



MEMBER GUIDE  
COMPREHENSIVE  
**2026**



## Hospitalisation

<b>Hospital accommodation</b>	Paid at 100% negotiated rate in general ward and specialised units at a DSP hospital. Subject to pre-authorisation
<b>GP and Specialist in hospital</b>	Unlimited. Paid at 100% of the Scheme rate except for PMB's which are paid at cost
<b>Medication, material and equipment</b>	Paid at 100% of Scheme rate
<b>Medication in hospital</b>	Paid at 100% of Scheme rate
<b>TTO's (To Take Out Medication)</b>	Up to 30 days' supply paid at 100% SEP plus a dispensing fee
<b>MRI, CT and PET scans</b>	Paid at 100% of Scheme rate limited to R37 670 pbpa
<b>Xrays and Ultrasounds</b>	Paid at 100% of Scheme rate
<b>Pathology in hospital</b>	Paid at 100% of Scheme rate.
<b>Oncology</b>	Unlimited subject to pre-authorisation and application of Icon Core protocols. Paid at 100% of Scheme rate. DSP network applicable.
<b>Physiotherapy in hospital</b>	Payable at 100% Scheme rate subject to pre-authorisation and protocols. Post-operative physiotherapy out of hospital within 60 days of surgery limited to R3 780 pbpa and subject to pre-authorisation
<b>Psychiatric admissions</b>	Up to 35 days per beneficiary per annum in hospital paid at 100% negotiated rate at a DSP hospital. Subject to pre-authorisation
<b>Private Nursing</b>	Limited to R1 140 pd for up to 60 days. Overall limit R67 900 pbpa
<b>Frail Care</b>	Limited to R190 pbpd. Overall limit of R67 900 pbpa
<b>Hospice</b> <i>(imminent death regardless of the diagnosis, Step down or rehabilitation)</i>	To be recommended by a medical practitioner and subject to pre-authorisation and protocols: <ul style="list-style-type: none"> <li>• PMB's paid at cost</li> <li>• Non PMB cases limited to R2 070 pbpd in hospital and R630 pbpd for home visits. Subject to overall limit of R67 900</li> </ul>
<b>Internal prosthesis/appliances</b>	Paid at 100% of Scheme rate and subject to an annual combined overall limit of R96 410. Subject to pre-authorisation
<b>Cochlear Implants</b>	Limited to R180 760 pb every 5 years. Subject to clinical protocols
<b>Narcotism, Alcoholism and Drugs</b>	Up to 30 days per beneficiary per annum. Paid 100% of Scheme rate
<b>Organ transplants</b>	Paid at 100% of Scheme rate. PMB's unlimited. Subject to pre-authorisation and protocols
<b>Chronic Renal Dialysis</b>	Paid at 100% of Scheme rate limited to R106 000 pbpa unless a PMB condition. Subject to pre-authorisation and protocols
<b>Ambulance and emergency evacuation</b>	Paid at negotiated rate or 100% of Scheme rate

## Day-to-Day Benefits

<b>GP Consultations</b>	Paid at 100% of Scheme rate from MSA
<b>Specialist Consultations</b>	Paid at 100% of Scheme rate from MSA Paediatric visits only paid in respect of beneficiaries younger than 16 years
<b>Optometric Services</b>	Paid at 100% of Scheme rate from MSA
<b>Excimer laser/lasik procedure</b>	Paid at 100% of Scheme rate limited to R16 970 per beneficiary per eye Subject to pre-authorisation and protocols
<b>Acute and Over the Counter Medication</b>	Paid at 100% of SEP plus a dispensing fee from MSA
<b>Chronic Medicines</b>	Paid at 100% of SEP plus a dispensing fee MMAP, Formulary and Reference Pricing is applied A 15% co-payment will apply to medicine obtained from a non-PPO provider

