GLOSSARY OF TERMS USED IN THIS GUIDE:

Benefit Limit: The maximum amount that the member or dependant is entitled to for a specific benefit category, taking into account the Scheme Rules and Scheme Tariff paid for goods, services or appliances.

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

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

PBPA: Per Beneficiary Per Annum

Designated Service Provider (DSP): The service provider that the Scheme has chosen to provide certain medical care for PMBs.

Exclusions: Any treatments, medications, appliances or similar that are not covered in terms of the Rules of the Scheme.

Formulary: A list of medicines.

ICD-10 Code: The International Classification of Diseases (ICD), – 10. A system that organises diseases and the complications linked to these diseases according to specific categories.

Medical Schemes Act: The law that governs all medical schemes in South Africa.

Overall Annual Limit (OAL): The limit that every member and their dependants cannot exceed during each benefit year.

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

Pre-existing Medical Condition: A medical condition or illness that already exists at the time a member or their dependant joins the Scheme.

Prescribed Minimum Benefits (PMBs): A list of conditions, specified in the Medical Schemes Act 131 of 1998, for which all members are entitled to treatment.

Prescribed Cycles: The number of times a member is allowed to access certain benefits during a specific benefit year(s).

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

Pro-rated Benefits: Benefits allocated to a member based on the number of contributions they have paid. This applies to members who join after March of the benefit year.

Scheme Tariff: The rate according to which the Scheme pays for claims.

Sub-limit: Forms part of a broader benefit category.

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

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) additional chronic (Non-PMB) conditions such as:

OPTION A: GORD • GOUT • MENOPAUSE
OPTION B: DEPRESSION • GORD • GOUT • MENOPAUSE • ECZEMA

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

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

HIV MANAGEMENT PROGRAMME

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

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

Your treating doctor will need to fax the HIV application form to our HIV Managed Care Provider, Aid for AIDS on 0800 600 773 or call 0800 227 700 to register you on the HIV Management Programme.

BENEFITS EXPLAINED

We advise you to discuss the cost of care with health providers before undertaking the care. We also strongly advise you to make use of our managed care agents before seeking care – use the call centre numbers provided to you. In this way you will be better protected against potential over-charging and the risk of out of pocket payments.

SUMMARY OF BENEFIT REFINEMENTS FOR 2019
[including but not limited to]:

1. Effective Network Management
2. Effective case management and other managed care interventions
3. Improved out-of-hospital specialised radiology

MANAGING YOUR BENEFITS

1. Understand what is provided in your benefit rules before you go for treatment.
2. Understand what is paid for in your scale of benefits and at what rate.
3. Understand and negotiate with your health service provider on what they charge and what the medical aid pays.
4. Understand what the Scheme networks are and what providers you may use.

For the Scheme to render an effective and sustainable service, requires of us to manage a sound risk pool. To this end we require your understanding and co-operation in using your benefits wisely and prudently. Think of your Scheme as a collective fund, where the young and healthy cross-subsidises the weak and infirm – and in turn when you have a health crisis there is enough funds for your needs.

BENEFITS CAN BE GROUPED INTO TWO CATEGORIES

DAY–TO–DAY BENEFITS

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

SECONDARY OR TERTIARY CARE

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

FREQUENTLY ASKED QUESTIONS

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 with 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.

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.

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 dependants get cost efficient, quality care in hospital. Managed Care offers you useful advice and their team of doctors and nurses will make sure that you are admitted at the appropriate facility at the correct fee.

YOU MUST CONTACT MANAGED CARE FOR PRE-AUTHORISATION ON 0860 33 33 87 AT LEAST THREE (3) WORKING DAYS

before a planned procedure or on the first working day after an emergency hospital admission to obtain an authorisation number for your treatment.

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

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

WHY IS PRE–AUTHORISATION NECESSARY?

Pre-authorisation for hospital admissions and certain out-of-hospital care is a key component in managing your access to affordable, appropriate, safe and quality healthcare. 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:

- Membership number
- Patient's name, surname and date of birth
- Doctor's name and practice number
- Name of hospital
- Procedure to be performed and ICD-10 code(s)
- Date of admission

WHAT IF I'M DIAGNOSED WITH CANCER?

REGISTER WITH THE

SAMWUMED ONCOLOGY MANAGEMENT PROGRAMME

Tel: 0860 33 33 87 or
Email: 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 Scheme Oncology Management Programme of any change in your treatment, as your authorisation will have to be re-assessed and updated accordingly to ensure that your claim(s) are not rejected or paid from the incorrect benefit.

WHAT HAPPENS IN AN EMERGENCY? DON'T WORRY. IN THE CASE OF AN EMERGENCY SITUATION YOU OR A FAMILY MEMBER MAY PRE-AUTHORISE THE ADMISSION ON THE FIRST WORKING DAY AFTER BEING ADMITTED.

