

# CompCare

Medical Scheme



# Hospicare



Administered by



**Universal**<sup>®</sup>

CompCare Medical Scheme is administered by  
Universal Healthcare Administrators (Pty) Ltd.

# Hospicare

Hospicare ensures that you and your loved ones have access to quality healthcare for in-hospital treatment and medical emergencies. With cover for hospital stays, surgeries, and essential treatments, you'll have peace of mind knowing you are protected. This plan gives you access to Netcare private hospitals, ensuring you receive the best care.



### Preventative care and wellness

Enhance your everyday healthcare with comprehensive preventative cover, featuring a range of health tests designed for early detection of potential issues. This plan also includes essential vaccinations, cancer screenings, and malaria prevention medications for when you're travelling.

### Emotional health is important

Benefit from unlimited counselling sessions with experienced psychologists or social workers. Plus, if you need extra support, you can enjoy up to three one-on-one sessions per year with qualified professionals, ensuring personalised care when you need it most.

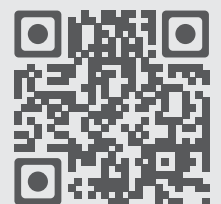
### Virtual nurse consultations

CompCare members on this option have unlimited virtual nurse consultations at 100% of the CompCare rate—fully covered from Risk. Simply connect via uHealthChat on the Universal.one App for CompCare members, to get instant, professional health support whenever you need it.

### Hospital cover

Our hospital plan offers vital protection for life's unexpected medical events. It ensures comprehensive cover for a wide range of treatments, from medical emergency procedures to specialised care, all while guaranteeing access to quality treatment through a network of private healthcare providers. With your health and finances safeguarded, you can focus on your recovery with confidence.

Monthly Contributions	
Principal member	R5 192
Adult dependant	R5 192
Child dependant	R1 817



Scan to speak to a product specialist to join



# Speciality healthcare bundles

Being on autopilot doesn't mean switching off — it means staying in motion through every life stage. From starting a new venture to having a family — your health and wellness can keep up, effortlessly. That's why these bundles are designed for real life — giving you the right care, at the right time, no matter where you are in your journey.

## Flu prevention

Protect the people you love from flu's grip with proactive care and all-season defence.

- Flu and pneumococcal vaccines.
- Ask SARAH how to protect your family before flu season — with science you can trust.
- Unlimited virtual nurse consults.

## Cancer prevention

Take control with screenings and support that empower you to face life with confidence.

- HPV (Cervical Cancer) vaccine.
- Pap smear screening.
- Mammogram.
- Prostate-specific antigen (PSA) blood test.
- Colorectal cancer screening.
- Unlimited virtual nurse consults for any questions.
- Unlimited telephonic psychosocial counselling.
- We'll waive the co-payment for an elective hysterectomy if there's a family history — across three generations — of breast, uterine, or ovarian cancer.
- SARAH answers your cancer screening questions with WHO-approved information.

## Heart health

Give your heart the care it deserves with personalised plans and expert, ongoing guidance.

- An annual health check that includes a blood pressure and a cholesterol test.
- Fitness & exercise – Stay active with an annual assessment, custom plan, and expert support to keep your heart strong.
- Nutrition – Eat smart with a tailored plan, guided by annual assessments and check-ins for a healthy heart.
- Unlimited virtual nurse consults for any questions.
- SARAH helps you understand your results and make heart-smart choices, backed by WHO expertise.



## Mental health

Compassionate care, counselling, and support to help you feel stronger, lighter, and more in control.

- Psychiatric and psychological treatment in and out of hospital.
- Alcoholism, drug dependence and narcotics.
- Psychosocial counselling with unlimited telephonic counselling including 3 face-to-face sessions.

## Travel health

Explore the world with peace of mind, knowing your health is protected every step.

- Preventative malaria medication.
- Travel vaccinations such as Yellow Fever, Typhoid Fever, Hepatitis A, Rabies and Meningococcal disease.
- International Travel cover for emergency medical costs (via Universal Rewards).
- Plan trips safely with SARAH's WHO-approved travel health and vaccine advice.





# Preventative care and wellness benefits

Enjoy the comprehensive preventative care and wellness benefits to proactively manage your health. From routine screenings and vaccinations to personalised nutrition plans and fitness support, we help you to stay healthy and prevent illness without having to use your day-to-day benefits.

