WCMAS
Witbank Coalfields Medical Aid Scheme
MEMBERS' GUIDE
2022
NTSIKA OPTION

BENEFIT SCHEDULE

HOSPITALISATION

Hospital admission 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
Ward Fees – General, ICU, High Care	Paid at 100% of Scheme Rate
Theatre Fees	Paid at 100% of Scheme Rate
Medication, materials and equipment *(only whilst in Hospital)*	Paid at 100% of Scheme Rate
Medication on discharge from hospital	Maximum of 7 days' supply (TTO's) limited to R390 per event
Visits by GP and Specialist	Paid 100% of the Scheme rate except for PMB's paid at cost
All Specialist Radiology including MRI. CT and PET scans	Limited to R8 340 per beneficiary per annum paid at 100% of the Scheme rate, except for PMB's paid at cost. Subject to pre-authorisation protocols and case management.
Basic Radiology in hospital including black and white X-rays and Ultrasound	Paid 100% of the Scheme rate subject to protocols and case management.
Pathology in hospital	Paid 100% of the Scheme rate subject to protocols and case management.
Hospice *(imminent death regardless of the diagnosis)*	**PMB cases unlimited. Paid at 100% of cost subject to pre-authorisation and protocols**
Hospice *(stepdown or rehabilitation)*	**PMB cases unlimited. Paid at 100% of cost subject to pre-authorisation and protocols**
Private Nursing	**No benefit**
MATERNITY	• Normal birth limited to 3 days. Caesarean Section limited to 4 days. • Co-payment R6000 for elective caesarean. Subject to Scheme protocols and authorisation. DSP Network only.
Oncology	Paid at 100% of Scheme rate if from a DSP. Subject to pre-authorisation and application of ICON Essential treatment protocols.
Physiotherapy in hospital (Post-operative physiotherapy within 60 days limited)	Paid 100% of the Scheme rate. (Post-op treatment to be pre-authorised subject to protocols)
Psychiatric Treatment	Limited to 21 days p.b.p.a in hospital. Paid at 100% of Scheme rate except for PMB's paid at cost
Vasectomy	Paid 100% of the Scheme rate unless PMB paid at cost
Dialysis	PMB only paid at 100% cost subject to pre-authorisation and protocols
Organ Transplants	PMB only paid at 100% cost subject to pre-authorisation
HIV/AIDS PROGRAMME	PMB's are paid at 100% of cost. PMB's are paid at 100% of cost. Subject to registration on the programme. Protocols apply.
Narcotism, Alcoholism and Drugs	Subject to registration on the programme. Protocols apply. Limited to 21 days p.b.p.a. Paid 100% of Scheme rate
Prosthesis	PMB's only. Paid at 100% of cost

OTHER PROCEDURES

The following in-hospital procedures are excluded:
(Except for PMB's paid at 100% cost)

• Dental surgery • Back and neck surgery • Hip and knee replacements • Cochlear implants • Auditory brain implants and internal nerve stimulators	• **Nissen fundoplication (reflux surgery)** • **Treatment for obesity, skin disorders and functional nasal problems** • **Elective caesarean section** • **Refractive eye surgery** • **Brachytherapy for prostate cancer** • **Fibroadenosis**
MEDICAL APPLIANCES - HEARING AIDS	Paid at 100% of the Scheme rate subject to a limit of R8 728 per ear, every 2 years. Includes repairs, excludes batteries
Oxygen Treatment	Paid at 100% of cost subject to pre-authorisation.
MATERNITY PROGRAMME *(subject to registration on the maternity program before the third trimester of pregnancy)*	• Paid at 100% of cost. Subject to protocols and authorisation. DSP network only • 12 ante-natal visits • Ante-natal pathology for risk screening • Scripted antenatal vitamins R600 per pregnancy • 2 x 2D scans • 1 post-natal visit
FREE BABY BAG Loaded with goodies	Subject to registration on the maternity program before the third trimester of pregnancy
Ambulance and Emergency Evacuation	Paid at 100% of Scheme rate

