SAMWUMED

Real Heritage. Real People. Real Health Care.

2026 MEMBER GUIDE

HERE TO SERVE THOSE WHO SERVE OTHERS.

*** Disclaimer**

This 2026 Member Guide is designed subject to the approval of the Council for Medical Schemes (CMS).
It is designed purely for marketing purposes of the Scheme's product offering. The information contained herein, does not supersede the Scheme Rules.

CONTENTS

ABOUT SAMWUMED

The South African Municipal Workers Union National Medical Scheme (SAMWUMED) is a fully funded, nationally-accredited and self-administered medical aid scheme which covers local government/municipality employees nationally.

We welcome and cover all South African local government / municipalityemployees irrespective of gender, colour and affiliation. Our Scheme is financially healthy. It has good reserve levels and can pay claims.

SAMWUMED
Real Heritage. Real People. Real Health Care.

Welcome to 2026: More care, more value, more for you

At **SAMWUMED**, every change we make has one goal: to give you and your family more peace of mind, more value, and more reasons to feel secure about your health.

What this means for you in 2026

No limits on your care

Whether you're on Option A or Option B, you now have an **UNLIMITED overall annual limit**, so you'll never have to worry about your cover running out.

Keeping healthcare affordable

With an average increase of just 8.9% (lower than last year's 9.7%), we've worked hard to keep your contributions fair, while protecting your benefits.

Better chronic support

Our Chronic Formulary now covers even more conditions, making sure you get the medicine you need without extra stress.

Save your savings

Dental and Optical benefits are paid from Risk, so if you're on Option A, the savings option, you can keep your savings for other needs.

Cover that grows with your family

Option B has additional benefits for large families, where we cover for dependants up to Member + eight (8) dependants.

When you belong to SAMWUMED, you belong to a scheme that is:

Financially strong with high reserves to guarantee your claims are paid, giving you peace of mind.

Trusted by leading hospitals, with access to a wide network of reputable private facilities nationwide, including Mediclinic and Netcare Hospitals.

Backed by experts, partnering with specialists in dental, optometry, and maternity care.

Close at hand, with 19 walk-in centres across all nine provinces to help you with your face-to-face queries.

Easy to reach, through our WhatsApp line, our new AI tool SAMMY, and a mobile app for on-the-go support.

We welcome and provide private medical cover for all South African local government/municipality employees, nationally.

SAMWUMED, serving those who serve others.

Living the SAMWUMED promise

From new and improved benefits to comprehensive healthcare programmes, everything we do is designed with one purpose: **to empower you and your family to live healthier, fuller lives.**

By combining affordable, quality healthcare with rich benefits tailored to municipal workers across South Africa, SAMWUMED continues to be the trusted partner of choice for thousands of families.

Our products are designed to meet different needs, whether you're looking for cover that protects your everyday healthcare (with full private hospital cover) or support for managing chronic conditions with the right medication and hospital benefits when you need them most.

Why members choose (and stay with) SAMWUMED

Your well-being always comes first.

In 2026, **Option A has a 15% savings component**, giving members more value for everyday care.

Enjoy rich day-to-day and comprehensive hospital benefits, with 4.2% increase in benefits at lower contributions, giving you more value for your money.

Access **reputable private hospitals** across our enhanced networks, including Mediclinic, Netcare, and many more.

Expecting? You'll receive **Comprehensive Maternity Benefits**, plus a baby bag with essentials for mom and baby.

Our broad networks of pharmacies, family practitioners, specialists, dental, optometry, oncology, and renal dialysis services mean **no surprise co-payments.**

A new benefit to accommodate Non-PMB and non-formulary medication, which will include:

additional diabetes and asthma medication.

Take care of your health with **free preventative screenings and assessments** - covering diabetes, breast and prostate cancer, HIV, and vaccinations.

Healthcare programmes that support you

SAMWUMED Primary Healthcare
Tel: 0860 104 117

HIV Management Programme
Tel: 0860 100 646 | Email: afa@afadm.co.za

Mental Health Programme
Tel: 0860 33 33 87

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

Cancer Disease Management Programme
Tel: 0860 100 572
Email: cancerinfo@medscheme.co.za

DBC Back and Neck Rehabilitation Programme
Tel: 0860 106 155
Email: membercare@medscheme.co.za

GoSmokeFree Programme
Email: info@gosmokefree.co.za

SMILE BRIGHTER WITH SAMWUMED + denis

SAMWUMED
Real Heritage. Real People. Real Health Care.