Total value in addition to your day-to-day benefits	R10 400
<b>Essential health test</b> Blood pressure, blood sugar, cholesterol, BMI and waist circumference: <ul style="list-style-type: none"><li>• One measurement per beneficiary over the age of 18 years, limited to R300 per event. Only at a DSP pharmacy.</li></ul>	✓
<b>Rapid HIV test</b> As required.	✓
<b>Prophylaxis for malaria</b> Preventative medicine as required.	✓
<b>Flu vaccine</b> One per beneficiary per annum.	✓
<b>Tetanus vaccine</b> One injection when required.	✓
<b>PSA (Prostate Specific Antigen)</b> One test per male beneficiary over the age 40.	✓
<b>Colorectal cancer screening</b> One test every 24 months (from date of service) for beneficiaries between the ages of 45 and 75.	✓
<b>Lipogram</b> One fasting lipogram per beneficiary over the age of 20 years. Once every five years.	✓
<b>Pap smear</b> One test per female beneficiary over the age of 18 per annum.	✓
<b>Mammogram</b> One test per female beneficiary over the age of 35 every second year.	✓
<b>HPV (cervical cancer) vaccine</b> One course per female beneficiary between 9 and 18 years of age per lifetime.	✓
<b>Adult and child pneumococcal vaccine</b> Per beneficiary as required, subject to pre-authorisation and protocols.	✓
<b>Travel vaccinations such as Yellow Fever, Hepatitis A, Rabies and Meningococcal disease</b> Per beneficiary as required.	✓
<b>Childhood immunisations</b> As recommended by the Department of Health up to 12 years.	✓



# Hospitalisation and major benefits

Extensive hospital and major benefit cover ensure financial protection in case of medical emergencies, covering hospital stays, surgeries and other life-saving medical procedures. For any hospital stay it is important to obtain pre-authorization to avoid unnecessary out-of-pocket expenses. All hospital visits and related treatment are subject to case management, clinical guidelines and managed care protocols. These measures are put in place to ensure that members obtain quality, appropriate care at specially negotiated tariffs.



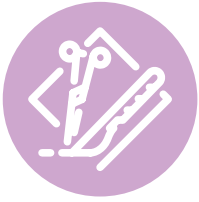
For any hospital stay, it is important to obtain pre-authorization to avoid unnecessary out-of-pocket expenses. All hospital visits and related treatment are subject to case management, specialist programmes and Scheme protocols. These measures are put in place to ensure that members obtain quality, appropriate care at specially negotiated tariffs.

<b>Hospitalisation</b>	100% of the CompCare rate. Any Netcare hospital. Subject to pre-authorization, clinical guidelines and managed care protocols.
<b>GPs and specialist treatment while in hospital</b>	Unlimited. 100% of the CompCare rate. Subject to pre-authorization, clinical guidelines and managed care protocols.
<b>Medication - only while in hospital</b>	Unlimited.
<b>Medication on discharge from hospital (TTO)</b>	Limited to 7 days per discharge. Subject to RP and formularies.
<b>Surgical prostheses</b>	Subject to pre-authorization, clinical guidelines and protocols. Limited to an overall benefit amount of R37 540. Sub-limits per category apply.
<b>Auxiliary services such as physiotherapy, dietician, etc</b>	100% of the CompCare rate. Limited to R3 540 PMF for non-PMBs. Subject to pre-authorization, clinical guidelines and protocols. A separate pre-authorization number is required - the claim will not be paid as part of the hospital pre-authorization. A 20% co-payment will apply if not pre-authorized.
<b>Psychiatric treatment in hospital</b>	100% of the CompCare rate. Subject to pre-authorization, clinical guidelines, protocols and PMBs. Up to a maximum of 21 days' admission OR 15 consultations.
<b>All specialised radiology including MRI and CT scans</b>	100% of the CompCare tariff. Limited to R28 600 PMF unless otherwise pre-authorized. Pre-authorization and medical motivation are required for MRI, CT and high-resolution CT scans. No benefit for PET scans. R3 950 co-payment PB applies for each scan, except for PMBs.
<b>Basic radiology, including black and white X-rays and Ultrasounds.</b>	100% of the CompCare rate. Unlimited. Referral by a GP/specialist is required to avoid a 35% co-payment.
<b>Pathology</b>	100% of the CompCare rate. Limited to R31 200 PMF for non-PMBs.
<b>Confinements (In hospital or home deliveries.)</b>	100% of the CompCare rate. Unlimited. Subject to pre-authorization, clinical guidelines and protocols.

<b>Alcoholism, drug dependence and narcotics</b>	Unlimited for PMBs. Subject to pre-authorization, clinical guidelines and protocols.
<b>Organ transplants, plasmapheresis, renal dialysis</b>	Unlimited for PMBs. Subject to pre-authorization, clinical guidelines and protocols. A DSP may apply.
<b>Oncology including chemotherapy and radiotherapy</b>	100% of the CompCare rate. Unlimited for PMBs at our oncology DSP. Subject to pre-authorization, clinical guidelines and protocols. Oncology formulary applies.
<b>Prophylactic, mastectomy and hysterectomy</b>	100% of the CompCare rate. Subject to pre-authorization, clinical guidelines and protocols.

