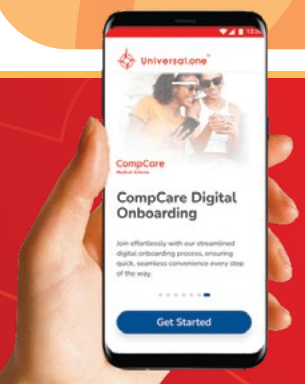
CompCare

Medical Scheme

Umbono

/Plus

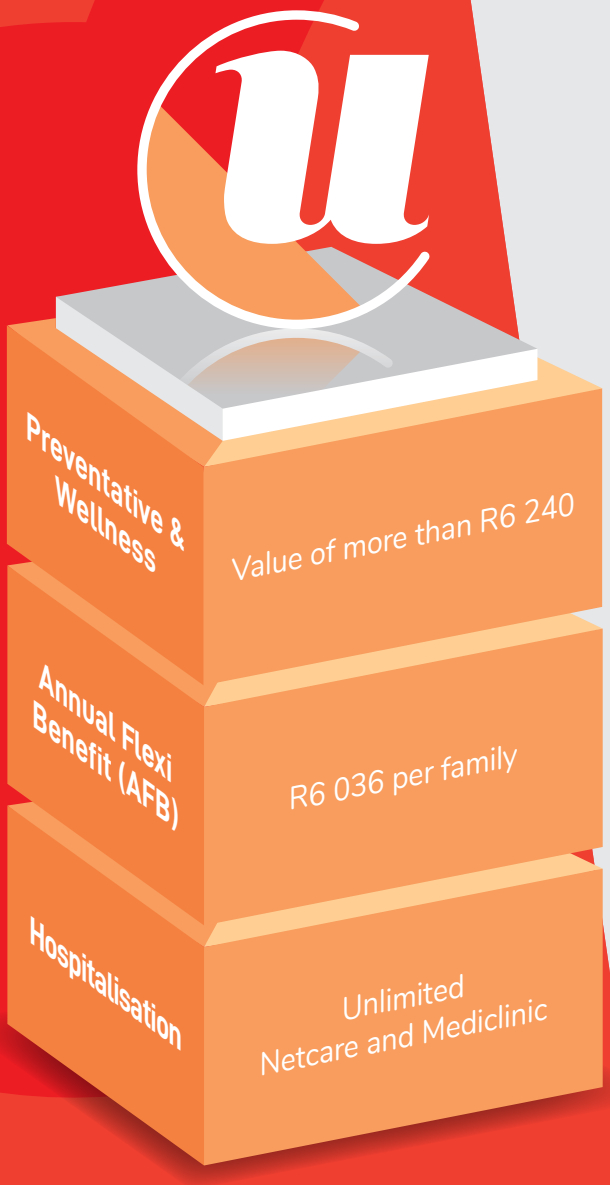


Administered by Universal®

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

Umbono Plus

Taking care of yourself and your family is your top priority, and having reliable medical cover is a big part of that. You've chosen a top-ranking medical scheme option to ensure that when you or your family need medical care, you're fully supported.



The Umbono Plus option gives you essential cover through the Universal Provider Network, with access to private healthcare providers. It also includes an Annual Flexi Benefit (AFB) for specialist consultations, dentistry, optometry, and radiology. As a network plan, Umbono ensures full access to private hospitals, with in-hospital claims paid from the Scheme's risk pool.

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.

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 tailored to support your overall well-being.

Hospital benefits

The Umbono option offers unlimited cover for in-hospital related services at a network of private hospitals at 100% of the CompCare rate.

Specialists are paid at 100% of the CompCare rate.

Comprehensive chronic cover

Covers the 27 listed Chronic Disease List (CDL) conditions and 5 additional chronic conditions, offering peace of mind for long-term health management.

Income bands	Principal member	Adult dependant	Child dependant
R501-R8 400	R1 777	R1 688	R 622
R8 401-R10 500	R2 186	R2 079	R 768
R10 501-R12 600	R2 434	R2 310	R 856
R12 601-R18 900	R2 672	R2 538	R 889
R18 901-R21 000	R3 694	R3 506	R1 301
R21 000+	R4 144	R3 724	R1 449

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

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.

Women

At CompCare, we're dedicated to the holistic health and wellness of modern women. Whether navigating the challenges of a professional career or managing the demands of a growing family, our range of benefits caters to their diverse needs.

Maternity Benefits:

- **Confinements:** Paid from risk. Includes 2 x 2D ultrasound pregnancy scans.

