WCMAS

Our members Our passion

Witbank Coalfields Medical Aid Scheme

2023 COMPREHENSIVE OPTION

HOSPITALISATION

Hospital accommodation	Paid at 100% Negotiated Rate in general ward and specialised units at a DSP hospital. Subject to pre-authorisation
GP and Specialist in hospital	Unlimited. Paid at 100% of the Scheme rate except for PMB's which are paid at cost
Medication, material and equipment	Paid at 100% of Scheme rate
Medication in hospital	Paid at 100% of Scheme rate
TTO's *(To Take Out Medication)*	Up to 30 days' supply paid at 100% SEP plus a dispensing fee
MRI, CT and PET scans	Paid at 100% of Scheme rate limited to R33 040 pbpa
Xrays and Ultrasounds	Paid at 100% of Scheme rate
Pathology in hospital	Paid at 100% of Scheme rate. Allergy test limited to R4 550 pbpa
Maternity Programme *(subject to registration on the maternity programme before the third trimester of pregnancy)*	• 1 Post natal visit • Pre-natal visits: 12 visits paid at 100% Scheme rate from risk pool, thereafter paid from MSA • Selected pre-natal pathology tests paid at 100% Scheme rate • 3 x 2D Ultrasounds per pregnancy. • 4D scans from MSA • Vitamins: R340 per month payable from risk • Maternity bag for baby and mom subject to registration on programme
Oncology	Unlimited subject to pre-authorisation and application of Icon Core protocols. Paid at 100% of Scheme rate, DSP network applicable
Physiotherapy in hospital	Post-operative physiotherapy out of hospital within 60 days of surgery limited to R3 310 pbpa and subject to pre-authorisation
Psychiatric admissions	Up to 35 days per beneficiary per annum in hospital paid at 100% negotiated rate at a DSP hospital. Subject to pre-authorisation
Private Nursing	Limited to R980 pd further limited to 60 days pbpa. Overall limit R58 710 pbpa
Frail Care	Limited to R160 pbpd . Overall limit of R58 710 pbpa
Hospice in hospital care	PMB's unlimited. Non-PMB in hospital limited to R1 730 pbpd
Hospice home visits	PMB's unlimited. Non-PMB limited to R540 pbpd
Internal prosthesis/appliances	Paid at 100% of Scheme rate and subject to an annual combined overall limit of R84 560. Subject to pre-authorisation
Cochlear Implants	Limited to R158 550 pb every 5 years. Subject to clinical protocols
Narcotism, Alcoholism and Drugs	Up to 30 days per beneficiary per annum. Paid 100% of Scheme rate
Organ transplants	Paid at 100% of Scheme rate and limited to R114 630 pbpa unless a PMB condition. Subject to pre-authorisation
Chronic Renal Dialysis	Paid at 100% of Scheme rate limited to R92 970 pbpa unless a PMB condition
Ambulance and emergency evacuation	Paid at negotiated rate or 100% of Scheme rate

DAY-TO-DAY BENEFITS

MSA LIMITED TO A MAXIMUM OF 25% OF ANNUAL CONTRIBUTIONS	
GP Consultations	Paid at 100% of Scheme rate from MSA
Specialist Consultations	Paid at 100% of Scheme rate from MSA Paediatric visits only paid in respect of beneficiaries younger than 16 years
Optometric Services	Paid at 100% of Scheme rate from MSA
Excimer laser/lasik procedure	Paid at 100% of Scheme rate limited to R14 890 per beneficiary per eye Subject to pre-authorisation and protocols
Acute and Over the Counter Medication	Paid at 100% of SEP plus a dispensing fee from MSA
Chronic Medicines	Paid at 100% of SEP plus a dispensing fee MMAP, Formulary and Reference Pricing is applied A 15% co-payment will apply to medicine obtained from a non-PPO provider
DENTAL SERVICES	
Preventative Treatments	R770 pbpa selected preventative dentistry will be allowed from the Risk Pool
Basic Dentistry	Paid at 100% of Scheme rate from MSA
Surgical Procedures	In doctors room 100% at Scheme rate from MSA In hospital e.g. removal of impacted teeth, implants, periodontics etc., paid at Scheme rate from risk. Subject to pre-authorisation Non-surgical procedures paid at 100% of Scheme rate from MSA
Orthodontics	Initial fee paid at 100% of Scheme rate up to R6 590 per treatment plan Thereafter payable at 100% of Scheme rate from MSA. Subject to pre-authorisation
RADIOLOGY	
Radiographers *Out of hospital*	Limited to R1 320 per beneficiary per year
Scans *MRI, CAT & PET*	Non-PMB's limited to R33 040 per beneficiary per year. Pre-authorisation required