We have partnered with DENIS to bring our members even better dental services.

To speak to an agent, contact DENIS on:
0860 104 932
customercare@denis.co.za

SEE CLEARLY WITH SAMWUMED + PPN

SAMWUMED
Real Heritage. Real People. Real Health Care.

PPN
Preferred Provider Negotiators

We have partnered with PPN to provide enhanced optometry services.

To speak to an agent, contact PPN on:
041 065 0650
info@ppn.co.za

Dental & Optical benefits are covered under Risk, leaving your savings (Option A) untouched for when they're needed.

2026 BENEFITS AT A GLANCE

To make it easier for you to see exactly what's covered, we've grouped the benefits into clear categories. Each option has its own strengths, and with unlimited hospital cover across both, you can choose the option that suits your needs and budget best.

Option A	Benefit	Option B
Cover for out of hospital services is subject to available savings which is 15% each beneficiaries' contribution	Day-to-Day	Cover for out-of-hosptial services subject to benefit limits
UNLIMITED cover	Hospital benefits	UNLIMITED cover
Out-of-hospital benefits not covered from Savings	Risk benefits	Out-of-hospital benefits not funded from day-today
UNLIMITED cover	Chronic/PMB cover	UNLIMITED cover

OPTION COMPARISON

Category	Option A – Savings Plan	Option B – Comprehensive Plan
Hospital cover	**UNLIMITED** at Netcare & Mediclinic DSP hospitals. Pre-auth required, 25% co-pay if using non-DSP voluntarily.	**UNLIMITED** at Netcare & Mediclinic DSP hospitals. Pre-auth required, 25% co-pay if using non-DSP voluntarily.z
Day-to-day care	Funded from 15% Medical Savings Account (MSA). Covers GPs, specialists, tests, and minor procedures. 2 out-of-area visits allowed.	Covered from set annual limits (e.g., GP/specialists up to R8,670 pp). 2 out-of-area visits allowed.
Medication	Acute & OTC: paid from savings. Chronic: unlimited on registration, subject to formulary.	Acute: R6,280 pp/year. OTC: R3,540 per family (R250 daily limit). Chronic: unlimited on registration, expanded formulary in 2026.
Tests & procedures	Basic pathology & radiology paid from savings (limits apply). Specialised radiology: R10,760 per year.	Pathology: R12,230 per family/ year. Radiology: R10,400 (general), R15,670 (specialised).
Dental (Capitated/ flat fee arrangements benefit)	Capitated benefit: Preventative & restorative care. Family limits range from R4,460 (single) to R9,270 (family of 3+).	Comprehensive dental (incl. root canals, crowns, orthodontics). Family limits range from R9,900 (single) to R14,880 (family of 3+).
Optical (Capitated/ flat fee arrangements benefit)	Eye test fully covered at DSP (R420 if non-DSP). Frames/lenses: R1,136 at non-network provider and R1,420 at PPN Network Provider. 2-year cycle applies.	Eye test fully covered at DSP (R420 if non-DSP). Frames/lenses: R1,480 at non-network provider and R1,850 at PPN Network Provider. Contact lenses: R3,000 per beneficiary. 2-year cycle applies.
Mental Health	R3,290 per family per year. Unlimited if registered on programme. Covers psychiatrists, psychologists, counsellors, GPs, social workers.	R5,480 per family/year. Unlimited if registered on programme. Covers same providers, plus nurse practitioners.
Other Risk Benefits	Ambulance: unlimited (Netcare911). Appliances: R3,730–R6,690 depending on family size. Sport Injury Benefit: R5,110 per person per year, includes GP (R630), specialist (R1,560), physio (R1,880) radiology (R1,040).	Ambulance: unlimited (Netcare911). Appliances: R8,320 per family per year. Sport injuries: same as Option A.
Best For…	Members who want flexibility to manage their own savings for day-to-day care, while enjoying unlimited hospital cover.	Members who prefer predictable benefits with set limits for day-to-day care, plus broader dental & optical benefits.

