CompCare
Medical Scheme

2027

SuperCare /Plus

Life is full of surprises.
CompCare has you *covered.*

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

Administered by Universal®

Why Choose CompCare?

Well-Versed
With 48 years' experience, CompCare offers medical aid cover to all South Africans.

Cover for Moms and Babies
Get access to additional maternity, newborn, and toddler benefits.

Maximise your Benefits
In addition to your day-to-day benefits, members receive wellness, preventative care and care maximiser benefits worth up to R26 000.

Quality Care
Access to quality private healthcare via the Universal Network of 12 000+ providers nationwide.

Unlimited Emergency Transportation
By road and air in South Africa.

Comprehensive Medical Cover
All options include assistance to manage chronic conditions such as diabetes and hypertension.

Convenient Virtual Consultations
Benefit from virtual consultations with GPs and online nurse chats from the comfort of your home via uConsult™.

Trusted Mental Health Benefits
24/7 access to professional telephonic counselling.

All your Medical Aid Information at your Fingertips
View your membership details, claims, and more on the Universal.one App for CompCare members.

International Cover
International emergency medical travel cover.

Instant Cover
Regardless of the day of the month, we offer you instant next day cover at a prorated contribution. Simply join via our easy-to-use online application form.

Join CompCare Via the App

Simply download the Universal.one App for CompCare members from the Apple or Google Play store.

GET IT ON Google Play | Download on the App Store

Open the app, select **Register** and follow the step-by-step prompts to be automatically logged in.

Apply in Under 10 Minutes
You can join CompCare Medical Scheme right now through a simple, quick and user-friendly process of completing an application on your smartphone.

Membership at Midnight on the Day of Joining
Once approved, you will immediately receive your membership number and digital membership card, and you can start enjoying the peace of mind that comes from being covered by the comprehensive benefits of CompCare.

Universal.one App

Your Membership App in Motion

uHealthCheck
Your Health in 30 Seconds

A 30-second AI-driven video selfie that provides health and wellness insights, and a wellness score you can track over time, using advanced TOI™ and DeepAffex technology.

uWellness®
Total Well-Being in One App

A comprehensive wellness platform offering tools, tips, assessments, and device integration to support all eight dimensions of wellbeing.

uHealthChat®
Unlimited Nurse Consults

Connect with qualified nurses through a secure online chat for instant, nurse-led care anytime, anywhere.

uConsult™
Virtual Doctor Visits

A secure online platform for doctor consultations, e-prescriptions, test requests, and sick notes, anytime and anywhere.

uSmartRecords

Secure, instant access to your complete health history – including medications, test results, consultations, and hospital records – all in one digital record.

Personal Health Assistant

An AI-powered assistant that keeps you on track with timely reminders for prescription renewals, medication refills, appointments, vaccinations, and follow-ups.

Daily Journal

Track your mood, symptoms and important health moments in one place. Use text or voice-to-text, with AI helping turn symptoms into trackable entries.

SuperCare Plus

Premium Cover for Complete Peace of Mind

SuperCare Plus is premium medical aid for individuals and established families who want more choice, more comprehensive cover and greater peace of mind. Enjoy access to private hospitals, a substantial medical savings account and an Above Threshold Benefit (ATB) that extends your day-to-day healthcare cover when you need it most.

Day-to-Day Benefits

Generous day-to-day cover for your out-of-hospital expenses including GP visits, medicines, and dental care, helping manage healthcare costs.