MEDICAL APPLIANCES & PROSTHESIS

Internal Prostheses/Appliances	Limited to R84 560 per case unless a PMB, which is payable at cost. Subject to pre-authorisation
Hearing Aids *(appliance and repairs excluding batteries)*	Limited to R24 310 per ear every 3 years Repairs limited to R2 070 pbpa
Wheelchairs	Limited to R7 830 per beneficiary every 2 years
Artificial Eyes/Limbs	Limited to R52 850 per beneficiary every 2 years subject to clinical motivation
Breast Prostheses and Bras	Limited to R5 290 per beneficiary per year with a sub-limit of R4 230 applicable to bras
Orthopaedic Braces and Other Similar Aids	Limited to R14 320 per beneficiary per year. Subject to being prescribed by medical practitioner
Insulin Pumps	Limited to R61 310 per beneficiary every 5 years subject to clinical protocols

OTHER MEDICAL / SURGICAL APPLIANCES /AIDS

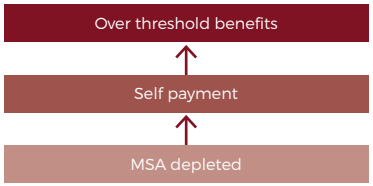
Oxygen and home ventilation	Rental paid at R1 200 p.b.p.m and subject to pre-authorisation
CPAP *(including mask)*	Limited to R12 170 per beneficiary every 5 years
Nebulizer	Limited to R730 per family every 5 years if an applicable condition is registered, otherwise payable from MSA
Blood Pressure Monitors	Limited to R800 per family every 5 years if an applicable condition is registered, otherwise payable from MSA
Glucose Monitors	Limited to R590 per family every 2 years if an applicable condition is registered, otherwise payable from MSA
AUXILIARY SERVICES	
• **Audiology** • **Dietician** • **Occupational therapy** • **Speech therapy** • **Chiropody** • **Chiropractor**	Paid at 100% of Scheme rate from MSA
Mental Health	• Consultations paid with a psychiatrist or psychologist paid at 100% of Scheme rate from MSA • Unlimited telephonic consultations via our emotional wellness programme

WELLNESS BENEFITS

YOUR WELLNESS BENEFITS INCLUDE ACTIVE NURSE BASED DISEASE MANAGEMENT PROGRAMMES	
Contraceptives	Paid from MSA at 100% Scheme Rate
Pre-Screenings *(one screening test pbpa)*	**One GP consultation per beneficiary per annum paid at 100% of Scheme Rate from risk benefit. Subject to protocols and correct ICD10 coding** FEMALES: • Mammogram if older than 45 years or if at risk for breast cancer • Bone densitometry test if 50 years' or older • Pap smear • Blood pressure exam • Cholesterol test • Glucose test • HIV test MALES: • PSA blood test if older than 45 years old or if at risk for prostate cancer • Colorectal test if between 50 and 75 years old or if at risk for colon cancer • Glaucoma test • Cystoscopy test • Blood pressure test • Cholesterol test • Glucose test • HIV test
Flu Vaccines	Payable at 100% SEP plus a dispensing fee
360° Wellness Check	Limited to R230 pbpa includes BP, Cholesterol, Glucose test, BMI
Childhood Vaccinations	Ages 0 – 1 limited to R4 900 pb Ages 1 – 2 limited to R490 pb Ages 3 – 5 limited to R190 pb Age 6 – 12 limited to R190 pb
Emotional Wellness	Unlimited telephonic consultations

BENEFITS AFTER MSA LIMIT HAS BEEN DEPLETED AND THRESHOLD(SELFPAYMENT GAP) REACHED	Payable from Risk *(limits apply only after self-payment/threshold has been reached)*

