FREQUENTLY ASKED QUESTIONS

Comprehensive option

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 the approval by the CMS

INDEX

DEFINITIONS

Medical Savings Account (MSA)

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. A portion of a member's monthly contributions will be allocated to the medical savings account every month. The savings account balance is provided upfront for the full financial year (1 January until 31 December) and is therefore reduced pro-rata should a member resign or should a dependant be registered or deregistered 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 re-join a medical aid with a MSA then the refund will be paid to him/her.

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. Refer to your member guide for limits and benefits.

IMPORTANT CONTACT INFORMATION

WCMAS office telephone:	013 656 1407 Email: wcmas@wcmas.co.za
Hospital pre-authorisation:	086 137 0337 Email: preauthorisation@wcmas.co.za
Disease management programme:	086 137 0337 Email: diseasemanagement@wcmas.co.za
Chronic medicine:	080 013 2345 (Swiftauth) Email: chronic@medikredit.co.za
Oncology programme:	086 137 0337 Email: oncology@wcmas.co.za
ER24	084 124 (Ambulance)

MEMBERSHIP

1) Can anyone join WCMAS?

WCMAS is a restricted Scheme providing medical aid cover to participating employers only.

2) Who is eligible for membership?

Subject to approval by the Scheme, members may apply to register the following as their dependants: -

- the spouse of a member irrespective of the gender of either party, married in terms of any law or custom who is not a member or registered dependant of another medical scheme and cannot include a divorced spouse or former partner of the member,
- the partner of a member with whom the member has a committed relationship based on objective criteria of mutual dependency irrespective of the gender of either party and shall include the spouse of a member to whom he/she is married in terms of custom or tradition and must provide satisfactory proof to the Scheme of the committed relationship or marriage,

- 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 unmarried and a student at a recognised institution. 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.

3) What is the process of applying for membership?

Prospective members must be employed by employer groups associated with the scheme and can apply for membership through their respective HR or time offices. The person with whom the application form is completed will submit the form and supporting documents to the scheme.

4) How do I register my dependents?

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 new-born 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.

5) What documents should I submit with applications, amendments or resignations?

<u>Applications & Amendments – all types of members:</u>

- Copies of identity documents of the principal member and his / her spouse (if
- applicable)
- Copies of marriage certificate (if applicable)
- Copies of identity documents or unabridged birth certificates of child dependants
- Copies of the membership certificates of previous medical schemes to which the principal member / dependant belonged
- Proof of banking details (either a bank stamped statement, confirmation from the bank confirming banking details or a cancelled cheque none of which should be older than 3 months.)

<u>Applications & Amendments – Pensioner or Widow Members:</u>

In addition to the above, the following will also be required:

- Copies of the signed records of service
- Proof from the pension fund confirming monthly income (if applicable)
- Proof of being declared totally unfit for all work on the mines (ill-health or disabled applicants) (if applicable)
- Copy of death certificate (only Widow / widower members)
- Letter from the employer confirming the payment subsidy (if applicable)

<u>Applications & Amendments – Special dependants:</u>

In addition to the above, the following will also be required:

- In the case of Common law wives: Signed affidavit confirming the relationship with the principal member, as well as a copy of the membership certificate of the previous medical aid.
- In the case of children over the age of 21: Proof of registration as a full-time student at a recognised tertiary institution.

Resignations:

- Proof of banking details (either a bank stamped statement, confirmation from the bank confirming banking details or a cancelled cheque none of which should be older than 3 months.)

6) How long will it take to register me or to make amendments on my membership?

The scheme endeavours to maintain a 5-day turnaround time, subject to receipt of all supporting documentation.

7) How will I know when I have been registered or my requested amendment made?

You will receive a membership certificate via e-mail or it will be sent to your time office. Alternatively, you can phone the scheme's call centre on (013) 656 1407.

8) Can my divorced spouse be registered as a dependent if the divorce settlement decrees that I am liable for cover?

The Scheme does not provide cover for divorced spouses even if the divorce settlement decrees that the member is liable for cover.

9) How much time do I have to inform the scheme of changes in my personal details?

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 (this is not the complete list).

10) May my dependents or I be a beneficiary of more than one medical scheme?

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.

11) Can my membership be cancelled?

Membership may be cancelled by the scheme as per section 29(2) of the Act which provides that a member's membership will be terminated or suspended in the case of:

- Failure to pay contributions, within the time allocated in the scheme rules (rule 12.4);
- Submission of fraudulent claims (rule 12.5);
- Committing of any fraudulent act (rule 12.5);
- The non-disclosure of material information.

12) Do I have to provide notice when resigning from membership?

Members are allowed to resign from the scheme at any time during the year when submitting a written notice to the scheme which must not be less than 1 month (rule 12.2.1).

13) How do I change benefit options?

Members are allowed to change benefit options with effect from 1 January every year only. The change may be effected by completing and submitting an option change form for the option currently registered on and completing and submitting an application for the option that you wish to change to. All supporting documents will be required in the event of changing benefit options. You are required to provide the scheme with 30 days' prior notification of any intended changes.

WAITING PERIODS

1) What is a waiting period?

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 waiting period of up to 12 months.

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

2) What are the different types of waiting periods?

i. General waiting periods

This is a period of 3 months in which a beneficiary is not entitled to claim any benefits.

ii. Condition specific waiting periods

This is a period of up to 12 months in which a beneficiary is not entitled to claim benefits 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. This waiting period can be applied to members who were not previously on a medical aid for a period of at least 90 days preceding the date of application.

3) What is a late joiner penalty?

The law provides that a 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.

4) How are late joiner penalties calculated?

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 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).

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.

CONTRIBUTIONS

1) What are my monthly contributions?