Preventative Care and Wellness

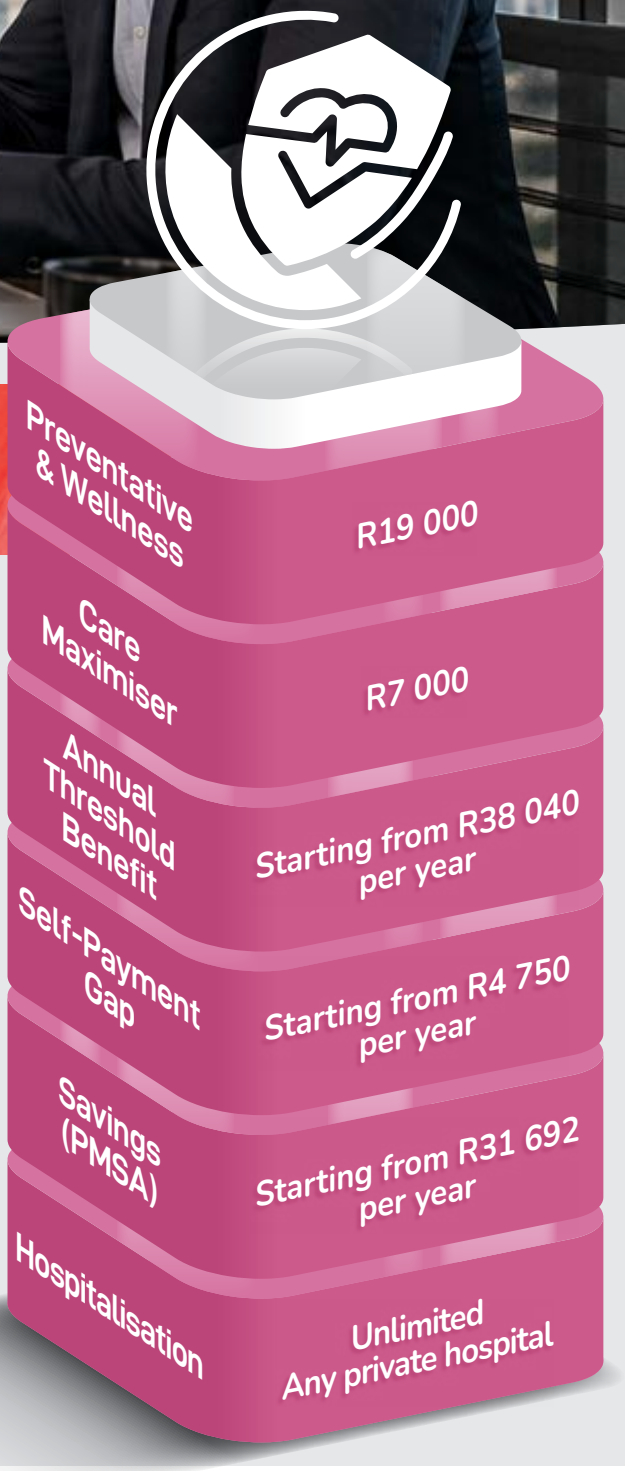
These benefits enhance your day-to-day cover with screenings and checkups for early health issue detection, tailored to support overall well-being.

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.

Comprehensive Chronic Cover

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



Your Monthly Contributions

	Principal member	Adult dependant	Child dependant
Contribution	**R10 567**	**R10 038**	**R2 112**
PMSA	R31 692	R30 108	R6 324

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

Everyday Care

These help cover your everyday healthcare needs, including GP consultations, prescription medicine, dental check-ups, radiology, pathology and optometry.

Day-to-Day Benefits

Overall benefit

- **25% PMSA**
  - **P: R31 692** **A: R30 108** **C: R6 324** (to a maximum of three children.)
- **SPG:**
  - A Self-Payment Gap (SPG) is applicable once the PMSA is depleted and before the Annual Threshold is reached. Thereafter the ATB becomes available. The annual SPG amounts are:
  - **P: R4 750** **A: R6 410** **C: R650** (to a maximum of three children.)
  - GP and specialist consultations, prescribed acute medication, dentistry, optometry, radiology and pathology will accumulate to the Annual Threshold and then the ATB will be available.
- **ATB:**
  - Once the SPG is reached, the following ATB amounts become available for specified day-to-day expenses:
  - **P: R38 040** **A: R38 040** **C: R9 240** (to a maximum of three children.)

Online Nurse Consultations

- 100% of the CompCare Rate.
- Unlimited via uHealthChat® on the Universal.one App.
- DSP applies.

General Practitioner Consultations

Face-to-face consultations

- 100% of the CompCare Rate.
- First paid from the PMSA, then from the SPG, and thereafter from the ATB once the Annual Threshold is reached.

