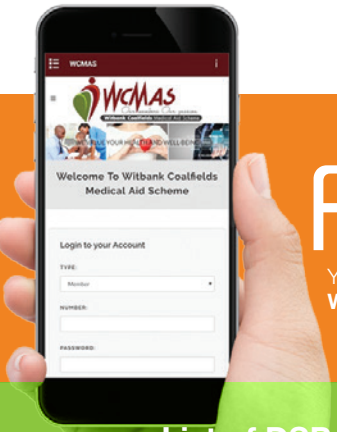
WCMAS
Our members
Our passion

NTSIKA OPTION

Members' Guide 2019

We have network providers all over SA



FIND US

Google play

App Store

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

List of DSP GP' Network doctors in your area please call: 080 362 8677 | e-mail: network@universal.co.za

If you require an agent to call you back within 24 hours, send a sms with your membership number to 47977.

IMPORTANT CONTACT NUMBERS

WCMAS
013 656 1407

WCMAS Facsimile
0866 277 795

SMS call back facility
If you require an agent to call you back within 24 hours, send a sms with your membership number to 47977

Hospital pre-authorisation
0861 486 472

Disease Management Program
0861 486 472

Chronic medicine Program
0860 111 900

ER24 Ambulance
084 124

Oncology Program
0861 486 472

WCMAS Building
Corner OR Tambo & Susanna Str,
P O Box 26
Witbank
1035

E-mail: **wcmas@wcmas.co.za**

Web: **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

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Witbank Coalfields Medical Aid Scheme Aid Scheme

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Benefit Schedule

HOSPITALISATION	
Hospital admissions to be pre-authorised. 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	Treatment subject to Scheme pre-authorisation, case management and Scheme protocols in a network of Private Hospitals. Some non-PMB related treatment is excluded as per Scheme Rules. Unlimited access to DSP Private Hospitals is covered at 100% of the Scheme rate except for PMB's which are paid at cost.
All other procedure accounts other than the hospital account	Paid 100% of the Scheme rate except for PMB's paid at cost.
Ward Fees – General, ICU, High Care	Paid 100% of the Scheme rate except for PMB's paid at cost.
Theatre Fees	Paid 100% of the Scheme rate except for PMB's paid at cost.
Medication, materials and equipment (only whilst in Hospital)	Paid 100% of the Scheme rate except for PMB's paid at cost.
Medication on discharge from hospital	Maximum of 7 days' supply (TTO's) limited to R336 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	PMB's only paid at 100% of 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 except for PMB's paid at cost subject to protocols and case management.
Pathology in hospital	Paid 100% of the Scheme rate except for PMB's paid at cost subject to protocols and case management.
Maternity	Normal birth limited to 3 days. Caesarean Section limited to 4 days. Subject to Scheme protocols and authorisation. DSP Network only.
Blood Transfusion	Paid at 100% of the Scheme rate except for PMB's which are paid at cost.
Physiotherapy in hospital	Paid 100% of the Scheme rate except for PMB's paid at cost. (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 Program	PMB paid at 100% of cost subject to DSP.
Narcotism, alcoholism and drugs	Subject to DSP, limited to 21 days p.b.p.a. Paid 100% of Scheme rate.
Prosthesis	PMB's only, paid at 100% of cost.

Benefit Schedule Continued

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 and Surgical appliances and prosthesis	PMB's only. Paid at cost.
Oxygen treatment	Paid at 100% of cost subject to pre-authorisation.
Circumcision benefit	Adults funded in Dr's rooms. Children under 10 as a day case. Authorisation, clinical protocols apply and medical reasons only
MATERNITY PROGRAM **Free Baby Bag loaded with goodies**	Paid at 100% of cost, subject to Scheme protocols and authorisation: Limited to 12 ante-natal visits. Limited to 2 2D scans.
Ambulance and emergency evacuation	Paid at 100% of Scheme rate.
DAY TO DAY BENEFITS	
Visits to General Practitioner	Paid at 100% of the DSP Network agreed rate unless PMB which is paid at cost within a DSP GP Network only. Clinical motivation may be required for more than 6 visits. **Ensure that you visit a DSP GP Network doctor.**
General practitioners out-of-area/network	Limited to 2 visit per beneficiary per annum limited to a maximum of R1,120 per event (including medicine, pathology and radiology) and excluding the facility fees.
Emergencies	Medical conditions: First paid as an out of area GP visit thereafter limited to -Member R1,070 - M+ R2,130. Injuries and trauma (not resulting in hospitalisation): Unlimited for life threatening injuries and paid from risk benefit. Emergency transportation and stabilisation.
Visits to Specialist	Paid at 100% of Scheme rate limited to maximum of 2 visits per beneficiary with maximum of 3 visits per family. **Subject to referral by DSP network GP and pre-authorisation of each specialist visit.** Limited: - Member R1,550 - M+ R3,380 Paediatric visits – age restricted until 16 years of age.
Dentistry	All dental procedures (e.g. removal of impacted teeth, implants, periodontics, etc.) in hospital are excluded. 1 set of dentures every 3 years and must be pre-authorised.
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 R1,180 - M+ R3,190 No benefit for out-of-network dental visits/procedures except for involuntary PMB emergencies.
Specialised dentistry e.g. orthodontics	No benefit unless a PMB which is paid at cost.