### DENTAL SERVICES

<b>Basic Dentistry</b>	Paid at 100% of Scheme rate from MSA
<b>Surgical Procedures</b>	In doctors room 100% at Scheme rate from MSA In hospital, paid at Scheme rate from risk. Subject to pre-authorisation Non-surgical procedures paid at 100% of Scheme rate from MSA
<b>Dental Implants</b>	One implant payable from risk pbpa. additional implants payable from MSA.
<b>Orthodontics</b>	Initial fee paid at 100% of Scheme rate up to R7 510 per treatment plan. Thereafter payable at 100% of Scheme rate from MSA. Subject to pre-authorisation

### RADIOLOGY & PATHOLOGY

<b>Radiology</b> <i>Out of hospital</i>	Limited to R2 700 pbpa thereafter MSA
<b>Pathology</b> <i>Out of hospital</i>	Limited to R3 600 pbpa thereafter MSA
<b>Scans</b> <i>MRI, CAT &amp; PET</i>	Non-PMB's limited to R37 670 pbpa. Pre-authorisation required

Above Threshold benefits once MSA depleted on page 7.

Medical Appliances & Prosthesis

Internal Prostheses / Appliances	Overall limit of R96 410 unless a PMB, which is payable at cost. Subject to pre-authorisation
Hearing Aids <i>(appliances and repairs, excluding batteries)</i>	Limited to R55 440 per beneficiary every 3 years Repairs limited to R2 360 pbpa
Wheelchairs	Limited to R8 920 per beneficiary every 2 years
Artificial Eyes/Limbs	Limited to R60 250 per beneficiary every 2 years subject to clinical motivation
Breast Prostheses and Bras	Limited to R6 020 pbpa with a sub-limit of R4 830 applicable to bras
Orthopaedic Braces and Other Similar Aids	Limited to R16 330 pbpa. Subject to being prescribed by medical practitioner
Insulin Pumps	Limited to R69 900 per beneficiary every 5 years subject to clinical protocols

Other Medical / Surgical Appliances /Aids

Oxygen and home ventilation - Rental	Rental paid at R1 370 per beneficiary per month and subject to pre-authorisation
Oxygen and home ventilation - Purchase	Purchase limited to R37 440 per beneficiary every 3 years
CPAP <i>(including mask)</i>	Limited to R13 870 per beneficiary every 5 years
Nebulizer	Limited to R830 per family every 5 years if an applicable condition is registered, otherwise payable from MSA
Blood Pressure Monitors	Limited to R920 per family every 5 years if an applicable condition is registered, otherwise payable from MSA
Glucose Monitors	Limited to R680 per family every 2 years if an applicable condition is registered, otherwise payable from MSA

AUXILIARY SERVICES

<ul style="list-style-type: none"><li>Audiology</li><li>Dietician</li><li>Occupational therapy</li><li>Speech therapy</li><li>Chiropody</li><li>Chiropractor</li></ul>	Paid at 100% of Scheme rate from MSA
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SUPPLEMENTARY HEALTH SERVICES

Flu vaccines	Payable at 100% SEP
DBC Back and Neck Program	Subject to protocols and pre-authorisation
Mental Wellbeing Program	Consultation with a psychiatrist or psychologist paid at 100% scheme rate from MSA. PMB paid from risk at cost. Visit WCMAS mobile app for more information

WELLNESS BENEFITS

Each Wellness Map contains generous benefits which will cover a clinically recommended screening at up to 200% of the Scheme Rate, so that you can pursue preventative wellness without worrying about co-pays.

Not only do we fund the benefit generously, but we are also offering Wellness Rewards for completing the recommended screening. You can earn up to R2 500 for doing what is healthy. This Wellness Reward Fund will be used to extend your day to day cover and can be used for glasses, dentists, doctor consultations and the like.

Here is a step by step guide on how it will work:

Step 1: Find your wellness map



STRONG CARE  
For men 18 and older



THRIVE CARE  
For women 18 and older



FUTURE CARE  
For teens ages 13 to 17



MOMMY CARE  
For expecting mothers



BRIGHT CARE  
For children ages 2 to 12



TENDER CARE  
For babies and toddlers under 2

Step 2: Go for the screening at the start of your map

See the guidance in the wellness maps illustrated to know where to start, or consult your GP.

