SAMWUMED

Affordable Quality Health Care for all local government workers.

2025 MEMBER GUIDE

At SAMWUMED we believe that a healthier tomorrow begins with the choices we make today. That's why we're dedicated to providing innovative solutions to support our members' wellness journey. We have been doing that since 1952.

From new and improved benefits to comprehensive healthcare programmes- our mission is to empower our members to live their best lives.

Join and Stay with SAMWUMED

SAMWUMED, here to serve those who serve others.

Samwumed SAMWUMEDhealth Samwumed Whatsapp:060 019 3547

SAMWUMED
Real Heritage. Real People. Real Health Care.

Our mission goes beyond providing high quality healthcare services and benefits. SAMWUMED is dedicated to inspiring communities to live healthy and happy lives.
By continuously reviewing and improving our products and benefits we aim to transform our members' health into a source of joy and vitality.
Your well-being is at the heart of everything we do.

Your health, Our mission!

and we're here to make it a reality.

ABOUT SAMWUMED

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

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

REASONS TO JOIN & STAY
WITH SAMWUMED

BRIGHTER THAN EVER!

GET READY TO SMILE

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

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denis

To speak to an agent, please Contact DENIS on 0860 104 932 or email customercare@denis.co.za

DENIS has been appointed by SAMWUMED in the form of a capitated agreement to provide dental risk management services to SAMWUMED from 01/08/2024.

We're easily accessible:

SAMWUMED has extended its already comprehensive communication channels to include WhatsApp for business. Members will be able to WhatsApp us for any queries for fast and effective service.

Member support and customer service is at the heart of what we do:

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 members have access to their information and manage it 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 are **increasing our walk-in centres** from 5 to 20 in 2025 for effective servicing and in-person consultations.

WE HAVE PARTNERED WITH PPN FOR

IMPROVED OPTOMETRY SERVICES

To speak to an agent, please contact the PPN Contact Centre on

041 065 0650 or Email: info@ppn.co.za, Monday – Friday, between 08h00 and 16h30.

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PPN
Preferred Provider Negotiation

All claims are subject to the Validated IT lab order controls and fraud prevention measures.

2025 BENEFIT CHANGES FOR ALL OPTIONS

NEW BENEFIT STRUCTURE

Option A:

- Overall Annual Limit- **UNLIMITED**
- Day-to-Day with Savings
- Special Programmes
- Capitated Dental & Optical Benefits
- Hospital Benefits
- Preventative Care

Option B:

- Overall Annual Limit-R2,021,000 per family
- Day-to-Day from Risk
- Special Programmes
- Capitated Dental & Optical Benefits
- Hospital Benefits
- Preventative Care

NEW BENEFITS FOR ALL OPTIONS

Family Size Increase **(additional benefits for dependants up to M+8)**

New Sports Injury Benefit **(additional radiology, GP, Specialist and Allied Therapy sessions)** funded from risk

New Weight Loss Programme for those with a **BMI >30 kg/m²**

New Oncology Programme with networks to **reduce co-payments for members.**

Additional Funding for Diabetic Nurse Educators.

Expanded DBC physiotherapy network **to reach more members with back pain.**

BENEFITS FROM M+3 to M+8

OPTION A
Increase in savings as dependants are added **(15% of contributions)**

OPTION B
5.2% Benefit Increase. Increased from **M3+ to M8+:**

	GP & Specialist Consults		Acute Medicine	
Family	**2024 Limit**	**2025 Limit**	**2024 Limit**	**2025 Limit**
M+0	R4 870	R5 120	R4 350	R4 580
M+1	R7 910	R8 320	R5 730	R6 030
M+2	R10 730	R11 290	R8 760	R9 220
M+3	R13 380	R14 080	R11 540	R12 140
M+4		R17 160		R14 460
M+5		R20 140		R17 050
M+6		R23 120		R19 640
M+7		R26 100		R22 230
M+8		R29 080		R24 820

SPORTS INJURY BENEFIT

Additional basket of benefits funded from risk for sports injuries to attract young and healthy members. Limited to R4 900 per person per year, with sub limits as follows:

1 x Radiologist visit up to R1000

1 x GP Consultation up to R600

2 x Auxiliary Consultation (physio,biokineticist etc.) up to R900

1 x Specialist Consultation up to R1500

WEIGHT LOSS PROGRAM

The core weight management intervention is a 12-week (3 month) programme with a weight management care plan inclusive of the following services. For Obese individuals additional treatment services would be added to the existing care plan and differentiated according to obesity class:

Code description
Initial consultation.
Antihropometric/body composition assessment.
Physical work capacity.
Individual exercise sessions.
Group exercise sessions,per patient.
Exercise on Isokinetic apparatus/ Isotonic/ Isometric resistance equiment.
Posture, gait, and activities of daily living (ADL), without equipment use.
Passive and active range of motion exercise therapy.
Nutritional Assessment, Counselling/treatment
Psychology Assessment and Counsultations.