MSA MEMBER RISK



SELF PAYMENT GAP = 50% OF ANNUAL MSA CONTRIBUTIONS, ACCUMULATING AT 100% SCHEME RATE

Visits to General Practitioner Limits apply after threshold	Paid 100% at Scheme rate and limited as follows:			
	M-	15 visits	M+3	30 visits
	M+1	21 visits	M4+	34 visits
	M+2	26 visits		
Visits to Specialist Limits apply after threshold	Paid 100% at Scheme rate and limited as follows:			
	M-	10 visits		
	M+	12 visits		
Dentistry Limits apply after threshold	Paid 100% at Scheme rate and limited as follows:			
	M-	R7 380	M+3	R15 540
	M+1	R10 190	M4+	R16 560
	M+2	R14 650		
Optical Limits apply after threshold 1 eye test pbpa. after threshold	Paid 100% at Scheme rate and limited as follows:			
	Eye test	Scheme rate	Contact lenses	R2 800
	Frame	R1 290	(Sunglasses excluded from benefits)	
	Lenses	R2 800		
Acute Medicines *(must be prescribed)* Limits apply after threshold	Paid 100% at Scheme rate and limited as follows:			
	M-	R7 380	M+3	R15 540
	M+1	R10 190	M4+	R16 560
	M+2	R14 650		
Audiology	Paid 100% of Scheme rate and limited to R4 270 pbpa			
Chiropodist/Podiatrists	Paid 100% of Scheme rate and limited to R4 270 pbpa			
Chiropractor	Paid 100% of Scheme rate and limited to R4 270 pbpa			
Clinical Psychology	Paid 100% of Scheme rate and limited to R4 270 pbpa			
Dieticians	Paid 100% of Scheme rate and limited to R1 100 pbpa			
Homeopathic Medication	Paid 100% of Scheme rate and limited to R8 870 pbpa			
Medical Appliances	Paid 100% of Scheme rate and limited to R4 610 pbpa			
Occupational Therapy	Paid 100% of Scheme rate and limited to R4 270 pbpa			
Speech Therapy	Paid 100% of Scheme rate and limited to R4 270 pbpa			
Physiotherapy/Bio-Kinetics	Paid 100% at Scheme rate and limited as follows:			
	M	R4 270 pbpa	M+	R8 530 pbpa

CONTRIBUTIONS

INCOME	MAIN MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 – R2000	R2 428	R2 428	R644
R2001 – R3000	R2 780	R2 780	R644
R3001 – R5 000	R3 455	R3 455	R644
R5001 – R8000	R3 782	R3 782	R644
R8001 – R10 000	R3 931	R3 931	R644
R10 001 +	R4 315	R4 315	R644

MEMBERSHIP

WCMAS is a restricted Scheme providing medical aid cover to participating employers. Application forms are available from HR/time offices.

WHO IS ELIGIBLE FOR MEMBERSHIP?

Subject to approval by the Board of Trustees, members may apply to register the following as their dependants:

- the spouse or partner of a member who is not a member or registered dependant of another medical scheme irrespective of the gender of either party,
- a child, stepchild or legally adopted child of a member under the age of 21 or a child who has attained the age of 21 years but not yet 26, who is a student at an institution recognised by the Board of Trustees. Should a member elect to cancel the registration of a child between the ages of 21 and 25 years as a dependant of the fund, such child will not be eligible for re-registration as a dependant on the fund at a later date,
- a dependent child who due to a mental or physical disability, remains dependent upon the member after the age of 21.

REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

A member may apply for the registration of his or her dependants at the time that he/she applies for membership or as follows:

- A member must register a newborn or newly adopted child within 30 days of the date of birth or adoption of the child, and increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption,
- A member who marries subsequent to joining the Scheme must within 30 days of such marriage register his or her spouse as a dependant. Increased contributions shall then be due as from the date of marriage and benefits will accrue as from the date of marriage.
- Students that are accepted as child dependants shall be recognised as such for periods of not more than twelve (12) months at a time.
- When a dependant ceases to be eligible to be a dependant, he shall no longer be deemed to be registered as such for the purposes of the Scheme Rules or entitled to receive any benefits, regardless of whether notice has been given.
- Members shall complete and submit the application forms required by the Scheme together with satisfactory evidence to the employer who in turn will submit same to the Scheme.
- The Scheme may require an applicant to provide the Scheme with a medical report in respect of any proposed beneficiary in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made.
- No person may be a member of more than one medical scheme or a dependant of more than one member of a particular scheme. The membership will terminate if he or she becomes a member or a dependant of a member of another medical scheme.
- Maximum benefits are allocated in proportion (pro-rata) to the period of membership calculated from date of admission to the end of the financial year.

