



# MIDMAS OPTION



Members' Guide

2019



# IMPORTANT CONTACT NUMBERS

## WCMAS

013 656 1407

## WCMAS Facsimile

0866 277 795

## Hospital pre-authorisation

0861 486 472

## Disease Management Program

0861 486 472

## Chronic medicine SwiftAuth

0800 132 345

## ER24 Ambulance

084 124

## Oncology Program

0861 486 472

## WCMAS Building

Corner OR Tambo & Susanna Str,

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Web: [www.wcmas.co.za](http://www.wcmas.co.za)

## HOW TO FIND US

GPS Coordinates

**S25 ° 52'23.7" E29 ° 14'23.6**

These are the abbreviated benefits; a copy of the Scheme Rules is available from the Scheme Office or on the Scheme website.

Benefits are subject to approval by the CMS



# We cover our members all over SA

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## FIND US



You can use your smart device and search on your appropriate store for: WCMAS to find and download the App.

# Benefit Schedule

## HOSPITALISATION


<p>Hospital admissions to be pre-authorized. A 72 hour leeway for all direct admissions and all booked cases (pre-admissions) need to apply 72 hours prior to admission to assist with obtaining the required clinical supporting document.</p>		<p>Services rendered by Designated Service Providers. Where the Scheme has DSP arrangements in place and the member makes use of a non-DSP, the member shall be liable for a co-payment(s).</p> <p>Unlimited access to DSP Private Hospitals is covered at 100% of the Scheme rate except for PMB's paid at cost.</p>
<p>All other procedure accounts other than the hospital account</p>	<p>Paid at 100% of the Scheme rate except for PMB's which are paid at cost.</p>	
<p>Ward Fees – General, ICU, High Care</p>	<p>Paid at 100% of the Scheme rate except for PMB's which are paid at cost.</p>	
<p>Theatre Fees</p>	<p>Paid at 100% of the Scheme rate except for PMB's which are paid at cost.</p>	
<p>Medication, materials and equipment (only whilst in Hospital)</p>	<p>Paid at 100% of the Scheme rate except for PMB's which are paid at cost.</p>	
<p>Medication on discharge from hospital</p>	<p>Maximum of 7 days' supply (TTO's).</p>	
<p>Visits by GP and Specialist</p>	<p>Paid at 100% of the Scheme rate except for PMB's which are paid at cost.</p>	
<p>All Specialist Radiology including MRI. CT and PET scans</p>	<p>All Specialist Radiology including MRI, CT and PET scans – PMB's are paid at 100% of cost. Subject to pre-authorization. Non-PMB's limited to R17,925 p.b.p.a.</p>	
<p>Basic Radiology in hospital including black and white X-rays and Ultrasound</p>	<p>Paid at 100% of the Scheme rate except for PMB's which are paid at cost.</p>	
<p>Pathology in hospital</p>	<p>Paid at 100% of the Scheme rate except for PMB's which are paid at cost.</p>	
<p><b>Maternity Program</b> <b>Free Baby Bag loaded with goodies</b></p>	 <p>Normal birth limited to 3 days. Caesarean Section limited to 4 days' subject to Scheme protocols and authorisation. DSP Network only.</p>	
<p>Blood Transfusion</p>	<p>Paid at 100% of the Scheme rate except for PMB's which are paid at cost.</p>	
<p>Physiotherapy in hospital (Post-operative physiotherapy within 60 days limited)</p>	<p>Paid at 100% of the Scheme rate except for PMB's which are paid at cost. Post-operative physiotherapy limited to R2,015 paid 100% Scheme Rate.</p>	
<p>Psychiatric treatment</p>	<p>Limited to 21 days p.b.p.a in hospital. Paid at 100% of Scheme rate except for PMB's which are paid at cost.</p>	
<p>Vasectomy</p>	<p>Paid at 100% of the Scheme rate unless PMB's which are paid at cost.</p>	
<p>Dialysis</p>	<p>PMB's are paid at 100% of cost. Subject to pre-authorization and protocols.</p>	
<p>Organ transplants</p>	<p>PMB's are paid at 100% of cost. Subject to pre-authorization.</p>	
<p><b>HIV/Aids Program</b></p>	 <p>PMB's are paid at 100% of cost. Subject to DSP.</p>	
<p>Narcotism, alcoholism and drugs</p>	<p>Limited to 21 days p.b.p.a. Paid at 100% of Scheme rate unless PMB paid at cost</p>	
<p>Prosthesis</p>	<p>Internal prosthesis subject to overall limit of R39,120 p.b.p.a.</p>	

# Benefit Schedule Continued

## OTHER PROCEDURES

Co-payments and sub-limits apply.

The following procedures will have a co-payment payable to the hospital on admission: (Where two or more procedures are done simultaneously only the highest co-payment will apply).