Additional Benefits:

- **Contraceptives** limited to **R200 PB per month** for oral contraceptives (RP applies) for female beneficiaries up to 55 years - paid from risk.
- **Pap smear:** One per female beneficiary over the age of 18 per annum - paid from risk.
- **Mammogram:** One per female beneficiary over the age of 35 every second year - paid from risk.
- **Annual Wellness Check:** Blood pressure, Blood Sugar, Cholesterol, BMI and waist circumference at a DSP pharmacy. **R300 PB per year**.

Men

We're tuned into the varied health and wellness needs of men. From young professionals leading dynamic active lives, to family men and seasoned executives, our speciality benefits enhance well-being at every relevant touchpoint.

- **Prostate-specific antigen (PSA) blood test:** Paid from risk, one test per male beneficiary over the age of 40 per annum.
- **Annual Wellness Check:** Blood pressure, Blood Sugar, Cholesterol, BMI and waist circumference at a DSP pharmacy, **R300 PB per year**.

Sport: Professional and adventure sports cover

Embracing adventure and professional sports, our benefits protect you against unexpected injuries.

- Unlimited emergency evacuation, including airlifts.
- Emergency search and rescue.
- Hospitalisation due to professional sport injuries are also covered.

Emotional wellness

We recognise the profound impact of emotional well-being on overall health and ensure that our members receive comprehensive support and access to emotional wellness benefits.

- **Alcoholism, drug dependence and narcotics:** Unlimited for Prescribed Minimum Benefits. Subject to pre-authorisation, clinical guidelines and protocols.
- **Psychosocial counselling benefit:** Paid from Risk. Unlimited telephonic counselling sessions through the Universal Wellness Care Centre, with an option for referral to face-to-face sessions with qualified psychologists, social workers or registered counsellors to a maximum of 3 referral sessions per beneficiary per year.

Preventative care benefits

Prioritising the power of prevention over cure, we offer our members an extensive range of preventative care benefits that promote a proactive approach to maintaining good health, all paid from risk.

- **GP wellness consultation:** One code per year, excluding procedures. Limited to tariff code 0190/1/2 and diagnosis code (ICD10) Z00.0 or Z00.1.
- **Health check:** Blood pressure, blood sugar, cholesterol, BMI and waist circumference – one measurement per beneficiary over the age of 18 years, limited to **R300 per event.** Available at DSP pharmacies.
- **Rapid HIV test.**
- **Flu vaccine:** One per beneficiary.

Travel cover

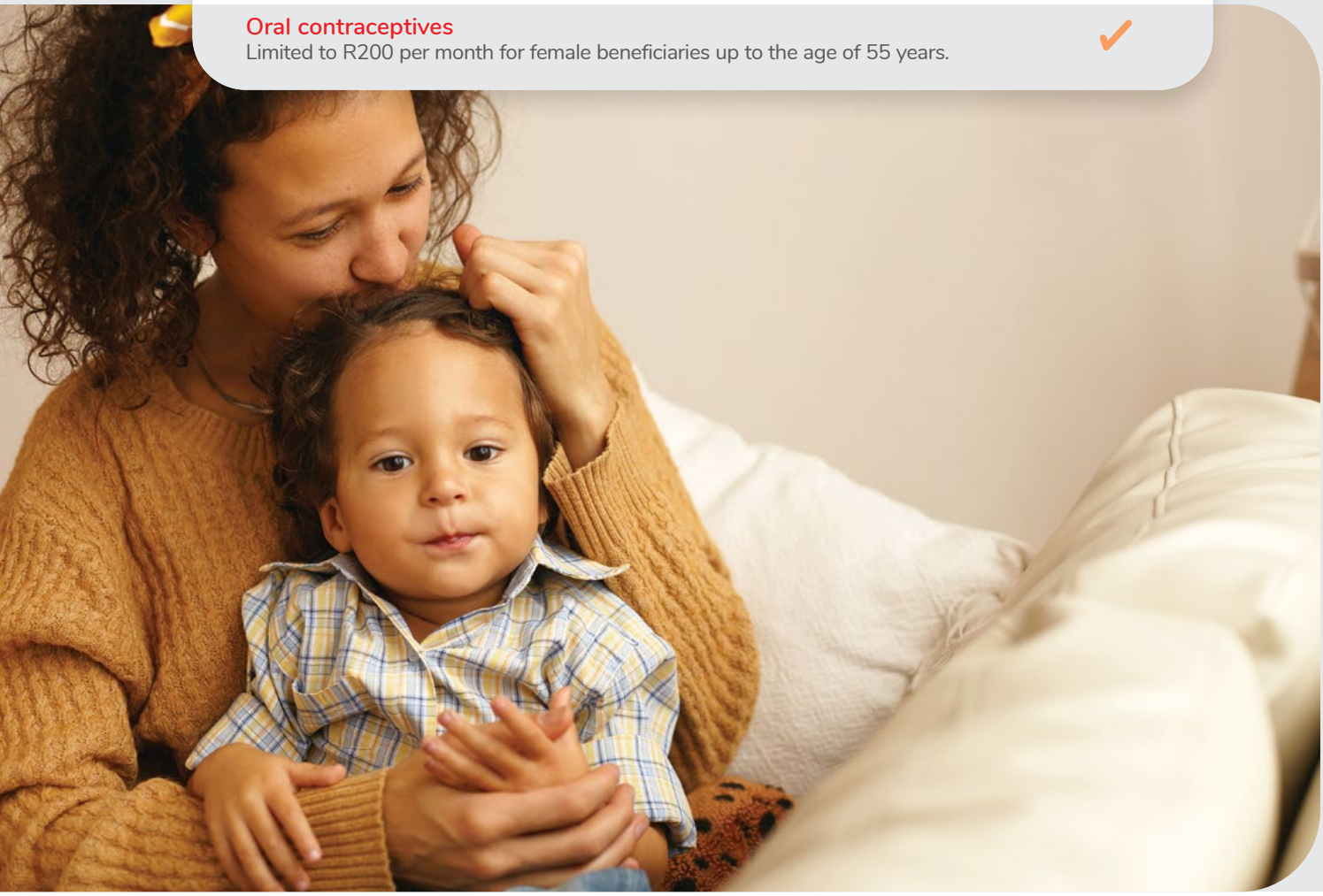
Travel is about creating memories, not worries. We've developed benefits (paid from risk) that let you focus on your adventure, knowing we've got you covered for the unexpected.