Prioritising your health, Enhancing our Services

We are excited to partner with **Tshela Healthcare as they are offering comprehensive maternity care for expecting mothers.**

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TSHELA HEALTHCARE

For more information call Tshela Contact centre on: 021 003 0256

For maternity benefit related queries, contact Tshela Healthcare on **021 003 0256 or email samwumed@tshela.co.za**

BENEFITS FUNDED FROM SAVINGS

Option A

Non-Surgical Procedures & Tests (In Rooms)

Includes ECG, treadmill test, aspiration of joints, etc.
(Specialist referral authorization required for medical specialists). ***(subject to availability of savings).***

Sleep Studies (In & Out-of-Hospital)

Covers diagnostic sleep disorder tests **(Specialist referral authorization required for medical specialists).** ***(subject to availability of savings).***

Auxiliary Services (In & Out-of-Hospital)

Includes Occupational Therapy, Speech Therapy, Audiology, Dieticians, etc.
(specialist referral authorization required).
(subject to availability of savings).

Radiology:

Subject to **R3,390** per family limit per year when performed out of hospital and included in Savings account.
(subject to availability of savings).

Pathology (Out-of-Hospital)

Subject to savings for out-of-hospital services. Excludes certain tariff codes which are covered elsewhere in the rules.
(subject to availability of savings).

Physiotherapy & Biokinetics (Out-of-Hospital)

Subject to savings.**(Specialist referral authorization required for medical specialists).** ***(subject to availability of savings).***

BENEFITS FUNDED FROM RISK

Option A

Hospitalisation

Unlimited benefits subject to pre-authorisation at a DSP (Scheme Network hospitals).

The following is for services rendered out of hospital but not included in Savings.

Mental Health
(Out-of-Hospital)

Limited to **R3,160 per family per annum**.

Following sub-limits are applicable:

- **Registered Counsellors:** 3 consultations
- **Social Workers:** 3 consultations

Appliances (In & Out-of-Hospital)

- **Benefits for medical appliances like hearing aids and wheelchairs:**
  - **M0:** R3,580
  - **M1:** R5,060
  - **M2+:** R6,420
- Subject to formularies, preferred suppliers, and scheme rules.

2025 BENEFITS CONTRIBUTIONS OPTION A & B

OVERALL ANNUAL LIMIT (OAL)

OAL
OPTION A
UNLIMITED

OAL
OPTION B
R2,021,000
per family
per year

DAY-TO-DAY BENEFITS

BENEFITS	OPTION A (Savings Option)
Overall Annual limit	**Unlimited**
(Out of Hospital)	Some benefits funded from Medical Savings Account, which is **15%** of total contributions excluding late joiner penalties.
GP and Specialist consultations, minor procedures and visits. Specialist consultations subject to Nominated GP referral. **Alternative Healthcare** Consultations with Chiropractors, Homeopaths, Naturopaths and Podiatrists. Excludes X-rays performed by Chiropractors.	Funded from available savings, family limit increases with each dependant that is added to the membership.
Occupational Therapist, Speech Therapist, Audiologist, Dietician, Nurse and Orthoptist consultations subject to Nominated GP referral.	
Physiotherapy and Biokinetics consultations subject to Nominated GP referral and use of Network Providers.	
Pathology and Medical Technology subject to Scheme Network.	
General Radiology subject to Scheme protocols and Designated Service Provider (DSP) Networks	From available savings, limited to **R3,390** per family per year if performed out-of-hospital. Unlimited if performed in-hospital.
Specialised Radiology subject to Nominated GP referral and Scheme protocols. Pre- authorisation required for CT scans, MUGA scans, MRI scans Radio isotope studies and virtual colonography.	From available savings, limited to **R10,330** per family per year for both in and out-of-hospital services, subject to authorisation. Virtual colonography and Coronary Angiography limited to one per beneficiary per year. Oncology, organ and stem cell transplant, and renal dialysis radiology expenses are covered under their respective benefits and not from this limit.
Acute medicine, which includes **Over the Counter (OTC)** medicine	From available savings, family limit increases for each dependant that is added to the membership.

OPTION B (Traditional Option)

R2,021,000 per family per year

All benefits funded from Main Risk Benefit

From risk, family limit increases as up to eight dependants are added to the membership.