WHAT IS A PMB?

PRESCRIBED MINIMUM BENEFITS (PMB) IS A SET OF DEFINED BENEFITS THAT ENSURE YOU HAVE ACCESS TO CERTAIN MINIMUM HEALTH SERVICES, REGARDLESS OF THE BENEFIT OPTION YOU HAVE SELECTED.

In accordance with the Medical Scheme's Act, medical schemes have to cover the costs related to these conditions which include:
- **Any emergency medical admission**
- **A limited set of 270 pre-defined medical conditions**
- **Twenty-six (26) chronic medical conditions**

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

MEMBERSHIP MANAGEMENT

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

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

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

MOVEMENT BETWEEN SCHEMES DURING THE YEAR IS NOT ALLOWED.

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

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

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

You should be mindful not to disclose information such as your membership number or hand over tax or membership certificates/cards to any third party.

REGISTERING DEPENDANTS

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

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

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

CHILD DEPENDANTS

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

BIRTH OF A CHILD

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

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

ADULT DEPENDANTS

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

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

Dependants over the age of 21, who are not spouses or partners, but are dependent on the main member for care and financial support, can be registered as adult dependants. An affidavit proving this dependency is required. If you have any questions regarding membership, please contact our Premiums Department by dialling 0860 104 117.

SAMWUMED OFFERS

TWO AFFORDABLE MEDICAL AID OPTIONS

OPTION A

This option is suited for
YOUNGER MEMBERS AND YOUNG FAMILIES.

Maybe you have young children, recently got married or planning to start a family. You and your spouse are young, fit and healthy. You enjoy the preventative care benefits programme and take responsibility for your health. You need moderate day-to-day medical care, but a comprehensive Maternity Benefit Programme and good Hospital Care are essential for your lifestyle.

OPTION B

This option is suited for
MIDDLE AND OLDER AGE MEMBERS AND THEIR FAMILIES.

Getting older means you need more Day-to-Day Benefits, Chronic Illness Benefits and at times Hospital Care. You enjoy managing your health by taking advantage of Early Detection Tests. You're also still responsible of taking care of your older children while they live at home as well as your extended family who are dependent on you.

GO AHEAD AND CHOOSE THE MOST SUITABLE OPTION FOR YOU AND YOUR FAMILY'S NEEDS.

SAMWUMED OFFERS

COMPREHENSIVE BENEFIT OPTIONS

THAT WILL COVER YOU FOR YOUR PRIMARY AND SECONDARY MEDICAL NEEDS.

INCLUDING BUT NOT LIMITED TO:

- **Comprehensive preventative care benefits and early detection**
- **Day-to-day medical care**
- **Chronic illness benefits**
- **Hospital care**
- **Medical emergencies**

IT'S SIMPLE TO BECOME A MEMBER OF SAMWUMED

1. Request and complete an **APPLICATION FORM** from our Sales & Servicing and Broker Consultants or via your HR office.
2. Submit your application with photo copies of **SOUTH AFRICAN IDENTITY.**
3. You will receive an **SMS** from SAMWUMED to confirm receipt of your application.
4. You will receive your SAMWUMED **WELCOME PACK** which includes your Membership Guide and Membership Card.

WHAT DOCUMENTS DO I NEED TO BECOME A MEMBER?

- **SOUTH AFRICAN ID**
  Book/Card, Birth Certificates.
- **A SWORN AFFIDAVIT**
  proving financial dependency for children over the age of 21.
- **LEGAL DOCUMENTS**
  of adopted/foster children.
- Confirmation of **BANKING DETAILS.**

HIGHLIGHTS 2019

SAMWUMED IS PROUD TO INTRODUCE ITS IMPROVED BENEFIT OFFERINGS FOR 2019:

- **Removal of State hospitals** from Network of DSPS for all in-hospital procedures
- Increase in overal annual limit for hospitilisation to **R750,000** on Option A and **R1,500,000** on Option B
- Yet still the lowest contribution you will pay in the entire sector
- Improved oncology benefits – members on both options get to enjoy the non-PMB oncology benefit
- Improved preventative care benefits

PROPOSED 2019 CONTRIBUTION INCREASES OPTION A

Table below represents 100% contribution.
EMPLOYEES ONLY PAY UP TO 40%.

A] Contributions are paid monthly in arrears.

