shows how much the main member, who is a local government employee registered with SAMWUMED, has to pay.
- **Adult column:** this column shows how much you have to pay for your adult dependants.
- **Child column:** this column shows how much you have to pay for a child dependant. **SAMWUMED covers** children up to the age of 21, unless the child is mentally or physically disabled or is below 25 years of age and is a student registered at a recognised educational institution and proof thereof is provided. See Scheme Rules on the scheme website for full details.

# WHAT DO I NEED TO BECOME A MEMBER?

## IT'S SIMPLE TO BECOME A MEMBER OF SAMWUMED

### STEP 1

Request and complete an APPLICATION FORM from our Sales & Servicing and Broker Consultants, our website at [www.samwumed.org](http://www.samwumed.org) or via your HR office.



### STEP 2

Submit your application with photo copies of SOUTH AFRICAN IDENTITY.

### STEP 3

You will receive a SMS from SAMWUMED to confirm receipt of your application.



### STEP 4

You will receive your SAMWUMED WELCOME PACK which includes your Membership Quick Guide and Membership Card.

## 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



Legal documents of adopted /foster children



Confirmation of banking details



Previous membership certificate;



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 applies, subject to Scheme Rules.

**Condition specific waiting periods of up to 12 months apply.**

For more information members may contact the Premiums Management Department via email at [premiums@samwumed.org](mailto:premiums@samwumed.org)

# MEMBERSHIP MANAGEMENT

## **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 Bargaining 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 email: **memberupdates@samwumed.org**.

## **ALL INFORMATION THAT YOU DISCLOSE TO THE SCHEME IS CONSIDERED CONFIDENTIAL.**

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.

# 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 register with 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.(30 days)

## ADULT DEPENDANTS

Adult dependants are 21 years and older and can be a spouse or life 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. (30 days)

Dependants over the age of 21, who are not spouses or life partners, but are children and 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, PLEASE CONTACT OUR PREMIUMS DEPARTMENT BY DIALLING 0860 104 117 OR EMAIL [PREMIUMS@SAMWUMED.ORG](mailto:PREMIUMS@SAMWUMED.ORG) OR VISIT OUR WEB CHATS ON OUR WEBSITE AT [WWW.SAMWUMED.ORG](http://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.

## GETTING AUTHORISATION FOR YOUR HOSPITAL STAY

- A Managed Care partner has been contracted by the Scheme to ensure that you and your dependants get cost efficient, quality care in hospital. Managed Care offers you 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 or your dependant 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.

## 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 hospital/facility
- 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](mailto: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

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 discharged. 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 (depending 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](http://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.

## 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**

**Depression, Gout, Gord**

**Option B**

**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 33 33 87 TO REGISTER YOUR CHRONIC MEDICATION.**



HIV is a chronic condition where treatment is available and must be taken for life. SAMWUMED will cover the treatment, pathology monitoring and doctor consultations in order to keep all HIV positive beneficiaries healthy.

SAMWUMED works with Aid for AIDS to give members the best advice on how to manage their HIV status and the use of their HIV medication, blood monitoring tests and other associated medication.



**YOUR TREATING DOCTOR WILL NEED TO FAX THE HIV APPLICATION FORM TO OUR HIV MANAGED CARE PROVIDER, AID FOR AIDS ON 0800 600 773 OR CALL 0800 227 700 TO REGISTER YOU ON THE HIV MANAGEMENT PROGRAMME.**

## HOW AND WHEN TO USE THE SAMWUMED PRIMARY HEALTHCARE PROGRAMME BENEFIT

- 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:**

### Visits per beneficiary per year

1. Stomach pain, heartburn, indigestion (including reflux) (2)
2. Headache (4)
3. Acute gastroenteritis: vomiting and diarrhoea (2)
4. Bacterial conjunctivitis: eye infection (2)
5. Upper and lower respiratory tract infections (3)
6. Urinary tract infection (acute uncomplicated cystitis) (1)
7. Oral and topical candidiasis: thrush/fungal or yeast infections (2)
8. Urticarial: skin rashes, usually due to an allergic reaction; insect bites and stings (2)
9. Helminthic infestation: tapeworm (2)
10. Wound care and infections of the skin/subcutaneous tissue (excluding post-operative care.) (1)

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. The details and guidelines for this benefit category is outlined in the benefit section on pages 20 - 34

## 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](http://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.

## 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 complaints mechanisms 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 her/him 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 3 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 in person at our Offices from Mondays to Fridays during 08:00 – 17:00. The complaint form is available on [www.medicalschemes.com](http://www.medicalschemes.com).

