CompCare

Medical Scheme

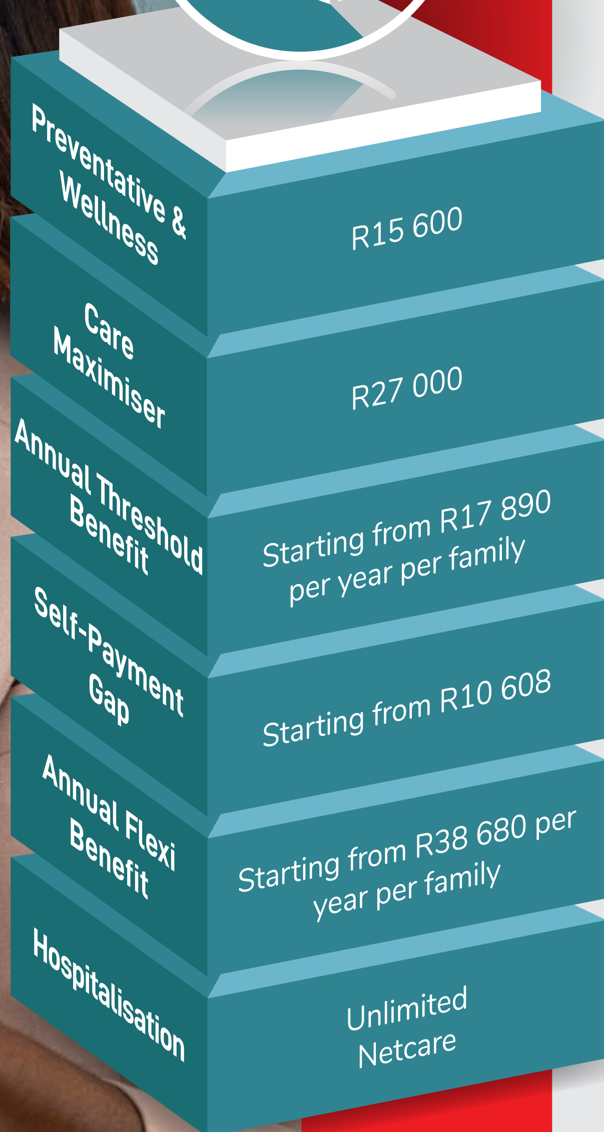
UltraCare

Administered by Universal®

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

UltraCare

UltraCare is an exceptional medical aid option, offering complete cover, including unlimited hospital stays and comprehensive day-to-day benefits, with a substantial Above Threshold Benefit. Ideal for those who've achieved career success and enjoy luxury living.



Annual Flexi Benefit (AFB)

Generous day-to-day cover for out-of-hospital expenses such as GP visits, medicines, and dental care, helping you manage ongoing healthcare costs.

Above Threshold Benefit (ATB)

The ATB provides additional benefit amounts for selected medical expenses once your AFB is depleted and the Annual Threshold is reached.

Preventative Care and Wellness

These benefits enhance your day-to-day cover by offering screenings and checkups for early detection of health issues, while also being tailored to support your overall well-being.

Care Maximiser

The Care Maximiser provides an additional range of day-to-day benefits, covered by scheme risk, without impacting your pocket, ensuring extended cover.

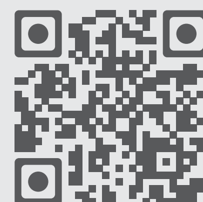
Through the Care Maximiser, Preventative Care and Wellness benefits, you can enjoy up to an extra R42 600 in additional coverage, on top of your day-to-day benefits.

Comprehensive Chronic Cover

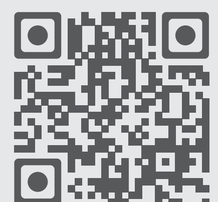
Covers the 27 listed Chronic Disease List (CDL) conditions and 39 additional chronic conditions, offering peace of mind for long-term health management.