MEMBERSHIP CARDS

Every member shall be furnished with a membership card containing membership number, date of joining, identity number/s and names of all registered dependants.

A member must inform the Scheme within 30 days of the occurrence of any event which results in any one of his or her dependants no longer satisfying the conditions in terms of which he may be a dependant e.g. divorce or child dependant full time employed or married (this is not the complete list). The Scheme does not provide cover for divorced spouses even if the divorce settlement decrees that the member is liable for cover.

PERSONAL INFORMATION

We support the POPI Act (Protection of Personal Information Act) which is structured to protect the individual's right to privacy. In light of the above we have in our call centre implemented security checks which must be adhered to before information may be provided. It is important to make sure that all your membership details are correctly **updated**, e.g. contact numbers, e-mail addresses, postal addresses and banking details. Please contact your Employer's HR Department or should you be a CAWM member our membership department on 013 656 1407.

The member undertakes to **update** his / her personal information as soon as reasonably practicable after changes have occurred. This will ensure that the records of WCMAS contain information that is accurate and up to date.

The personal information of the member and his / her dependants will be **retained** as part of the records of WCMAS for as long as required by the Medical Schemes Act, the Scheme Rules, the South African Revenue Service and any other applicable legislation and to provide medical scheme services to the member and his / her dependants.

YOUR MONTHLY STATEMENTS, TAX CERTIFICATES, AND OTHERS

COMMUNICATION VIA E-MAIL OR POST

Electronic communication via e-mail is the preferred way of communication. Members with e-mail addresses will receive - mail statements and correspondence only unless the member has requested **WCMAS** to send a hardcopy to the member's postal address as well. Members not receiving their statements via e-mail who wishes to receive it electronically must ensure that **WCMAS** has their correct e-mail address. Changes to their e-mail addresses and any queries regarding the process can be e-mailed to **wcmas@wcmas.co.za**. The Scheme encourages members to use this cost saving and reliable facility.

BANKING DETAILS

For security reasons no cheques are issued to members. Members must ensure that the Scheme has correct banking details for refunds/payments due to them. The following documentation is required: Copy of ID, bank statement (stamped) or a bank letter (stamped and signed) not older than three months or a cancelled cheque and the EFT form.

CHANGE OF BANKING AND ADDRESS DETAILS OF MEMBER

A member must notify the Scheme within 30 days of any change of banking, address details (including e-mail) and contact numbers. The Scheme shall not be held liable if a member's rights are prejudiced or forfeited as a result of the member's neglecting to comply with the requirements of this Rule.

INFORMATION AT YOUR FINGERTIPS

Members are again encouraged to visit the Scheme's webpage at **www.wcmas.co.za**

A once off registration is required to enable you to fully make use of our website. Once you have registered and logged onto our website you will have access to the following information:

- **Frequently asked questions**
- Confirmation of membership 24 hours a day, 7 days a week
- Request a **new membership card**
- View registered **dependants** linked to your membership
- See if any **current suspensions** exist on your membership
- View any **chronic diseases** registered
- View and send a message to WCMAS to **update your contact details**
- Print a **membership certificate**
- Print your latest **tax certificate**
- View any **new medical claims** received by WCMAS pending payment
- View **medical claim statements** for the past 6 months.
- View your MSA balance
- Find our **contact details**, including a street map to easily locate our offices
- See who our **Board of Trustee members** are, and have access to the **WCMAS Annual Reports**
- Read our monthly **newsletters** to members and medical practices
- Find out about the scheme's **Benefits and Rules** for members, and what our subscription costs are and
- List of DSPs

PREVENTATIVE CARE AND WELLNESS PROGRAMME

WCMAS offers a preventative care and wellness programme for early detection of health risks. Benefits are reflected under the Additional Wellness benefits column. Your wellness benefit includes active nurse based disease management programmes.

CONTRIBUTIONS

Contributions are calculated on an employee's monthly basic rate of pay. It is collected monthly and paid by the employer by no later than the 3rd day of each month.

A WCMAS member's monthly contribution is based on his or her monthly income, pension (including income from investments, fixed deposits and retirement annuities); due on the day of the month or agreed pension payment run dates. Survival Certificates: It is compulsory for all WCMAS CAWM members to complete and return to the Scheme an annual survivor certificate before 31 July every year.

Members remain liable at all times for payment of contributions to the Scheme, irrespective of whether he/she receives financial assistance from the employer towards a subsidy.