Outpatient emergency room consultations (excluding the facility fee)

- 100% of the CompCare Rate.
- First paid from the PMSA, then from the SPG, and thereafter from the ATB once the Annual Threshold is reached.

Virtual Consultations

- 100% of the CompCare Rate.
- Virtual GP consultations, including medication to the value of R500 per event, PB, via uConsult™.
- First paid from the PMSA, then from the SPG, and thereafter from the ATB once the Annual Threshold is reached.

Specialist Consultations

- 200% of the CompCare Rate (excluding dental treatment which is covered at 100% of the CompCare Rate).
- First paid from the PMSA, thereafter from the available ATB once the Annual Threshold is reached.
- Subject to pre-authorisation and managed care protocols.
- Referral by a GP/specialist and pre-authorisation are required to avoid a 35% co-payment.

Acute Medicines

- 100% of RP.
- First paid from the PMSA, thereafter from the available ATB once the Annual Threshold is reached.
- Limited to the following amounts in the PMSA and ATB:
- **P: R43 640 P+1: R51 130 P+2: R59 390 P+3+: R67 710**
- A 25% co-payment applies to all non-generic products.

Over-the-Counter Medication

And homeopathic medicine

- 100% of RP.
- Paid from the PMSA.
- Does not accumulate towards the Annual Threshold.
- No ATB benefit.

Medicine: Chronic Medicines (27 CDL Conditions)

- 100% of RP.
- Subject to pre-authorisation, managed care protocols and formularies.
- A 25% co-payment applies to non-formulary medicine.

Medicine: Chronic medicine for non-CDL conditions

- 48 non-CDL conditions.
- 100% of RP.
- Subject to pre-authorisation, clinical guidelines, managed care protocols and formularies.
- A 25% co-payment applies to non-formulary medicine.

Pathology

- 100% of the CompCare Rate.
- First paid from the PMSA, thereafter from the available ATB once the Annual Threshold is reached.
- Referral by a GP/specialist is required to avoid a 35% co-payment.
- Protocols apply.

Basic Radiology

Black-and-white X-rays and ultrasound

- 100% of the CompCare Rate.
- First paid from the PMSA, thereafter from the available ATB once the Annual Threshold is reached.
- 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.
- R4 130 co-payment PB applies for each scan, except PMBs.

Specialised Dentistry

Including maxillofacial and oral surgery – combined in- and out-of-hospital benefit

(A quotation must be submitted for approval before treatment commences. Orthodontic treatment for patients older than 18 is excluded.)

- 100% of the CompCare Rate.
- First paid from PMSA, thereafter from the available ATB once the Annual Threshold is reached.
- Limited to the amount of R37 490 PF in the PMSA and ATB (for both conservative and specialised dentistry).
- Subject to managed care protocols.

Conservative Dentistry

Including consultations, preventative care, fillings, extractions (including wisdom teeth), root canal treatment and infection control

- 100% of the CompCare Rate.
- First paid from PMSA, thereafter from the available ATB once the Annual Threshold is reached.
- Limited to the amount of R37 490 PF in the PMSA and ATB (for both conservative and specialised dentistry).
- Subject to managed care protocols.

Optometry

- 100% of the SAOA tariff.
- First paid from the PMSA, thereafter from the available ATB once the Annual Threshold is reached.
- Limited to R7 880 PB in the PMSA and ATB.
- Combined limit for optometry visits, lenses, frames, intraocular lenses and refractive eye surgery.
- Subject to managed care protocols.

Auxiliary Services

(Speech therapists, social workers, podiatrists, occupational therapists, homeopaths and naturopaths, dietitians, chiropractors (X-rays excluded), audiologists, physiotherapists and biokineticists.)

- 100% of the CompCare Rate.
- First paid from PMSA, thereafter from the available ATB once the Annual Threshold is reached. Limited to the following amounts in the PMSA and ATB:
- **P: R25 540 P+1: R34 730 P+2: R42 280 P+3+: R49 070**
- Subject to managed care protocols.

Maternity Benefit

Confinements

In-hospital or home births

- 100% of the CompCare Rate.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Ultrasound Scans for Pregnancies

- 100% of the CompCare Rate.
- Two 2D scans per pregnancy (3D scans are paid at the 2D rate), to a maximum of R600 per sonar.