UltraCare	Principal member	Adult dependant	Child dependant
Contribution	**R9 014**	**R8 112**	**R3 154**
AFB	R16 640	R12 480	R4 780
SPG	R10 608	R7 900	R2 910
Threshhold	R27 248	R20 380	R7 690
ATB	R10 050 per beneficiary to a maximum of R17 890 per family.		

Child rates apply until the child turns 21 years.
Members only pay for a maximum of 3 children.



Scan to apply online



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 student life to your first job, late-night hustles to weekend resets, solo moves to starting 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.

Maternity

Cherish every moment with care that supports you and your baby from bump to beyond.

- Antenatal classes and visits.
- Maternity bag.
- Confinements including 2D ultrasound scans.
- Breast pump per pregnancy
- One additional nutritional and fitness assessment per pregnancy.
- Unlimited virtual nurse consults.
- Unlimited telephonic psychosocial counselling.
- Cover for hospitalisation and home births.
- Get trusted, WHO-endorsed maternity advice 24/7 from SARAH — your AI health assistant.

Child wellness

Nurturing little lives with protection, guidance, and support through every milestone and magical moment.

- New-born hearing screening benefit.
- New-born congenital hypothyroidism test.
- Baby wellness visits.
- Childhood immunisations.
- School readiness assessments.
- Pre-school eye, hearing, and dental screening.
- One additional emergency room visit for children younger than 6 years.
- Three additional paediatric consultations.
- Unlimited GP consultations and basic dentistry for children younger than 6 years.
- Initial occupational therapy consultation.
- Kids' fitness assessment and exercise prescription programme.
- Kids' nutritional assessment and healthy eating programme.
- Hearing aids for children under 12.
- From teething tips to school health checks, SARAH offers WHO-backed guidance anytime.

Flu prevention

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

- Flu and pneumococcal vaccines.
- Cover for a humidifier/nebuliser.
- 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.
- Papsmear 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.
- R170 depression medication benefit on most benefit options.
- Psychosocial counselling with unlimited telephonic counselling including 3 face-to-face sessions.

Healthy weight

Feel energised and confident with a plan built around your body, your goals, your life.

- **Fitness assessment and exercise prescription:** Access to the Universal Network of biokineticists for annual fitness assessment, virtual consultations, exercise prescription and regular monitoring.
- **Nutritional assessment and healthy eating plan:** Access to the Universal Network of dieticians for annual assessment, virtual consultations, healthy eating plan prescription, and regular monitoring.
- Unlimited virtual nurse consults for any questions.
- An annual health check that includes a Body Mass Index (BMI) measurement.
- SARAH provides WHO-backed nutrition and exercise insights to help you reach your goals.

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	R15 600
Essential health tests Blood pressure, blood sugar, cholesterol, BMI and waist circumference: • One measurement per beneficiary over the age of 18 years, limited to R300 per event. Only at DSP pharmacy.	✓
Rapid HIV tests As required.	✓
Prophylaxis for malaria Preventative medicine as required.	✓
Flu vaccine One per beneficiary per annum.	✓
Tetanus vaccine One injection when required.	✓
PSA (Prostate Specific Antigen) One test per male beneficiary over the age 40.	✓
Colorectal cancer screening One test every 24 months (from date of service) for beneficiaries between the ages of 45 and 75.	✓
Glaucoma test One per beneficiary per annum.	✓
Lipogram One fasting lipogram per beneficiary over the age of 20 years. Once every five years.	✓
Pap smear One test per female beneficiary over the age of 18 per annum.	✓
Mammogram One test per female beneficiary over the age of 35 every second year.	✓
HPV (cervical cancer) vaccine One course per female beneficiary between 9 and 18 years of age per lifetime.	✓
Adult and child pneumococcal vaccine Per beneficiary as required, subject to pre-authorisation and protocols.	✓
Fitness assessment and exercise prescription • Access to Universal's Network of biokineticists for annual fitness assessments, virtual consultations, exercise prescription and regular monitoring. • One additional assessment per pregnant member per pregnancy. Strict protocols apply.	✓
Nutritional assessment and healthy eating plan • Access to Universal's Network of dietitians for annual assessment, virtual consultations, healthy eating plan prescription and regular monitoring. • One additional assessment per pregnant member per pregnancy. Strict protocols apply.	✓
Travel vaccinations such as Yellow Fever, Hepititis A, Rabies and Meningococcal disease Per beneficiary as required.	✓

Care Maximiser

Unlock additional benefits with our Care Maximiser. Designed to help you stretch your benefits further, the Care Maximiser ensures that you get more value from CompCare - because your health deserves more.