LATE PAYMENTS

Where contributions or any other debt owing to the Scheme are not paid on the due date, the Scheme shall have the right to suspend all benefit until payments up to date.

WAITING PERIODS AND LATE JOINER PENALTIES

The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and **who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application** a general waiting period of up to 3 months and a condition-specific exclusion of up to 12 months.

Condition specific exclusions can also be applied to members who were members of a previous scheme for less than 2 years and general waiting periods to members who were on a previous medical scheme for more than 2 years.

The law also provides that a late joiner penalty may be imposed on a member or his/her adult dependant in certain circumstances when the applicant joins the scheme for the first time from the age of 35 years.

The late joiner penalty will depend on the number of uncovered years and is calculated as a percentage of the monthly contribution applicable to the late joiner.

EXAMPLE:

Member applied to join the Scheme on the 1st June 2011.

- He had previous medical cover 1971 – 1981 and again 1981 – 1990.
- Total monthly contribution = R2 500 of which R2 000 is risk and R500 is MSA.
- Member's age = 65 years old. Creditable coverage is 19 years (number of years covered by medical aid as an adult).

  65 years – (35 + 19) = 11 years not covered. Therefore, penalty band 5-14 years applies which = 25%. Member premium = Risk+MSA+Penalty. R2 500 + (25% x R2 000) = R3 000 contribution payable.

Penalty Bands	Maximum penalty
1 - 4 years	0.05 x contribution excluding MSA
5 - 14 years	0.25 x contribution excluding MSA
15 - 24 years	0.50 x contribution excluding MSA
25+ years	0.75 x contribution excluding MSA

MEDICAL AID SAVINGS ACCOUNT – MSA DAY TO DAY BENEFITS

The medical savings account is a member's own personal account and is used to pay for day to day medical expenses as long as a member has funds available. The medical savings account is in effect the member's own money and allows him/her to manage his/her own medical expenses without subsidising the everyday medical expenses of other members. 25% of a member's monthly contributions will be allocated to the medical savings account every month.

The savings account balance is provided upfront for the full financial year (1 January until 31 December) and is therefore reduced pro-rata should a member resign or should a dependant be registered or de-registered during the year. If a member resigns at e.g. the end of June, such member is only entitled to a MSA balance for six months. If a member has used the full MSA balance for twelve months, the member will be required to repay to the Scheme the portion he/she was not entitled to.

A credit balance in the MSA after resignation from the Scheme will be paid out after 4 months. In the event of a member joining another medical aid with a Medical Savings Account then the balance will be paid to the new medical aid. Should the member not rejoin a medical aid with a MSA then the refund will be paid to him/her.

EXAMPLE: 25% OF MONTHLY CONTRIBUTION X 12 MONTHS = R5,000

WHAT HAPPENS WHEN YOUR MEDICAL SAVINGS ACCOUNT IS EXHAUSTED?

When members have exhausted their medical savings account, all day to day expenses will be for the member's own account.

Medical expenses paid by the member must be submitted to the Scheme in order to be calculated towards the member's annual threshold. Once the annual threshold is reached the member will receive limited benefits paid from the Risk Pool account.

If the member has exhausted his MSA then the self-payment gap will be 50% of his annual MSA

EXAMPLE: MSA = R5,000 THEN THE SELF-PAYMENT GAP WILL BE R2,500

When the savings account maximum is reached, members must still submit claims in order that it accumulates towards thresholds and for tax purposes.

ABOVE THRESHOLD BENEFITS.

These are the benefits that become available after the MSA limit has been reached and the self-payment gap of medical expenses reached.

FULL LIST OF THE BENEFITS IS AVAILABLE ON PAGE 6 OF THE MEMBER'S GUIDE.

WHAT IS A THRESHOLD (SELF-PAYMENT GAP)

Annual thresholds provide for extended cover should a family experience significantly high or numerous day to day medical expenses. Annual threshold limits are equal to 50% of the annual MSA contribution. If a member's MSA is R5 000 the threshold will be R2 500 bringing the members self funding amount in respect of the threshold to R2 500. Medical expenses accumulated towards the annual threshold will be calculated at Scheme Rates or agreed tariffs. Once the medical expenses reach the threshold, the Scheme will again commence payment of the medical savings account benefits at the applicable benefit percentages and the annual limits from the risk pool.