Gastroscopy		R1,680
Colonoscopy		R1,680
Cystoscopy		R1,680
Nasal / sinus endoscopy		R1,680
Functional Nasal surgery (Septoplasty)		R1,680
Hysteroscopy		R1,680
Flexible Sigmoidoscopy		R1,680
Arthroscopy		R1,680
Minor gynaecological laparoscopic procedure		R1,680
Dental		R1,680
Excision lesion (Benign & Malignant)		R1,120
Joint replacements (Arthroplasty)		R8,960
Conservative back and neck treatment (spinal cord injections)		R1,680
Laminectomy and Spinal fusion		R8,960
Nissen Fundoplication (Reflux surgery)		R8,960
Hysterectomy (except of cancer)		R4,480
Laparoscopic hemi colectomy		R2,240
Laparoscopic inguinal hernia repair		R2,240
Laparoscopic appendectomy		R2,240

## MEDICAL AND SURGICAL APPLIANCES AND PROSTHESIS:


Subject to combined limit of R39,120. Sub-limits apply.

Coronary artery stents – max of 3	Sub-limit of R12,350 per stent, subject to overall limit of R39,120.
Coronary artery stents – medicated stents max 3	Sub-limit of R19,050 per stent, subject to overall limit of R39,120.




### Abdominal aortic aneurysm stents:

Carotid stents	Sub-limit of R16,830, subject to overall limit of R39,120.
Renal stents	Sub-limit of R5,610, subject to overall limit of R39,120.
Aneurysm coils	Sub-limit of R39,120, subject to overall limit of R39,120.
Heart valves (Mitral etc.)	Sub-limit of R24,700, subject to overall limit of R39,120.

### Orthopaedic prosthesis:








Hip and knee		Sub-limit of R39,120, subject to overall limit of R39,120.
Shoulder		Sub-limit of R39,120, subject to overall limit of R39,120.
Elbow prosthesis		Sub-limit of R39,120, subject to overall limit of R39,120.
Ankle or wrist prosthesis		Sub-limit of R28,000, subject to overall limit of R39,120.
Finger prosthesis		Sub-limit of R22,400, subject to overall limit of R39,120.
Spinal cages		Sub-limit of R12,325, subject to overall limit of R39,120.
Spinal implantable devices		Sub-limit of R28,000, subject to overall limit of R39,120.
Internal fixators for fractures		Sub-limit of R28,000, subject to overall limit of R39,120.
Spinal instrumentation – per level limited to 2 levels and 1 procedure per beneficiary per annum		Sub-limit of R24,650, subject to overall limit of R39,120.

# Benefit Schedule Continued


<b>Artificial limbs:</b>			<b>Prescribed by medical practitioner.</b>
• Through knee			Sub-limit of R39,120, subject to overall limit of R39,120.
• Below knee			Sub-limit of R39,120, subject to overall limit of R39,120.
• Above knee			Sub-limit of R39,120, subject to overall limit of R39,120.
• Below elbow			Sub-limit of R39,120, subject to overall limit of R39,120.
• Above elbow			Sub-limit of R39,120, subject to overall limit of R39,120.
• Partial foot			Sub-limit of R21,280, subject to overall limit of R39,120.
• Partial hand		Sub-limit of R13,440, subject to overall limit of R39,120.	
<b>Other prosthesis:</b>			
• Intra ocular lenses			Sub-limit of R4,480, subject to overall limit of R39,120.
• Bladder sling			Sub-limit of R6,720, subject to overall limit of R39,120.
• Hernia mesh			Sub-limit of R8,960, subject to overall limit of R39,120.
• Vascular grafts			Sub-limit of R27,450, subject to overall limit of R39,120.
<b>Electronic and nuclear devices:</b>			
• Internal cardia defibrillator			Subject to overall limit of R39,120.
• Single chamber pacemaker			Subject to overall limit of R39,120.
• Dual chamber pacemaker			Subject to overall limit of R39,120.
Internal nerve stimulators, cochlear implants and insulin pumps			Excluded.
<b>Surgical appliances:</b>			<b>Prescribed by medical practitioner and condition registration. Nappi price to apply</b>
• Hearing aids 1 per ear every 24 months			Sub-limit of R8,960, subject to overall limit of R39,120.
• Artificial eyes every 5 year interval			Sub-limit of R8,960, subject to overall limit of R39,120.
• BP monitor every 3 year interval			Sub-limit of R670, subject to overall limit of R39,120.
• Glucometer every 3 year interval			Sub-limit of R670, subject to overall limit of R39,120.
• Humidifier every 3 year interval			Sub-limit of R280, subject to overall limit of R39,120.
• Nebuliser every 3 year interval			Sub-limit of R560, subject to overall limit of R39,120.
• Moonboot – annual			Sub-limit of R2,245, subject to overall limit of R39,120.
• Elbow crutches – annual			Sub-limit of R670, subject to overall limit of R39,120.
• CPAP machines every 3 year interval			Sub-limit of R9,565, subject to overall limit of R39,120.
• Brace callipers – annual			Sub-limit of R730, subject to overall limit of R39,120.
• Rigid back brace – annual			Sub-limit of R5,600, subject to overall limit of R39,120.
• Sling clavicle brace – annual			Sub-limit of R224, subject to overall limit of R39,120.
• Wigs – annual			Sub-limit of R2,020, subject to overall limit of R39,120.
• Bra's (for breast prosthesis after mastectomy – 2 per annum)			Sub-limit of R2,800, subject to overall limit of R39,120.
• Breast prosthesis - annual			Sub-limit of R3,360, subject to overall limit of R39,120.
• Commodes every 3 year interval			Sub-limit of R1,010, subject to overall limit of R39,120.
• Wheelchairs every 3 year interval			Sub-limit of R4,480, subject to overall limit of R39,120.
• Walking frames – annual			Sub-limit of R670, subject to overall limit of R39,120.
• Rehabilitative foot orthotics – annual			Sub-limit of R3,360, subject to overall limit of R39,120.