Unlocking your Care Maximiser is easy.

To activate your Care Maximiser benefit, all you need to do is go for your essential health test.

All adult beneficiaries on your medical aid plan need to go for the following health tests at any of our DSP pharmacies:

- Blood pressure measurement
- Blood sugar test
- Cholesterol test
- BMI and waist circumference

Benefit	
Two virtual consultations including acute medicine at R470 per event. Universal Network applies.	
GP wellness consultation: One visit PB per annum excluding procedures. Limited to tariff code 0190/1/2 and ICD10 Z00.0 or Z00.1.	
Unlimited GP visits for children <6 years old.	
Unlimited basic dentistry for children <6 years old.	
Emergency room visit for children <6 years old.	To a maximum of R1 610 per event, if not a PMB.
Contraceptives up to the age of 55 years (Oral/ IUD device).	13 scripts to a maximum of R3 680, OR an IUD to a maximum of R3 680.
Covid benefit • Pulse Oximeter: R880 per family • Nebulizer: R570 per family • Thermal Thermometer: R470 per family	To the maximum value of R1 920.
Home test bundle	Overall limit of R360.
• One Covid test	
• One urinary tract test	
• One ovulation test	
• One pregnancy test	
Antenatal visits with a GP, specialist or midwife.	100% of the CompCare rate. 12 antenatal visits.

Day-to-day benefits

Day-to-day benefits cover routine healthcare costs such as GP visits, prescription medicine, dental check-ups, radiology, pathology and optometry.

Benefit	Details
Day-to-day benefits	**AFB:** Day-to-day benefits are first paid from the AFB: P: R16 640 A: R12 480 C: R4 780 (To a maximum of 3 children.) **SPG:** A self-payment gap is applicable once the AFB is depleted and before the Annual Threshold is reached. Thereafter the ATB becomes available. The annual SPG amounts are: P: R10 608 A: R7 900 C: R2 910 (GP and specialist consultations, prescribed acute medication, radiology and pathology will accumulate to the Annual Threshold and then paid from the ATB.) **ATB:** Once the Annual Threshold is reached, the following ATB amounts become available for specified day-to-day expenses: PB: R10 050 PF: R17 890
Virtual nurse consultations	100% of the CompCare rate. Unlimited at a DSP. Paid from risk.
General practitioner Virtual and face-to-face consultations, procedures and material costs	100% of the CompCare rate. First paid from the AFB, SPG and then the ATB once the Annual Threshold is reached.
Out-patient emergency room consultation	100% of the CompCare rate. First paid from the AFB, SPG and then the ATB once the Annual Threshold is reached.
Specialists	100% of the CompCare rate. First paid from the AFB and SPG. Thereafter a limit of R5 410 PMF applies, subject to the overall ATB limit. Referral by a GP is required, after which a specialist can refer a member to another specialist, to avoid a 35% co-payment. Subject to pre-authorisation and protocols.
Chronic medicines (27 CDL conditions)	100% of RP. First paid from the AFB. The Scheme will cover the costs once the AFB is depleted. DSP pharmacies apply, a 25% co-payment applies for the use of a non-DSP. Subject to formularies, protocols and pre-authorisation. 25% co-payment for non-formulary medicine.
Medicine for non-CDL conditions	39 non-CDL conditions. 100% of RP. First paid from available AFB and SPG. Thereafter a limit of R3 740 PMF applies, subject to the overall ATB limit. DSP pharmacies apply to UltraCare. Subject to formularies, protocols and pre-authorisation. 25% co-payment for non-formulary medicine, and use of a non-DSP.
Acute medicines	First paid from the AFB and SPG. Thereafter a limit of R3 630 PMF applies, subject to the overall ATB. 25% co-payment on medicines where no generic is available. RP applies.
Over the counter medication and homeopathic medicines	Paid from the AFB. Limited to a maximum of R1 090 PB and R1 560 PMF and one prescription per day up to a maximum of R250 per event. RP applies. **ATB:** No benefit.
Basic radiology Black and white X-rays and ultrasound	100% of the CompCare rate. Paid from the AFB and SPG. Thereafter from a combined radiology and pathology limit within the ATB to a limit of R4 340 PMF. Referral by a GP/specialist is required, to avoid a 35% co-payment.
All specialised radiology Including MRI and CT scans	100% of the CompCare rate. Unlimited. Pre-authorisation and medical. motivation are required for MRI, CT and high-resolution CT scans, except PMBs. R3 950 co-payment PB applies for each scan, except PMBs.
Pathology	100% of the CompCare rate. Paid from the AFB and SPG. Thereafter from a combined radiology and pathology limit within the ATB to a limit of R4 340 PMF. Referral by a GP/specialist is required, to avoid a 35% co-payment. Protocols apply.
Conservative dentistry Including consultations, preventative care, fillings, extractions including wisdom teeth, root canal treatment and infection control	100% of the CompCare rate. Paid from the AFB. Limited to R4 890 PB and subject to available AFB. **ATB:** No benefits. Protocols apply.
Specialised dentistry Including maxillofacial and oral surgery - in-and-out of hospital combined benefit. (A quotation must be submitted for approval prior to the commencement of the treatment. Orthodontic treatment for patients older than 18 is excluded.)	100% of the CompCare rate. Paid from the AFB, subject to a sub-limit of R16 020 PB and R21 630 PMF. Subject to protocols. **ATB:** No benefits.
Optometry visits	100% of the SAOA tariff. Paid from the AFB. Two eye tests PB per annum. **ATB:** No benefits.