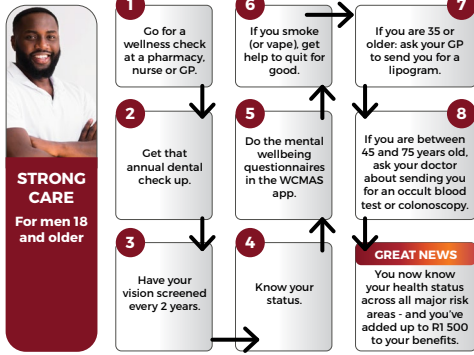
Step 3: Submit your claim and get rewarded

Guidance is given on the benefit guide on which codes the doctor should bill. In a year you can accumulate up to R2 500 in Wellness Rewards.

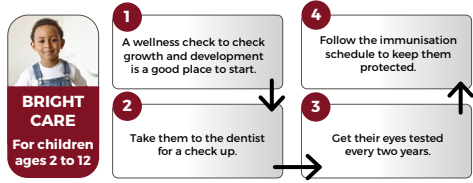
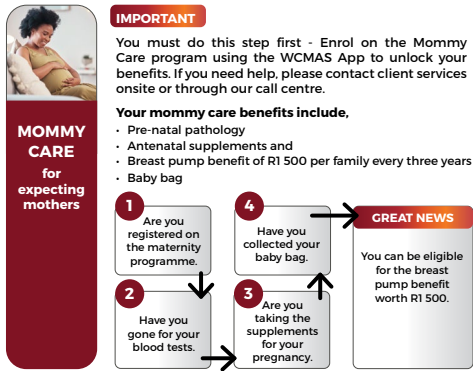
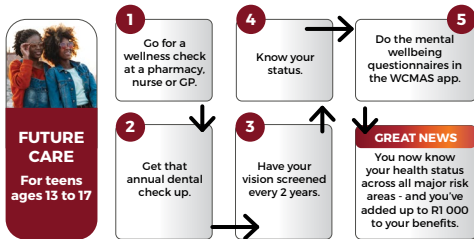
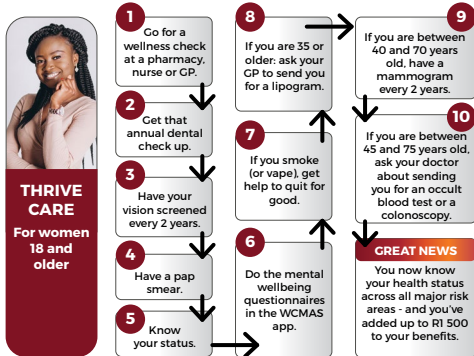
Wellness Reward Maximums	
R1 500	per adult
R1 000	per child
R2 500	per family

Step 4: Submit a day to day claim

The Wellness Reward Fund that you build up by going for screenings will extend your day to day cover and can be used by any dependant on your membership. On options with a MSA fund, the Wellness Reward Fund will be depleted first, helping you to preserve available money in your savings account. For other options, the fund will be used to cover co-payments or enhance benefits covered by your plan. Use the reward within the same benefit year.

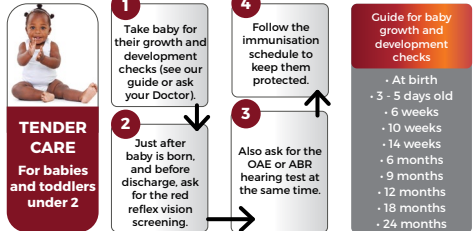


P.S. Don't worry too much if you don't follow this exact order, it's a guide. We will still reward you every step of the way. Consult our benefit guide or website for networks, rules and codes.