0% MEMBER CONTRIBUTION INCREASE

	100% Contribution			40% Contribution		
INCOME BAND	PRINCIPAL	ADULT	CHILD	PRINCIPAL	ADULT	CHILD
R0 - R3 700	R995	R995	R350	R398	R398	R140
R3 701 - R4 800	R1 176	R1 176	R412	R470	R470	R165
R4 801 - R5 900	R1 265	R1 265	R444	R506	R506	R178

ONLY 7% MEMBER CONTRIBUTION INCREASE

R5 901 - R7 500	R1 530	R1 530	R537	R612	R612	R215
R7 501 - R9 100	R1 640	R1 640	R577	R656	R656	R231
R9 101+	R1 757	R1 757	R620	R703	R703	R248

PROPOSED 2019 CONTRIBUTION INCREASES OPTION B

Table below represents 100% contribution.
EMPLOYEES ONLY PAY UP TO 40%.

B] Contributions are paid monthly in arrears.

0% MEMBER CONTRIBUTION INCREASE

	100% Contribution			40% Contribution		
INCOME BAND	PRINCIPAL	ADULT	CHILD	PRINCIPAL	ADULT	CHILD
R0 - R5 400	R1 694	R1 694	R594	R678	R678	R238

ONLY 8.3% MEMBER CONTRIBUTION INCREASE

R5 401 - R6 400	R2 050	R2 050	R720	R822	R822	R288
R6 401 - R7 500	R2 094	R2 094	R735	R838	R838	R294
R7 501 - R10 700	R2 137	R2 137	R751	R855	R855	R300
R10 701 - R13 900	R2 252	R2 252	R765	R901	R901	R306
* R13 901 +	R2 371	R2 371	R781	R948	R948	R312

HOW TO CALCULATE YOUR CONTRIBUTION AS PER YOUR EMPLOYMENT CONTRACT

1 Establish your income before deductions to establish your Income Band

2 Sum the values in the respective columns for the Principal member and beneficiaries

3 Multiply the total by your contribution percentage as per your Employment Contract

R2371 x (40% OR 0.4) = R948

OPTION A BENEFITS

ALTERNATIVE HEALTH CARE

PODIATRIST, HOMEOPATH, NATUROPATH, CHIROPRACTOR

INCLUDED with GP consultations and visits.

Practitioners to be registered with the **Health Professions Council of SA** or **Allied Health Professionals Council of South Africa.**

PFPA = R2,100

AMBULANCE SERVICES

ROAD AND AIR

Designated Service Provider only.

UNLIMITED FOR EMERGENCY ASSISTANCE ONLY – case managed, and protocols apply.

Co–Payment rule for voluntary use of a Non–DSP.

Scheme Members to be held liable for the full cost of transportation for non–medically justifiable cases.

APPLIANCES

MEDICAL AND SURGICAL

	R 2,650
1	R 3,750
2+	R 4,750

Subject to the submission of a **clinical motivation** with correct Tariff codes and costing for pre-authorisation by the Scheme.

The Scheme (or contracted managed care company on behalf of the Scheme) may from time to time contract with or pilot with or credential specific provider groups (networks) or centres of excellence or supplier groups as determined by the Scheme in order to ensure cost effective and appropriate care.

Beneficiaries are entitled to benefits from contracted networks appointed as the Scheme's DSP for PMB benefits and other benefits.

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 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.

Limits and cycles as per the Scheme's list of approved appliances apply

DENTISTRY

BASIC

	R 3,300
1	R 3,940
2+	R 5,470
3+	R 6,600

BASIC DENTISTRY INCLUDES fillings, root canal treatments, scaling & polishing, extractions, fissure sealants, dentures and repairs | Subject to prescribed cycles

FULL DENTURES — A 3 YEAR benefit cycle applies.

PARTIAL DENTURES — A 2 YEAR benefit cycle applies.

GP CONSULTATIONS, VISITS AND PROCEDURES

DOCTOR'S ROOMS OR HOME

	R 3,150
1	R 4,200
2+	R 5,250
3+	R 6,300

BENEFICIARY LIMIT R 3,150 PER ANNUM

EMERGENCY TREATMENT AND PROCEDURES

SUB–LIMIT R 1,180 PER FAMILY PER YEAR

THIS SUB–LIMIT IS INCLUDED WITH THE GP Consultations, Visits and Procedures limit.

INFERTILITY

ONLY PMB CONDITIONS

MEDICATION

PRESCRIBED, DISPENSED OR ACUTE

	R 1,700
1	R 2,900
2+	R 4,000
3+	R 5,300

SUB–LIMIT R 2,900 PER BENEFICIARY, PER YEAR

25% CO–PAYMENT voluntarily utilisation of an out-of-network pharmacy

25% CO–PAYMENT using out-of-formulary medication

INCLUDES ALTERNATIVE HEALTHCARE MEDICATION as prescribed and must be registered with the Medicines Control Council; injections and related materials.

Subject to Medicine Formularies and Exclusion Lists.

PRIMARY HEALTHCARE BENEFIT PROGRAMME

Condition specific benefits, sub limits and treatment plans apply.