## Alternatives to hospitalisation

<b>Step-down nursing facilities, hospice, rehabilitation and home-based care in lieu of hospitalisation</b>	100% of the CompCare rate. Unlimited for PMBs. Subject to pre-authorization, clinical guidelines and protocols.
<b>Surgical procedures out-of-hospital</b>	100% of the CompCare rate. No benefit unless in lieu of hospitalisation or a PMB. Subject to pre-authorization, clinical guidelines and protocols.
<b>Wound care in lieu of hospitalisation</b>	100% of the CompCare rate. Unlimited for PMBs, unless otherwise approved. Subject to pre-authorization, clinical guidelines and protocols.
<b>Emergency roadside assistance and ambulance transportation provided by Netcare 911</b>	100% of the CompCare rate. In non-emergency cases, authorisation must be obtained from Netcare 911 at the time of transportation or within 24 hours thereof, failing which will result in a 25% co-payment.
<b>Hospital emergency room and casualty emergency visits not requiring admission.</b>	Unlimited for PMBs.
<b>Hospital emergency as a result of physical injury caused by an external force</b>	Unlimited for PMBs.



# Sub-limits

## for Surgical Prosthesis, Electronic and Nuclear Devices and Appliances

Please note that exclusions are subject to PMB.

	Description	Frequency	Hospicare
<b>Overall internal prosthesis limit per family</b>			<b>R37 540</b>
<b>Coronary artery stents</b>	Stents Medicated stents	Annual	Subject to the overall internal prosthesis limit and a sub-limit of R14 560 per stent.
<b>Other stents</b> (Subject to the overall internal prosthesis limit)	Abdominal aortic aneurism stents Carotid stents Renal stents Aneurysm coils	Annual	Subject to the overall internal prosthesis limit. R34 320 R6 550 Subject to the overall internal prosthesis limit.
<b>Heart valves etc.</b> (Subject to the overall internal prosthesis limit)	Heart valves (Mitral etc)	Annual	R29 480
<b>Orthopaedic prosthesis</b> (Subject to the overall internal prosthesis limit)	Hip prosthesis Knee prosthesis Shoulder prosthesis Elbow prosthesis Ankle prosthesis Wrist prosthesis Finger prosthesis Spinal instrumentation Spinal cages Spinal implantable devices Internal fixators for fractures	-	Excluded
<b>Artificial limbs</b> (Subject to the overall internal prosthesis limit)	Through knee Below knee Above knee Partial foot Partial hand Below elbow Above elbow	Annual	Subject to the overall internal prosthesis limit.
<b>Other prosthesis</b> (Subject to the overall internal prosthesis limit)	Intra ocular lenses Bladder sling Hernia mesh Vascular grafts	Annual	PMBs

\*\* Please refer to scheme rules.

**Electronic and nuclear devices**  
(Subject to PMBs)

Description	Frequency	Hospicare
Internal cardiac defibrillator	Annual	Subject to the overall internal prosthesis limit.
Single chamber pacemaker	Annual	Subject to the overall internal prosthesis limit.
Dual chamber pacemaker	Annual	Subject to the overall internal prosthesis limit.
Internal nerve stimulators		Excluded
Cochlear implants and Bone Anchored Hearing Aids (BAHA)		Excluded
Insulin pumps		Excluded
Hearing aids		
Artificial eyes		
BP monitor		
Glucometer		
Humidifier		
Nebuliser		
Breast pump		
Moonboot		
Elbow crutches		
CPAP machines		
Apnoea monitors for infants < 1yr		Excluded
Braces and callipers		
Rigid back brace		
Sling clavicle brace		
Wigs		
Bras for breast prosthesis after mastectomies		
Breast prosthesis		
Commodes		
Swivel Bath chairs		
Walking frames		
Rehabilitative foot orthotics		
Wearable devices claimable only with a valid NAPPI code		Excluded
Stockings: Elastic, Full length and anti-embolic stockings, including compression socks	Annual	PMBs

**Wearable devices**

**Stockings**



# Chronic conditions covered

Addison's disease *	✓	Diabetes Mellitus type 2 *	✓
Asthma *	✓	Epilepsy *	✓
Bipolar mood disorder *	✓	Glaucoma *	✓
Bronchiectasis *	✓	Haemophilia *	✓
Cardiac arrhythmias *	✓	HIV/AIDS *	✓
Cardiomyopathy *	✓	Hypercholesterolemia/hyperlipidaemia *	✓
Chronic renal failure *	✓	Hypertension *	✓
Congestive cardiac failure *	✓	Hypothyroidism *	✓
Chronic obstructive pulmonary disease *	✓	Multiple sclerosis *	✓
Coronary artery disease *	✓	Parkinson's disease *	✓
Crohn's disease *	✓	Rheumatoid arthritis *	✓
Diabetes insipidus *	✓	Schizophrenia *	✓
Diabetes Mellitus type 1 *	✓	Systemic lupus erythematosus *	✓
		Ulcerative colitis *	✓

