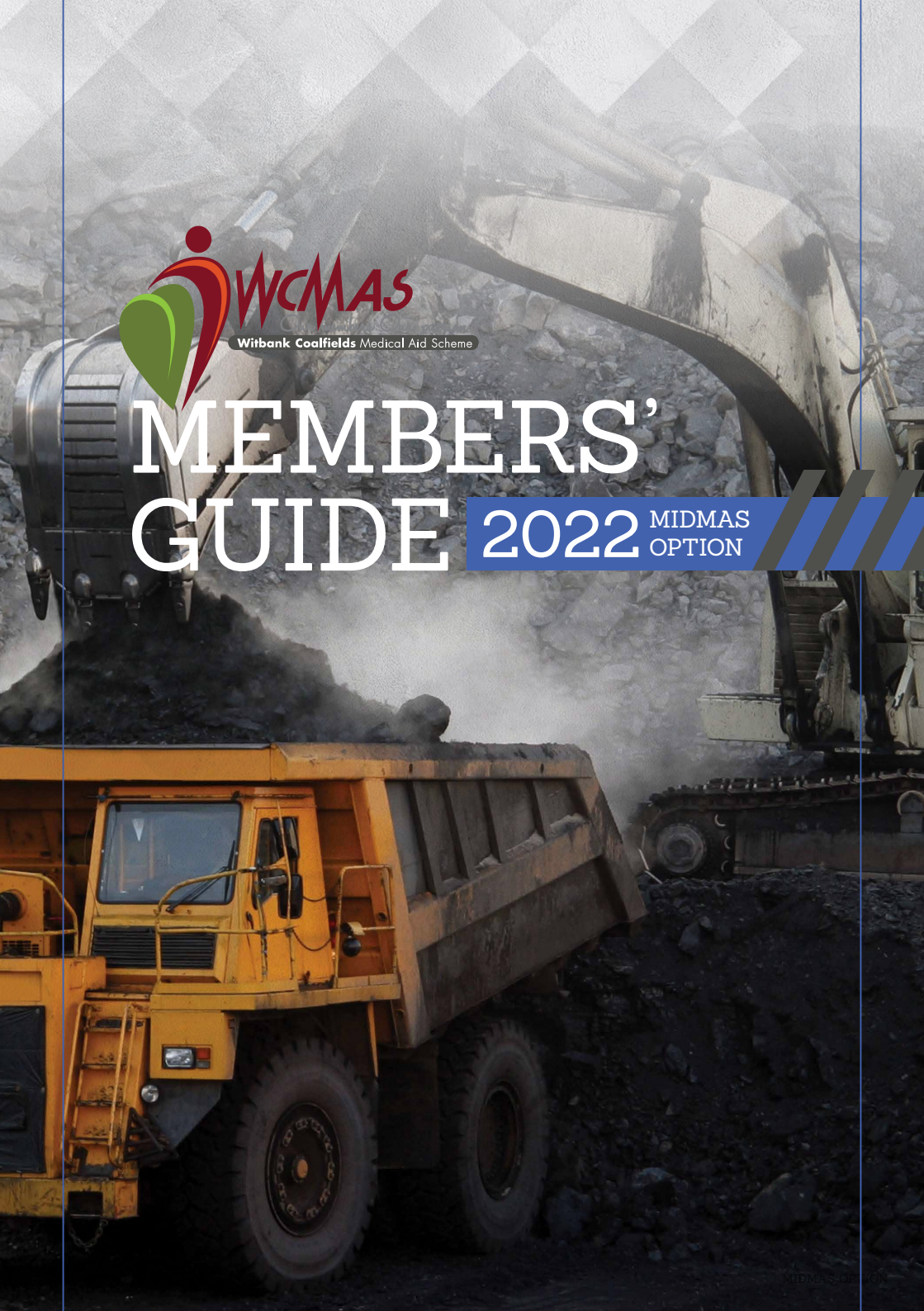

MEMBERS' GUIDE 2022 MIDMAS OPTION

BENEFIT SCHEDULE

HOSPITALISATION

Hospital admissions to be pre-authorised 72 hours prior to admission except for medical emergencies	Paid at 100% Negotiated Rate in general ward and specialised units at a DSP hospital. Subject to pre-authorisation
All other procedure accounts other than the hospital account	Paid at 100% of Scheme Rate from Risk Pool, except for PMBs which are paid at cost
Ward Fees – General, ICU, High Care	Paid at 100% of Scheme Rate from Risk Pool, except for PMBs which are paid at cost
Theatre Fees	Paid at 100% of Scheme Rate from Risk Pool, except for PMBs which are paid at cost
Medication, materials and equipment (only whilst in Hospital)	Paid at 100% of Scheme Rate from Risk Pool, except for PMBs which are paid at cost
Medication on discharge from hospital	Maximum of 7 days' supply (TTO's) from Risk Pool at 100% SEP plus a dispensing fee
Attending doctors in hospital	Paid at 100% of Scheme Rate from Risk Pool, except for PMBs which are paid at cost
All Specialist Radiology including MRI. CT and PET scans	Paid at 100% Scheme Rate from Risk Pool, except for PMBs which are paid at cost. Limited to R20 380 p.b.p.a. Subject to pre-authorisation.
Basic Radiology in hospital including black and white X-rays and Ultrasound	Paid at 100% of Scheme Rate from Risk Pool, except for PMBs which are paid at cost
Pathology in hospital	Paid at 100% of Scheme Rate from Risk Pool, except for PMBs which are paid at cost
Hospice ***(imminent death regardless of the diagnosis)***	Paid at 100% of cost for PMB's. Subject to pre-authorisation, protocols and case management