# Benefit Schedule Continued

<b>Stockings:</b>		<b>Prescribed by medical practitioners. Nappi price to apply</b>
• Elastic stockings – 2 per annum		Sub-limit of R840, subject to overall limit of R39,120.
• Full length stockings – 2 per annum		Sub-limit of R730, subject to overall limit of R39,120.
• Anti-embolic stockings – annual		Sub-limit of R1,120, subject to overall limit of R39,120.
• Oxygen treatment		Limited to R1,000 p.b.p.m. Paid at 100% of cost. Subject to pre-authorisation.
<b>Maternity Program</b>		Paid 100% of cost, subject to Scheme protocols and authorisation. Limited to 12 ante-natal visits. (5 from risk pool & 7 from MSA) Limited to 2 2D scans. Vitamins limited to R280 p.b.p.m
Ambulance and emergency evacuation		Paid at 100% of Scheme rate.
<b>MEDICAL SAVINGS ACCOUNT (MSA) DAY-TO-DAY BENEFITS</b>		
<b>MSA Limited to a maximum of 18% of a member's annual contribution.</b>		
Visits to General Practitioner		Paid at 100% at Scheme rate from MSA unless PMB's which are paid at cost. Additional 2 GP visits per member and 4 GP visits per family once savings has been depleted. Paid at Scheme rate. Code 0148 will not be funded for elective after hour's consultations.
Emergency Visits not resulting in hospitalisation		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Visits to Specialist		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost. Visits must be referred by GP except for Gynae, Pediatric ( age restricted until 16 years ), Ophthalmologist & Urology visits (males over 40 years for PSA tests only).
<b>Dentistry</b> Dentistry – non surgical		All dental procedures (e.g. removal of impacted teeth, implants, periodontics, etc. in hospital to be pre-authorised). Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Specialised dentistry e.g. orthodontics		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost. Orthodontics age restricted as from 9 years until 18 years old.
Radiographers – out of hospital		Limited to R1,100 p.b.p.a Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
<b>Prescribed Medicine</b>		Prescribed, administered and/or dispensed by a practitioner legally entitled to do so. Subject to managed care protocols and processes, Scheme's medicine benefit management programme, formulary and DSP's.
Chronic Medication (non CDL) (Reference pricing and MMAP will apply)		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Chronic Medication (26 CDL conditions/ PMB) (Reference pricing and MMAP will apply)		Paid at 100% of cost through DSP and Formulary. Authorisation required.
Acute and PAT Medication (Reference pricing and MMAP will apply)		Paid from MSA at 100% of Scheme rate unless a PMB paid at cost. <b>Certain vitamins and natural products allowed.</b>
<b>Auxiliary services</b>		
Physiotherapy (Physio benefit for counseling treatment to be paid from MSA)		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Chiropractor		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Biokineticist		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Dietician		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Occupational therapist		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Speech therapist		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Audiologists		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Homoeopath		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Naturopath		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Osteopath		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Chiropody/Podiatrist		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Orthoptist		Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.