OVERALL ANNUAL LIMITS (OAL)

OAL Option A: UNLIMITED

OAL Option B: UNLIMITED

2026 Anchor Hopitals
are Mediclinic and Netcare Hospitals

Contact the Scheme for a list of other filler hospitals

DAY-TO-DAY BENEFITS

What is day-to-day?

Treatment & services outside a hospital facility i.e. no admission

Risk Benefits

Some day-to-day benefits are considered as risk i.e. not funded from MSA

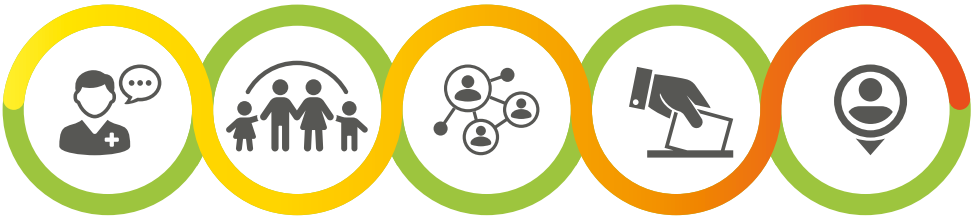
Funding

MSA funding for certain benefits

Authorisations

Specialist referral authorisation may be required for specialist visits. Certain procedures require pre-authorisation

DOCTOR'S CONSULTATIONS



Doctor Consultations

Covers consultations with GPs and specialists, including casualty visits when admission is not required.

Option A: Subject to Savings

Option B: Subject to annual limit of R8,670 per beneficiary, subject to family limit.

Network Options

Networks are available to avoid co-payments for members.

GP Nomination

A preferred GP must be nominated to prevent claim rejections.

Out-of-Area Visits

Allows for two out-of-area visits per person per year.

ACUTE MEDICATION

Prescription
Medication prescribed by a registered medical doctor for short-term illnesses.

Funding
Option A: Funded from available Savings.
Option B: Annual limit of R6,280 per person, subject to family limit.

Formularies
Subject to formularies, meaning not every item is covered.

OVER-THE-COUNTER MEDICATION

Accessibility
Medication available without a prescription.

Funding
Option A: Medication funded from medical savings account
Option B: Annual limit of R3,540 per family. R250 Per beneficiary per day and included in medications limit.

Coverage limitations:
Not all medications are covered.

GENERAL RADIOLOGY

X-rays
Basic imaging for bone and tissue

Ultrasounds
Non-invasive imaging using sound waves

Funding
Option A:
Paid from available savings (Only after the maximum limit is used up)

Annual Limit
Maximum limit of R3,530 paid from radiology out of hospital, and thereafter limited to savings.

SPECIALISED RADIOLOGY

CT Scans | MRI Scans | MUGA Scans

Can be done in-patient

Can be done out-patient

Funding: Option A: Pays from risk up to R10,760* per family per year, subject to DSP usage.

Funding: Option B: Subject to benefit limit of R15,670 per family per year

Authorisation required for both in & outpatient

*If the R10,760 is depleted, it pays from available savings; this is only applicable to out-patient treatment. In-patient is unlimited.

HOSPITAL BENEFITS (Funded from risk)

Covers treatment and services during hospital admission for both Options.

Designated service provider (DSP) use required for both Options.Using DSPs avoids 25% co-payment

Filler hospitals
Filler hospitals are used when a DSP is more than 30 km from the member's home.

Benefit limit
Option A: UNLIMITED
Option B: UNLIMITED

Anchor Hospitals
Netcare and Mediclinic are the Scheme's anchor hospitals.

Pre-Authorisation
Pre-authorisation is required unless it's an emergency. Call 0860 33 33 87.

The following services are covered from Risk, but are rendered out-of-hospital:

Mental health (out-of-hospital):

Option A: limited to **R3,290** per family per year.

Option B: limited to **R5,480** per family per year.