**IMMUNISATION SCHEDULE (BASED ON NDOH EPI)**

6 years	TD vaccine
From 9 years	HPV vaccine
12 years	TD vaccine



**IMMUNISATION SCHEDULE (BASED ON NDOH EPI)**

At birth	BCG and OPV(0) drops
6 weeks	OPV(1), RV(1), DTaP-IPV-Hib-HBV(1), PCV(1)
10 weeks	DTaP-IPV-Hib-HBV(2)
14 weeks	RV(2), DTaP-IPV-Hib-HBV(3), PCV(2)
6 months	Measles or MMR vaccine(1)
9 months	PCV(3)
12 months	Measles or MMR vaccine (2)
18 months	DTaP-IPV-Hib-HBV(4)

## Above Threshold Benefits

**BENEFITS AFTER MSA LIMIT HAS BEEN DEPLETED AND THRESHOLD(SELFPAYMENT GAP) REACHED**

Payable from Risk (limits apply only after self-payment/threshold has been reached)

**MSA MEMBER RISK**



**Visits to General Practitioner**  
Limits apply after threshold

Paid 100% at Scheme rate and limited as follows:

M-	15 visits	M+3	30 visits
M+1	21 visits	M4+	34 visits
M+2	26 visits		

**Visits to Specialist**  
Limits apply after threshold

Paid 100% at Scheme rate and limited as follows:

M-	10 visits
M+	12 visits

**Dentistry**  
Limits apply after threshold

Paid 100% at Scheme rate and limited as follows:

M-	R8 410	M+3	R17 720
M+1	R11 620	M4+	R18 890
M+2	R16 700		

**Optical**  
Limits apply after threshold  
1 eye test pbpa. after threshold

Paid 100% at Scheme rate and limited as follows:

Eye test	Scheme rate	Contact lenses	R3 190
Frame	R1 470	(Sunglasses excluded from benefits)	
Lenses	R3 190		

**Acute Medicines**  
(must be prescribed)

Paid 100% at Scheme rate and limited as follows:

M-	R8 410	M+3	R17 720
M+1	R11 620	M4+	R18 890
M+2	R16 700		

**Limits apply after threshold**

**Audiology**

Paid 100% of Scheme rate and limited to R4 870 pbpa

**Chiropodist/Podiatrists**

Paid 100% of Scheme rate and limited to R4 870 pbpa

**Chiropractor**

Paid 100% of Scheme rate and limited to R4 870 pbpa

**Clinical Psychology**

Paid 100% of Scheme rate and limited to R4 870 pbpa

**Dieticians**

Paid 100% of Scheme rate and limited to R1 260 pbpa

**Homeopathic Medication**

Paid 100% of Scheme rate and limited to R10 110 pfpa

**Medical Appliances**

Paid 100% of Scheme rate and limited to R5 250 pbpa

**Occupational Therapy**

Paid 100% of Scheme rate and limited to R4 870 pbpa

**Speech Therapy**

Paid 100% of Scheme rate and limited to R4 870 pbpa

**Physiotherapy/Bio-Kinetics**

Paid 100% at Scheme rate and limited as follows:

M	R4 870	M+	R9 720
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## GYM BENEFITS

Get Active with WCMAS

Members and their families can now enjoy unbeatable fitness offers.

**Planet fitness offers you and your family;**

- 10% off standard membership fees for all primary and adult dependant members.
- Under-18 Access: Members' children 17 and under train for free (excluding JustGym).
- Buddy Tag: One free Buddy Tag (linked training partner) per qualifying primary member only, funded by Planet Fitness.
- No joining fee.

**Virgin Active offers you and your family;**

- 10% off standard membership fees for the main member and all dependants linked to the WCMAS membership.
- No joining fee.

**Validation via WCMAS mobile app or WCMAS membership card.**



## Contributions

INCOME	MAIN MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 – R2 000	R2 933	R2 933	R778
R2 001 – R3 000	R3 358	R3 358	R778
R3 001 – R5 000	R4 173	R4 173	R778
R5 001 – R8 000	R4 569	R4 569	R778
R8 001 – R10 000	R4 749	R4 749	R778
R10 001 +	R5 212	R5 212	R778