M0 R5,120 | M1 R8,320 | M2 R11,290

M3 R14,080 | M4 R17,160 | M5 R20,140 | M6 R23,120

M7 R26,100 | M8+R29,080

R8,320 per beneficiary limit per year with a family limit of **R4,320** per year for consultations with Chiropractors, Homeopaths, Naturopaths and Podiatrists. Excludes X-rays performed by Chiropractors

From risk, **R5,880** per family per year.

From risk, **R5,880** limit per family per year with a **R2,410** limit per beneficiary per year.

From risk, **R11,740** limit per family per year,
subject to Scheme Network.

From risk, **R9,980** limit per family per year if performed out-of-hospital. Unlimited if performed in-hospital.

From risk, limited to **R15,040** per family per year for both in and out-of-hospital services, subject to authorisation. Virtual colonography and Coronary Angiography limited to one per beneficiary per year. Oncology, organ and stem cell transplant, and renal dialysis radiology expenses are covered under their respective benefits and not from this limit.

From risk, family limit increases as up to eight dependants are added to themembership: **M0 R4,580 |**

M1 R6,030 | M2 R9,220 | M3 R12,140

M4 R14,460 | M5 R17,050 | M6 R19,640 | M7 R22,230 | M8+R24,820

Subject to the Scheme's medicine list. **R6,030**, per beneficiary limit per year with an OTC limit of **R3,400**, per family per year and a sub-limit **R240** per person per day.

CAPITATED (FLAT FEE) BENEFITS

BENEFITS	OPTION A
Capitated arrangements	Not funded from savings.
DENTISTRY	Benefit available as follows: **M0 R4,460 | M1 R5,310 | M2 R7,400 | M3+R8,910**
Basic Dentistry subject to Scheme protocols. For queries, benefit confirmations, a list of network dentists or to file claims, contact **DENIS at 0860 104 932** or email **customercare@denis.co.za**	Includes consultations, X-rays, cleanings, fillings and restorative treatment, extractions, treatment for pain and sepsis, dentures and associated laboratory treatment. Two check-ups per beneficiary per year (once every 6 months); one extra oral X-rays per beneficiary in a 3-year period, fissure sealant and fluoride treatment limited to beneficiaries younger than 16 years of age, fillings granted once per tooth in 720 days, one set of plastic dentures (an upper and a lower) per beneficiary in a 4-year period, two partial metal frames (an upper and a lower) per beneficiary in a 5-year period. Orthodontic treatment limited to individuals between the ages of 9 and 18 years for functional impairment once per beneficiary per lifetime and one beneficiary per calendar year.
Advanced Dentistry subject to Scheme protocols and pre-authorisation. For queries, benefit confirmations, a list of network dentists or to file claims, contact **DENIS** at **0860 104 932** or email **customercare@denis.co.za .**	Limited to Prescribed Minimum Benefits (PMB) level of care.
OPTICAL	
Optical subject to Scheme protocols and PPN Network. 2-Year benefit cycle from date of service. To access your benefits, view your claim status, lodge a claim or locate the closest PPN Network Optician available 24/7, please visit **www.ppn.co.za.** If you prefer, email **PPN** with any queries at **info@ppn.co.za,** or **call 041 065 0650**	One composite eye test per beneficiary per benefit cycle limited to **R755** at Network Provider and **R400** at Non-Network Provider. One pair of clear single vision spectacle lenses limited to **R215** at Non-Network Provider or clear flat top bifocal spectacle lenses limited to **R460** at Non-Network Provider or clear multifocal spectacle lenses limited to **R810** at Non-Network Provider. Lenses covered in full at PPN Network Provider. Frame and/or lens enhancements per beneficiary limited to **R1,080** at non-network provider and **R1,350** at PPN Network Provider. No benefit for readers or contact lenses.

OPTION B

Do not accumulate to the OAL.

Benefit available as follows:
M0 R9,520 | M1 R10,930 | M2 R12,710 | M3+ R14,310

Includes consultations, X-rays, cleanings, fillings and restorative treatment, extractions, treatment for pain and sepsis, dentures and associated laboratory treatment. Two check-ups per beneficiary per year (once every 6 months); one extra oral X-rays per beneficiary in a 3-year period, fissure sealant and fluoride treatment limited to beneficiaries younger than 16 years of age, fillings granted once per tooth in 720 days, one set of plastic dentures (an upper and a lower) per beneficiary in a 4-year period, two partial metal frames (an upper and a lower) per beneficiary in a 5-year period. Orthodontic treatment limited to individuals between the ages of 9 and 18 years for functional impairment once per beneficiary per lifetime and one beneficiary per calendar year.