How are these benefits covered?

Annual Flexi Benefit (AFB)

The AFB is an insured benefit. Fixed amounts cover day-to-day medical expenses. These benefits are subject to specific limits, co-payments, or specified conditions based on your chosen option. Day-to-day claims are paid directly from the AFB.

Above Threshold Benefit (ATB)

Once your AFB insured benefits are depleted, you enter the Self-Payment Gap, where you are liable to fund your day-to-day expenses until you reach the Annual Threshold. GP and specialist consultations, prescribed acute medication, radiology and pathology will accumulate to the Annual Threshold. Once you reach the Annual Threshold, the ATB becomes available.
The ATB provides additional benefit amounts for specified medical expenses.

Benefit	Cover
Lenses and contact lenses	100% of the SAOA tariff. Paid from the AFB, subject to a sub-limit of R4 990 PB. Subject to protocols. **ATB:** No benefits.
Frames	100% of the SAOA tariff. Paid from the AFB, subject to a sub-limit of R2 160 per frame. One frame PB every 12 months (from date of service), included in the benefit limit for lenses. Protocols apply.
Speech therapists, social workers, podiatrists, occupational therapists, homeopaths and naturopaths, dietitians, chiropractors (X-rays excluded), audiologists, physiotherapists and biokineticists	100% of the CompCare rate. Paid from the AFB. Subject to a combined sub-limit of R9 150 PMF, in-and-out of hospital. Protocols apply.
Clinical psychologists and psychiatry	100% of the CompCare rate. **Clinical psychologists** Paid from the AFB, subject to a sub-limit of R3 220 PMF. **Psychiatry** Paid from the AFB, subject to a sub-limit of R13 570 PMF. **PMB benefit:** Up to a maximum of 21 days' admission OR 15 consultations. The 15 consultations will first be paid from the AFB, thereafter it is covered by the Scheme. Subject to pre-authorisation and protocols.
Surgical and medical appliances E.g. wheelchairs, crutches, glucometers, artificial eyes and external fixators. Pre-authorisation is required.	100% of the CompCare rate. Paid from the AFB. Sub-limits apply. Subject to protocols, clinical guidelines and pre-authorisation.
Psychosocial counselling benefit	Paid from risk. Unlimited telephonic counselling sessions through the Universal Wellness Care Centre, with an option for referral to one-on-one sessions with qualified psychologists, social workers or registered counsellors to a maximum of 3 referral sessions PB per annum.
Oxygen home ventilation	100% of the CompCare rate. Paid from the AFB. Subject to protocols, clinical guidelines and pre-authorisation.
Home nursing visits Nursing services by registered nurses or nursing assistants for the acute phase after hospitalisation or in lieu of hospitalisation (not for custodial or chronic care)	100% of the CompCare rate. Limited to 40 days PMF, unless otherwise authorised. Paid from the AFB. Subject to protocols, clinical guidelines and pre-authorisation.
Antenatal classes	100% of the CompCare rate. Subject to AFB. Limited to 12 antenatal classes and a lactation consultation with a midwife and limited to R1 870 per pregnancy.
Antenatal visits	100% of the CompCare rate. Limited to 12 antenatal visits with a GP, specialist or midwife. Paid from the Care Maximiser.
Antenatal scans and maternity bag	Foetal scans limited to 2 x 2D scans PB per year and can opt for a 3D scan (paid at the rate of a 2D scan). Maternity bag issued with registration on maternity programme.