Remind your pharmacist to include the appropriate ICD-10 diagnostic codes with all claims for this Programme.

Limited to listed conditions and number of incidents per beneficiary per year as outlined below: Stomach pain, heartburn, indigestion (including reflux), **2** | Acute gastroenteritis: - vomiting and diarrhoea, **2** | Upper and lower respiratory tract infections, **3** | Oral and topical candidiasis: - thrush/fungal or yeast infections, **2** | Helminthic infestation: - worms, **2** | Headache, **4** | Bacterial conjunctivitis: - eye infection, **2** | Urinary tract infection (acute uncomplicated cystitis), **1** | Urticarial: skin rashes, insect bites and stings, **2** | Treatment of wounds and/or infections of the skin/subcutaneous tissues (excl. post- operative wound care), **1**

CHRONIC MEDICATION

Subject to **Chronic Disease List (CDL)** and **Chronic Formulary** and **protocols apply.**

25% CO–PAYMENT for Chronic medication not on the Chronic Formulary

25% CO–PAYMENT for voluntarily utilisation of an out-of-network pharmacy

Chronic Medication for Depression, Gout, and GORD added to the chronic formulary

PAT: OVER–THE–COUNTER MEDICINE

LIMITED R 660 PER FAMILY, PER YEAR

SUB–LIMIT R 140 PER DAY

25% CO–PAYMENT for using out-of-formulary medication.

25% CO–PAYMENT for voluntarily utilisation of an out-of-network pharmacy

INCLUDED with prescribed, dispensed or acute medication limit.

Subject to Medicine Formularies and Exclusion Lists.

MENTAL HEALTH SUBSTANCE DEPENDENCY

CONSULTATIONS/VISITS AND PROCEDURES

INCLUDED with In-Patient benefit.

Subject to Scheme Network

Limited to PMB Conditions only

Scheme Rules and Protocols apply

Clinical motivation required for authorisation of continued consultations **AFTER FIRST 10 INITIAL ASSESSMENTS.**

HOSPITALISATION

SUBSTANCE DEPENDENCY Referral from an Employee Assistance Programme (EAP) or GP required

MENTAL HEALTH CONDITIONS Referral from specialist required

Subject to Scheme Network

PMB conditions and protocols apply.

OPTICAL

FRAMES/LENSES/CONTACT LENSES

R 6,300 PER FAMILY Subject to prescribed cycles.

SUB–LIMIT R 2,100 PER BENEFICIARY, PER YEAR

OPHTHALMOLOGIST VISIT subject to referral from Optometrist or GP

Exclusions apply, including but not limited to repairs.

FRAMES LENSES — A 2 YEAR benefit cycle applies.

SPECTACLE LENSES AND CONTACT LENSES CANNOT BE OBTAINED SIMULTANEOUSLY

FRAMES

FRAMES R 810 LIMIT PER BENEFICIARY

FRAMES LENSES — A 2 YEAR benefit cycle applies.

OPTICAL

EYE TESTS

LIMITED ONE CONSULTATION PER BENEFICIARY PER ANNUM

Subject to family limit

LENSES

WHITE LENSES:	PHOTOCHROMIC LENSES:	FIXED OR GRADIENT TINTS UP TO 35%
100% of the lower cost or Optical Assistant Tariff.	100% of the lower cost or Optical-Assistant Tariff up to a maximum of R 370 per pair Subject to a prescription of +0.50/-0.50 and above.	100% of the lower cost or Optical Association Tariff.

FRAMES LENSES — A 2 YEAR benefit cycle applies.

PATHOLOGY

OUT–OF–HOSPITAL

INCLUDED with Specialist Benefit.

Subject to Scheme Network

IN–HOSPITAL

R 4,300 PER FAMILY PER YEAR

INCLUDED with In-Patient benefit

Subject to Scheme Network

PHYSIOTHERAPY

OUT–OF–HOSPITAL

Clinical motivation required for authorisation of continued consultations after first two visits.

INCLUDED with Specialist Benefit.

Limited to PMB Conditions only

Subject to Scheme Network

IN–HOSPITAL

Clinical motivation required for authorisation of continued consultations after first two visits.

R 1,950 PER FAMILY PER YEAR

INCLUDED with Specialist Benefit.

Subject to Scheme Network

PROSTHESES

INTERNAL

R 25,100 PER FAMILY, PER YEAR Included with In-Patient benefit.

Subject to the submission of a **clinical motivation** and costings for pre-authorisation by the Scheme.

The Scheme reserves the right to purchase the appliance on behalf of the member and the purchase may be billed against the member's benefit.