Includes comprehensive root canal treatment, crown and bridge work
including associated laboratory costs, orthodontics, periodontics, maxillo-facial surgery and oral pathology.

One composite eye test per beneficiary per benefit cycle limited to **R755** at Network Provider and **R400** at Non-Network Provider. One pair of clear single vision spectacle lenses limited to **R215** at Non-Network Provider or clear flat top bifocal spectacle lenses limited to **R460** at Non-Network Provider or clear multifocal spectacle lenses
limited to **R850** at Non-Network Provider. Lenses covered in full at PPN Network Provider. Frame and/or lens enhancements per beneficiary limited to **R1,408** at Non-network provider and **R1,760** at PPN Network Provider. Contact lenses limited to **R3,000** per beneficiary. No benefit for readers.

MAIN RISK BENEFITS

BENEFITS	OPTION A Main Risk
Risk	Not funded from savings.
Chronic Medicine To use these benefits, your doctor must register your condition by calling **086 033 3387** or emailing **samwumedcmm@medscheme.co.za.** Funding is subject to protocols, formularies, pre-authorisation, and case management.	Option A covers 26 Chronic Disease List conditions plus depression, GORD, and gout. Covered CDL conditions include Addison's,asthma, bipolar, bronchiectasis, heart failure, cardiomyopathy, COPD, chronic kidney disease, coronary disease, Crohn's, diabetes, dysrhythmias, epilepsy, glaucoma, haemophilia, HIV, high cholesterol, hypertension, hypothyroidism, Multiple Sclerosis, Parkinson's, rheumatoid arthritis, schizophrenia, lupus, and ulcerative colitis. Your doctor should inform you about medication exclusions and prescribe from our formulary to avoid a **25%** co-payment. **Choose a listed pharmacy and consider generics to prevent extra co-payments.**
Oncology (cancer treatment) Contact **086 033 3387** or **cancerinfo@medscheme.co.za** to access this benefit, which requires adherence to health protocols and preapproval.	Option A offers unlimited PMB cancer coverage. Voluntary use of a non-network facility or non-Designated Service Provider for oncology medication and consumables will incur a **25%** co-payment. PET scans can only be performed at accredited practices and require additional authorisation. Post-chemo/radiotherapy chronic conditions aren't covered. Oncology medication is subject to Medicine Price List (MPL) and Preferred Product List, while the evolving Oncology Specialised Drug List covers various advanced therapies.
Ambulance services in the event of a life-threatening emergency necessitating an ambulance for transport to a hospital, please contact **082911.**	Ambulance services are covered in full when authorized by **Netcare911.**
Hospital authorise your hospitalisation at least three working days before a planned admission or on the first working day following an emergency admission by calling **086 033 3387** or email samwumed.authorisations@medscheme.co.za to. For a list of network hospitals anddoctors, visit www.samwumed.org or call us at **086 0104 117** for assistance	Your family has unlimited cover for hospitalisation. Avoid a **R1,000** co-payment by authorising your admission. Use our network doctors and hospitals that charge scheme rates to avoid extra **25%** co-payments. For planned admissions, ask your admitting doctor for the names of all healthcare providers who will be involved with your care to ensure that they are on our network .

OPTION B Main Risk

Accumulates to the Overall Annual Limit (OAL).

Option B covers 26 Chronic Disease List conditions plus depression, GORD, gout, eczema and menopause. Covered CDL conditions include Addison's disease, asthma, bipolar disorder, bronchiectasis, heart failure, cardiomyopathy, COPD, chronic kidney disease, coronary disease, Crohn's disease, diabetes, dysrhythmias, epilepsy, glaucoma, haemophilia, HIV, high cholesterol, hypertension, hypothyroidism, Multiple Sclerosis, Parkinson's disease, rheumatoid arthritis, schizophrenia, lupus, and ulcerative colitis. Your doctor should inform you about medication exclusions and prescribe from our formulary to avoid a **25%** co-payment. **Choose a listed pharmacy and consider generics to prevent extra co-payments.**

Option B offers unlimited PMB cancer coverage and up to **R384,500** annually for non-PMB cancers. Voluntary use of a non-network facility or non-Designated Service Provider for oncology medication and consumables will incur a **25%** co-payment. PET scans can only be performed at accredited practices and require additional authorisation. Post-chemo/radiotherapy chronic conditions aren't covered. Oncology medication is subject to Medicine Price List (MPL) and Preferred Product List, while the evolving Oncology Specialised Drug List covers various advanced therapies.