Hospice ***(limit changes stepdown and private nursing)***	PMB cases unlimited. Non-PMB cases limited to R1 520 p.b.p.d. in hospital care and limited to R480 p.b.p.d. for home visits. (To be recommended by medical practitioner and must be pre-authorised)
Private Nursing	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 R820 p.b.p.a.
MATERNITY PROGRAMME (Subject to registration on the maternity programme before the third trimester of pregnancy)	• Paid at 100% of cost, subject to Scheme protocols and authorisation • Up to 12 ante-natal visits per pregnancy • Ante-natal pathology for risk screening (Qualitative bHCG, Blood glucose, HIV status, Syphilis, German measles, Hepatitus B, Anaemia, Blood group, Blood cross-matching) • Limited to 2 x 2D scans • 4D scans from MSA • 1 post-natal visit • Ante-natal vitamins limited to R310 per beneficiary per month (script required) • Free baby bag loaded with goodies for baby and mom
Oncology	Paid at 100% of Scheme rate if from a DSP. Subject to pre-authorisation and application of ICON Essential Protocols
Physiotherapy in hospital	Paid at 100% of the Scheme rate except for PMB's which are paid at cost. Post-operative physiotherapy within 60 days of procedure limited to R2 290 paid at 100% of Scheme Rate
Psychiatric Treatment	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
Vasectomy	Paid at 100% of the Scheme rate unless PMB's which are paid at cost
Dialysis	PMB's are paid at 100% of cost. Subject to pre-authorisation and protocols
Organ Transplants	PMB's are paid at 100% of cost. Subject to pre-authorisation
HIV/AIDS PROGRAMME	Provides full cover for HIV management. Subject to registration on the programme. Protocols apply.
Narcotism, Alcoholism and Drugs	Limited to 21 days p.b.p.a. Paid at 100% of Scheme rate unless PMB paid at cost
Prosthesis	Internal prosthesis subject to overall limit of R44 470 p.f.p.a.