\* Note: Paid from day-to-day benefits first



# Co-payments

Overall co-payment for elective surgeries	R15 600 Member liable for full cost of procedure if procedure is less than R15 600.	Conservative back and neck treatment - spinal cord injections	PMBs only
Voluntary use of non-DSP/network hospital/facility - for the hospital/facility account	A 35% co-payment will apply to the voluntary use of a non-DSP/network hospital/facility, with a minimum of R15 600.	Laminectomy and spinal fusion	PMBs only
MRI and CT-scans - In and out of hospital	R3 950 per scan.	Nissen fundoplication - reflux surgery	PMBs only
Specialised medication	25% co-payment for non-PMB medicines.	Hysterectomy (Except for cancer and a Prophylactic hysterectomy)	PMBs only
Diagnostic scopes	PMB, except for a gastroscopy, which has a co-payment of R5 300 for non-PMBs.	Laparoscopic hemicolectomy and inguinal hernia repair	PMBs only
Arthroscopy	PMBs only	Adenoidectomy, myringotomy - grommets, tonsillectomy	R4 060
Minor gynaecological laparoscopic procedures e.g. Hysteroscopy, endometrial ablation and diagnostic laparoscopy.	PMBs only	<b>Other co-payments in day-to-day benefits</b>	
Dental	R5 300	Acute medication	25% co-payment on medicines where no generic is available. PMBs only.
Joint replacements - arthroplasty	PMBs only	Chronic medication, including CDLs	DSP pharmacies apply. 25% co-payment for non-formulary medicine, and the use of a non-DSP.

Prescribed Minimum Benefits (PMBs) are covered in full, without any co-payment required. Co-payments are applied per beneficiary, per event.

# List of exclusions



Please note that exclusions are subject to PMB.

<b>Procedures</b>	Arthroscopic surgery	✓	<b>Medicines</b>	Medication not registered by SAPHRA	✓
	Back and neck treatment - Conservative	✓		Medication used in clinical trials and / or treatment resulting from clinical trials	✓
	Back and neck surgery	✓		Anabolic steroids and immunostimulants	✓
	Bariatric surgery / treatment relating to obesity	✓		Vitamins and minerals	✓
	Breast reduction / Gynaecomastia surgery	✓		<b>Prosthesis</b>	Implantable ventricular assist devices (e.g. LVAD) and total artificial hearts
	Bunion surgery (Correction of Hallux Valgus)	✓	Internal fixators for fractures		✓
	Elective Caesarean sections for non-medical reasons	✓	<b>External appliances</b>	APS/TENS machines	✓
	Cochlear implants, auditory brain implants (Bone-anchored Hearing Aids)	✓		Chair seats / backrests and cushions (Excluding wheelchairs backrests and cushions)	✓
	Cosmetic surgery - blepharoplasty; septoplasty, nasal tip reconstruction and otoplasty, as well as any cosmetic preparations	✓		Hospital beds - purchase / rental	✓
	Corneal transplants	✓		Health shoes	✓
	Deep brain implants	✓		Hearing Aids	✓
	Excimer Laser / Refractive surgery	✓		Incontinence Products (Linen savers; disposable nappies, waterproof sheets)	✓
	Functional nasal and sinus surgery	✓		Mattresses	✓
	Gender reassignment surgery, medicines and treatment	✓		Motorised Scooters	✓
	Infertility -AI; IVF; GIFT; ZIFT and ICSI	✓		Shower and bath rails	✓
	Internal nerve stimulators	✓		Sunglasses (prescription and non-prescription)	✓
	Investigations and diagnostic work up only in hospital	✓		Braces including rigid back braces, and callipers	✓
	Joint replacement surgery and related orthopaedic prosthesis (including hip, knee, shoulder, elbows, ankle, wrist and finger prosthesis).	✓		Wigs	✓
	Polysomnograms and CPAP titrations	✓		CPAP machines	✓
	Reversal of Vasectomy or tubal ligation	✓		Apnoea monitors for infants <1 year	✓
	Robotic assisted surgery	✓		<b>Other</b>	Difference in cost between a cornea from outside SA and a locally acquired cornea
	Reflux and Hiatus hernia repair surgery	✓	Physiotherapy services - wisdom teeth; caesareans		✓
	Spinal surgery and related orthopaedic prosthesis (Instrumentation, implantable devices and spinal cages)	✓	Genetic and metabolic testing		✓
	Sleep therapy	✓	Aphrodisiacs		✓
	Treatment of keloids except for burns & functional impairment	✓	Smoking cessation agents		✓
<b>Dental</b>	Bleaching of teeth	✓	Contact lens preparations		✓
	Conscious sedation and general anaesthetics for dental procedures -7yrs and older	✓	Cosmetic preparations		✓
	Lingual orthodontics	✓			
	Orthodontic treatment over age of 18yrs	✓			
	Osseo-integrated implants, all implant-related procedures and orthognathic surgery	✓			
	Resin bonding of Metal fillings	✓			