Benefit Schedule Continued

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. The cost is included in the DSP Network agreement GP consultation tariff and is subject to formulary.
Chronic Medication (Reference pricing and MMAP will apply)	Subject to formulary and formulary reference pricing – 26 CDL conditions – unlimited only if prescribed by DSP network provider and dispensed within network pharmacy or dispensing DSP doctor. No cover for non-formulary medicines, unless otherwise pre-authorised 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 the Counter medicine - no prescription	Benefit - M = R100 p.a. and M+ R180 p.a.
Optometry	DSP Network only. 1 visit per beneficiary every second year. Subject to combined family limit per annum of R2,380. Single vision lenses and frames limited to R950 per beneficiary every second year subject to combined family limit. Bi-focal lenses and frames limited to R1,400 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) **Authorisation required for specialised radiology**	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. No benefit if not referred by a Network provider or a Specialist following referral by a DSP network GP (except when involuntary)
Pathology – Pathology and Histology	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	No benefit unless PMB which is paid at cost.
SUB-ACUTE FACILITIES	
Hospice – imminent death regardless of the diagnosis	PMB cases unlimited. Paid at 100% of cost subject to preauthorisation and protocols.
Hospice – stepdown or rehabilitation	PMB cases unlimited. Paid at 100% of cost subject to preauthorisation and protocols.
Private Nursing	No benefit
Oncology Program	Paid 100% of Scheme rate unless a PMB case paid at 100% of cost. Subject to protocols and authorisation on the Schemes oncology program. **oncology@universal.co.za**.
YOUR WELLNESS BENEFITS INCLUDE ACTIVE NURSE BASED DISEASE MANAGEMENT PROGRAM'S.	
Your wellness benefits include active nurse based disease management program's.	
Wellness 360° Check	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.
Emotional Wellness	Unlimited telephonic consultations.
Oral contraceptives (excludes treatment for skin conditions)	Limited to R140 per month.
Flu vaccines	1 dose per beneficiary per annum. Nappi price applies

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 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 6561407**.

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**. 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 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**

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 Wellness benefits column. Your wellness benefit includes active nurse based disease management program's.

On the Oncology program an introduction to the end of life program. Please refer to the Scheme for further information.

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 Member	Adult Dependant	Child Dependant
A	R0 – R6 000	R980	R935	R343
B	R6 001 – R8 500	R1,025	R980	R364
C	R8 501 – R10 500	R1,165	R1,110	R415
D	R10 501 – R13 000	R1,510	R1,450	R430
E	R13 000+	R2,225	R2,050	R800

From the 4th Child it is free.

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 an adult 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 waiting period 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 penalty to be applied depends 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
5 – 14 years	0.25 x contribution
15 – 24 years	0.50 x contribution
25+ years	0.75 x contribution

Designated Service Provider (DSP) and Managed Care Programs

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 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 Medicine 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 Programe on **0860 111 900**.

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 Program **diseasemanagement@universal.co.za**
- Oncology Program **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 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	Multiple Sclerosis
Bronchiectasis Cardiac failure	Diabetes Mellitus Type 2	Parkinson's disease
Cardiomyopathy disease	Dysrhythmias	Rheumatoid arthritis
Chronic renal disease	Epilepsy	Schizophrenia
Coronary artery disease	Systemic Lupus Erythematosus	Glaucoma
Crohn's disease	Haemophilia	Ulcerative Colitis
	Hyperlipidaemia	HIV/Aids

Members must register chronic conditions on the Chronic Medication Management program 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 member's 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 Universal Healthcare Call Centre at **0861 486 472**.

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:

1. WCMAS tip-off lines: share-call **0860 104 302**
2. WCMAS's Principal Officer (call **013 656-1407**) or any Board of Trustee member.
3. 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 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 hirs 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 or any of his dependants from any medical scheme in relation to which he 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
- Diagnosis
- Service code

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 English, 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 M+	=	member
p.b.p.a	=	member with dependants per
p.f.p.a	=	beneficiary per annum per
PMB	=	family per annum prescribed
Financial year:	=	minimum benefits 1 January to
DSP	=	31st December Designated
SR	=	Service Provider Scheme Rates
PPO	=	Preferred provider pharmacies
CDL	=	Chronic Disease List
TTO	=	To take out i.e. medicines taken out of hospital when discharged

NTSIKA

WCMAS
Our members
Our passion

Managed Care by
Universal
Care