- **International Travel cover** for emergency medical costs of up to R10 million per person on each journey while travelling outside of South Africa. This cover is for a period of 90 days from departure from South Africa. Pre-existing conditions are excluded (via Universal Rewards®).

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	R6 240
Essential health test 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 a DSP pharmacy.	✓
GP wellness consultation One visit per beneficiary, per annum - excluding procedures. Limited to tariff code 0190/1/2 and ICD10 Z00.0 or Z00.1.	✓
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.	✓
Flu vaccine One per beneficiary per annum.	✓
Oral contraceptives Limited to R200 per month for female beneficiaries up to the age of 55 years.	✓



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.

How are these benefits covered?

Annual Flexi Benefit (AFB)

Also known as insured benefits

Insured benefits are fixed amounts provided by CompCare to 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.

Day-to-day benefits	100% of the CompCare rate. **Annual Flexi Benefit (AFB):** R4 056 PB. R6 036 PMF.
General practitioner Virtual and face-to-face consultations, procedures and material costs	100% of the CompCare rate. **In-Network:** Unlimited. **Out-of-Network:** 2 visits PB. Limited to R2 080 per event including medicines, pathology, radiology. A 20% co-payment applies. Member to pay at point of service and claim back from the Scheme. Unlimited virtual consultations at participating Network GPs.
Virtual nurse consultations	100% of CompCare rate. Unlimited. Paid from risk.
Specialists	100% of CompCare rate for non-PMB conditions. Subject to referral from a Universal Care Network GP. Limited to 2 visits per beneficiary and 3 visits PMF per year. Two (2) additional antenatal visits per pregnancy. Subject to AFB. Once benefit is depleted, PMB rules apply.
Chronic medicines (27 CDL conditions)	100% of CompCare rate. DSP pharmacies apply. Subject to formularies, protocols and pre-authorisation. 25% co-payment for use of a non-DSP Pharmacy.
Medicine for non-CDL conditions	6 non-CDL conditions 100% of CompCare rate. Unlimited. Subject to formularies, protocols and pre-authorisation. 25% co-payment for use of a non-DSP Pharmacy.
Acute medicines	100% of the CompCare rate. Unlimited. Subject to the Universal Care medication formulary as prescribed by an Universal Care Network GP. Non-formulary medication limited to R420 PB. Prescription to be collected on same day of service.
Over-the-counter medication and homeopathic medicines	R170 x 3 events PB to a max overall limit of R830 PMF per year.
Basic radiology Black and white X-rays and ultrasound	Paid at 100% of the CompCare rate. Unlimited. Subject to Universal Care approved codes. Referral from a Network GP required.
All specialised radiology MRI, CT, High resolution and PET Scans	100% of the CompCare rate. A maximum of 2 scans PMF per year, subject to medical motivation and pre-authorisation. Combined in and out of hospital. No benefit for screening purposes. No benefit for PET scans unless a PMB.
Pathology	100% of the CompCare rate. Unlimited subject to Universal Care Approved List of Pathology Codes and managed care protocols. Referral from a Network GP required.
Conservative dentistry Including consultations, preventative care, fillings, extractions and infection control	100% of the CompCare rate. One consultation per beneficiary limited to R2 080 PB up to a maximum of R3 580 PMF per year. Services to be provided by a Universal Care Network service provider only. Voluntary out of network: services will be paid up to the agreed rate for services obtained from a DSP.