EXTERNAL (INCLUDING ARTIFICIAL EYES AND LIMBS)

R 13,150 PER FAMILY, PER YEAR

Subject to the submission of a **clinical motivation** and costings for pre-authorisation by the Scheme.

The Scheme reserves the right to purchase the appliance on behalf of the member and the purchase may be billed against the member's benefit.

RADIOLOGY RADIOGRAPHY

GENERAL (IN AND OUT–OF–HOSPITAL)

R 2,300 PER FAMILY, PER YEAR

INCLUDES two ultrasounds, per pregnancy

SPECIALISED (IN AND OUT–OF–HOSPITAL)

R 8,500 INCLUDED WITH IN-PATIENT BENEFIT

Limited to PMB Protocols only.

REMEDIAL THERAPY

OCCUPATIONAL, SPEECH THERAPY, AUDIOLOGY & DIETICIANS

SUBJECT TO R 2,110 PER FAMILY, PER YEAR

INCLUDED with Specialist benefit for In- or Out-of-hospital treatment.

Subject to GP Referral

SPECIALIST CONSULTATIONS, VISITS AND PROCEDURES

OUT–OF–HOSPITAL

	R 3,800
1	R 5,700
2+	R 7,600
3+	R 9,500

PER FAMILY, PER YEAR.

BENEFICIARY LIMIT R 4,600 PER YEAR

Subject to GP Referral

IN–HOSPITAL

INCLUDED with In-Patient benefit

HOSPITALISATION

IN–PATIENT

R 750,000 PER FAMILY PER YEAR

Subject to pre-authorisation.

Scheme Rules and Protocols apply

Subject to Scheme Network

"Take Home" medication limited to 7 days' supply

MATERNITY

CAESAREAN SECTION R 24,400 PER FAMILY, PER YEAR

NORMAL DELIVERY R 13,950 PER FAMILY, PER YEAR

ABORTION THREATENED	ABORTION INCOMPLETE	ABORTION INEVITABLE	ABORTION VOLUNTARY
R 5,900	R 16,550	R 16,550	R 4,650
PER FAMILY, PER YEAR	PER FAMILY, PER YEAR	PER FAMILY, PER YEAR	PER FAMILY, PER YEAR

ALTERNATIVES TO HOSPITALISATION

Private nursing, Frail care, Hospice, Step–down facility

INCLUDED with In-Patient benefit

BLOOD TRANSFUSION SERVICES

INCLUDED with In-Patient benefit

RENAL DIALYSIS

INCLUDED with In-Patient benefit

Subject to State Hospitals

PMB ONLY

ORGAN TRANSPLANT

Scheme Rules and treatment plans apply

Pre–Authorisation required

PMB Conditions only

OUT–OF–HOSPITAL Medication to be obtained from Scheme Networks.

IN–HOSPITAL Included with In-Patient Benefit. Subject to Scheme Networks.

ONCOLOGY

PMB Conditions only

Subject to Pre–Authorisation

OUT–OF–HOSPITAL Non-PMB subject to R 200,000 Subject to Overall Annual Limit and Scheme Networks.

IN–HOSPITAL Subject to Overall Annual Limit and Scheme Networks. Included with In-Patient benefit and subject to Scheme Networks.

OVERALL ANNUAL LIMIT - **R 750,000 PER FAMILY, PER YEAR.**

OPTION B BENEFITS

ALTERNATIVE HEALTH CARE

PODIATRIST, HOMEOPATH, NATUROPATH, CHIROPRACTOR

INCLUDED with GP and Specialist consultations and visits limit.

Practitioners to be registered with the **Health Professions Council of SA** or **Allied Health Professionals Council of South Africa.**

PFPA = R3,200

AMBULANCE SERVICES

ROAD AND AIR

Preferred Service Provider only: Netcare 911

UNLIMITED FOR VOLUNTARY USE OF A Non–DSP.

Co–Payment rule for voluntary use of a Non–DSP.

Scheme Members to be held liable for the full cost of transportation for non–medically justifiable cases.

APPLIANCES

MEDICAL AND SURGICAL

R 5,850 PER FAMILY PER YEAR

Subject to the submission of a **clinical motivation** with correct Tariff codes and costing for pre-authorisation by the Scheme.

The Scheme (or contracted managed care company on behalf of the Scheme) may from time to time contract with or pilot with or credential specific provider groups (networks) or centres of excellence or supplier groups as determined by the Scheme in order to ensure cost effective and appropriate care.

Beneficiaries are entitled to benefits from contracted networks appointed as the Scheme's DSP for PMB benefits and other benefits.

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.

Limits and cycles as per the Scheme's list of approved appliances apply

DENTISTRY

BASIC

	R 7,050
1	R 8,100
2+	R 9,400
3+	R 10,600

BASIC DENTISTRY INCLUDES Fillings, root canal treatments, scaling & polishing, extractions, fissure sealants, dentures and repairs | Subject to prescribed cycles

FULL DENTURES — A 3 YEAR benefit cycle applies.