FREE FROM THE 4<sup>TH</sup> CHILD

## Annual MSA allocation

INCOME	MAIN MEMBER	ADULT DEPENDANT	CHILD DEPENDANT
R0 – R2 000	R8 301	R8 301	R2 202
R2 001 – R3 000	R9 504	R9 504	R2 202
R3 001 – R5 000	R11 811	R11 811	R2 202
R5 001 – R8 000	R12 930	R12 930	R2 202
R8 001 – R10 000	R13 440	R13 440	R2 202
R10 001 +	R14 751	R14 751	R2 202

## Membership

**WCMA 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 statements, tax certificates, and others

### COMMUNICATION VIA E-MAIL

Electronic communication via e-mail is the preferred way of communication. Members with e-mail addresses will receive - mail statements and correspondence. 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 [membership@wcmas.co.za](mailto:membership@wcmas.co.za).

### 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

Download WCMAS mobile app or go to [www.wcmas.co.za](http://www.wcmas.co.za)

On the website go to the member portal and register. A once off registration is required to enable full access. Once you have registered on the mobile app or member portal, you will have access to the following information:

- Frequently asked questions
- View registered dependants linked to your membership

- View any chronic diseases registered
- Print your latest tax certificate
- View medical claim statements for the past 6 months.
- View your MSA balance
- See who our Board of Trustee members are, and have access to the WCMAS Annual Reports
- Find out about the scheme's Benefits and Rules.

## Preventative Care and Wellness Programme

WCMAS offers a preventative care and wellness programme for early detection of health risks. Benefits are reflected under the Wellness benefits.

## Contributions

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

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

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

## Late payments

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

## Waiting periods and late joiner penalties

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

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

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

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

**EXAMPLE:**

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

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

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

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

**Medical Aid Savings Account – MSA Day to Day Benefits**

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

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.

**What happens when your Medical Savings Account is exhausted?**

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

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

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

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

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

**Above threshold benefits.**

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

Full list of the benefits is available on page 7 of the member's guide.

What is a threshold  
(Self-payment Gap)

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

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.

Medicine Benefits

CHRONIC MEDICINE BENEFITS

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

Non-PMB and non-CDL (85% benefit)

PMB and 26 CDL conditions (100% benefit)

(PMB=prescribed minimum benefits)  
(CDL=Chronic Disease List)

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 Scheme directly with their request on 013 656 1407.

GENERIC REFERENCE PRICING & MMAP

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

In-Hospital and pre-authorisation treatment

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

Pre-authorisation can be obtained by calling or emailing us on:

- Hospital Pre-authorisation: 0861 370 337
- Pre-authorisation: [preauthorisation@wcmas.co.za](mailto:preauthorisation@wcmas.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              | • Material                              |
| • Theatre and ward drugs |   |





## What to do in case of an emergency

- Contact **ER24** for ambulance on **084124**
- **ER24** call centre can also assist with medical advice
- Should a Service Provider require proof of membership, use WCMAS electronic membership card on the mobile app.

## Prescribed Minimum Benefits (PMB)

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

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

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

- Addison's disease
- Chronic Obstructive Pulmonary Disorder
- Hypertension
- Asthma
- Diabetes Insipidus
- Hypothyroidism
- Bipolar Mood Disorder
- Diabetes Mellitus Type 1
- Multiple Sclerosis
- Bronchiectasis
- Cardiac Failure
- Diabetes Mellitus Type 2
- Parkinson's Disease
- Cardiomyopathy Disease
- Dysrhythmias
- Rheumatoid Arthritis
- Chronic Renal Disease
- Epilepsy
- Schizophrenia

- Coronary Artery Disease
- Systemic Lupus Erythematosus
- Glaucoma
- Crohn's Disease
- Haemophilia
- Ulcerative Colitis
- Hyperlipidaemia
- HIV/Aids

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

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

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

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

## Exclusions

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

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

- Holidays for recuperative purposes.
- Purchase of patent medicine, toiletries, beauty preparations, baby foods, household remedies.
- 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 and Ethics Hotline

The Vuvuzela Hotline, is an independent service provider appointed by Witbank Coalfields Medical Aid Scheme (WCMAS) to provide and manage the WCMAS Fraud and Ethics Hotline.