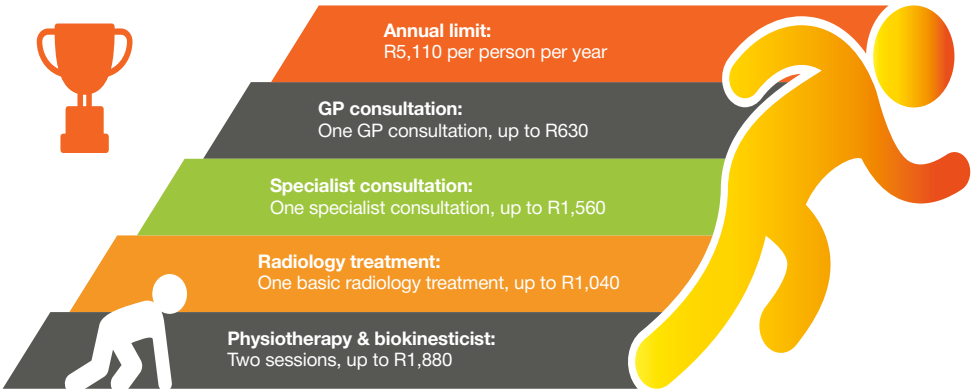
Unlimited for PMB level of care or when registered on the Mental Health Programme.

Medical Appliances:

- Benefits for medical appliances like hearing aids and wheelchairs. ***(Quotations, refferal letter and motivation are required)***
- Subject to formularies, preferred suppliers, and Scheme rules.

SPORTS INJURY BENEFIT

Our Sports Injury Benefit gives members access to radiologists, general practitioners, physiotherapists, biokineticists, and specialist consultations. This comprehensive benefit is designed to help our members bounce back from sports injuries quickly and effectively by getting the right care when they need it most.



This benefit are activated by the service provider who submits a claim with the related ICD10 code, for the specified benefits related ICD10 code. This benefit does not provide for professional sports injuries (the ICD10 code would provide this clarification). Members do not need to register or request to join, the benefit is automatically triggered by way of the ICD 10 code.

WEIGHT LOSS PROGRAMME

Our Weight Loss Programme is here to assist you with getting started on your weight loss journey.

How to get started:
During your first visit with a BASA-accredited biokineticist, a full health and fitness assessment is done. This will include taking measurements like blood pressure and waist-to-hip ratio, and completing a lifestyle questionnaire to help prescribe the most effective exercises for you.

What to expect:
Once your assessment is completed, an individualised exercise programme is created. The programme includes:

- A health risk assessment (once per year).
- Three monthly one-on-one consultations with a biokineticist to track your progress.
- Nine biokineticist-led group or individual exercise sessions.
- Two GP consultations.
- Four pathology consultations.
- Referral to a dietician and/or clinical psychologist for two consultations (initial assessment and follow-up), if necessary.

How much will it cost?
Nothing, as the cost for this programme will be covered by the Scheme's Weight Management Programme benefits.

HOW CAN WE HELP?
Contact the Member Care Team on:
0860 106 155
membercare@medscheme.co.za

OPTION A & B BENEFITS

SAMWUMED
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OPTION A
Savings Plan

Hospital care
- **Unlimited hospital cover** (DSP hospitals: Netcare and Mediclinic).
- Pre-authorisation needed (except in emergencies).
- 25% co-payment if you use non-DSP hospitals voluntarily.

GP (Day-to-day care)
- **Funding:** MSA funding for certain benefits
- **Risk Benefits:** Some day-to-day benefits are paid from Risk and not funded by the MSA.
- **Authorisations:** Specialist referral authorisation may be required for certain specialists. Certain procedures require pre-authorisation.
- **Savings account** = 15% of contributions to fund GP visits, specialists, and day-to-day needs.
- 2 out-of-area GP visits per person each year.
- **Nominate your GP to avoid claim rejections.**

Alternative healthcare consultations
Chiropractor, homeopath, podiatrist, naturopath: Consultations covered by MSA.

Medication
- **Acute and OTC medicine** paid from savings (subject to formularies).
- **Chronic medication:** unlimited, subject to registration and formularies.

Pathology and Medical Technology
- Subject to available savings.
- Family limit increases for each depandant

Radiology
- Subject to available savings
- **General radiology** (X-rays, ultrasounds, etc.) from savings. R3,530 per family per year.
- **Specialised radiology** R10,760 per family per year for both in and out of hospital services, subject to authorisation.

Mental health and wellness
- R3,290 family annual limit.
- Unlimited if registered on Mental Health Programme.
- Covers psychiatrists, psychologists, GPs, counsellors, and social workers.