PARTIAL DENTURES — A 2 YEAR benefit cycle applies.

ADVANCED DENTISTRY

Clinical motivation required for pre–authorisation from Scheme.

Orthodontics, crown and bridge work or any procedure that requires anaesthetics. Hospitalisation costs for removal of wisdom teeth or treatment for children under the age of 7 paid from the hospitalisation benefit. Dental procedure costs paid from dentistry benefit

EXCLUSIONS

Cosmetic dentistry such as veneers and implants is excluded

GP AND SPECIALIST CONSULTATIONS AND VISITS

ROOMS OR HOME

	R 3,700
1	R 6,000
2+	R 8,150
3+	R 10,150

BENEFICIARY LIMIT R 6,000 PER YEAR

Subject to Scheme networks and the appointment of a family practitioner.

GP AND SPECIALIST PROCEDURES AND TESTS

ROOMS OR HOME

R 7,710 PER FAMILY, PER YEAR

Subject to Scheme networks and the appointment of a family practitioner

INFERTILITY

ONLY PMB CONDITIONS

PMB Protocols Apply

MEDICATION

PRESCRIBED, DISPENSED OR ACUTE

	R 3,300
1	R 4,350
2+	R 6,650
3+	R 8,750

SUB–LIMIT R 4,350 PER BENEFICIARY, PER YEAR

25% CO–PAYMENT for voluntarily utilisation of an out-of-network pharmacy

25% CO–PAYMENT for using out-of-formulary medication

INCLUDES ALTERNATIVE HEALTHCARE MEDICATION as prescribed and must be registered with the Medicines Control Council; injections and related materials.

Subject to Medicine Formularies and Exclusion Lists.

PRIMARY HEALTHCARE BENEFIT PROGRAMME

Condition specific benefits, sub limits and treatment plans apply.

Remind your pharmacist to include the appropriate ICD-10 diagnostic codes with all claims for this Programme.

Limited to listed conditions and number of incidents per beneficiary per year as outlined below: Stomach pain, heartburn, indigestion (including reflux), **3** | Acute gastroenteritis: - vomiting and diarrhoea, **3** | Upper and lower respiratory tract infections, **4** | Oral and topical candidiasis: - thrush/fungal or yeast infections, **3** | Helminthic infestation: - worms, **2** | Headache, **6** | Bacterial conjunctivitis: - eye infection, **2** | Urinary tract infection (acute uncomplicated cystitis), **1** | Urticarial: skin rashes, insect bites and stings, **2** | Treatment of wounds and/or infections of the skin/subcutaneous tissues (excl. post- operative wound care), **2**

CHRONIC MEDICATION

Subject to **Chronic Disease List (CDL)** and **Chronic Formulary** and **protocols apply.**

Chronic Medication for Gout, GORD, Depression and Menopause added to the chronic formulary

25% CO–PAYMENT for Chronic medication not on the Chronic Formulary

25% CO–PAYMENT for voluntarily utilisation of an out-of-network pharmacy

PAT: OVER–THE–COUNTER MEDICINE

LIMITED R 1,400 PER FAMILY, PER YEAR

SUB–LIMIT R 180 PER DAY

25% CO–PAYMENT for using out-of-formulary medication

25% CO–PAYMENT for voluntarily utilisation of an out-of-network pharmacy

Subject to Medicine Formularies and Exclusion Lists. Included with prescribed, dispensed or acute medication limit.

Subject to Scheme Network

MENTAL HEALTH SUBSTANCE DEPENDENCY

CONSULTATIONS/VISITS AND PROCEDURES.

INCLUDED with In-Patient benefit

Clinical motivation required for authorisation of continued consultations **AFTER FIRST 10 INITIAL ASSESSMENTS.**

Subject to Scheme Network

Scheme Rules and PMB Protocols apply

HOSPITALISATION

SUBSTANCE DEPENDENCY Referral from an Employee Assistance Programme (EAP) or GP required

MENTAL HEALTH CONDITIONS Referral from specialist required

Subject to Scheme Network

Scheme Rules and PMB Protocols apply

OPTICAL

FRAMES/LENSES/CONTACT LENSES

R 8,450 PER FAMILY Subject to prescribed cycles.

SUB–LIMIT R 3,150 PER BENEFICIARY, PER YEAR

OPHTHALMOLOGIST CONSULTATION subject to referral from Optometrist or GP

Exclusions apply, including but not limited to repairs.

FRAMES LENSES — A 2 YEAR benefit cycle applies.