IMPORTANT TO NOTE:

- After hour consultations or emergency room consultations are charged at higher rates than normal consultations and will have a negative impact on your savings account.
- It sometimes saves money to pay cash for optical and dental services and claim a refund from the Scheme.
- GP's can now confirm benefits available for consultations on the website 24/7 – **www.wcmas.co.za**

DESIGNATED SERVICE PROVIDER (DSP) AND MANAGED CARE PROGRAMMES

DSP hospitals charge fees at the Scheme Rates determined for Private Hospitals. Charges from non-DSP Hospitals in excess of the Scheme Rates are for the members own account, except in cases of emergency, involuntary admission and where the service is not available at a DSP.

WCMAS has DSP arrangements with Life Healthcare Hospitals, Netcare Hospitals, NHN and Mediclinic Hospitals.

Where the Scheme has DSP arrangements in place and the member makes use of a non-DSP, the member shall be liable for the difference between the Scheme Rate and the fee charged by a non-DSP.

The Scheme also has Universal Hospital Case Management, HIV, pre-authorisation and Chronic Disease Management and Oncology Managed Care Programs in place.

CO-PAYMENTS AND OTHER CHARGES TO MEMBERS

MEDICAL SERVICES IN EXCESS OF MEDICAL SCHEME RATES (NON-PMB)

Members must please note that more and more providers of medical services charge fees in excess of the Medical Scheme Rates. WCMAS only pays fees up to the Scheme Rates. Where the Scheme has paid the Scheme Rates directly to a supplier who has charged in excess of the Scheme Rates, the excess amount must be paid directly to such supplier by the member. The amount to be paid will appear **in bold** in the **"member to pay provider"** column on members' monthly remittance advices. It remains the responsibility of members who need to have operations to enquire beforehand from the relevant doctors whether they charge in excess of the Scheme Rates or not. If in excess, members need also to arrange settlement of the account directly with the suppliers of medical services.

Members are reminded that should a doctor or specialist use any disposable products during a procedure, the member will be liable for the cost. Disposable items are regarded as an exclusion from benefits. The Scheme will only consider conventional methods for procedures.

MEDICINE BENEFITS

CHRONIC MEDICINE BENEFITS

Chronic medicine benefits are Subject to Benefit Management Programme, MMAP and Reference Pricing and paid from the Risk Pool Account.

Non-PMB and non-CDL (85% benefit)	
PMB and 26 CDL conditions (100% benefit)	(PMB=prescribed minimum benefits) (CDL=Chronic Disease List)
Homeopathic medicine (1st R1 403 per family from Risk Pool, thereafter benefits from MSA)	

PRESCRIBED MEDICINE

Prescribed medicine must be prescribed, administered and / or dispensed by a practitioner legally entitled to do so.

Benefits are subject to managed care protocols and processes, the Scheme's medicine benefit management program, formulary and DSP's.

DISPENSING DOCTORS

Dispensing doctors are required to register at the Scheme for direct payment for medicine dispensed to members. Members will be liable for the account of medicine dispensed by a doctor not registered as a DSP and dispensing doctor at the Scheme.

EARLY REFILL ON MEDICATION IF OUT OF THE COUNTRY/OVER SA BORDERS

Members are reminded that should they be overseas or across the country borders for an extended period of time to request their early refill on chronic/acute medication at least 5 days before their departure. They may contact the Scheme directly with their request on **013 656 1407**.

GENERIC REFERENCE PRICING & MMAP

MMAP refers to the maximum medical aid price. MMAP is the maximum price that WCMAS will pay for specific categories of medicine for which generic products exist. Although some generic products may be priced above MMAP, there are always products available that are below generic reference price. Your pharmacist can assist you by dispensing a product below MMAP so that you can **avoid a co-payment**. To check for generic medication on the MediKredit website **www.medikredit.co.za** click on scheme protocols.

IN HOSPITAL AND PRE-AUTHORISATION TREATMENT

100% benefit from Risk Pool at Scheme Rates for Private Hospitals. Pre-authorisation must be obtained at the Scheme's Case Managers at Universal pre-authorisations.

Authorisation must be obtained at least 72 hours before hospitalisation except for emergency or involuntary admission.