DAY-TO-DAY BENEFITS

Visits to General Practitioner	Unlimited but managed, each beneficiary is required to nominate 2 GPs to consult with. Pre-authorisation needed from the 6th visit
General practitioners out-of-area/network	Limited to 2 visits per beneficiary per annum limited to a maximum of R1 270 per event (including medicine, pathology and radiology) excluding facility fees
Emergencies	Medical conditions: First paid as an out of area GP visit thereafter limited to - Member R1 220 - M+ R2 420 Injuries and trauma (not resulting in hospitalisation): Unlimited for life threatening injuries and paid from risk benefit Emergency transportation and stabilisation
Non-PMB visits to Specialist	Subject to referral by nominated GP. Paid at 100% of Scheme rate limited to maximum of 2 visits per beneficiary with a maximum of 3 visits per family Pre-authorisation required for each specialist visit A 30% co-payment will be applicable to voluntary use of a specialist without referral by a DSP Network GP Limited: - Member R1 760 - M+ R3 840 Paediatric visits – age restricted until 16 years of age
Basic dentistry	One consultation per beneficiary per annum at a DSP Network dentist or dental therapist. Preventative care, infection control, fillings, extractions and dental x-rays, subject to protocols and list of applicable dental codes Limited: - Member R1 340 - M+ R3 630 No benefit for out-of-network dental visits/procedures except for involuntary PMB emergencies
Specialised Dentistry	No benefit unless PMB. Subject to protocols and Scheme rate
Acute Medicine	All acute medication will be provided as part of the acute consultation (when dispensed by a dispensing practitioner) or by an accredited designated service provider/pharmacy if prescribed by a non-dispensing practitioner

BENEFIT SCHEDULE continued

Chronic Medication *(Reference pricing and MMAP will apply)*	26 CDL conditions – unlimited only if prescribed by DSP network provider and dispensed within the pharmacy network or by a dispensing DSP doctor Non-formulary medicines must pre-authorised and is subject to a 30% co-payment No cover in cases of voluntary use of non-DSP or voluntary use of a specialist without referral by DSP Network GP
Over counter medication (OTC)	Unscripted medication Benefit – M R150 p.a. and M+ R210 p.a.
Optometry	DSP Network only. 1 visit per beneficiary every second year. Subject to combined family limit per annum M+1 – R2 710 and M+2 – R3 646 Single vision lenses and frames limited to R1 080 per beneficiary every second year subject to combined family limit Bi-focal lenses and frames limited to R1 590 per beneficiary every second year subject to combined family limit Frames limited to range within DSP Network subject to combined family limit No benefit for contact lenses
Radiology *(basic)*	100% of Scheme rate. Unlimited when clinically appropriate within the DSP network and subject to referral by a DSP Network GP. Limited to a list of codes, subject to case management. A 30% co-payment will be applicable if not referred by a Network provider or a Specialist following referral by a DSP network GP (except when involuntary). Authorisation required for specialised radiology
Specialised Radiology *(out of hospital)* MRI/CT/PET Scans	100% of Scheme rate limited R8 340 per beneficiary per annum, unless PMB which is paid a cost. Subject to pre-authorisation and case management
Pathology and Histology	100% of Scheme rate. Unlimited when clinically appropriate within the DSP Network and subject to referral by a DSP Network GP. Limited to a list of codes, subject to case management. 30% co-payment will be applicable if not referred by a Network Provider or a Specialist following referral by a DSP network GP (except when involuntary)
Psychiatry (out of hospital)	One consultation payable at 100% of Scheme rate
Physiotherapy (out of hospital)	One consultation payable at 100% of Scheme rate

YOUR WELLNESS BENEFITS

YOUR WELLNESS BENEFITS INCLUDE ACTIVE NURSE BASED DISEASE MANAGEMENT PROGRAMMES

Circumcision benefit	Adults funded in Dr's rooms. Children under age 10 years as a day case
Wellness 360˚ Check	Limited to R220 p.b.p.a. and shall include Blood pressure test, cholesterol test, blood sugar test, BMI, waist circumference and healthy meal plans
Emotional Wellness	Unlimited telephonic consultations. 3 psychologist visits on referral by the case manager on the telephonic programme.
Contraceptives : Oral and Injections *(excludes treatment for skin conditions)*	Limited to R160 per month
Flu Vaccines	1 dose per beneficiary per annum. Nappi price applies
Pap Smear	1 per adult female every three years (payable at 100% of Scheme rate)
Mammogram	1 per annum for females aged 45 to 54 1 every 2 years for females aged 55+ (payable at 100% Scheme rate)
Prostate Specific Antigen *(PSA)* Test	1 every 2 years males aged 45 to 75 (payable at 100% Scheme rate)
Baby/Child Vaccinations	0-2 years: R445 p.b.p.a 3-5 years: R170 p.b.p.a 6-12 years: R170 p.b.p.a