Day-to-day benefits (continued)

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).	Subject to AFB for non-PMBs. Unlimited for PMBs.
Optometry visits	100% of SAOA rate. 1 Visit PB every 2 years. Benefits through Universal Network Optometrists. Subject to AFB.
Lenses and contact lenses	Clear, plastic single vision lenses. Limited to R1 200 PB or bi-focal lenses to R1 870 per beneficiary, every 2 years. R1 200 PB for contact lenses, included in the single vision lenses limit.
Frames	Included in lenses limit.
Speech therapists, social workers, podiatrists, occupational therapists, homeopaths and naturopaths, dietitians, chiropractors (X-rays excluded), audiologists, physiotherapists and biokineticists	100% of the CompCare rate. Limited to R8 010 PMF for non-PMBs. Sub-limit for physiotherapy applies of R3 220.
Clinical psychologists and psychiatry	Unlimited for PMBs. Subject to pre-authorisation and protocols.
Surgical and medical appliances E.g. wheelchairs, crutches, glucometers, artificial eyes and external fixators.	100% of the CompCare rate. Subject to PMBs. Subject to pre-authorisation, clinical guidelines and protocols.
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 year.
Oxygen home ventilation	Unlimited for PMBs. Subject to pre-authorisation, clinical guidelines and protocols.
Home nursing visits Nursing services by registered nurses or nursing assistance for the acute phase after hospitalisation or in lieu of hospitalisation (not for custodial or chronic care).	Subject to PMBs, unless otherwise authorised. Subject to pre-authorisation and protocols.
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 as a result of physical injury caused by an external force	100% of the CompCare Rate rate. Subject to protocols and PMBs.

Chronic conditions covered

Acne (Severe)	✓	Epilepsy*	✓
Addison's Disease*	✓	Glaucoma*	✓
Anaemia	✓	Haemophilia*	✓
Asthma*	✓	HIV/Aids	✓
Bipolar Mood Disorder*	✓	Huntington's Disease	✓
Bronchiectasis*	✓	Hypercholesterolemia/Hyperlipidaemia*	✓
Cardiac Arrhythmias*	✓	Hypertension*	✓
Cardiomyopathy*	✓	Hypothyroidism*	✓
Chronic Renal Failure*	✓	Multiple Sclerosis*	✓
Congestive Cardiac Failure*	✓	Parkinson's Disease*	✓
Chronic Obstructive Pulmonary Disease*	✓	Pemphigus	✓
Coronary Artery Disease*	✓	Rheumatoid Arthritis*	✓
Crohn's Disease*	✓	Rosacea	✓
Diabetes Insipidus*	✓	Schizophrenia*	✓
Diabetes Mellitus type 1* and 2*	✓	Systemic Lupus Erythematosus*	✓
Depression	✓	Ulcerative Colitis*	✓

*27 Chronic Diseases List (CDL)

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 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	100% of the CompCare rate. Unlimited. A network of private hospitals. Non pre-autherisation of elective admissions will attract a co-payment (excluding PMBs). Voluntary admission to a non-DSP will attract a co-payment of 35% with a minimum of R8 220.
GPs and specialist treatment while in hospital.	100% of the CompCare rate. Subject to pre-authorisation, clinical guidelines and protocols.
Medication - only while in hospital	Unlimited
Medication on discharge from hospital (TTO)	Limited to 7 days per discharge. Subject to Reference Pricing (RP) and formularies.
Surgical prostheses	Unlimited for PMBs. Subject to pre-authorisation, clinical guidelines and protocols.
Auxiliary services such as physiotherapy, psychology, etc.	Limited to R8 010 PMF for non-PMBs. Sub-limit for physiotherapy applies of R3 220. Subject to a separate pre-authorisation per provider, clinical guidelines and protocols. A co-payment of 20% will apply in the case of late authorisation.
Psychiatric treatment in hospital	100% of the CompCare rate. Subject to pre-authorisation, clinical guidelines, protocols. 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. Subject to PMBs.
All specialised radiology including MRI and CT scans	100% of the CompCare rate. A maximum of 2 scans PMF per year, subject to medical motivation and pre-authorisation. Combined in and out of hospital. No benefit for screening purposes. No benefit for PET scans unless a PMB.
Basic radiology	100% of the CompCare rate. Unlimited.
Pathology	100% of the CompCare rate. Subject to case management and a list of covered tests and procedures.