# Terms explained

## Abbreviations

A	Adult Dependant
BMI	Body Mass Index
C	Child Dependant
CDL	Chronic Disease List
CPAP	Continuous Positive Airway Pressure appliance
CT scan	Computerised Tomography scan
DSP	Designated Service Provider
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
M	Member
MRI	Magnetic Resonance Imaging
OAL	Overall Annual Limit
OTC	Over-the-Counter Medicine
P	Principal Member
PB	Per Beneficiary
PET scan	Positron Emission Tomography scan
PM	Per Member
PMB	Prescribed Minimum Benefits
PMF	Per Member Family
PSA	Prostate-Specific Antigen blood test
RP	Reference Pricing or Medicine Reference Price
TTO	To-Take-Out (medicine taken on discharge from hospital)

**Adult dependant (A):** a dependant who is 21 years and older.

**Chronic Disease List (CDL):** the Chronic Disease List determined by the Medical Schemes Act which is covered in terms of Prescribed Minimum Benefits.

**Child dependant (C):** a child until the age of 21 years, including biological and legally adopted children as well as stepchildren.

**CompCare rate:** the tariff paid by the Scheme for different medical services and can include the contracted tariff for services agreed with certain groups of service providers such as hospitals.

**Co-payments:** the difference between the cover provided by the Scheme and the cost/tariff charged for the medical service for which the member is liable.

**Cost:** the cost of Prescribed Minimum Benefit (PMB) services, payable by the Scheme, subject to the registration of the conditions with the Administrator as qualifying for PMBs and rendered by designated service providers (DSPs) according to accepted PMB treatment protocols.

**Continuous Positive Airway Pressure appliance (CPAP):** a device that provides continuous positive airway pressure to help prevent breathing interruptions during sleep.

**Designated Service Provider (DSP):** is a service provider contracted or appointed by the Scheme to provide certain medical services.

**Emergency medical condition:** any sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide such treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy. Emergencies that qualify as PMBs must also be registered as a PMB with supporting evidence.

**Hospital benefits:** benefits for services rendered in hospital during a patient's stay. Services include ward accommodation and ward medicine, radiology, pathology, and consultations during hospitalisation. Certain procedures performed in hospital, for example, scopes and specialised radiology, require the member to

make an upfront payment, which differs per option. All planned hospital admissions must be pre-authorized to avoid a co-payment. Emergency admissions must be registered on the first workday following the admission (see “Emergency medical condition”). Members who are required to use Medclinic or Netcare hospitals but choose to voluntarily be admitted to another hospital will incur a co-payment in the hospital and all related accounts.

**Prescribed Minimum Benefits (PMBs):** a set of defined benefits as per the Medical Schemes Act to ensure that all medical scheme members have access to certain minimum health services. PMBs apply to 27 chronic conditions on the Chronic Disease List (CDL) and 272 diagnoses with their treatments as published in the Regulations under the Act. In terms of these Regulations, medical schemes must grant benefits for the diagnosis, treatment, and care costs of any of these conditions as well as emergency medical conditions (that meet the published definitions) without imposing any limits. PMBs are subject to pre-authorization, protocols, and the use of designated service providers, where applicable. Benefits for PMB services are first funded from the related day-to-day benefits.

**Protocol:** a set of clinical guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard treatment guidelines, disease management guidelines, treatment algorithms, clinical pathways, and evidence-based medicine.

**Reference Price (RP):** applies to all pre-authorized PMB medicine. The price is determined according to the most cost-effective treatment based on evidence-based principles. Members are advised to consult their doctor when using PMB medicine to make sure they use medicine on the formulary and within the reference price where possible and avoid or minimise co-payments.

**Over-the-Counter medicine (OTC):** medicine that is not prescribed and is available to buy over the counter at pharmacies. Claims for self-medication must have valid NAPPI codes to be processed.

**To-Take-Out medicine (TTO):** medicine that is dispensed and charged by the hospital for the patient to take home when discharged.

**Vascular/cardiac prosthesis:** includes artificial aortic valves, pacemakers, and related or connected functional prostheses.

**Virtual consultations:** the online consultations made possible by uConsult™ and accessible via the Universal. one App or by visiting [u-consult.co.za](http://u-consult.co.za).



# Member guide

## 1. Rules of the Scheme

The Scheme is governed by a set of rules submitted to and approved by the Council for Medical Schemes. All terms and conditions are set out in detail in the rules of the Scheme, which can be viewed at the office of the administrator. The rules of the Scheme always apply during a dispute resolution.