Auxiliary Services (In & Out-of-Hospital)
Subject to available savings.
Includes Occupational Therapy, Speech Therapy, Audiology, Dieticians, etc.
(Specialist referral authorization required).

Physiotherapy & Biokinetics (Out-of-Hospital)
Subject to available savings.
(Specialist referral authorization required)

Other risk benefits
- **Ambulance services:** Unlimited (Netcare911 preferred).
- **Appliances:** Wheelchairs, walking aids, monitors (R3,730 – R6,690 depending on family size).
- **Sport injuries:** GP (1x R630), Specialist (1x R1,560), Allied Health Profesional visits (2x R940), Radiology (R1,040)

OPTION B
Comprehensive Plan

Hospital care

Unlimited hospital cover.

- DSP hospitals: Netcare and Mediclinic.
- Pre-authorisation required (except in emergencies).
- 25% co-payment if you use non-DSP hospitals voluntarily.

GP (Day-to-day care)

- **Risk Benefits:** Some day-to-day benefits are paid from Risk Authorisations**: Specialist referral authorisatio**n may be required for certain specialists. Certain procedures require pre-authorisation.
- GP and specialist consultations covered (annual limit R8,670 per person, subject to family limits).
- 2 out-of-area visits per year.
- **Nominate your GP to avoid claim rejections.**

Medication

- **Acute medicine:** From risk starting from R4,770 to R25,860 annual limit (family limit applies).
- **OTC medication:** R6,280 per beneficiary per year with an OTC limit of R3,540 per family per year and a daily limit of R250 per person per day.
- **Chronic medication:** Unlimited on registration, with expanded formulary in 2026.

Pathology and Medical Technology

- **From risk** R12,230 per family per year.

Radiology

- **General radiology** (x-rays, ultrasounds): R10,400 per family per year

Specialised radiology

(MRI, CT): From risk R15,670 per family per year for both in and out of hospital services *(Subj to authorisation)*

Mental health and wellness

- R5,480 per family per year.
- Unlimited when registered on Mental Health Programme.
- Covers psychiatrists, psychologists, GPs, counsellors, and nurse practitioners.

Auxiliary Services (In & Out-of-Hospital)

From risk, R6,130 per family per year. Includes Occupational Therapy, Speech Therapy, Audiology, Dieticians, etc. **(Specialist referral authorization required).**

Physiotherapy & Biokinetics (Out-of-Hospital)

From risk, R6,130 per family per year with a R2,510 limit per beneficiary per year **(Specialist referral authorization required)**

Other risk benefits

- **Ambulance services**: Unlimited (Netcare911 preferred).
- **Appliances**: Wheelchairs, walking aids, monitors (R8,320 per family).
- **Sport injuries:** GP (1x R630), Specialist (1x R1,560), Allied Health Profesional visits (2x R940), Radiology (R1,040)

OPTION A
Savings Plan

OPTION B
Comprehensive Plan

Continued

Option A

Internal prostheses and devices-

- Annual family limit of R36,010. Use of preferred provideres for hip and knee replacement prostheses to avoid R10.000 co-payment for voluntary out-of- network use

External prosthesis and devices-

- Annual family limit of R26,780 with a an annual limit of R18,780 per beneficiary for artificial iris implants

Option B

Internal prostheses and devices-

- Annual family limit of R36,730. Use of preferred provideres for hip and knee replacement prostheses to avoid R10.000 co-payment for voluntary out-of- network use

External prosthesis and devices-

- Annual family limit of R26,780 with a an annual limit of R18,780 per beneficiary for artificial iris implants

Option A

Martenity

- Member to register on maternity programme.
- Use network doctors and approved hospitals to avoid a 25% co-payment
- Pre-authorisation required.
- R34,330 annual limit for Caesarean per family unless PMB level of care.

Option B

Martenity

- Member to register on maternity programme.
- Use network doctors and approved hospitals to avoid a 25% co-payment
- Pre-authorisation required.
- R36,730 annual limit for Caesarean per family unless PMB level of care.

CAPITATED BENEFITS

OPTION A

OPTION B

Dental and optical

- **Dental:** Preventative and restorative care, dentures and fillings.
- Limits: From PM only R4,640
- PM & 1 Dep R5,520
- PM & 2 Dep's R7,700
- PM & 3 or more Dep's R9,270

Optical:

- Eye test: R800 at network optometrist (R420 if non-DSP).
- Frames and lenses: R1,420 at DSP/ R1,136 at non-DSP.
- Benefits cycle: every 2 years.