Ambulance services are covered in full when authorized by **Netcare911.**

Your family is covered for hospitalisation up to your overall annual limit of **R2,021,000**. Avoid a **R1,000** co-payment by authorising your admission. Use our network doctors and hospitals that charge scheme rates to avoid extra 25% co-payments. For planned admissions, ask your admitting doctor for the names of all healthcare providers who will be involved with your care to ensure that they are on our network .

MAIN RISK BENEFITS

BENEFITS	OPTION A Main Risk
Maternity Register on our maternity programme to receive a maternity bag in your third trimester by calling **021 003 0256** or emailing **Samwumed@Tshela.co.za.**	Our maternity benefits include folic acid and iron support in the first trimester, up to eight midwife antenatal visits, and two yearly 2D ultrasounds per person. Use network doctors and approved hospitals to avoid a **25%** co-payment fee. Pre-authorise your child's birth at either a registered birthing facility for natural delivery with a midwife and receive four midwife postnatal appointments or at a network hospital with a network doctor and receive a six-week post-birth checkup. Note that there's an annual **R32,950** limit for Caesarean sections per family unless PMB level of care.
Mental Health In Hospital PMB protocols apply. Subject to clinical motivation and authorisation	Limited to PMB level of care and to a maximum of 21 days or 15 outpatient contacts per year.
Mental Health Out of Hospital PMB protocols apply. Subject to clinical motivation and authorisatio	Limited to **R3,160** per family per year. Unlimited for PMB level of care or when registered on the Mental Health Programme.
Appliances Subject to clinical motivation and authorisation	Option A covers medical and surgical devices, including orthotics, within a yearly limit based on your number of Dependant numbers: **M0 R3,580 | M1 R5,060 | M2+R6,420** Mobility aids like crutches, walking frames, slings, and collars are covered without prior approval up to the yearly limit. Immobilisation splints for limbs are also covered every year, and foot-related orthotics every two years without pre-authorisation. However, oxygen therapy, CPAP devices, certain boots and braces, incontinence and stoma products require pre-authorisation. Blood pressure monitors and other medical devices have a four-year cycle but need chronic medicine authorization, while costly items like hearing aids, manual wheelchairs and spinal braces also need authorisation and have a four-year cycle. There is no funding for electric wheelchairs and scooters.
Internal Prostheses and Devices Clinical motivation, quotations from at least three providers and pre-authorisation are required to access these benefits. The Scheme maintains the right to procure prostheses on behalf of members and to deduct the members' allocated benefits	There is an annual family limit of **R34,560** for internal prostheses. This includes temporary prostheses and any related apparatus, such as bone cement, bone graft substitutes, and bone anchors. Use our preferred providers for hip and knee replacement prostheses to avoid a **R10,000** co-payment for voluntary out-of-network use.
External Prostheses and Devices Clinical motivation, quotations from at least three providers and pre-authorisation are required to access these benefits. The Scheme maintains the right to procure prostheses on behalf of members and to deduct the members' allocated benefits.	An annual family benefit of **R25,700** is in place for external prosthetics, including artificial eyes, limbs, breast prosthetics and bras. The scheme also has the discretion to directly procure the needed appliance, which may be charged against the member's entitlement. An annual limit of **R18,020** per beneficiary is in place for artificial iris implants.

OPTION B Main Risk

Our maternity benefits include folic acid and iron support in the first trimester, up to eight midwife antenatal visits, and three yearly 2D ultrasounds per person. Use network doctors and approved hospitals to avoid a **25%** co-payment fee. Pre-authorise your child's birth at either a registered birthing facility for natural delivery with a midwife and receive four midwife postnatal appointments or at a network hospital with a network doctor and receive a six-week post-birth checkup. Note that there's an annual **R35,250** limit for Caesarean sections per family unless PMB level of care

Limited to **R5,260** per family per year. Unlimited for PMB level of care or when registered on the Mental Health Programme.

Option B covers medical and surgical devices, including orthotics, within an annual family limit of **R 7,890.** Mobility aids like crutches, walking frames, slings, and collars are covered and immobilisation splints are funded without prior approval. Foot-related orthotics are funded every two years without pre-authorisation. However, oxygen therapy, CPAP devices, certain boots and braces, incontinence and stoma products require pre-authorisation. Blood pressure monitors and other medical devices have a four-year cycle but need chronic medicine authorization, while costly items like hearing aids, manual wheelchairs and spinal braces also need authorisation and have a four-year cycle. There is no funding for electric wheelchairs and scooters.

There is an annual family limit of **R35,250** for internal prostheses. This includes temporary prostheses and any related apparatus, such as bone cement, bone graft substitutes, and bone anchors. Use our preferred providers for hip and knee replacement prostheses to avoid a **R10,000** co-payment for voluntary out-of-network use.