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 wcmas@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 and send a message to **WCMAS to update your contact details**
- Print a **membership certificate**
- Print your latest **tax certificate**
- 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**

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..

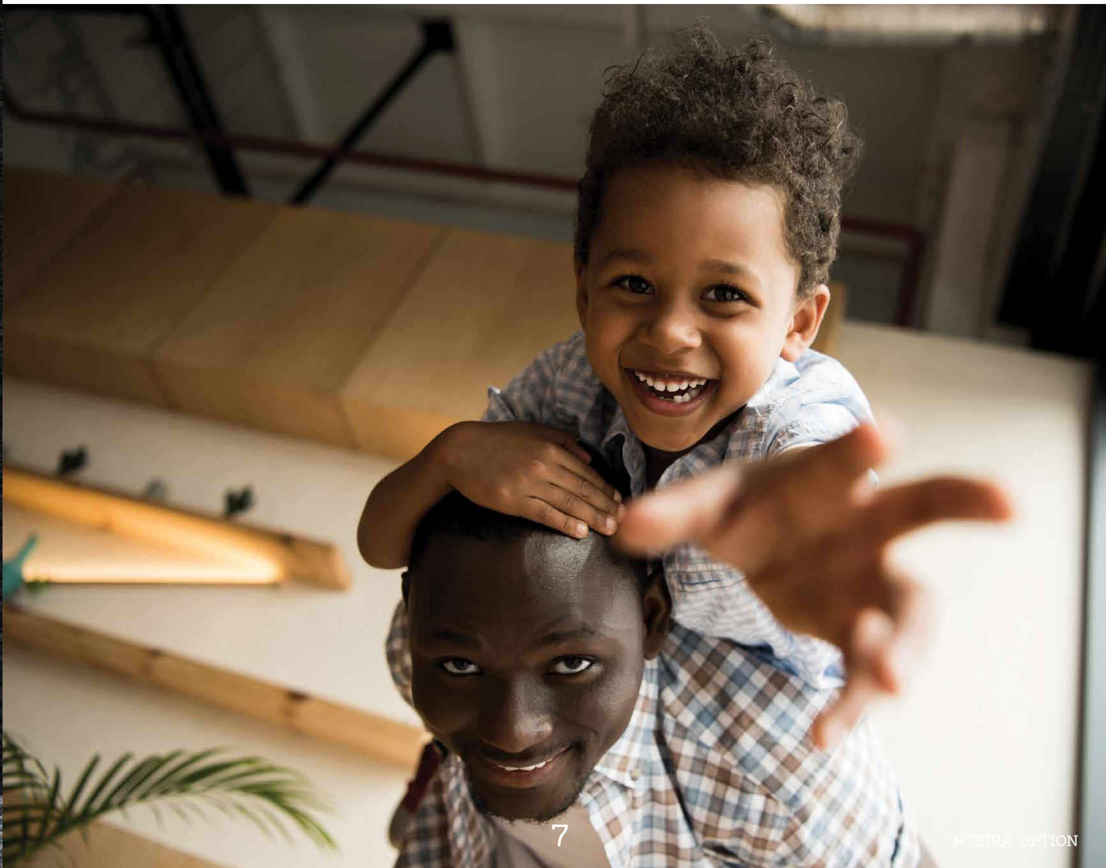
CONTRIBUTIONS

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 and shall be as follows:

TABLE	INCOME GROUP	PRINCIPAL	ADULT	CHILD
A	R0 – R10 000	R 990	R 990	R 417
B	R10 001 – R15 000	R 1037	R 1037	R 469
C	R15 001+	R1 563	R1 563	R 677

Free from the 4th child.