Dental and optical

- **Dental:** Basic + specialised dentistry, including root canals, crowns, orthodontics.
- Annual family limits: R9,900 (single) up to R14,880 (3+ dependants).

Optical:

- Eye test: R800 at DSP (R420 if non-DSP).
- Frames & lenses: R1,850 at DSP/ R1,480 at non-DSP.
- Contact lenses: R3,000 pp.
- Benefit cycle: every 2 years.

SAMWUMED PARTNERS

Medscheme
Managed Care

Dis-Chem PHARMACIES
Pharmacists who care
Oncology Medication

denis
Dental

workforce healthcare
Helping you help your employees
Wellness

PPN
The Optical Network Of Choice
Optical

AidforAids
Your life. Our life.
HIV Management

NETCARE 082 911
24HR EMERGENCY MEDICAL ASSISTANCE
Ambulance Services

aligned.
Value. Trust. Solutions.
Oncology Paliative

NETCARE
Anchor Hospital

TSHELA HEALTHCARE
Maternity

MEDICLINIC
Anchor Hospital

WE COVER SLEEP STUDIES (IN & OUT-OF-HOSPITAL)

WHAT IS SLEEP STUDIES?

Lower average contribution increase of 8.9% across both options, compared to 9.7% last year.

2026 CONTRIBUTIONS

OPTION A

Members are encouraged to check their subsidy as it differs per municipality.

Salary Band	Principal Member	Adult Dep	Child Dep	Member + Spouse	Member + Spouse + 1 Child
R0 - R4 370	1 882,00	1 882,00	664,00	3 764,00	4 428,00
R4 371 - R7 060	2 221,00	2 221,00	780,00	4 442,00	5 222,00
R7 061- R10 870	2 829,00	2 829,00	988,00	5 658,00	6 646,00
R10 871+	3 107,00	3 107,00	1 095,00	6 214,00	7 309,00

OPTION B

Members are encouraged to check their subsidy as it differs per municipality.

Salary Band	Principal Member	Adult Dep	Child Dep	Member + Spouse	Member + Spouse + 1 Child
R0 - R6 500	3 176,00	3 176,00	1 114,00	6 352,00	7 466,00
R6 501- R8 960	3 842,00	3 842,00	1 349,00	7 684,00	9 033,00
R8 961- R16 580	3 938,00	3 938,00	1 384,00	7 876,00	9 260,00
R16 581+	4 354,00	4 354,00	1 434,00	8 708,00	10 142,00

Member + Spouse + 2 Children	Member + Spouse + 3 Children	Member + 1 child	Member + 2 children	Member + 3 children	Member + 4 children
5 092,00	5 756,00	2 546,00	3 210,00	3 874,00	4 538,00
6 002,00	6 782,00	3 001,00	3 781,00	4 561,00	5 341,00
7 634,00	8 622,00	3 817,00	4 805,00	5 793,00	6 781,00
8 404,00	9 499,00	4 202,00	5 297,00	6 392,00	7 487,00

Member + Spouse + 2 Children	Member + Spouse + 3 Children	Member + 1 child	Member + 2 children	Member + 3 children	Member + 4 children
8 580,00	9 694,00	4 290,00	5 404,00	6 518,00	7 632,00
10 382,00	11 731,00	5 191,00	6 540,00	7 889,00	9 238,00
10 644,00	12 028,00	5 322,00	6 706,00	8 090,00	9 474,00
11 576,00	13 010,00	5 788,00	7 222,00	8 656,00	10 090,00

SAMWUMED CARES WELLNESS PROGRAMME

SAMWUMED CARES WELLNESS PROGRAMME (PREVENTATIVE CARE) PROGRAMME

Performed by a GP or Registered Nurse in a Hospital or Primary Care Clinic. Certain screening tests and vaccinations are performed at Wellness Days or Pharmacy Clinics.