International travel Healthcare services while traveling outside of the borders of South Africa	Subject to benefits per individual benefit category (via Universal Rewards®). Paid at South African rates. Register your journey and obtain a travel certificate on www.tic.co.za/compcare
Emergency room child benefit	One additional visit at an emergency room per annum per child younger than 6 years. To a maximum of R1 610 per event, unless a PMB. Paid from the Care Maximiser.
Emergency roadside assistance and ambulance transportation provided by Netcare 911	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.
Hospital emergency room and casualty emergency visits not requiring admission. Excluding facility fees	Paid from the AFB.
Hospital emergency as a result of physical injury caused by an external force	100% of the CompCare rate. Subject to protocols and PMBs.

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-authorisation to avoid unnecessary out-of-pocket expenses. All hospital visits and related treatment are subject to case management, clinical guidlines, specialist programmes and Scheme 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-authorisation to avoid unnecessary out-of-pocket expenses. All hospital visits and related treatment are subject to case management, clinical guidelines, specialist programmes and Scheme protocols. These measures are put in place to ensure that members obtain quality, appropriate care at specially negotiated tariffs.

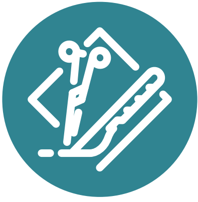
Hospitalisation (Including medical emergencies requiring hospital admission).	100% of the CompCare rate. Any Netcare hospitals. Subject to pre-authorisation, clinical guidelines, case management, and managed care protocols.
GPs and specialist treatment while in hospital.	100% of the CompCare rate. Unlimited. Subject to pre-authorisation, clinical guidelines and managed care protocols.
Medication - only while in hospital	Unlimited.
Medication on discharge from hospital (TTO)	Limited to 7 days per discharge. Subject to RP and formularies.
Surgical prostheses	Subject to pre-authorisation, clinical guidelines and protocols. Limited to an overall benefit amount of R48 880 PMF. Sub-limits per category apply.
Auxiliary services such as physiotherapy, psychology, etc.	100% of the CompCare rate. Limited to a combined sub-limit of R9 150 PMF, in-and-out of hospital. Subject to pre-authorisation, clinical guidelines and managed care protocols. A separate pre-authorisation number is required - the claim will not be paid under the hospital pre-authorisation. A 20% co-payment will apply if not pre-authorised.
Psychiatric treatment in hospital	100% of the CompCare rate. Subject to pre-authorisation, clinical guidelines, protocols and PMBs. Up to a maximum of 21 days' admission OR 15 consultations which will first be paid from the AFB, thereafter it is covered by the Scheme.
Psychology (non-psychiatric admissions)	Limited to R4 650 PMF. Subject to pre-authorisation, clinical guidelines and protocols.
All specialised radiology including MRI and CT scans	100% of the CompCare rate. Unlimited. Pre-authorisation and medical motivation are required for MRI, CT and high resolution CT scans. R3 950 co-payment PB for each scan. This applies for each scan, except PMBs. Protocols apply.
Basic radiology	100% of the CompCare rate. Unlimited. Subject to protocols.
Pathology	100% of the CompCare rate. Unlimited. Subject to protocols.
Confinements	100% of the CompCare rate. Subject to pre-authorisation, clinical guidelines and protocols.