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 = R2,000.
- 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+Penalty. R2,000 + (25% x R2,000) = R2,500 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

DESIGNATED SERVICE PROVIDER (DSP) AND MANAGED CARE PROGRAMMES

Members are required to obtain medical services from the Universal Network of Service Providers. Please contact Universal on 0803 628 677 to obtain details of the DSP Network.

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 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.

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 Chronic Medicine Programme on 0860 111 900.

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.

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

Benefit 100% at scheme rates for Private Hospitals. Pre-authorisation must be obtained at the Scheme's Case Managers at Universal pre-authorisations, subject to pre-authorisation

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)
- 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
- 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

Register chronic conditions at:
chronicmedicine@universal.co.za

0860 111 900

Practice to register condition and treatment plan. ICD10 codes to be indicated.

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

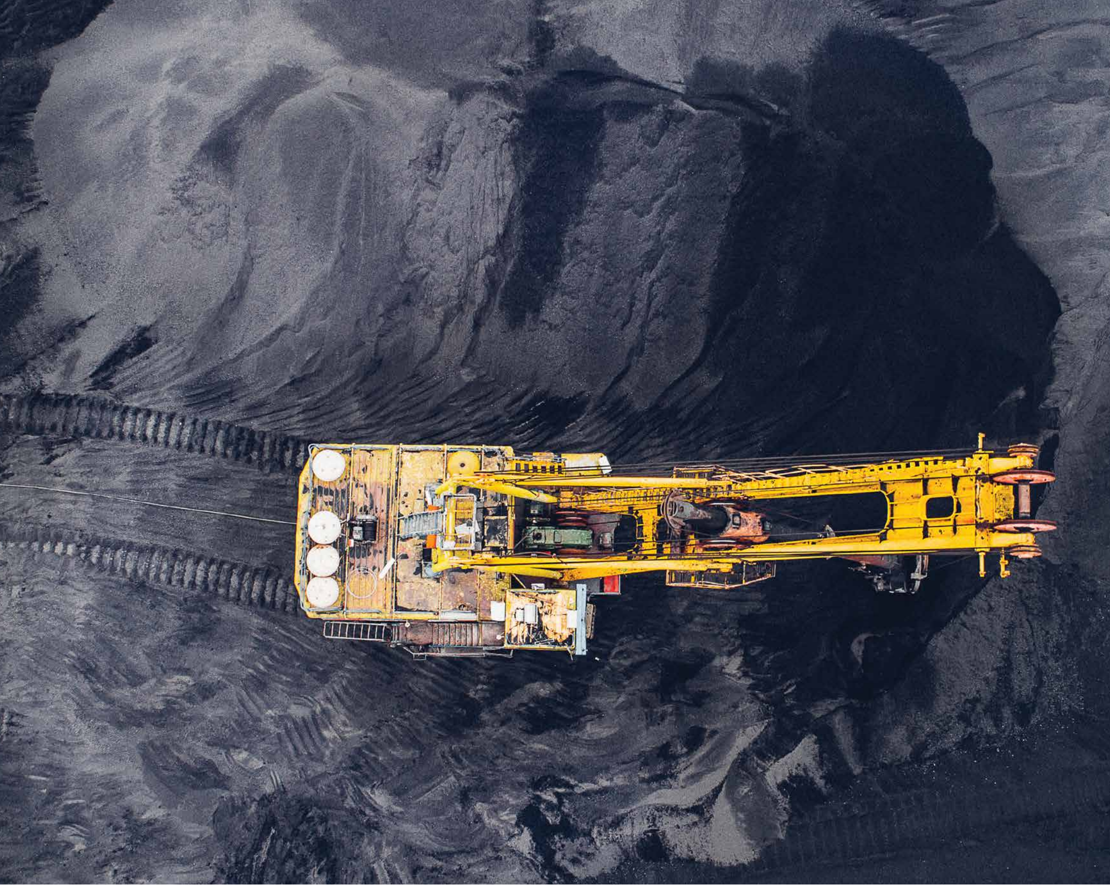
For more information on site-visits by our representatives, please contact your HR office or the WCMAS at 013 656 1407.

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

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
0860 111 900
chronicmedicine@universal.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@wcmas.co.za

S25°52’23.7” E29°14’23.6

www.wcmas.co.za

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