RSVpref Vaccination

- One RSVpref vaccination per pregnancy, administered between 32 and 36 weeks of pregnancy.
- Available to pregnant beneficiaries whose expected date of delivery falls within the RSV season.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Antenatal Visits with GP, Specialist or Midwife

- 100% of the CompCare Rate.
- To a maximum of 12 antenatal visits.
- Paid first from available PMSA, then from risk.
- Subject to clinical guidelines and managed care protocols.

Antenatal/Lactation Classes

- 100% of the CompCare Rate.
- Subject to the PMSA.
- Limited to a maximum of R1 950 per pregnancy.

Fitness Assessment and Exercise Prescription

- One fitness assessment and exercise prescription per pregnant member per pregnancy via the Universal Network of biokineticists. (The initial assessment should be face-to-face with the biokineticist.)
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Nutritional Assessment and Healthy Eating Plan

- One nutritional assessment and healthy eating plan per pregnant member per pregnancy via the Universal Network of dietitians. (The initial assessment should be face-to-face with the dietitian.)
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Maternal Emotional Support

- Available through the Universal Wellness Care Centre. Includes unlimited telephonic counselling, with referral to one-on-one sessions with qualified psychologists, social workers or registered counsellors, to a maximum of three referral sessions per beneficiary per annum. The benefit also provides emotional and psychological support following childbirth. A combined benefit (see Mental Health benefits)

Folic Acid Supplement

Over-the-counter with a NAPPI code

- Over-the-counter folic acid supplements (with a valid NAPPI code).
- 100% of RP to a maximum of R150 PB per pregnancy.

Cervical Length Scan

- One scan PB per pregnancy.
- From 12 weeks of pregnancy onwards.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.
- Motivation required.

Fetal Fibronectin Test

- One test PB per pregnancy.
- From 12 weeks of pregnancy onwards.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.
- Motivation required.

Maternity Bag

- Get your maternity bag when registered on the maternity programme.

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.

Preventative Care

Essential Health Test

Blood pressure, blood sugar, cholesterol, BMI and waist circumference

- One measurement PB over the age of 18 years, limited to R310 per annum.
- Only at a DSP pharmacy.

Prediabetes Test (HbA1c)

- 100% of the CompCare Rate.
- One HbA1c test PB, to the value of R190, is covered if the fasting essential health test indicates a high blood sugar level.
- Subject to the test results of the Essential health test.

Rapid HIV Test

- As required.

Prophylaxis for Malaria

- Preventative medicine as required.

Tetanus Vaccine

- One injection when required.

Lipogram

- One fasting lipogram PB over the age of 20, once every five years.

Bone Density Test (DEXA Scan)

- 100% of the CompCare Rate.
- One bone density test (DEXA scan) PB.
- Beneficiaries older than 65 years, every two years.
- Protocols apply.

Glaucoma Test

- One per beneficiary per annum.

Respiratory Care

Adult and Child Pneumococcal Vaccine

- Two pneumococcal vaccinations PB per lifetime for the following groups:
  - aged 65 years and older
  - aged 12 to 64 years who are classified as being at high clinical risk
- Subject to pre-authorisation and managed care protocols.
- As per the standard childhood vaccination schedule, for children aged 0–12 years.

Flu Vaccine

- One vaccination PB per annum.
- Includes the administration fee charged by a DSP pharmacy.

RSVpref Vaccination

- One RSVpref vaccination per pregnancy between 32–36 weeks of pregnancy.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.
- Available to pregnant beneficiaries whose expected date of delivery falls within the RSV season.

Contraceptives

Overall annual limit R3 850 PB

Oral Contraceptives
- Maximum of 13 scripts per year.
- Subject to the overall annual limit.
- Subject to RP and formulary.

Injections/Implants
- Subject to the overall annual limit.
- Subject to pre-authorisation and managed care protocols.

IUD
- Subject to the overall annual limit.
- Subject to pre-authorisation and managed care protocols.