SPECTACLE LENSES AND CONTACT LENSES CANNOT BE OBTAINED SIMULTANEOUSLY

OPTICAL

FRAMES

FRAMES R 1,050 LIMIT PER BENEFICIARY

FRAMES LENSES — A 2 YEAR benefit cycle applies

LENSES

WHITE LENSES:	PHOTOCHROMIC LENSES:	FIXED OR GRADIENT TINTS:
100% of the lower cost or Optical Assistant Tariff.	100% of the lower cost or Scheme Tariff up to a maximum of R 370 per pair Subject to a prescription of +0.50/-0.50 and above.	100% of the lower cost or Optical Association Tariff.

FRAMES LENSES — A 2 YEAR benefit cycle applies

CONTACT LENSES

Contact lenses with a prescription reading of –0.75 or +1.00 and above: 100% of the lower of costs or Optical Assistant Tariff up to a maximum of **R 2,350** per beneficiary

CONTACT LENSES — A 2 YEAR benefit cycle applies

EYE TESTS

ONE EYE TEST PER BENEFICIARY, PER ANNUM AT OPTICAL ASSISTANT'S TARIFF

Subject to family limit

PATHOLOGY

IN–AND–OUT–OF–HOSPITAL

R 8,700 PER FAMILY PER YEAR

Subject to Scheme Network

PHYSIOTHERAPY

IN–AND–OUT–OF–HOSPITAL

R 4,130 PER FAMILY PER YEAR

SUB–LIMIT R 1,690 PER BENEFICIARY, PER YEAR

Clinical motivation required for authorisation of continued consultations after first two visits.

Subject to Scheme Network

PROSTHESES

INTERNAL

R 26,100 PER FAMILY PER YEAR Included with In-Patient benefit.

Subject to the submission of a **clinical motivation** and costings for pre-authorisation by the Scheme.

The Scheme reserves the right to purchase the appliance on behalf of the member and the purchase may be billed against the member's benefit.

EXTERNAL (INCLUDING ARTIFICIAL EYES AND LIMBS)

R 15,350 PER FAMILY PER YEAR Included with In-Patient benefit.

Subject to the submission of a **clinical motivation** and costings for pre-authorisation by the Scheme.

The Scheme reserves the right to purchase the appliance on behalf of the member and the purchase may be billed against the member's benefit.

RADIOLOGY RADIOGRAPHY

GENERAL (IN AND OUT–OF–HOSPITAL)

R 8,700 PER FAMILY, PER YEAR

SPECIALISED (IN AND OUT–OF–HOSPITAL)

R 13,100 PER FAMILY PER YEAR MRI/CAT or similar Scans limited

Subject to pre-authorisation from the Scheme

Limited to 2 scans per family per year.

REMEDIAL THERAPY

OCCUPATIONAL, SPEECH THERAPY, AUDIOLOGY & DIETICIANS

SUB–LIMIT R 4,350 PER FAMILY, PER YEAR

In–and–Out of Hospital

Subject to GP Referral

HOSPITALISATION

IN–PATIENT

R 1,500,000 PER FAMILY, PER YEAR

Subject to Scheme Network

Subject to pre–authorisation and registration with Clinical Disease Management Programme for asthma, cardiovascular disease, diabetes, and cancer, where applicable. Scheme Networks for joint replacements, cardiac and abdominal surgery.

Scheme Rules and PMB Protocols apply

"Take Home" medication up to 7 days' supply

MATERNITY

CAESAREAN SECTION R 26,100 PER FAMILY, PER YEAR

NORMAL DELIVERY R 17,400 PER FAMILY, PER YEAR

ABORTION THREATENED	ABORTION INCOMPLETE	ABORTION INEVITABLE	ABORTION VOLUNTARY
R 6,400	R 17,750	R 17,750	R 4,950
PER FAMILY, PER YEAR	PER FAMILY, PER YEAR	PER FAMILY, PER YEAR	PER FAMILY, PER YEAR

ALTERNATIVES TO HOSPITALISATION

Private nursing, Frail Care, Hospice, Step down Facilities

INCLUDED with In-Patient benefit

BLOOD TRANSFUSION SERVICES

INCLUDED with In-Patient benefit

RENAL DIALYSIS

INCLUDED with In-Patient benefit

Subject to Scheme Networks.

PMB ONLY

ORGAN TRANSPLANT

Scheme Rules and treatment plans apply

Pre–Authorisation required

PMB Conditions only

OUT–OF–HOSPITAL Subject to Overall Annual Limit and Scheme Networks.

IN–HOSPITAL Included with In-Patient benefit. Subject to Scheme Networks.

ONCOLOGY

Subject to pre-authorisation and registration with Disease Management Programme.

PMB Conditions only

OUT–OF–HOSPITAL NON-PMB SUBJECT TO R300,000 Subject to Overall Annual Limit and Scheme Networks.