An annual family benefit of **R30,000** is in place for external prosthetics, including artificial eyes, limbs, breast prosthetics and bras. The scheme also has the discretion to directly procure the needed appliance, which may be charged against the member's entitlement. An annual limit of **R18,020** per beneficiary is in place for artificial iris implants.

SAMWUMED CARES WELLNESS (PREVENTATIVE CARE) PROGRAMME

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

Age: 18 yrs and older
Screening Test: Blood Pressure
2025 Benefit: Up to one screening, per beneficiary per year.

Age: 18 yrs and older
Screening Test: Type II Diabetes
2025 Benefit: Up to one screening per beneficiary aged 18 years and older per year.

Age: From age 20
Screening Test: Total Blood Cholesterol
2025 Benefit: Up to one test for all adults at least once from the age of 20 years old and every year for high risk members.

Age: 18 yrs and older
Screening Test: Papanicolaou (Pap) Test
2025 Benefit: Up to one screening per female beneficiary per year within a 2-year cycle.

Age: 18 yrs and older
Screening Test: Chlamydia Screening
2025 Benefit: Up to one screening per female beneficiary per year within a 2-year cycle.

Age: Child-bearing age
Screening Test: Folic Acid
2025 Benefit: Up to 1 per month for the first 3 months of pregnancy

Age: 50 yrs and older
Screening Test: Faecal Occult Blood Test
2025 Benefit: Up to one screening per beneficiary per year.

Age: Over the age of 50 until the age of 70
Screening Test: Mammogram
2025 Benefit: Up to one screening per female beneficiary every two years over the age of 50 until age of 70 years.

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

Age: 65 yrs to 70 yrs
Screening Test: Bone Density Test
2025 Benefit: Up to one test for male beneficiaries aged 70 years and older and one test for female beneficiaries aged 65 years and older per year.

Age: All ages
Screening Test: HIV
2025 Benefit: One test per beneficiary per year.

Age:
Screening Test: Cytology
2025 Benefit: One test per beneficiary, every three years.

Age: Less than 1 month old
Screening Test: TSH Screening
2025 Benefit: Up to 1 test per new born less than 1 month old per year.

Age:
Screening Test: Flu Vaccine
2025 Benefit: Up to one vaccination per beneficiary per year.

Age:
Screening Test: HIV Counselling & Tests
2025 Benefit: Unlimited based on clinical and PMB protocols per beneficiary per year.

Age:
Screening Test: Child Immunisation
2025 Benefit: As per Immunisations prescribed by the South African Expanded Immunisation Programme.

Age: 2 yrs to 65 yrs
Screening Test: Pneumococcal Vaccine
2025 Benefit: Up to one vaccination per beneficiary 65 years and older and for beneficiaries aged 2 to 64 years who are at risk of serious pneumococcal disease per lifetime.

Age: Female
Screening Test: HPV Vaccine
2025 Benefit: Up to one vaccination per female beneficiary between age 9 and 14 years per annum. 3 doses per benficiary between 15 and 26 years.

Age: 7 yrs to 64 yrs
Screening Test: Pertussis (Whooping Cough) Booster
2025 Benefit: Up to one vaccination per beneficiary between age 7 and 64 and1vaccine per pregnancy in the third trimester.

Age: All beneficiaries
Screening Test: Health Risk Assessment
2025 Benefit: Up to one assessment per beneficiary per year.

Age: New-borns
Screening Test: Hearing Test
2025 Benefit: One hearing test per new-born baby before 6 weeks of age.

Age: 45 yrs to 70 yrs
Screening Test: Prostate Antigen Test
2025 Benefit: Up to one test per year per male beneficiary aged between 45 - 70 years.

2025 Anchor Hospitals
are Mediclinic and Netcare Hospitals

CONTRIBUTIONS

2025 CONTRIBUTION 100% TABLES

Option A 2025

Salary Band	Principal Member	Adult Dep
R0 - R4 220	R1 728,00	R1 728,00
R4 221 - R6 810	R2 040,00	R2 040,00
R6 811- R10 490	R2 598,00	R2 598,00
R10 491+	R2 853,00	R2 853,00

Option A 2025 ANNUAL UPFRONT MEDICAL SAVINGS

Salary Band	R0 - R4 220	R4 221 - R6 810
Principal Member	R3 108,00	R3 672,00
Adult Dependant	R3 108,00	R3 672,00
Child Dependant	R1 092,00	R1 284,00
Member + Spouse	R6 216,00	R7 344,00
Member+ Spouse + 1 Child	R7 308,00	R8 628,00
Member+Spouse + 2 Children	R8 400,00	R9 912,00
Member + Spouse + 3 Children	R9 492,00	R11196,00