Cancer Prevention

HPV/Cervical Cancer Vaccine
- Female beneficiaries from nine to 26 years.
- Three vaccinations PB, depending on the age of the beneficiary.

Mammogram
- One test per female beneficiary over the age of 35 every second year.

Pap Smear
- One test per female beneficiary over the age of 18 per annum.

Prophylactic Mastectomy and Oophorectomy
- 100% of the CompCare Rate.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.
- The Scheme will fund a prophylactic mastectomy with immediate reconstruction and waive applicable co-payments for a medically indicated oophorectomy for members at high risk of developing breast or ovarian cancer. This includes members with a strong family history of cancer spanning at least three generations.

PSA Blood Test
- One test per male beneficiary over the age of 40 per annum.

Colorectal Cancer Screening
- One faecal occult blood test every 24 months (from the date of service) for beneficiaries aged 45 to 75.
- Subject to clinical guidelines and managed care protocols.

Preventative Care and Wellness Benefits (continued)

Healthy Weight

Fitness Assessment and Exercise Prescription
- Access to the Universal Network of biokineticists for an annual fitness assessment, exercise prescription and regular monitoring. (The initial assessment should be face-to-face with the biokineticist.)
- Subject to pre-authorisation and managed care protocols.

Nutritional Assessment and Healthy Eating Plan
- Access to the Universal Network of dietitians for an annual assessment, healthy eating plan prescription and regular monitoring. (The initial assessment should be face-to-face with the dietitian.)
- Subject to pre-authorisation and managed care protocols.

Child Benefit

Newborn Screenings
Hearing screening and congenital hypothyroidism test
- 100% of the CompCare Rate.
- One test per newborn.
- Paid from risk.

Baby wellness visits.
- 100% of the CompCare Rate.
- Two visits per annum for children aged four weeks to 18 months with a registered nurse at our DSP. (ICD code Z00.1 only.)
- Paid from risk.

Paediatric Consultations
- 100% of the CompCare Rate.
- Three visits to track development and milestones per child up to the age of two years.
- Paid from risk.

Childhood Standard Immunisations
- 100% of the CompCare Rate.
- Childhood immunisations
- According to Department of Health guidelines, children up to age 12.
- Paid from risk.

Kids' Active Benefit
- Fitness assessment and exercise plan for children aged 8–12 with a Universal Network biokineticist.

Kids' Nutritional Benefit
- Access to a Universal Network dietitian for assessments and a healthy eating plan for children aged 8–15.

School readiness assessments
- 100% of the CompCare Rate.
- Psychometric testing (ages 14–18), preschool eye and hearing screenings (ages 5–6), and dental screenings (ages 5–7).
- Paid from risk.

SporTeen
- Annual fitness assessment, virtual consultations and exercise plan for children aged 13–17 with a Universal Network biokineticist.

Mental Health

Psychosocial Counselling Benefit – Telephonic
- Paid from risk.
- Unlimited telephonic counselling sessions through the Universal Wellness Care Centre.

Psychosocial Counselling Benefit – Face-to-Face
- Through the Universal Wellness Care Centre's telephonic counselling benefit, a beneficiary may be referred for up to three one-on-one sessions per annum with a qualified psychologist, social worker or registered counsellor.

Psychiatric/Clinical Psychologist Treatment In and Out of Hospital
- 100% of the CompCare Rate.
- PMB benefit: Up to a maximum of 21 days' admission OR
- 15 consultations.
- Subject to pre-authorisation, clinical guidelines, managed care protocols and PMBs.
- DSP may apply.

Psychology Consult During Hospitalisation
(non-psychiatric admissions)
- 100% of the CompCare Rate.
- Limited to R7 320 PF.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Medicine for Non-CDL Conditions
- R180 PB per month for depression medicine.
- Subject to pre-authorisation, managed care protocols and formularies.
- A 25% co-payment applies to non-formulary medicine.

Value-Add Benefits

Value-add benefits give you access to extra support beyond your core medical scheme benefits, helping you manage your health, wellbeing and everyday needs.

These include travel health benefits as well as the Care Maximiser, which gives you access to additional healthcare benefits once the required health checks have been completed.