Confinements (in-hospital and home deliveries)	100% of the CompCare rate. Unlimited. 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	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, clinical guidelines and protocols.
Adventure Sport injuries	100% of the CompCare rate . Unlimited. Pre-authorisation required and protocols apply.
Oncology including chemotherapy and radiotherapy	100% of the CompCare rate. Unlimited for PMBs 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.

Alternatives to hospitalisation

Step-down nursing facilities, hospice, rehabilitation and home-based care in lieu of hospitalisation	100% of the CompCare rate. Unlimited for PMBs, unless otherwise authorised. Subject to pre-authorisation, clinical guidelines and protocols.
Surgical procedures out-of-hospital	100% of the CompCare rate. Unlimited for PMBs, unless otherwise authorised. Subject to pre-authorisation, clinical guidelines and protocols.
Wound care in lieu of hospitalisation	100% of the CompCare rate. Unlimited for PMBs, unless otherwise authorised. Subject to pre-authorisation, clinical guidelines and protocols.

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)

List of exclusions

Please note that exclusions are subject to PMB.

Procedures	Back and neck surgery	✔
	Bariatric surgery / treatment relating to obesity	✔
	Breast reduction / Gynaecomastia surgery	✔
	Bunion surgery (Correction of Hallux Valgus)	✔
	Elective Caesarean sections for non-medical reasons	✔
	Cochlear implants, auditory brain implants (Bone-anchored Hearing Aids)	✔
	Cosmetic surgery - blepharoplasty; septoplasty, nasal tip reconstruction and otoplasty, as well as any cosmetic preparations	✔
	Corneal transplants	✔
	Deep brain implants	✔
	Excimer Laser / Refractive surgery	✔
	Functional nasal and sinus surgery	✔
	Gender reassignment surgery, medicines and treatment	✔
	Infertility -AI; IVF; GIFT; ZIFT and ICSI	✔
	In-hospital dental surgery	✔
	Internal nerve stimulators	✔
	Investigations and diagnostic work up only in hospital	✔
	Joint replacement surgery and related orthopaedic prosthesis (including hip, knee, shoulder, elbows, ankle, wrist and finger prosthesis).	✔
	Polysomnograms and CPAP titrations	✔
	Removal of port-wine stains, scars and tattoos	✔
	Reversal of Vasectomy or tubal ligation	✔
	Robotic assisted surgery	✔
	Reflux and Hiatus hernia repair surgery	✔
	Spinal surgery and related orthopaedic prosthesis (Instrumentation, implantable devices and spinal cages)	✔
	Sleep therapy	✔
	Treatment of keloids except for burns & functional impairment	✔
Dental	Bleaching of teeth	✔
	Conscious sedation and general anaesthetics for dental procedures -7yrs and older	✔
	Lingual orthodontics	✔
	Orthodontic treatment over age of 18yrs	✔
	Osseo-integrated implants, all implant-related procedures and orthognathic surgery	✔
	Resin bonding of Metal fillings	✔

Medicines	Medication not registered by SAPHRA	✔
	Medication used in clinical trials and / or treatment resulting from clinical trials	✔
	Anabolic steroids and immunostimulants	✔
	Vitamins and minerals	✔
Prosthesis	Implantable ventricular assist devices (e.g. LVAD) and total artificial hearts	✔
	Internal fixators for fractures	✔
External appliances	APS/TENS machines	✔
	Chair seats / backrests and cushions (Excluding wheelchairs backrests and cushions)	✔
	Hearing aids	✔
	Hospital beds - purchase / rental	✔
	Health shoes	✔
	Incontinence Products (Linen savers; disposable nappies, waterproof sheets)	✔
	Mattresses	✔
	Motorised Scooters	✔
	Shower and bath rails	✔
	Sunglasses (prescription and non-prescription)	✔
	Braces including rigid back braces, and callipers	✔
	Wigs	✔
	CPAP machines	✔
	Apnoea monitors for infants <1 year	✔
Other	Difference in cost between a cornea from outside SA and a locally acquired cornea	✔
	Physiotherapy services - wisdom teeth; caesareans	✔
	Genetic and metabolic testing	✔
	Aphrodisiacs	✔
	Smoking cessation agents	✔
	Contact lens preparations	✔
	Cosmetic preparations	✔

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 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 Universal®