Alcoholism, drug dependence and narcotics	Unlimited for PMBs. Subject to pre-authorisation, clinical guidelines and protocols.
Organ transplants, plasmapheresis, renal dialysis	100% of cost. Unlimited for PMBs. Subject to pre-authorisation, clinical guidelines and protocols. A DSP may apply.
Professional sports injuries	100% of the CompCare rate. Unlimited. Subject to pre-authorisation and protocols.
Oncology including chemotherapy and radiotherapy	100% of the CompCare rate. Unlimited at our oncology DSP. Subject to pre-authorisation, clinical guidelines and protocols. Oncology formulary applies.
Prophylactic mastectomy and hysterectomy	100% of the CompCare rate. Subject to pre-authorisation, clinical guidelines and protocols.
Specialised medication	Unlimited for PMBs. **Non-PMBs:** R271 440 PMF. 25% co-payment on non-PMB medicines. Subject to pre-authorisation, clinical guidelines and protocols.

Alternatives to hospitalisation

Step-down nursing facilities, hospice, rehabilitation and home-based care in lieu of hospitalisation	100% of the CompCare rate. Unlimited. Subject to pre-authorisation, clinical guidelines and protocols.
Surgical procedures out-of-hospital	100% of the CompCare rate. Unlimited. Subject to pre-authorisation, clinical guidelines and protocols.
Refractive Eye Surgery	Annual limit of R8 680 per eye. Subject to pre-authorisation, clinical guidelines and protocols. Limit includes all services rendered: Hospitalisation and all related costs.
Wound care in lieu of hospitalisation	100% of the CompCare rate. Unlimited. Subject to pre-authorisation, clinical guidelines and protocols.

Important to remember:
Always use a network hospital (where applicable) to avoid co-payments. In an emergency, go to the closest appropriate network hospital. If none are nearby, you may go to the nearest appropriate facility. For any procedures requiring a specialist, it's crucial to ensure that the specialist operates or attends to you at a network hospital. **A 35% co-payment will apply to the voluntary use of a non-DSP/network hospital/facility, with a minimum of R8 220**.



Sub-limits

for Surgical Prosthesis, Electronic and Nuclear Devices and Appliances

	Description	Frequency	UltraCare
Overall internal prosthesis limit per family			R48 880
Coronary artery stents (Subject to the overall internal prosthesis limit)	Stents	Annual	Subject to the overall internal prosthesis limit and a limit of R14 560 per stent.
	Medicated stents		
Other stents (Subject to the overall internal prosthesis limit)	Abdominal aortic aneurism stents	Annual	Subject to the overall internal prosthesis limit.
	Carotid stents		R35 780
	Renal stents		R6 760
	Aneurysm coils		R47 740
Heart valves etc. (Subject to the overall internal prosthesis limit)	Heart valves (Mitral etc)	Annual	R32 550
Orthopaedic prosthesis (Subject to the overall internal prosthesis limit)	Hip prosthesis	Annual	R42 120
	Knee prosthesis		R42 120
	Shoulder prosthesis		R42 120
	Elbow prosthesis		R40 460
	Ankle prosthesis		R40 460
	Wrist prosthesis		R40 460
	Finger prosthesis		R24 960
	Spinal instrumentation – Sub-limit per level subject to the overall internal prosthesis limit and limited to 1 procedure per beneficiary per year		R26 210
	Spinal cages		R33 590
	Spinal implantable devices		Subject to the overall internal prosthesis limit
	Internal fixators for fractures		R30 370
Artificial limbs (Subject to the overall internal prosthesis limit)	Through knee	Annual	Subject to the overall internal prosthesis limit
	Below knee		
	Above knee		
	Partial foot		
	Partial hand		
	Below elbow		
	Above elbow		
Other prosthesis (Subject to the overall internal prosthesis limit)	Intra ocular lenses	Annual	R4 260
	Bladder sling		R9 670
	Hernia mesh		R10 090
	Vascular grafts		R32 550