Pre-authorisation can be obtained by one of the following:

- Print and complete the hospital authorisation form from our website – **www.wcmas.co.za**, and email to Universal **pre-authorisations at preauthorisation@universal.co.za**
- Phone Universal Hospital pre-authorisation on **0861 486 472**
- HIV Programme **diseasemanagement@universal.co.za**
- Oncology Programme **oncology@universal.co.za**

In hospital treatment benefits include the following:

- Ward fees
- Step-down
- Theatre fees
- Internal prosthesis (Limited to R59,655 pbpa.)
- Theatre and ward drugs
- ICU
- High Care
- Medical Appliances (e.g. back braces)
- Equipment
- Material

WHAT TO DO IN CASE OF AN EMERGENCY

- Contact **ER24** for ambulance on **084124**
- **ER24** call centre can also assist with medical advice
- Should Service Provider require proof of membership - can log onto the website 24/7 **www.wcmas.co.za** via theservice provider Portal, or the member may log onto the website via the member portal and follow the prompts.

PRESCRIBED MINIMUM BENEFITS (PMB)

Prescribed Minimum Benefits (PMBs) are defined in the Regulations to the Medical Schemes Act and must be provided to all beneficiaries of a medical scheme. The diagnosis, medical management and treatment of these benefits are paid according to specific treatment plans subject to therapeutic algorithms, protocols, formularies and DSP's. Should services for a PMB not be available at a DSP, arrangements will be made at another setting. Members must ensure that ICD10 codes are reflected on all accounts so that the correct allocations to relevant benefits can be made.

It is noted that some doctors charge exorbitant fees for PMB conditions and we could encourage members to first obtain a quotation before proceeding with the procedure.

List of chronic conditions (CDL) covered under PMB's:

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

Members must register chronic conditions on the Chronic Medication Management programme at SwiftAuth (MediKredit) who have a complete formulary of chronic medication.

MediKredit website detail is www.medikredit.co.za

WCMAS is using the SwiftAuth (MediKredit) system whereby doctors need to phone the **toll free number 0800 132 345** to register members chronic conditions. No application forms are needed. SwiftAuth (Medikredit) will require clinical information of patients and staff at WCMAS **will not** be able to assist practices or members with registrations. When receiving a prescription for medication from a doctor or after being discharged from hospital members can submit the prescription at any of our DSP pharmacies to avoid excessive co-payments.

If you require any information on the clinical entrance criteria, prescribed minimum benefits algorithms, medicine exclusions and tariffs codes and amounts, please refer to the WCMAS Call Centre at **013 656 1407**.

EXCLUSIONS

Unless otherwise provided for or decided by the BOT, with due regard to the prescribed minimum benefits, expenses incurred in connection with any of the following will not be paid by the Scheme:

- Costs of whatsoever nature incurred for treatment of sickness condition or injuries for which any other party is liable.
- Costs in respect of injuries arising from professional sport, speed contests and speed trials subject to PMB.
- Costs for operations, medicines, treatment and procedures for cosmetic purposes unless medically necessary.

- Holidays for recuperative purposes.
- Purchase of patent medicine, toiletries, beauty preparations, baby foods, household remedies and contraceptives and apparatus to prevent pregnancy.
- Costs for obesity, willfully self-inflicted injuries, infertility, artificial insemination, gold in dentures or as an alternative to non-precious metals in crowns.
- Charges for appointments which a member or dependant fails to keep.
- Costs for services rendered by persons not registered by a recognised professional body constituted in terms of an Act of Parliament.
- Services rendered whilst a waiting period or condition specific condition was excluded.
- Bandages, cotton wool, patented foods, tonics, slimming preparations, drugs advertised to the public.

FRAUD

FRAUD MAY COST YOU YOUR MEMBERSHIP OF THE MEDICAL SCHEME

The Board of Trustees would like to point out to members that a number of cases have been detected where members and their dependants have committed fraud against the Scheme. These members have been reported to the SAPS and their membership of the Scheme has been cancelled. Some members' employers terminated their employment due to them defrauding the medical scheme. The Scheme views fraud in a very serious light and would like to encourage members who have some concerns regarding fraud, whether committed by a member or a supplier of services, to contact the Manager of the Scheme, or the Board of Trustees, or the Disputes Committee or the Audit Committee.

REPORTING SUSPECTED FRAUD

Reporting suspected fraud committed by a member, managed care organisation, doctor, healthcare practitioner, medical scheme or employee to:

- WCMAS tip-off lines: share-call **0860 104 302**
- WCMAS's Principal Officer (call **013 656 1407**) or any Board of Trustee member.
- Council for Medical Schemes Tip off Anonymous Hotline using its Toll Free number **0800 867 426** or on their e-mail address **cms@tip-offs.com**

WCMAS offers a R3 000 reward where fraudulent medical cases are successfully investigated and prosecuted. All information will be treated strictly confidential.