## 2. Membership

### Who is eligible for membership?

Membership is open to any individual or company/group, except where the member ceases to be a permanent resident of the Republic of South Africa. The Scheme provides cover for all international students while studying in the Republic of South Africa.

### 2.1 Who can be registered as dependants?

- A member's spouse or partner – a person with whom the member is legally married, or has a two-year or longer committed relationship akin to marriage, based on objective criteria of mutual dependency and a shared common household, married in terms of any law or traditional/customary marriage (marriage certificate/affidavit/suitable other certificate required).
- Surviving spouse members – continuation of a surviving spouse of the main member is allowed to continue on the medical aid, provided that they were registered as dependants at the time of the main member's death (marriage and death certificate required).
- A child until the age of the age of 21 – who is not in receipt of a regular remuneration of more than the maximum social pension per month, or a child of any age due to being mentally or physically challenged is a dependent of the member, or legally adopted child/children placed in your care and custody by virtue of a court order (legal proof required).
- Full-time student – Proof of registration of the current year is required from a secondary or recognised tertiary institution and each year thereafter, in order for the dependant to qualify at child rates to a maximum of up to 21 years.
- Part-time students – an affidavit is required, stating that the child is unemployed and financially dependent on the principal member. Proof of registration as a student is required from the recognised institution. The dependant will be billed at adult rates.
- Unemployed child – (up to a maximum age of 21) who is unemployed and financially dependent on the principal member (affidavit required).
- Disabled/mentally challenged – a full medical report required upon application in order to qualify at child dependant rates.

### 2.2 How are waiting periods applied?

Prospective members are required to disclose all details in full of any sickness or medical condition for which medical advice, diagnosis, care or treatment was recommended and/or received prior to the twelve-month period ending on the date on which application is made.

Waiting periods are applied when members join the Scheme or are registered as dependants according to the following instances:

- If you have never been a member/dependant or not covered on a medical scheme for a period of more than 90 days immediately before applying to the Scheme, the Scheme may impose a general waiting period of three months and twelve months condition-specific waiting period on any/all pre-existing medical conditions. This will also be applicable to Prescribed Minimum Benefits.
- If you have been on a medical scheme for a period of less than 24 months and you apply for membership within the three months of termination from the previous medical scheme, a condition-specific waiting period of twelve months will apply. If the beneficiary suffers from any pre-existing condition, the Scheme may impose any unexpired balances imposed by the previous scheme. The beneficiary will be entitled to the Prescribed Minimum Benefits.
- If you have been on a medical scheme for a period of more than 24 months and apply for membership within the three-month period from termination from the previous medical scheme, the general waiting period of three months will apply. You will be entitled to the Prescribed Minimum Benefits.

### When does the benefit year start?

The Scheme's benefit year begins on 1 January and ends on 31 December of that year. This means that if you join the Scheme on 1 January, you are entitled to the full allocation of the year's benefits and limits. However, if you join the Scheme during the course of the benefit year, you will be entitled to pro-rated

benefits and limits, meaning that you will only be entitled to a time-appropriate proportion of the annual benefits and limits.

**Please note:** You have the opportunity to review and change your choice of benefit option once during the benefit year with effect from 1 January of the next year. Once you have selected a benefit option for the benefit year, you cannot change your benefit option during that benefit year.

### 2.3 Proof of membership

Every member shall be provided with a membership card. You will be required to exhibit this membership card when visiting a healthcare service provider and/or admission to a hospital. You therefore need to ensure that your card is kept secure at all times in order to prove your membership of the Scheme. Your membership card can also be downloaded on the Universal.one App.

### 2.4 How do I go about changing my details?

Complete a Member Update Information form, available from our website ([compcare.co.za](http://compcare.co.za)) or our offices at **0861 222 777**. A member must notify the Scheme within 30 days of any change of address, including the address at which legal proceedings may be instituted (domicilium citandi et executandi.)

The Scheme shall not be held liable if a member's rights are prejudiced or forfeited as a result of the member neglecting to comply with the requirements of this rule.

### 2.5 Late joiner penalties

Late joiner penalties are applicable to an applicant or adult dependant of an applicant who, at the date of application for membership or admission as a dependant, is older than the age of 35 years, depending on the number of years that they have not belonged to a registered South African medical scheme. This excludes beneficiaries who enjoyed coverage with one or more medical schemes as from the date preceeding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001. Penalties shall be applied only to that portion

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

The penalty is calculated as per the following formula:

$$A = B \text{ minus } (35+C)$$

Where in terms of the Medical Schemes Act No 131 of 1998:

**A** = number of years referred to in the first column of the table in subregulation (2), for purposes of determining the appropriate penalty band;

**B** = age of the late joiner at the time of his or her application for membership or admission as a dependant;

**C** = the number of years of creditable coverage, which can be demonstrated by the late joiner.

of the contribution relative to the late joiner and shall not exceed the following bands:

### 2.6 Complaints and disputes:

Members may lodge their complaints telephonically, or in writing, to Universal Healthcare Administrators on **0861 222 777** or e-mail address [escalations@universal.co.za](mailto:escalations@universal.co.za).