2025 CONTRIBUTION 100% TABLES

Option B 2025

Salary Band	Principal Member	Adult Dep
R0 - R6 270	R2 916,00	R2 916,00
R6 271- R8 650	R3 528,00	R3 528,00
R8 651- R16 000	R3 616,00	R3 616,00
R16 001+	R3 998,00	R3 998,00

Child Dep	Member +Spouse	Member +Spouse +1 Child
R609,00	R3 456,00	R4 065,00
R716,00	R4 080,00	R4 796,00
R907,00	R5 196,00	R6 103,00
R1006,00	R5 706,00	R6 712,00

R6 811- R10 490	R10 491+
R4 680,00	R5 136,00
R4 680,00	R5 136,00
R1 632,00	R1 812,00
R9 360,00	R10 272,00
R10 992,00	R12 084,00
R12 624,00	R13 896,00
R14 256,00	R15 708,00

Child Dep	Member +Spouse	Member +Spouse +1 Child
R1 023,00	R5 832,00	R6 855,00
R1 239,00	R7 056,00	R8 295,00
R1 271,00	R7 232,00	R8 503,00
R1 317,00	R7 996,00	R9 313,00

SAMWUMED HEALTHCARE PROGRAMMES

Mental Health Programme - Tel: 0860 33 33 87

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

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

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

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

The Programme is aimed at helping our members and their dependents who suffers from chronic illnesses to receive their Chronic Medication un-interrupted.

How to access this benefit:-
Registering on the Chronic Medicine Management (CMM) Programme

To be able to access this benefit, Members and their dependents have to register on the Programme.
Register Telephonically: Call CMM between 08:30am and 4pm on 0860 33 33 87 and select the chronic option.

SAMWUMED offers Members and beneficiaries with HIV/AIDS complete HIV disease management assistance under its AID for AID (AfA) Programme.

How to access this benefit:-
If you are diagnosed with HIV, your doctor must contact Aid for AIDS to register you on the HIV Management Programme. The details are:
Tel: 0860 100 646 or 083 410 9078
Email: afa@afadm.co.za

SAMWUMED HEALTHCARE PROGRAMMES

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

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

How to access this benefit:-

Pre-Authorisation

Pre authorisation is the process where the treatment process is approved first before it is provided. This is to ensure that there is value through the planned intervention.
The treating doctor can call **0860 100 572** for patient pre authorisation.

Smoking Cessation - Tel: 0860 002 103

Are you struggling with smoking, SAMWUMED has a programme to help members to stop smoking for their own health.
How to access the programme
SAMWUMED members quality for up to one course per beneficiary per lifetime.
Please consult with your local pharmacy to confirm if they offer the service.

DBC Back and Neck Rehabilitation Programme - Tel: 0860 106 155

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

How to access the programme:-

Accessing **the Programme**

Members can access the programme through various ways, for example:

- If admitted to hospital with back or neck surgery (for example a spinal fusion), pain management (for example a rhizotomy) or specialised radiology (for example an MRI scan)
- A member may also contact the Member Contact Centre on **0860 106 155** or email: **membercare@medscheme.co.za** should they experience chronic, ongoing back or neck pain.

Weight loss Progrsme

The core weight management intervention is a 12-week (3 month) programme with a weight management care plan inclusive of the following services. For Obese individuals additional treatment services would be added to the existing care plan and differentiated according to obesity class:

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")

"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;

PRESCRIBED MINIMUM BENEFITS ("PMB")

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.

INFORMATION ON ACCESSING YOUR BENEFITS EFFICIENTLY

GETTING AUTHORISATION FOR YOUR HOSPITAL STAY

- A Managed Care partner has been contracted by the Scheme to ensure that you and your dependents get cost efficient, quality care in hospital. Managed Care offers useful advice, and their team of doctors and nurses will make sure that you are admitted at the appropriate facility at the correct fee. **You must contact Managed Care for pre-authorisation on 0860 33 33 87, at least three (3) working days before a planned procedure or on the first work-ing day after an emergency hospital admission to obtain an authorisation number for your treatment.**
- Authorisation requests for major surgery should be submitted at least thirty (30) days in advance to allow the Scheme to obtain a second opinion to ensure that you and your dependent receive appropriate treatment.
- It is important to note that pre-authorisation is compulsory for hospitalisation and failure to comply could result in a commensurate penalty.

WHY IS PRE-AUTHORISATION NECESSARY?

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

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

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

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.

INFORMATION ON ACCESSING YOUR BENEFITS EFFICIENTLY

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, 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

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 \ BONUSOR 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.