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 910**
Colonoscopy	**R1 910**
Cystoscopy	**R1 910**
Nasal / Sinus Endoscopy	**R1 910**
Functional Nasal Surgery *(Septoplasty)*	**R1 910**
Hysteroscopy	**R1 910**
Flexible Sigmoidoscopy	**R1 910**
Arthroscopy	**R1 910**
Minor Gynaecological Laparoscopic Procedure	**R1 910**
Dental	**R1 910**
Excision Lesion *(Benign & Malignant)*	**R1 270**
Joint Replacements (Arthroplasty)	**R10 190**
Conservative Back And Neck Treatment *(Spinal Cord Injections)*	**R1 910**
Laminectomy And Spinal Fusion	**R10 190**
Nissen Fundoplication *(Reflux Surgery)*	**R10 190**
Hysterectomy *(Except of Cancer)*	**R5 090**
Laparoscopic Hemi Colectomy	**R2 540**
Laparoscopic Inguinal Hernia Repair	**R2 540**
Laparoscopic Appendectomy	**R2 540**

MEDICAL AND SURGICAL APPLIANCES AND PROSTHESIS:

SUBJECT TO COMBINED LIMIT OF R44 470. SUB-LIMITS APPLY.

Coronary Artery Stents *(max of 3)*	**Sub-limit of R14 040 per stent, subject to overall limit of R44 470**
Coronary Artery Stents *(medicated stents max 3)*	**Sub-limit of R21 660 per stent, subject to overall limit of R44 470**
ABDOMINAL AORTIC ANEURYSM STENTS:	
Carotid stents	**Sub-limit of R19 130, subject to overall limit of R44 470**
Renal stents	**Sub-limit of R6 380, subject to overall limit of R44 470**
Aneurysm coils	**Sub-limit of R44 470, subject to overall limit of R44 470**
Heart valves *(Mitral etc.)*	**Sub-limit of R28 080, subject to overall limit of R44 470**
ORTHOPAEDIC PROSTHESIS	
Hip and knee	**Sub-limit of R44 470, subject to overall limit of R44 470**
Shoulder	**Sub-limit of R44 470, subject to overall limit of R44 470**
Elbow prosthesis	**Sub-limit of R44 470, subject to overall limit of R44 470**
Ankle or wrist prosthesis	**Sub-limit of R31 830, subject to overall limit of R44 470**
Finger prosthesis	**Sub-limit of R25 460, subject to overall limit of R44 470**
Spinal cages	**Sub-limit of R14 010, subject to overall limit of R44 470**
Spinal implantable devices	**Sub-limit of R31 830, subject to overall limit of R44 470**
Internal fixators for fractures	**Sub-limit of R31 830, subject to overall limit of R44 470**
Spinal instrumentation *(per level limited to 2 levels and 1 procedure per beneficiary per annum)*	**Sub-limit of R28 020, subject to overall limit of R44 470**