Travel Health Benefits

Travel Vaccinations

Such as yellow fever, hepatitis A, rabies and meningococcal disease. PB, as required

- 100% of the CompCare Rate.
- Limited to R630 PB per annum.

International Health Insurance

- Cover of up to 10 million.
- Paid at South African rates.
- For member <65.
- Benefits as per Scheme Rules and protocols.
- Register your journey and obtain a travel certificate at **tiportal.santam.co.za/CompCare**

Care Maximiser

GP Wellness Consultation

- GP wellness consultation: One visit PB per annum – excluding procedures. Limited to tariff code 0190/1/2 and ICD-10 Z00.0 or Z00.1.

Acute Medicine

- 100% of RP to a maximum of R450 PB per annum.

Medicine Benefit to Help With Concentration/Studies

As prescribed by a GP

- 100% of RP to a maximum of R500 PB per annum.
- DSP pharmacies apply.

Home Test Bundle

- 100% of RP to a maximum of R380 PB per annum.
- DSP pharmacies apply.

GP Visits for Children <6 Years

- 100% of the CompCare Rate.
- Unlimited.

Basic Dentistry for Children <6 Years

- 100% of the CompCare Rate.
- Unlimited.

Children <6: Emergency Room Visit

- One additional visit per annum, limited to a maximum of R1 680, unless a PMB. (Including the facility fee and all associated costs.)

Unlocking Your Care Maximiser is Easy.

To activate your Care Maximiser benefit, all you need to do is go for your essential health test (see the list of preventative care benefits).

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

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

The Care Maximizer will become available once the PMSA is depleted.

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. Hospital admissions and related treatment are subject to case management, clinical guidelines and managed care protocols. These measures help ensure that members receive appropriate, quality care at negotiated tariffs.

Emergency Transportation
- 100% of the CompCare Rate at Netcare 911.
- Subject to pre-authorisation.
- For non-emergency cases, authorisation must be obtained from the service provider at the time of transportation or within twenty-four (24) hours thereafter; failure to do so will result in a 25% co-payment.

Medical Emergency
Including the emergency room and hospitalisation

(A medical emergency is when someone suddenly becomes seriously ill or injured and needs immediate treatment to prevent serious harm to body functions, damage to an organ or body part, or death.)
- 100% of the CompCare Rate.
- Unlimited for PMBs.
- Subject to managed care protocols.
- Authorisation is required for emergency hospital admissions.

Hospitalisation
- 100% of the CompCare Rate.
- **Any hospital.**
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Day Hospital Procedures
Including theatre, ward, medication, medical appliances and related costs
- 100% of the CompCare Rate.
- **Any day hospital.**
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

GP and Specialist Treatment While In Hospital
- Specialists are paid at 200% of the CompCare Rate (excluding dental specialists), and GPs are paid at 100% of the CompCare Rate.
- Unlimited.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Medication – Only While in Hospital
- Subject to RP and formulary.

Medication on Discharge from Hospital (TTO)
- Limited to seven days per discharge.
- Subject to RP and formularies.

Surgical Prostheses
- 100% of the CompCare Rate, with an overall annual limit of R65 210 PF.
- Limits and sub-limits per category apply.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Auxiliary Services Such as Physiotherapy, Dietitian, etc.
Such as 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 R16 300 PF.
- Combined in- and out-of-hospital limit.
- 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.
- Referral by the treating medical practitioner is required.
- A 20% co-payment will apply if not pre-authorised.

Alcoholism, Drug Dependence and Narcotics
- 100% of cost.
- Unlimited for PMBs.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.
- DSP may apply.
- Voluntary admission to a non-DSP will incur a 35% co-payment, with a minimum of R8 590 payable directly to the hospital.

All Specialised Radiology
Including MRI and CT scans
- 100% of the CompCare Rate.
- Unlimited for PMBs.
- Unlimited.
- A R4 130 co-payment PB, payable from the PMSA, applies for each scan except PMBs.
- Pre-authorisation and a medical motivation are required for MRI, CT and high-resolution CT scans.
- Subject to managed care protocols and clinical guidelines.
- Excluding non-PMB PET scans.