The contributions are listed in the benefit guide and are also available on the scheme's website.

2) Whose responsibility is it for the payment of my contributions?

You remain liable at all times for payment of contributions to the scheme, irrespective whether you receive assistance from your employer towards a subsidy.

CLAIMS, BENEFITS AND ENTITLEMENTS

1) Are any benefits pro-rated if I only join the scheme after January? , Yes, benefits are pro-rated if joining after 01 January

2) How do I apply for managed care programmes?

Please refer to the scheme for details on specific programmes offered. Please call 0861 370 337 or 013 656 1407.

3) **What happens when an annual limit on non-PMB medication benefit has been exhausted?**

You will be liable for any balance once benefits are exhausted.

CHRONIC MEDICATION

1) **Why is it important for a beneficiary to be registered for chronic medication?**

It is important that you apply for chronic medication benefits as soon as your doctor has diagnosed you with a chronic condition and provided you with a prescription for on-going medication. WCMAS may require additional information from your doctor before authorising your medicine.

2) **What happens when a beneficiary is not registered for chronic medication?**

The member's medication will be paid from his MSA for 2 months where after it will be rejected until the chronic medication is registered.

3) **Who should be registered for chronic medicine?**

Any beneficiary who is diagnosed with a chronic condition should be registered.

4) **Does each dependant need to apply separately for chronic medication?**

Yes

5) **How many times does a beneficiary have to apply for the medication?**

Every time when a new condition is diagnosed the beneficiary should apply. Beneficiaries will also be required to renew their script every 6 months. Once a year general check-ups may also be required.

6) **In addition to the beneficiary, who else must complete and sign the registration form when applying for chronic medication?**

All registrations must be done by the doctor, by contacting SwiftAuth Online on the toll free no 0800132345 or send an email to chronic@medikredit.co.za.

7) **What additional documents are required to support the application?** SwiftAuth will request the supplier for any additional documentation it may require to register the condition.

8) **Where do I have to send the completed registration form?** Send the completed registration form to chronic@medikredit.co.za.

9) **How will I know that my application has been approved?** There will be an immediate answer when the supplier or his/her receptionist phones Swiftauth for authorisation.

10) **What process should I follow to update any modification to the chronic authorisation?**

Contacting SwiftAuth Online on the toll free number 0800132345 or send an email to chronic@medikredit.co.za, where all updates are made.

11) **Can I get my chronic medication at any pharmacy and / or dispensing doctor?**

Yes, at any pharmacy and some dispensing doctors.

12) **What happens if a doctor changes a beneficiary's medication in the middle of the month?**

The supplier contacts SwiftAuth Online on the toll free number 0800132345 or send an email to chronic@medikredit.co.za to make any changes.

13) What happens when a beneficiary uses medication that is not on the formulary list?

Please refer to Medikredit formulary list. WCMAS does not have a formulary list but we apply MMAP reference pricing and have limits on certain medication e.g. sleeping medicationand pain medication.

14) Can a beneficiary receive benefits for more than one month's supply of medication? And how do I apply for it?

Medication can only be claimed every 25 to 30 days depending on the product, except where a member goes overseas then they can apply for an early refill.

PRE-AUTHORISATION

1) What is meant by pre-authorisation?

The pre-authorisation process and Special Care Programmes (managed care) ensure that members get the most cost-effective and appropriate care for their illness. This also allows the cost of hospitalisation, medicine and treatment to be managed to the benefit of our members.

Even though pre-authorisation is obtained, it does not guarantee payment of subsequent claims.

2) Which benefits require pre-authorisation?

Pre-authorisation is required for planned hospital admissions, MRI/CT/PET scans, ICON program, chronic medication and other major medical expenses where specified in the Benefit and Contribution Schedule for various plans.

Pre-authorisation is also required for frail care and nursing homes.

3) What is the process that should be followed to obtain preauthorisation?

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 methods:

- Email pre-authorisation request to PPS Healthcare Administrators at preauthorisation@wcmas.co.za
- Phone PPS Healthcare Administrators Hospital pre-authorisation on **086 137 0337**
- Disease Management Programme diseasemanagement@wcmas.co.za
- Oncology Programme oncology@wcmas.co.za

- For frail care and nursing homes, please forward a medical motivation, treatment plan and quotation for approval to preauthorisation@wcmas.co.za or call **086 137 0337**

4) What information should I have on hand when obtaining preauthorisation?

Before phoning for a hospital pre-authorisation, you will need to have the following information available:

- Name and contact details of principal member
- Initials, surname and date of birth of the patient
- WCMAS membership number
- Name and practice number of treating doctor
- Name and practice number of hospital where you are to be admitted
- Proposed duration of hospitalization
- Date and time of admissions
- CPT4 (procedure) code - remember to ask your doctor for this
- ICD-10 (diagnosis) code - remember to ask your doctor for this

COMPLAINTS AND DISPUTE RESOLUTION

1) How do I lodge a complaint with the scheme

Members are encouraged to explore the Scheme's dispute resolution process prior to lodging any complaints with the CMS.

- A complaint can be lodged in terms of the medical scheme rules to the Scheme Principal Officer in writing 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 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 to wcmas@wcmas.co.za and marked for the attention of the Disputes Committee.

2) How do I lodge a complaint with CMS

The Medical Schemes Act allows members to lodge their complaint directly to CMS. However, members are encouraged to explore the scheme's dispute resolution process prior to lodging their complaints with CMS.

Written complaints can be addressed to the CMS complaints division and sent to:

CONTACT DETAILS OF REGULATOR

Council for Medical Schemes
Private Bag X34
HATFIELD
0028

Telephone: 086 112 3267
www.medicalschemes.com
support@medicalschemes.com
complaints@medicalschemes.com