*** Please refer to scheme rules.*

	Description	Frequency	UltraCare
Electronic and nuclear devices (Subject to PMBs)	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	Annual	R142 480
	Cochlear implants and Bone Anchored Hearing Aids (BAHA)	Annual	R250 740
	Insulin pumps	Every 5 years	R29 020
Appliances (Subject to day-to-day benefits)	**Overall limit**	**Annual**	**R21 630**
	Hearing aids (13 years and older)	3 year interval	R21 630
	Hearing aids (0 - 12 years)	3 year interval	R6 500
	Artificial eyes	5 year interval	R21 630
	BP monitor	3 year interval	R790
	Glucometer	3 year interval	R790
	Humidifier	3 year interval	R350
	Nebuliser	3 year interval	R680
	Breast pump	Per pregnancy	R3 330
	Moonboot	Annual	R2 810
	Elbow crutches	Annual	R840
	CPAP machines	3 year interval	R12 790
	Apnoea monitors for infants < 1yr	Once per beneficiary per lifetime	R12 480
	Braces and callipers	Annual	R930
	Rigid back brace	Annual	R6 760
	Sling clavicle brace	Annual	R680
	Wigs	Annual	R2 500
	Bras for breast prosthesis after mastectomies	2 per annum	R3 530
	Breast prosthesis	Annual	R4 210
	Wheelchairs	3 year interval	R5 250
	Commodes	3 year interval	R2 600
	Swivel Bath chairs	3 year interval	R2 160
	Walking frames	3 year interval	R1 300
	Rehabilitative foot orthotics	Annual	R4 210
Wearable devices	Wearable devices claimable only with a valid NAPPI code	Annual	Excluded
Stockings (Subject to day-to-day benefits)	Stockings: Elastic, Full length and anti-embolic stockings, including compression socks	Annual	R1 920

Chronic conditions covered

Condition	Covered
Addison's disease *	✔
Allergic rhinitis	✔
Angina	✔
Ankylosing spondylitis	✔
Asthma *	✔
Attention deficit disorder	✔
Barrett's oesophagitis	✔
Bipolar mood disorder *	✔
Bronchiectasis *	✔
Cardiac arrhythmias *	✔
Cardiomyopathy *	✔
Chronic renal failure *	✔
Congestive cardiac failure *	✔
Chronic obstructive pulmonary disease *	✔
Chronic bronchitis	✔
Connective tissue disorders (mixed)	✔
Coronary artery disease *	✔
Crohn's disease *	✔
Cushing's syndrome	✔
Cystic fibrosis	✔
Depression medication	R170 pbpm
Diabetes insipidus *	✔
Diabetes Mellitus type 1 *	✔
Diabetes Mellitus type 2 *	✔
Emphysema	✔
Epilepsy *	✔
Generalised anxiety disorder	✔
Glaucoma *	✔
Gastro-oesophageal reflux disease	✔
Gout/hyperuricemia	✔
Haemophilia *	✔
HIV/AIDS *	✔
Hormone replacement therapy	✔
Huntington's disease	✔
Hypercholesterolemia/ hyperlipidaemia *	✔
Hypertension *	✔
Hypoparathyroidism	✔
Hypothyroidism *	✔
Ischaemic heart disease	✔
Migraine	✔
Motor neuron disease	✔
Multiple sclerosis *	✔
Muscular dystrophy	✔
Myasthenia gravis	✔
Obsessive compulsive disorder	✔
Osteoporosis	✔
Paget's Disease of the Bone	✔
Panic disorder	✔
Paraplegia/quadriplegia	✔
Parkinson's disease *	✔
Pemphigus	✔
Peripheral Arteriosclerotic disease	✔
Polyarthritis nodosa	✔
Post-traumatic stress syndrome	✔
Pulmonary interstitial fibrosis	✔
Rheumatoid arthritis *	✔
Schizophrenia *	✔
Scleroderma (systemic sclerosis)	✔
Stroke	✔
Systemic lupus erythematosus *	✔
Thrombocytopenic purpura	✔
Ulcerative colitis *	✔
Unipolar mood disorder/ major depression	✔
Valvular heart disease	✔
Vertigo	✔
Zollinger-Ellison syndrome	✔