Abuse of privileges, false claims, misrepresentation and non-disclosure of factual information.

The Board may 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 and relevant information. In such event he/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.

No person may be a member of more than one medical scheme or a dependant of more than one member of a particular scheme. The membership will terminate if he or she becomes a member or a dependant of a member of another medical scheme.

No person may claim or accept benefits in respect of himself/herself or any of his/her dependants from any medical scheme in relation to which he/she is not a member or dependant.

OTHER INFORMATION

MEDICAL CLAIMS REQUIREMENTS

The Scheme receives accounts from members which cannot be processed for payment due to incorrect or insufficient details.

To ensure that your claims are being paid correctly and timeously within 4 months after service date, you are requested to ensure that the following details are clearly indicated on your accounts:

- Medical aid number
- Member details
- ICD10 codes
- Patient details
- Service dates
- Service codes
- Diagnosis

REFUNDS & STALE CLAIMS

Should members first pay their accounts before submitting it to the Scheme for a refund, they must ensure that the account is fully specified and proof of payment is submitted together with the claim. In order to qualify for benefits, any claims must, unless otherwise arranged, be signed and certified as correct and must be submitted to the Scheme not later than the last day of the fourth (4th) month following the month in which the service was rendered. Any claims older than this will be for the member's own account.

SECTION 32 MSA

The rules of a medical scheme and any amendment thereof shall be binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming.

OVERSEAS TRAVEL

WCMAS is not an international medical scheme and members are advised to ensure adequate medical insurance is taken out to cover unforeseen medical expenses that may occur whilst travelling overseas. Should a member incur minor expenses (e.g. flu or tooth ache) then a fully specified, receipted account must be submitted to the Scheme for consideration of a refund at the **Scheme Rate** and at SA Currency. Visa tests will be paid from medical savings account.

DISPUTES

Members are encouraged to explore the Scheme's dispute resolution process prior to lodging any complaints with the CMS.

Disputes resolution at Scheme level:

- A complaint can be lodged in terms of the medical scheme rules to the Scheme Principal Officer in writing either via facsimile on **0866 277 795** or via e-mail to **wcmas@wcmas.co.za**
- Should the member's complaint warrant further investigation then the member may address the complaint to the Board of Trustees in writing either via facsimile **0866 277 795** or via e-mail to **wcmas@wcmas.co.za** and marked for the attention of the Chairperson
- Final submission can be sent to the Schemes Disputes Committee in writing either via facsimile **0866 277 795** and via e-mail at **wcmas@wcmas.co.za** and marked for the attention of the Disputes Committee

COUNCIL FOR MEDICAL SCHEMES

Private Bag X34
HATFIELD
0028

Share Call number: **0861 123 267**

www.medicalschemes.com

support@medicalschemes.com

complaints@medicalschemes.com

LEGEND

M	member
M+	member with dependants
pbpa	per beneficiary per annum
p.f.p.a	per family per annum
PMB	prescribed minimum benefits
Financial Year	1 January to 31st December
MSA	Medical Savings Account
DSP	Designated Service Provider
SR	Scheme Rates
PPO	Preferred provider pharmacies
CDL	Chronic Disease List
TTO	To take out i.e. medicines taken out of hospital when discharged
ADL	Additional Disease List as per Annexure L of the Scheme Rules

CONTACT

WCMAS
013 656 1407

WCMAS Facsimile
0866 277 795

Hospital Pre-Authorisation
0861 486 472

Disease Management Programme
0861 486 472

Chronic Medicine Registration
0800 132 345
chronic@medikredit.co.za

ER24 Ambulance
084 124

Oncology Programme
0861 486 472

Emotional Wellness Programme
0800 390 003

WCMAS Building
Corner OR Tambo & Susanna Street
PO Box 26, Emalahleni, 1035

WCMAS
Our members Our passion
Witbank Coalfields Medical Aid Scheme

wcmas@wcmas.co.za

S25°52'23.7" E29°14'23.6

www.wcmas.co.za

EMERGENCY MEDICAL CARE
ER24
084 124

THESE ARE THE ABBREVIATED BENEFITS
A copy of the Scheme Rules is available from the Scheme Office or on the Scheme website

SUBJECT TO CMS APPROVAL