BENEFIT SCHEDULE continued

Artificial Limbs	Prescribed by Medical Practitioner
Through knee	**Sub-limit of R44 470 subject to overall limit of R44 470**
Below knee	**Sub-limit of R44 470 subject to overall limit of R44 470**
Above knee	**Sub-limit of R44 470 subject to overall limit of R44 470**
Below elbow	**Sub-limit of R44 470 subject to overall limit of R44 470**
Above elbow	**Sub-limit of R44 470 subject to overall limit of R44 470**
Partial foot	**Sub-limit of R24 190 subject to overall limit of R44 470**
Partial hand	**Sub-limit of R15 280 subject to overall limit of R44 470**
OTHER PROSTHESIS	
Intra ocular lenses	**Sub-limit of R5 090, subject to overall limit of R44 470**
Bladder sling	**Sub-limit of R7 640, subject to overall limit of R44 470**
Hernia mesh	**Sub-limit of R10 190, subject to overall limit of R44 470**
Vascular grafts	**Sub-limit of R31 210, subject to overall limit of R44 470**
ELECTRONIC AND NUCLEAR DEVICES	
Internal cardia defibrillator	**Subject to overall limit of R44 470**
Single chamber pacemaker	**Subject to overall limit of R44 470**
Dual chamber pacemaker	**Subject to overall limit of R44 470**
Internal nerve stimulators and insulin pumps	**Excluded**
Medical and Surgical Appliances and Prosthesis	Prescribed by Medical Practitioner and Condition Registration
Hearing aid per ear *(every 3 years)*	**Sub-limit of R17 000 subject to overall limit of R44 470**
Artificial eyes *(every 5 year interval)*	**Sub-limit of R10 190 subject to overall limit of R44 470**
BP monitor *(every 3 year interval)*	**Sub-limit of R760 subject to overall limit of R44 470**
Glucometer *(every 3 year interval)*	**Sub-limit of R760 subject to overall limit of R44 470**
Humidifier *(every 3 year interval)*	**Sub-limit of R320 subject to overall limit of R44 470**
Nebuliser *(every 3 year interval)*	**Sub-limit of R640 subject to overall limit of R44 470**
Moonboot *(annual)*	**Sub-limit of R2 550 subject to overall limit of R44 470**
Elbow crutches *(annual)*	**Sub-limit of R760 subject to overall limit of R44 470**
CPAP machines *(every 3 year interval)*	**Sub-limit of R10 880 subject to overall limit of R44 470**
Brace calipers *(annual)*	**Sub-limit of R830 subject to overall limit of R44 470**
Rigid back brace *(annual)*	**Sub-limit of R6 370 subject to overall limit of R44 470**
Sling clavicle brace *(annual)*	**Sub-limit of R250 subject to overall limit of R44 470**
Wigs *(annual)*	**Sub-limit of R2 300 subject to overall limit of R44 470**
Bras *(for breast prosthesis after mastectomy – 2 per annum)*	**Sub-limit of R3 180 subject to overall limit of R44 470**
Breast prosthesis *(annual)*	**Sub-limit of R3 820 subject to overall limit of R44 470**
Commodes *(every 3 year interval)*	**Sub-limit of R1 150 subject to overall limit of R44 470**
Wheelchairs *(every 3 year interval)*	**Sub-limit of R5 090 subject to overall limit of R44 470**
Walking frames *(annual)*	**Sub-limit of R760 subject to overall limit of R44 470**
Rehabilitative foot orthotics *(annual)*	**Sub-limit of R3 820 subject to overall limit of R44 470**
Cochlear Implants	**Payable at 100% Scheme Rate up to a limit of R150 000 per beneficiary every 5 years. Not subject to a combined overall limit. NAPPI codes and clinical protocols apply.**

BENEFIT SCHEDULE continued

Stockings:	Prescribed by medical practitioners *(Nappi price to apply)*
Elastic stockings *(2 per annum)*	**Sub-limit of R950 subject to overall limit of R44 470**
Full length stockings *(2 per annum)*	**Sub-limit of R850 subject to overall limit of R44 470**
Anti-embolic stockings *(annual)*	**Sub-limit of R1 270 subject to overall limit of R44 470**
Other:	Prescribed by medical practitioners *(Nappi price to apply)*
Oxygen treatment	**Limited to R1 140 p.b.p.m. Paid at 100% of cost. Subject to pre-authorisation**
Ambulance and emergency evacuation	**Paid at 100% of Scheme rate**