- One blood pressure, Type 2 diabetes test per beneficiary **aged 18 years and older per year.**
- One faecal occult blood test per beneficiary aged **50 years and older per year.**
- Unlimited **HIV counselling and testing per beneficiary per year.**
- One mammogram per female beneficiary every two years over the **age of 40 years until the age of 74 years.**
- One full lipogram (total cholesterol test) for all adults at least once from the **age 20 and annually for high-risk members.**
- One bone density (osteoporosis) test for male beneficiaries **aged 70 years and older and for female beneficiaries aged 65 years and older per year.**
- One Pap smear and chlamydia test per female beneficiary **aged 18 years and older within a 2-year cycle.**
- One Health Risk Assessment per beneficiary per year.
- Neonatal Vision Screening - **one test per beneficiary before 6 weeks.**

SAMWUMED CARES WELLNESS (PREVENTATIVE CARE) PROGRAMME Continued...

One prostate antigen test per year per male beneficiary **aged between 45 - 70 years.**

One hearing test per newborn baby administered by an audiologist before 6 weeks.

One HPV test per female beneficiary to be repeated **every 5 years**, if HIV negative or unknown and every 3 years, if HIV positive.

One vaccination per beneficiary a**ged 65 years and older** and for beneficiaries aged **2 to 64** years who are at risk of serious pneumococcal disease per lifetime.

One cytology test per beneficiary every three years, if HIV negative or unknown, and annually if HIV positive.

Child Immunisations as per Immunisations prescribed by the South African Expanded Immunisation Programme.

One thyroid function test (TSH) test per new-born beneficiary **less than one month old per year.**

One flu vaccination per beneficiary per year.

Up to one HPV vaccination per female beneficiary, which includes multiple doses administered over **6 months** in the same benefit year. Two doses per female beneficiary between the **ages of 9-14 years, and three doses per beneficiary between 15 and 26 years**

One pertussis (whooping cough) booster vaccination per beneficiary between **age 4 and 64 are eligible for the booster dose every 5 years.**

SAMWUMED HEALTHCARE PROGRAMMES

Smoking Cessation Programme

Contact details- Email: info@gosmokefree.co.za

One course per beneficiary per lifetime. Nurse supported pharmacy-based stop smoking programme. Pre-quit assessment where a smoker's readiness and motivations to stop smoking is determined and a quit date is set, followed by four once a week, one-on-one sessions with a Nursing Sister who is trained as a GoSmokeFree advisor.

Weight Loss Programme

Subject to contract with the preferred provider BASA (Biokineticist Association of South Africa).

Contact details:-Tel: 0860 106 155 Email: membercare@medscheme.co.za

Limited to one event per beneficiary if relevant protocols are met. Core weight management intervention is a 12-week (3 month) programme with a weight management care plan inclusive of Biokinetics, Dietician and Psychologist services. For Obese individuals' additional treatment services would be added to the existing care plan and differentiated according to obesity class

SAMWUMED HEALTHCARE PROGRAMMES

Back and Neck Rehabilitation Programme

subject to managed care protocols

Contact details- Tel: 0860 106 155

Limited to one protocol per beneficiary per annum. Physiotherapy and rehabilitation programme that helps members and dependents who suffer primarily from back and neck problems. The programme, which takes place at specific DBC Centres, consists of up to 12 sessions over a 6-week period. 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.

AID for AIDS (AfA) Programme

if you are diagnosed with HIV call **0860 100 646** or **0834 109 078** or email: **afa@afadm.co.za** to register on the HIV Management Programme.

Beneficiaries with HIV/AIDS can enrol on the AfA Programme to obtain HIV medicine, including drugs to prevent mother-to child transmission, treatment to prevent opportunistic infections, regular monitoring of response to therapy, regular tests to identify treatment side effects, ongoing Nurse-Line support, and assistance with finding a registered counsellor. AfA also provides clinical guidelines and telephonic support for doctors.

SAMWUMED HEALTHCARE PROGRAMMES

Mental Health Programme

subject to eligibility criteria. **Call 0860 106 155** or
email: **membercare@medscheme.co.za**

Members who qualify for this programme receive direct access to a Care Manager, and an individualised care plan to allow their family practitioners, psychiatrists and other healthcare professionals to manage their condition. They also receive relevant education and information including accessing community support groups.

Cancer (Oncology) Programme

subject to registration by contacting **0860 100 572** or emailing **cancerinfo@medscheme.co.za.**

Provides cancer patients with comprehensive treatment plans, including hospitalisation, private nursing, hospice services, and various scans. Patients must register and obtain pre-authorisation for their treatment plans, managed by a clinical team.