Organ Transplants, Plasmapheresis and Renal Dialysis
- 100% of cost.
- Unlimited for PMBs.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.
- A DSP may apply.

Professional Sports Injuries

- 100% of the CompCare Rate.
- Unlimited.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.
- Voluntary admission to a non-DSP will incur a 35% co-payment, with a minimum of R8 590 payable directly to the hospital.

Oncology

Including chemotherapy and radiotherapy

- 100% of the CompCare Rate.
- Unlimited.
- The oncology DSP applies.
- Subject to pre-authorisation, clinical guidelines, managed care protocols and oncology formularies.

Specialised Medication

- 100% of the CompCare Rate.
- Unlimited for PMBs.
- Non-PMBs limited to R217 360 PF.
- A 25% co-payment applies to non-PMBs.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Surgical and Medical Appliances

E.g. wheelchairs, crutches, glucometers, artificial eyes and external fixators.

- 100% of the CompCare Rate.
- First paid from the PMSA, thereafter from the available ATB once the Annual Threshold is reached.
- Limited to R69 770 PF in the PMSA and available ATB.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Refractive Eye Surgery

- 100% of the CompCare rate.
- Subject to the available overall optometry benefit amount of R7 880 PB.
- Subject to pre-authorisation, clinical guidelines and managed care protocols. protocols.
- Limit includes all services rendered: Hospitalisation and all related costs.

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 590.

Alternatives to Hospitalisation

Wound Care In Lieu of Hospitalisation

- 100% of the CompCare rate.
- Unlimited.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

Surgical Procedures

Out-of-hospital

- 100% of the CompCare rate.
- Unlimited.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

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 managed care protocols.

Oxygen Home Ventilation

- 100% of the CompCare Rate.
- Unlimited.
- Subject to pre-authorisation, clinical guidelines and managed care protocols.

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.
- First paid from the PMSA, thereafter from the available ATB once the Annual Threshold is reached.
- Subject to managed care protocols and pre-authorisation.

Going to Hospital?
Here's What You Need to Know

Hospital treatment can feel overwhelming, so we've made the important information as simple as possible.

A few checks before you go can help you avoid unexpected co-payments and make sure your treatment is covered correctly.

Before You Go to Hospital

1 Get pre-authorisation

All hospital admissions must be **pre-authorised** and are subject to CompCare's clinical guidelines and managed care protocols. For a planned admission, contact us **at least 48 hours before you are admitted.**

2 Choose the right hospital

Where your benefit option has a hospital network, always use a **network hospital** to avoid unnecessary co-payments. If your treatment requires a specialist, also check that your specialist **works at or admits patients to a hospital within your network.**

3 What happens in an emergency?

In an emergency, go to the **closest appropriate network hospital.** If there isn't one nearby, go to the **nearest appropriate medical facility.** Your health comes first.

Choosing a Non-Network Hospital Could Cost You

If you **choose to be admitted to a non-DSP hospital** where a DSP applies, you will need to pay **35% of the hospital account, with a minimum co-payment of R8 590.**

This co-payment does not apply to **life-threatening emergencies or possible loss of limbs,** as defined as PMB medical emergencies in section 29(1)(o) of the Act.

Planned, Urgent or Emergency Admission?

1 Planned or elective admission

If you know in advance that you are going to hospital or a day hospital, get pre-authorisation **at least 48 hours before admission.** If authorisation is obtained late – less than 48 hours before admission – a **R3 140 late-authorisation co-payment** will apply.

2 Urgent admission

If you need to be admitted urgently, obtain authorisation **before you are admitted,** wherever possible.

3 Emergency admission

In a medical emergency, get the treatment you need first. CompCare must then be notified **within one working day after admission.** If we are not notified in time, a **R3 140 co-payment per admission** will apply.

Don't Forget About Other Healthcare Professionals

During a hospital stay, you may need services from other healthcare professionals.

For in-hospital auxiliary services:

- Your treating medical practitioner must refer you.
- A **separate pre-authorisation is required for each provider.**
- If pre-authorisation is not obtained, a **20% co-payment** will apply.