The Escalations team will assist the member immediately where possible. All unresolved telephonic complaints, or complaints received in writing, will be responded to by the Universal Healthcare Escalations team, in writing, within 30 days of receipt thereof and copy the Fund Manager on the response. Should the member not be satisfied with the outcome of the query, then this query or dispute can be escalated to the Fund Manager.

E-mail escalations can be sent to [compcare@universal.co.za](mailto:compcare@universal.co.za) or the call centre agent can transfer the member to the appropriate senior official. All escalations will have to be accompanied by supporting evidence. Any dispute, which may arise between a member, prospective member, former member or a person claiming by virtue of such membership and the Scheme or an officer of the Scheme, may be referred by the Principal Officer

to a disputes committee (appointed as and when needed, by the Board of Trustees) for adjudication. On receipt of a request in terms of this rule, the Principal Officer must convene a meeting with the disputes committee by giving not less than 21 days' notice in writing to the complainant and all the members of the disputes committee, stating the date, time and venue of the meeting and particulars of the dispute. The disputes committee must determine the procedure to be followed. The parties to any dispute have the right to be heard at the proceedings, either in person or through a representative.

An aggrieved person has the right to appeal to the Council for Medical Schemes against the decision of the disputes committee. Such appeal must be in the form of an affidavit and directed to the Council for Medical Schemes not later than three months after the date on which the decision concerned was made. The contact details of the Council for Medical Schemes: **086 112 326** and e-mail: [complaints@medicalschemes.com](mailto:complaints@medicalschemes.com).

### 3. Contributions payable

The total monthly contributions payable to the Scheme by or in respect of a member are as stipulated in the contribution tables in the Scheme rules. It shall be the responsibility of the member to notify the Scheme of changes in income that may necessitate a change in contribution for income-based benefit option members. Contributions shall be due monthly in arrears or advance, as stipulated in the rules and payable by not later than the third day of each month.

Where contributions or any other debt owing to the Scheme have not been paid within three days of the due date, the Scheme shall have the right to suspend all benefit payments in respect of claims which arose during the period of default. In the event that payments are brought up to date, and provided membership has not been cancelled, benefits shall be reinstated without any break in continuity, subject to the right of the Scheme to levy a reasonable fee to cover any expenses associated with the default, and to recover interest on the arrear amount at the prime overdraft rate of the Scheme's bankers. If such payments are not brought up to date, no benefits shall be due to the member from the date of default, and any such benefit paid will be recovered by the Scheme.

#### 3.1 Savings

Your total annual savings is advanced and will be available to you at the beginning of the benefit year (Jan to Dec) for the full calendar year (Jan to Dec). Termination of membership during the benefit year will result in savings being pro-rated. This pro-ration could result in savings being owed to the Scheme. Should you terminate your membership with the Scheme, the savings balance will be payable to the member or transferable to the new medical aid of the member in the 5th month following resignation from the Scheme.

#### 3.2 Termination of membership

##### 3.2.1 Resignation

A member who, in terms of his/her conditions of employment, is required to be a member of the Scheme may not terminate his/her membership while he/she remains an employee without the prior written consent of his/her employer. A member of the Scheme who resigns from the service of his/her employer shall, on the date of such termination, be eligible to continue as an individual member without re-applying or the imposition of any new restrictions that did not exist at the time of his/her resignation from the employer.

##### 3.2.2 Voluntary termination of membership

A member, who is not required in terms of his/her conditions of employment to be a member, may terminate his/her membership of the Scheme by giving one month's written notice. All rights to benefits cease after the last day of membership.

##### 3.2.3 Deceased members

The dependants of a deceased member, who are registered with the Scheme as his/her dependants at the time of such member's death, shall be entitled to continued membership of the Scheme without any new restrictions, limitations or waiting periods. Where a child dependant/s has been orphaned, the eldest child may be deemed to be the member, and any younger siblings as the child dependant/s.

### 4. Members' portions

Members' portions arise when healthcare service providers are refunded in full by the Scheme, but the member still has to cover the cost of a co-payment applicable to the particular benefit or where levies are imposed. Members can refund the Scheme by EFT, payroll deduction (if part of an employer group) or make use of the convenience of a debit order.

### 5. Benefits

#### 5.1 Choosing a benefit option

Members are entitled to benefits during a financial year, as per the rules of the Scheme, and such benefits extend through the member to his/her registered dependants. A member must, on admission, elect to participate in any one of the available benefit options detailed in the rules of the Scheme.