Co-payments

Procedure	Co-payment
Overall co-payment for elective surgeries	N/A
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 R8 220.
MRI and CT-scans - In and out of hospital	R3 950 per scan
Specialised medication	A 25% co-payment for non-PMB medicines.
Diagnostic scopes including: • Gastroscopy • Colonoscopy • Cystoscopy • Proctoscopy • Flexible sigamoidoscopy	R3 410
Functional nasal surgery including: • Endoscopic Sinus Surgery • Septoplasty	R3 410
Arthroscopy	R3 410
Minor gynaecological laparoscopic procedures e.g. Hysteroscopy, endometrial ablation and diagnostic laparoscopy.	R3 430
Dental	R3 410
Joint replacements - arthroplasty	R4 160
Conservative back and neck treatment - spinal cord injections	R4 160
Laminectomy and spinal fusion	R4 160
Nissen fundoplication - reflux surgery	R4 160
Hysterectomy (Except for cancer and a Prophylactic hysterectomy)	R3 430
Major laparoscopic surgery including hemicolectomy and hernia repairs	R3 430
Adenoidectomy, myringotomy - grommets, tonsillectomy	No co-payment

Other co-payments in day-to-day benefits

Benefit	Co-payment
Acute medication	25% co-payment on medicines where no generic is available.
Chronic medication, including CDLs	DSP pharmacies apply. 25% co-payment for non-formulary medicine, and the use of a non-DSP.
Specialist visits out-of-hospital	35% co-payment will apply to specialist services, including related costs, e.g. pathology and radiology without GP referral.

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.

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

Terms explained

Abbreviations

A	Adult Dependant
AFB	Annual Flexi Benefit
AT	Annual Threshold
ATB	Above Threshold Benefit
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
SPG	Self-Payment Gap
SAOA	South African Optometry Association
TTO	To-Take-Out (medicine taken on discharge from hospital)

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

Annual Flexi Benefit (AFB): an insured benefit which is a fixed amount provided by CompCare to cover Day-to-Day medical expenses. These benefits are subject to specific limits, co-payments, or specified conditions based on the member's chosen benefit option. For traditional plans without a PMSA, day-to-day claims are paid directly from the AFB.

Above Threshold Benefit (ATB): available on UltraCare, ExecuCare and the Plus versions of these benefit options, the ATB consists of additional benefits which become available once the AFB insured benefits are depleted, and the annual thresholds for the Self-Payment Gap have been reached. The ATB offers additional benefit amounts for selected medical expenses.

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.

Contraceptives: injectable, implantable, intra-uterine, trans- and subdermal, as well as oral contraceptives.

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-authorised 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 for 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-authorisation, 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-authorised 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.

Self-Payment Gap (SPG): applicable to the UltraCare, ExecuCare and the Plus versions of these benefit options. Once the Annual Flexi Benefit is depleted, annual thresholds for the Self-Payment Gap apply where the member is liable for day-to-day medical expenses up to a certain threshold. Once the Threshold is reached, the Above Threshold Benefits will offer additional benefit amounts for selected medical expenses.

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.

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

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 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.*

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**.

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** 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.**

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

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 form 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.**

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 benefit will include any homeopathic medication.

Contact Details

CompCare Medical Scheme

Universal House, 15 Tambach Road,
Sunninghill Park, Sandton
PO Box 1411, Rivonia, 2128
Tel: 0861 222 777
Email: compcare@universal.co.za
Web: compcare.co.za

Complaints escalated to the Council for Medical Schemes

Tel: 0861 123 267
Email: complaints@medicalschemes.com
Web: 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.

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

Administered by

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