# Benefit Schedule Continued

Clinical Psychology	Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost. To be referred by GP.
Optometry – single vision, frames, lenses & consult.	Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Optometry – multifocal lenses	Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Excimer laser – need clinic motivation	Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost. The minimum degree of myopia is -3.00 dioptres, astigmatism -2.5 dioptres, or combined myopia/astigmatism with a spherical equivalent of -4.00 dioptres.
Radiology – X-rays	Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
Pathology and Histology	Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost.
<b>Psychiatry</b>	Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost. To be referred by GP.
<b>Sub-acute facilities:</b>	
<b>Hospice – imminent death regardless of the diagnosis</b>	Paid at 100% of cost for PMB's. Subject to pre-authorisation, protocols and case management.
<b>Hospice – stepdown or rehabilitation</b>	PMB cases unlimited. Non-PMB cases limited to R1,295 p.b.p.d. in hospital care and limited to R420 p.b.p.d. for home visits. (To be recommended by medical practitioner and must be pre-authorized)
<b>Private Nursing</b>	Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost. Subject to pre-authorisation. Limited to maximum of 60 days and at R728 p.b.p.a.
<b>Oncology Program</b>	 <p>Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost. Subject to protocols and authorisation on the Schemes oncology program. <a href="mailto:oncology@universal.co.za">oncology@universal.co.za</a></p>
<b>Your Wellness Benefits:</b>	
<b>Your wellness benefits include active nurse based disease management programs.</b>	
<b>Back treatment program (DBC)</b>	Paid at 100% at Scheme rate from MSA. Subject to pre-authorisation, protocols and DSP.
<b>Wellness 360° Check</b>	Limited to R193 p.b.p.a. and shall include Blood pressure test, cholesterol test, blood sugar test, BMI, waist circumference and healthy meal plans from risk.
<b>Emotional Wellness &amp; Trauma</b>	Unlimited telephonic consultations.
<b>Oral contraceptives (excludes treatment for skin conditions)</b>	Paid from MSA 100% of Scheme rate.
<b>Flu vaccines – Nappi price applies</b>	From risk p.b.p.a. as from March to May of each year @ DSP's.

# Contributions

Principal member	Adult dependant	Child dependant
R2,240	R2,075	R745



# 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 CAVM 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 e-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](mailto: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](http://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 DSP's



Members can visit our Facebook page at Witbank Coalfields Medical Aid Scheme for helpful medical tips and information as well as any new developments of the Scheme.



## Preventative Care and Wellness Program

WCMAS offers a preventative care and wellness program for early detection of health risks. Benefits are reflected under the Additional Wellness benefits column. Your wellness benefit includes active nurse based disease management programs. On the Oncology program an introduction **to the end of life program**. Please refer to the Scheme for further information.

### Contributions

The monthly contributions payable by members or their Units shall be collected monthly and paid by the employer by no later than the 3rd day of each month and shall be as follows:

Principal Member	Adult dependant	Child dependant
R2,240	R2,075	R745

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 within thirty days of the due date, the Scheme shall have the right to suspend all benefit payments in respect of claims which arise during the period of default.

### 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 three 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.

### 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.
- GPs can now confirm benefits available for consultations on the website 24/7 – [www.wcmas.co.za](http://www.wcmas.co.za)

## Designated Service Provider (DSP) and Managed Care Programs

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 certain Mediclinic Hospitals. The latest complete list of DSP Hospitals is available on our website [www.wcmas.co.za](http://www.wcmas.co.za) or contact our offices at **013 656 1407**. 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.

#### PMB and 26 CDL conditions (100% benefit)

(PMB = Prescribed Minimum Benefits)  
(CDL = Chronic Disease List)  
(MMAP = Maximum Medical Aid Price)



#### 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](http://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](http://www.wcmas.co.za), and email or fax to Universal pre-authorisations at [preauthorisation@universal.co.za](mailto:preauthorisation@universal.co.za)
- Phone Universal Hospital pre-authorisation on **0861 486 472**
- HIV Program [diseasemanagement@universal.co.za](mailto:diseasemanagement@universal.co.za)
- Oncology Program [oncology@universal.co.za](mailto:oncology@universal.co.za)

**In hospital treatment benefits include the following:**

- Ward fees
- Step-down
- Theatre fees
- Internal prosthesis (Limited to R39,120 p.b.p.a.)
- 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](http://www.wcmas.co.za) via the service 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 & Type 2	Multiple Sclerosis
Bronchiectasis	Dysrhythmias	Parkinson's disease
Cardiac failure	Epilepsy	Rheumatoid arthritis
Cardiomyopathy disease	Glaucoma	Schizophrenia
Chronic renal disease	Haemophilia	Systemic Lupus Erythematosus
Coronary artery disease	HIV/aids	Ulcerative Colitis
Crohn's disease	Hyperlipidaemia	

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

**MediKredit website detail is [www.medikredit.co.za](http://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](mailto: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.

### 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. a bout of 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.

### 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.

### On Site Visits by Our Representatives

For more information on site-visits by our representatives, please contact your HR office or the Uzinzo Group Benefits at **0878 088 766/0741 241 895**.

## 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
p.b.p.a	=	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



MIDMAS



Managed Care by

**Universal**  
Care