Fraud and Ethic Hotline's provide a third-party anonymous and confidential whistle blowing reporting service for you to report potential fraud, corruption, misappropriation of resources or any other unethical conduct.

In an environment of increasing fraud and corruption, and declining ethical values, hotlines are a necessity in organizations fight against theft, misconduct, abuse, bribery and dishonesty.

The Hotline provides seven (7) reporting channels, Free Call telephone, email, mobile application, Website, SMS, fax and post available in all eleven (11) official South African languages, 24 hours a day, 7 days a week, 365 days a year, for you to voice your concerns and report incidents of Fraud or Corruption.

Whatever preferred reporting channel is used, your anonymity is guaranteed and information treated confidentially in line with the Protected Disclosure Act (Act 26 of 2000).

The Hotline's highly secured environment, systems and processes can provide you with the

peace of mind that your concerns are dealt with, confidentially, securely and professionally.

### HOW IT WORKS

- Whistleblower reports incident via preferred reporting channel
- Our Agent interviews caller using an approved questionnaire to compile an incident report
- Each incident report allocated a unique reference number
- Incident report reviewed by Team leader and Manager
- Incident report is password protected and distributed to designated recipient within 24 hours.
- Incident report sent to investigators for investigation
- Investigators provide updates and feedback to Fraud Hotline on progress of the investigation
- Fraud Hotline provides updates to whistle blower
- Investigation can take up to 21 days working days
- Reported incident could result in a conviction

**Toll Free Number:** 0800 212 174

**Email:** [wcmas@thehotline.co.za](mailto:wcmas@thehotline.co.za)

**Website:** [www.thehotline.co.za/report](http://www.thehotline.co.za/report)  
(Use 0800 212 174 to report)

**SMS:** 30916

**Mobile App:** Vuvuzela Hotline  
(Use 0800 212 174 to report)

*Available in all eleven (11) official South African languages, 24 hours a day, 7 days a week, 365 days a year.*

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.

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.

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 to [wcmas@wcmas.co.za](mailto: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 to [wcmas@wcmas.co.za](mailto:wcmas@wcmas.co.za) and marked for the attention of the Chairperson
- Final submission can be sent to the Schemes Disputes Committee in writing to [wcmas@wcmas.co.za](mailto:wcmas@wcmas.co.za) and marked for the attention of the Disputes Committee

Legend

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



COUNCIL FOR MEDICAL SCHEMES

Private Bag X34  
HATFIELD  
0028  
Share Call number: 0861 123 267  
[www.medicalschemes.com](http://www.medicalschemes.com)  
[support@medicalschemes.com](mailto:support@medicalschemes.com)  
[complaints@medicalschemes.com](mailto:complaints@medicalschemes.com)



## WCMAS

013 656 1407

### Please call me

066 516 3574 (office hours only)

### Hospital Pre-authorisation

0861 370 337

preauthorisation@wcmas.co.za

### Disease management programme

0861 370 337

diseasemanagement@wcmas.co.za

### Chronic medicine registration

0800 132 345

chronic@medikredit.co.za

## Mental wellbeing programme

013 656 1407 press 5

well@wcmas.co.za

## Oncology programme

oncology@wcmas.co.za

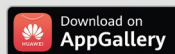
www.wcmas.co.za



**084 124**

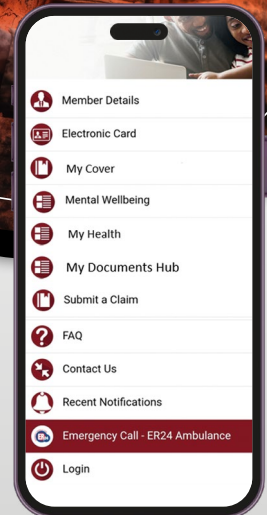
# Download our Mobile app today

With the WCMAS app, your benefits  
are always at your fingertips - from  
MSA balances to claims and more.



wcmas@wcmas.co.za

S25°52'23.7" E29°14'23.6



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