ICON is the Scheme's oncology network provider and Dis-chem is a Scheme's oncology medication network provider.

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.

PRESCRIBED MINIMUM BENEFITS ("PMB") Continued

"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") Continued

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

- 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 Treatmen,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

INFORMATION ON ACCESSING YOUR BENEFITS EFFICIENTLY

- 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 conditionsname 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

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 (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. 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.

INFORMATION ON ACCESSING YOUR BENEFITS EFFICIENTLY

- To access the mental health or substance dependency benefit.
- 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 three (3) and five (5) additional chronic (non-PMB) conditions on Option A and Option B respectively such as:

Option A
Depression, Gout, Gord

Option B
Depression, Eczema, Gout, Gord, 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

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.

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**

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.

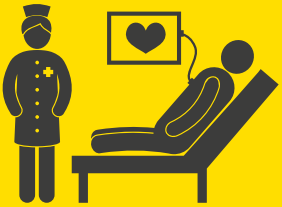
HOW SOON WILL I BE ABLE TO USE MY BENEFITS AFTER REGISTERING AS A MEMBER OF THE SCHEME?

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.

SAMWUMED HAS A WEIGHT LOSS PROGRAMME

The aim of this programme is to assist with getting you started on your weight loss journey.

HOW TO GET STARTED...

During your first visit with a BASA-accredited biokineticist, a full health and fitness assessment is done. This will include taking measurements like blood pressure and waist-to-hip ratio, and completing a lifestyle questionnaire to help prescribe the most effective exercises for you.

WHAT TO EXPECT...

Once your assessment is completed, an individualised exercise programme is created. The programme includes:

- a health risk assessment (one per year);
- three monthly one-on-one consultations with a biokineticist to track your progress;
- nine biokineticist-led group or individual exercise sessions;
- referral to a dietician and/or clinical psychologist for two consultations (initial assessment and follow-up), if necessary;
- two General Practitioner (GP) consultations; and
- four pathology consultations.

HOW MUCH WILL IT COST?

Nothing, as the cost of the above programme will be covered by the Scheme's Weight Management Programme benefits! effective exercises for you.

HOW CAN WE HELP?

Please do not hesitate to contact the MemberCare Team on **0860 106 155** or email **membercare@medscheme.co.za** should you require any further assistance or information.

NATIONWIDE WALK-IN CENTRES

Gauteng: Pretoria, Roodepoort, and Vereeniging

North West: Klerksdorp, Mafikeng, and Rustenburg

Northern Cape: Kimberley and Kathu

Limpopo: Lephalale and Polokwane

Kwazulu-Natal: Durban and Pietermaritzburg

Eastern Cape: East London and Gqeberha

Western Cape: Cape Town and Worcester

Free State: Bloemfontein

Mpumalanga: Nelspruit

TALK TO SAMWUMED TODAY

We're easily accessible:
Member support and customer service are at the heart of what we do:

- Members can WhatsApp us for any queries, ensuring fast and effective service. Or, chat with SAMMY, our new AI tool.
- Through our newly designed and revamped mobile App, members have access to all their membership information, including benefits and updates at the palm of their hands.
- Our user-friendly member portal on our interactive website allows members to access and manage their information from wherever they may be at their convenience.
- For face-to-face interaction and engagement, we have expanded our network of Service Agents and Broker partners.
- We have 19 walk-in centres across all nine provinces to help you face-to-face.

SAMWUMED Operating Hours:
Contact Centre
08h30 - 16h00 Mon - Fri
0860 104 117

Fraud number - 082 450 9539

WhatsApp number: 060 019 3547

Hospital Authorisation Enquiries:
Tel: 0860 33 33 87,
Email: samwumed.authorisations@medscheme.co.za
Website: www.samwumed.org

Social media:
Follow and like our social media pages, including

SAMWUMED
Real Heritage. Real People. Real Health Care.

NOTES:

NOTES:

SAMWUMED

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

Want to refer Colleagues to SAMWUMED?
Ask them to Scan this easy application form.

SCAN ME

*** Disclaimer**

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It is designed purely for marketing purposes of the Scheme's product offering. The information contained herein does not supersede the Scheme Rules.