If you are a member of an employer group, your choice may be limited to the options agreed on between you and your employer.

If you join as an individual, you may choose any of the various benefit options according to your needs and affordability.

#### 5.2 Option changes

A member is entitled to change from one to another benefit option subject to the following conditions. The change may be made only with effect from 1 January of any calendar year.

Application to change from one benefit option to another must be in writing and lodged with the Scheme within the period notified by the Scheme.

#### 5.3 Pro-rated benefits

If members join the Scheme later than 1 January during a specific year, pro rata annual benefits will apply until the end of the year. From 1 January of the following year, members will qualify for the full annual benefit.

### 6. How do I submit a claim?

Members are not required to complete a claim form. Simply sign all accounts and invoices and submit them directly to the Scheme.

#### 6.1 Electronic claims

Most service providers have the facility to submit claims electronically. These claims are then paid directly to the service provider, subject to the available benefits, ensuring a very short processing turn-around time. However, it is the member's responsibility to ensure that the claim/s reaches the medical aid within the four-month time period from the date of treatment and to check claims statements for accuracy and validity of the claims submitted by the service providers.

#### 6.2 Email/scan

To ensure that claims are promptly processed, please ensure that your name, membership number and contact number/s are on the claims and must be legible. Claims must be submitted within the four-month period from the date of treatment.

Email: [compcare@universal.co.za](mailto:compcare@universal.co.za)

Post: Universal Healthcare Administrators (Pty) Ltd, Private Bag X49, Rivonia, 2128

#### 6.3 Via the Mobi App

Submit a claim and track your expenses via the Universal.one App for CompCare Medical Scheme members.

#### 6.4 How does the claim process work?

Claims are settled every two weeks for payment to the service providers or members. Members will receive a monthly detailed statement of claims transactions and of all payments made to the member and/or service providers. Kindly ensure that the Scheme has your correct banking details to allow for electronic payment. It is ultimately the member's responsibility to ensure that claims are submitted timeously for payment.

Specialist referral process

A referral from a GP is required before seeking treatment from a specialist, failing which will attract a 35% co-payment on the visit as well as related services.

Members are required to notify the Scheme of a specialist visit prior to the visit by requesting a "Spec Auth". This can be done by contacting the call centre at **0861 222 777** or by sending an email to [specauth@universal.co.za](mailto:specauth@universal.co.za).

The following information is required:

- The referral letter from the member's GP on the practice letterhead.
- The medical aid number.
- The name of the dependant.
- The member's correct contact numbers.
- The intended date of the specialist consultation.
- The specialist's name, practice number and contact details.

Should a specialist refer the member to another specialist, the referral letter from the initial specialist referring to the other specialist needs to be provided (the visit to the first specialist should have been authorised). The member need not return to their GP for another referral letter in this instance.

A GP referral is not required in the following cases:

- One gynaecologist visit per female over the age of 16, per year.
- One urologist visit per male over the age of 40, per year.
- Paediatrician consultations for children under the age of 2.
- Specialist visits during pregnancy.
- Oncologist consultations, as this will be approved as part of an Oncology Management Programme.
- Optical and dental specialist consultations (ophthalmologists and orthodontists).
- Where multiple specialist visits have been authorised.

#### 6.5 Over-the-Counter-Medicines (OTC)

This medicine is dispensed by a registered pharmacist, who may prescribe medication for minor ailments that do not require a general practitioner consultation and will not incur a consultation fee that your GP will normally charge. Please consult your benefit guide for the OTC rules and limits applicable to your option. This



**CompCare  
Medical Scheme**

## Contact Details

Universal House, 15 Tambach Road,  
Sunninghill Park, Sandton  
PO Box 1411, Rivonia, 2128

**Tel:** 0861 222 777

**Email:** [compcare@universal.co.za](mailto:compcare@universal.co.za)

**Web:** [compcare.co.za](http://compcare.co.za)

**Complaints escalated to the  
Council for Medical Schemes**

**Tel:** 0861 123 267

**Email:** [complaints@medicalschemes.com](mailto:complaints@medicalschemes.com)

**Web:** [medicalschemes.com](http://medicalschemes.com)

*This brochure is a summary of the benefits of CompCare Medical Scheme. All information relating to the 2026 CompCare Medical Scheme benefits and contributions is subject to formal approval by the Council for Medical Schemes. On joining the Scheme, all members will receive a detailed member brochure, as approved. The final registered Rules of the Scheme will apply.*

*All limits are pro-rated when a member or a beneficiary joins the Scheme during the year, calculated from the date of registration to the end of that financial year. This summary is for information purposes only and does not supersede the Rules of the Scheme. In the event of a discrepancy between the summary and the Rules, the Rules will prevail.*