MEDICAL SAVINGS ACCOUNT (MSA) DAY-TO-DAY BENEFITS

MSA LIMITED TO A MAXIMUM OF 20% OF A MEMBER'S ANNUAL CONTRIBUTION

Visits to General Practitioner	**Paid at 100% at of Scheme rate from MSA. Additional 4 GP visits per member and 6 GP visits per family once savings has been depleted**
Emergency Visits not resulting in hospitalisation	**Paid at 100% at of Scheme rate**
Visits to Specialist	**Paid at 100% at of Scheme rate from MSA unless a PMB which is paid at cost. Pediatric visits restricted to the age up to 16 years**
Basic dentistry	**Paid at 100% of Scheme rate from MSA**
Optometry *(frames, lenses, consult, excimer laser)*	**Paid from MSA at 100% of Scheme Rate** **Excimer laser funding subject to meeting the minimum clinical entry criteria (myopia -3.00 dioptres, astigmatism -2.5 dioptres, or combined myopia/astigmatism with a spherical equivalent of -4.00 dioptres)**
Specialised dentistry e.g. orthodontics	**Paid at 100% of Scheme rate from MSA. Dental procedures in hospital subject to pre-authorisation.**
Radiology	**X-RAYS: Paid from MSA at 100% of Scheme rate unless a PMB which is paid at cost** **RADIOGRAPHER: Out of hospital limited to R1,250 per beneficiary per year**
Pathology and Histology	**Paid at 100% at Scheme rate from MSA unless a PMB which is paid at cost**
Prescribed Medicine	**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, non ADL) *(reference pricing and MMAP will apply)*	**Paid from MSA at 100% of Scheme Rate, unless a PMB which is paid from risk at cost**
Chronic Medication (CDL/PMB and ADL conditions) *(Reference pricing and MMAP will apply)*	**Paid at 100% of cost through DSP and Formulary. Authorisation required**
Acute and Over the Counter Medication *(reference pricing and MMAP will apply)*	**Paid from MSA at 100% of Scheme rate, unless a PMB which is paid from Risk Pool at cost.**
AUXILIARY SERVICES	
Physiotherapists	**Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost**
Speech Therapist	**Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost**
Audiologists	**Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost**
Occupational Therapist	**Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost**
Homoeopath	**Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost**
Other Allied Health Workers	**Paid from MSA at 100% of Scheme Rate unless a PMB which is paid from risk at cost**

BENEFIT SCHEDULE continued

AUXILIARY SERVICES	
Mental Health	Consultations with a clinical psychologist or psychiatrist are paid from MSA at 100% of Scheme Rate, subject to referral by a GP. PMB conditions are covered at cost from the Risk Pool, subject to condition registration and protocols. Unlimited telephonic consultations with a mental health practitioner via the emotional wellness programme.
YOUR WELLNESS BENEFITS	
YOUR WELLNESS BENEFITS INCLUDE ACTIVE NURSE BASED DISEASE MANAGEMENT PROGRAMMES	
Wellness 360° Check	Limited to R220 p.b.p.a.
Back Treatment Programme (DBC)	Paid from MSA at 100% of Scheme Rate subject to pre-auth, protocols and DSP
Emotional Wellness & Trauma	Unlimited telephonic consultations
Oral contraceptives and Injections *(excludes treatment for skin conditions)*	Paid from MSA at 100% of Scheme Rate
Flu Vaccines	Unlimited payable at 100% SEP plus dispensing fee
Pap Smear	1 per female 18+ every three years
Mammogram	1 per annum for females aged 45 to 54
	1 every 2 years for females aged 55+
Prostate Specific Antigen *(PSA)* Test	1 every 2 years males aged 45 to 75
Baby/Child Vaccinations	0-2 years: R850 p.b.p.a 3-5 years: R600 p.b.p.a 6-12 years: R450 p.b.p.a

CONTRIBUTIONS

PRINCIPAL MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R2 607	**R2 415**	**R599**

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 DSP's

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

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:

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. 20% 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.
- 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 certain Mediclinic Hospitals. The latest complete list of DSP Hospitals is available on our website **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 Programmes 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, 26 CDL and 3 ADL conditions (100% benefit)

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

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 programme, 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 or fax 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
- ICU
- Step-down
- High Care
- Theatre fees
- Medical Appliances (e.g. back braces)
- Internal prosthesis
- Equipment
- Theatre and ward drugs
- 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
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy disease
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Chronic obstructive pulmonary disorder
- Diabetes Insipidus
- Diabetes Mellitus Type 1 & Type 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- HIV/aids
- Hyperlipidaemia
- Hypertension
- Hypothyroidism
- Multiple Sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic Lupus Erythematosus
- Ulcerative Colitis

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.

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**.

ADDITIONAL DISEASE LIST (ADL)

WCMAS have enhanced cover on the option to assist young families who often encounter the following childhood conditions:

- Acne
- Attention Deficit Hyperactivity Disorder
- Eczema

Funding is at 100% Scheme Rate from the Risk Pool and is subject to condition registration and protocols.

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.

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.

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 WCMAS at **013 656 1407**.

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
ADL	Additional Disease List as per Annexure L of the Scheme Rules

IMPORTANT CONTACT NUMBERS

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