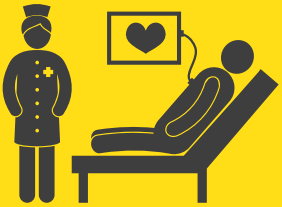
HOW SOON WILL I BE ABLE TO USE MY BENEFITS AFTER REGISTERING AS A MEMBER OF THE SCHEME?

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 IS INTRODUCING A NEW 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.

GUIDELINES FOR SUBMISSION OF CLAIMS:

Providers must ensure that the **ICD10 code Z50.1** is used when a claim is submitted as well as any one of the below codes, for it to be covered from the **Weight Management Programme benefit.**

DIETICIANS
84201 – Nutritional assessment, counselling/treatment. Duration: 11 - 20 minutes.
84202 – Nutritional assessment, counselling/treatment. Duration: 21 - 30 minutes.
84203 – Nutritional assessment, counselling/treatment. Duration: 31 - 40 minutes.
84204 – Nutritional assessment, counselling/treatment. Duration: 41 - 50 minutes.
84205 – Nutritional assessment, counselling/treatment. Duration: 51 - 60 minutes.
78330 – Virtual consultation (all hours), healthcare professionals, including medical practitioners (GPs and specialists).
78340 – Telephone consultation (all hours), healthcare professionals (non-medical doctors).
PSYCHOLOGISTS
86201 – Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 11 - 20 minutes.
86202 – Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 21 - 30 minutes
86203 – Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 31 - 40 minutes.
86204 – Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 41 - 50 minutes.
86205 – Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 51 - 60 minutes.
078330 – Virtual consultation (all hours), healthcare professionals, including medical practitioners (GPs and specialists).
078340 – Telephone consultation (all hours), healthcare professionals (non-medical doctors).

BIOKINETICISTS		
Health risk assessment (HRA) (1) – Initial assessment		
Treatment code	Code description	ICD10 code
91901	Initial consult including: Problem focused history; short problem focused examination and straight forward biokineticist. Decision making but excluding evaluation. May only be charged once per course of treatment.	Z50.1 Other physical therapy, therapeutic and remedial exercises

91912	Anthropometric/body composition assessment.	Z50.1 Other physical therapy, therapeutic and remedial exercises
91917	Physical work capacity (treadmill or bicycle ergometer/other electronic equipment)/ musculoskeletal assessment (strength, endurance, range of motion, posture).	Z50.1 Other physical therapy, therapeutic and remedial exercises
Reassessments (3) – Measurements are taken again at week 4, 8 and 12		
Treatment code	Code description	ICD10 code
91926	Exercise on isokinetic apparatus/isotonic/ isometric resistance equipment.	Z50.1 Other physical therapy,therapeutic and remedial exercises
91927	Posture, gait and activities of daily living (ADL), with/without equipment use.	Z50.1 Other physical therapy, therapeutic and remedial exercises
91931	Passive and active range of motion exercise therapy.	Z50.1 Other physical therapy, therapeutic and remedial exercises
Therapy session for the rest of the 12 weeks = 9 sessions		
Treatment code	Code description	CD10 code
91934	Group exercise session	Z50.1 Other physical therapy, therapeutic and remedial exercises
OR		
07409	Individual exercise	Z50.1 Other physical therapy, therapeutic and remedial exercises
GENERAL PRACTITIONERS		
0190 – **New and established patient**: Consultation/visit of a new or established patient of an average duration and/or complexity. Typically, the doctor spends up to 15 minutes with the patient and/or family.		
0191 – **New and established patient:** Consultation/visit of a new or established patient of a moderately above-average duration and/or complexity. Typically, the doctor spends between 16 and 30 minutes with the patient and/or family.		
0192 – **New and established patient**: Consultation/visit of a new or established patient of long duration and/or high complexity. Typically, the doctor spends between 31 and 45 minutes with the patient and/or family.		

PATHOLOGY
4052 – Glucose tolerance test (three specimens)
4507 – Thyrotropin (TSH)
4482 – Free thyroxine (FT4)
4484 – Thyrotropin (TSH)/free thyroxine (FT4): This item includes items 4507 and 4482
4025 – Chol/HDL/LDL/Trig (lipogram)
4027 – Total cholesterol
4050 – Glucose strip-test with photometric reading
P.S. Remember to take this letter with you to your dietician, clinical psychologist, biokineticist and/or GP on your first visit. Providers will be paid in accordance with Scheme Rules and at Scheme rates.

We wish you all the best on your weight loss journey!

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**

2025 MEMBER GUIDE

SAMWUMED

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

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