IN–HOSPITAL Included with In-Patient benefit and subject to Scheme Networks

OVERALL ANNUAL LIMIT - **R 1,500,000 PER FAMILY, PER YEAR.**

COMPREHENSIVE PREVENTATIVE CARE BENEFITS AND EARLY DETECTION

Apart from ensuring our members do not find themselves in hospitals, the SAMWUMED Preventative Healthcare and early detection benefit provides members with an opportunity to take ownership of their own health as a means to better manage quality health outcomes which would ultimately result in lower medical aid premiums. Our amazing Preventative Healthcare Programmes includes the following screenings:

AGE	SCREENING TEST	CONDITIONS	2019
Adults aged 18 years and older	Blood Pressure		Up to one screening Pbpa
Adults	Type II diabetes	Adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg or BMI in the overweight or obese ranges.	Up to one screening Pbpa
25 to 64 years	Total Blood Cholesterol	Males between 25-64 years of age. Females between 45-64 years of age. Persons with a family history of familial hypercholesterolemia, heart attacks and cholesterol problems	Up to one screening Pbpa
11 To 24 years, 25 To 64 years, over 65 years old	Papanicolaou (Pap) test	Sexually active females or beginning at age 18. Chlamydia screen is recommended as part of this process. Teach clinical breast examination to >18	Up to one screening Pbpa within a 2 year cycle
	Chlamydia screening	This should be done concomitantly with Pap Smear.	Up to one screening Pbpa within a 2 year cycle
Child bearing age	Folic acid	Limit to 1 per month for the first 3 months of pregnancy	Up to 1 per month for the first 3 months of pregnancy
50 Years and older	Faecal occult blood test	Limited to one screening Pbpa	Up to one screening Pbpa
Over the age of 50 until the age of 70.	Mammogram	Breast Cancer Every 3 years* - females over the age of 50 until the age 70 If sister or mother had/ has breast cancer start annually at 40 years of age. Every 1-2 years - Females between 65-69 years of age. If normal previously: do every 2 years, if clinical examination normal and self-examination is done.	Up to one screening Pb every three years until the age of 70
Women older than 60 years and men older than 70 years	Bone density Test	Screening from 60 years for patients who are at risk of developing osteoporosis. Limited to one Pbpa	Up to one Pbpa
45 years to 69 years	Screening for prostate cancer	Limited to one Pbpa	Up to one Pbpa
All Ages	HIV		One test per member per annum
25 years to 65 years	Cervical cancer	Initiate screening at age 25 or at diagnosis of HIV positivity End screening at age 65 or after hysterectomy. End screening only after previous negative tests, never end if HIV positive. HPV tests to be repeated every 5 years if HIV negative or unknown and every 3 years if HIV positive. Cytology tests to be repeated every 3 years if HIV negative or unknown and annually if HIV positive	Repeat every 5 years if HIV negative, every 3 years if HIV positive
Less than 1 month old	TSH screening	Congenital hyperthyroidism	Once-off for hyperthyroidism in new-borns
2 to 64 years, over 65 years old	Pneumococcal vaccine	Limit to one vaccination per beneficiary over 65 and beneficiaries aged 2-64 who are at risk of serious pneumococcal disease per lifetime.	One vaccination per beneficiary per lifetime
50 – 75 years old	Colorectal cancer	Annual high-sensitivity faecal occult blood screening for members aged 50-75	Up to one screening Pbpa
Age 65 for women Age 70 for men	Osteoporosis	Initiate screening age 65 for woman and 70 for men with routine follow-ups every 18-24 months	Routine follow-ups every 18-24 months
Adults from age 20	Cholesterol	Full lipogram for all adults at least once from age 20 and annually for high risk members.	Once per annum for high risk members

* Pbpa = Per beneficiary per annum

(CDL) THE CHRONIC DISEASE LIST

SPECIFIES MEDICATION AND TREATMENT FOR THE 26 CHRONIC CONDITIONS THAT ARE COVERED UNDER THE PMBs:

- Addison's Disease
- Asthma
- Bronchiectasis
- Cardiac Failure
- Cardiomyopathy
- Chronic Obstructive Pulmonary Disorder
- Chronic Renal Disease
- Coronary Artery Disease
- Crohn's Disease
- Diabetes Insipidus
- Diabetes Mellitus Types 1 & 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- HIV/Aids
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple Sclerosis
- Parkinson's Disease
- Rheumatoid Arthritis
- Schizophrenia
- Systemic Lupus Erythematosus
- Ulcerative Colitis
- Bipolar Mood Disorder

IF YOU HAVE ANY QUESTIONS PLEASE CONTACT OUR CONTACT CENTRE ON 0860 104 117