**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.hpcs.co.za](http://www.hpcs.co.za) or call 012 338 9300
- For complaints against Private Hospitals – [www.hasa.co.za](http://www.hasa.co.za) or call 011 784 6828

- For complaints against Nurses – [www.sanc.co.za](http://www.sanc.co.za) or call 012 420 1000
- For complaints against Brokers – [www.faisombud.co.za](http://www.faisombud.co.za) or call 012 762 5000
- For complaints in respect of other health insurance products – [www.osti.co.za](http://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**

## 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 4 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.

The Appeal Board shall have the powers which the High Court has to summon witnesses, to cause an oath or affirmation to be administered by them, to examine them, and to call for the production of books, documents and objects.

The decisions of the Appeal Board are in writing and a copy thereof shall be furnished to parties. The prescribed fee of R2000.00 is payable for Section 50 Appeals.

## HOW TO AVOID COMPLAINTS

- Make sure you have read and understood your scheme rules.
- Study your benefit guide and familiarise yourself with the benefit option you have chosen.
- Read all correspondence from your scheme, e.g. newsletters and statements.
- Make sure your contributions are paid in full and on time each month.
- Remember: Avoid complaints by informing yourself!

The Council for Medical Schemes (CMS) protects and informs the public about their medical scheme rights and obligations, ensuring that complaints raised are handled appropriately and speedily.



# FAQ'S FREQUENTLY ASKED QUESTIONS

- **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:

- Only if minor was a dependant on the medical aid when the main member passed away

- With the assistance of his/her parents or guardian and provided that the relevant contributions are paid.

- **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.

# SAMWUMED SPECIALISTS REFERRAL LIST

Specialist	Referring discipline	Referring Provider
Dermatologist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Pulmonologist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Physician	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Gastroenterologist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Neurologist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Cardiologist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Psychiatrist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
	86	Psychologist
Medical Oncologist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Ophthalmologist	14	General Practitioner
	15	General Practitioner

	32	Paediatrician
	50	Group Practice
	70	Optometrist
Haematologist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Orthopaedics	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Otorhinolaryngologist	14	General Practitioner
	15	General Practitioner
	16	Gynaecology - Obstetrics
	32	Paediatrician
	50	Group Practice
	83	Audiologist
	90(3)	Ear and Voice Prosthetic Supplier
Rheumatologist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Paediatric Cardiologist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Plastic surgeon	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Oncologist	14	General Practitioner
	15	General Practitioner
	16	Gynaecology - Obstetrics
	32	Paediatrician
	23	Oncologist
	50	Group Practice

Urologist	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice
Orthodontics	54	Dentist
Paediatric Cardiology	14	General Practitioner
	15	General Practitioner
	32	Paediatrician
	50	Group Practice



TIME IS  
SUBJECTIVE,  
BUT OURS IS  
REAL-TIME!

 SAMWUMED

 SAMWUMED Health

 SAMWUMED Medical Scheme

 SAMWUMED

 SHARECALL / Call Centre : 0860 104 117 / 021 697 9000 [www.samwumed.org](http://www.samwumed.org)

**SAMWUMED**  
Real Heritage. Real People. Real Health Care.

# TALK TO SAMWUMED TODAY

## AMBULANCE SERVICES NETCARE 911 Tel: 082 911

☎ 0860 104 117 (Share Call) or 021 697 9000

### OPERATING HOURS

Contact Centre: 08h30 - 16h00, Mon - Fri

Physical Address: Cnr Trematon & Lascelles Streets, Athlone, Cape Town

Postal Address: P.O. Box 134, Athlone, 7760

Email: [info@samwumed.org](mailto:info@samwumed.org)

Website: [www.samwumed.org](http://www.samwumed.org)

### MEDSCHEME

Hospital Benefit Management: 0860 33 33 87

Email: [samwumed.authorisations@medscheme.co.za](mailto:samwumed.authorisations@medscheme.co.za)

Chronic Medicine Management: 0860 33 33 87

Email: [samwumedcmm@medscheme.co.za](mailto:samwumedcmm@medscheme.co.za)

Oncology Management: 0860 33 33 87

Email: [cancerinfo@medscheme.co.za](mailto:cancerinfo@medscheme.co.za)

### HIV MANAGEMENT - Aid for Aids

Member Enquiries: 0860 100 646

Email: [afa@afadm.co.za](mailto:afa@afadm.co.za)

### FRAUD HOTLINE

Tel: 0800 112 811

SMS: 33490 (R1,50)

Email: [fraud@medscheme.co.za](mailto:fraud@medscheme.co.za)

### QR CODE



SCAN FOR WEBSITE



SAMWUMED



SAMWUMEDHEALTH



SAMWUMED



SAMWUMED MEDICAL HEALTH

#### 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. It is not a full guide to the Scheme Rules and Benefits and does not supersede the Scheme Rules. **All contributions and benefit options presented in the Member Guide are subject to the approval by the Council for Medical Schemes.** Kindly familiarise yourself with your 2020 chosen benefit option and note where pre-authorisations, motivations and or letters of referral are required to access benefits.

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