Day Hospitals

Sometimes you don't need an overnight hospital stay

Many procedures can safely be performed in a **day hospital,** allowing you to have your procedure and return home on the same day.

And there's another advantage:

For the selected procedures listed below, CompCare will waive any possible procedure-specific facility/hospital co-payment when you use an appropriate day hospital.

If you choose to have the same procedure performed in a **medical hospital,** a procedure-specific co-payment may apply.

Going to Hospital? Here's What You Need to Know (continued)

When is a Medical Hospital More Appropriate?

You may need to use an acute hospital if:

- You are considered high risk.
- You need additional treatment beyond the listed day-hospital procedure.
- Your condition requires admission to an acute hospital.
- There are no day hospitals within a 50 km radius.
- Your treating healthcare professional determines that an acute hospital is clinically necessary.

Where a hospital network applies to your option, the day hospital should still fall within the applicable **Netcare or Mediclinic hospital network.**

Before booking your procedure, check your network and apply for pre-authorisation.

Procedures That May be Performed in a Day Hospital:

Category	Procedures
Biopsies	Skin and soft-tissue biopsies.
Skin and minor soft-tissue procedures	Removal of skin lesions, debridement, simple wound repair, foreign body removal, incision and drainage of abscesses or cysts, lipoma excision and superficial lymph node removal.
ENT	Tonsillectomy, adenoidectomy, grommets, myringotomy, myringoplasty, tympanoplasty, nasal endoscopy, laryngoscopy, cautery for nose bleeds, sinus lavage, and nasal septum and turbinate repair.
Eye procedures	Cataract surgery, glaucoma treatment, corneal procedures, pterygium/conjunctival surgery, tear-duct procedures, eyelid surgery, strabismus repair, retinal surgery and foreign body removal.
Gastrointestinal scopes	Gastroscopy, colonoscopy, sigmoidoscopy, proctoscopy, anoscopy and oesophagoscopy.
Anorectal procedures	Procedures for haemorrhoids, fissures and fistulas, anal dilatation and related minor anorectal procedures.
Gynaecology	D&C, hysteroscopy, endometrial ablation, colposcopy with LLETZ, diagnostic laparoscopy, cervical cerclage, tubal ligation/sterilisation, suction curettage, uterine evacuation and simple vulval or Bartholin's gland procedures.
General surgery	Umbilical hernia repair, inguinal hernia repair, haemorrhoidectomy, drainage of abscesses or haematomas, selected laparoscopic appendicectomy and selected minor abdominal procedures.
Orthopaedic, hand and foot procedures	Arthroscopy, arthrotomy, minor joint arthroplasty, tendon or ligament repair, trigger finger release, ganglionectomy, carpal tunnel/peripheral nerve neuroplasty, bunion or toe deformity repair, Achilles tendon release, simple fracture or dislocation treatment and removal of pins, plates or wires, subject to case review.
Urology	Cystoscopy, ureteral dilatation, pyelogram, ureteral stone removal, renal calculus removal with stent insertion, circumcision, vasectomy, vasostomy, hydrocoele, varicocoele, scrotal/testicular exploration and related male genital procedures.
Dental and maxillofacial	Dental extractions, wisdom tooth removal, apicectomy, oral biopsies, cystectomy, frenectomy, implants, bone grafts and sinus augmentation, depending on benefit rules and clinical suitability.
Pain management	Facet blocks, facet joint infiltrations, radiofrequency ablation/rhizotomy, epidural steroid injections, nerve root blocks and occipital nerve blocks, where clinically appropriate.

Three Things to Remember

- Check your hospital network.
- Apply for pre-authorisation.
- Know your co-payment before you go.

Co-Payments

Overall co-payment for elective surgeries	N/A
Voluntary use of non-DSP/ network hospital/facility 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 590.
MRI and CT-scans In and out of hospital	R4 130 per scan
Specialised medication	25% co-payment for non-PMB medicines.
Diagnostic scopes including: • Gastroscopy • Colonoscopy • Cystoscopy • Proctoscopy • Flexible sigamoidoscopy	R5 850
Functional nasal surgery including: • Endoscopic Sinus Surgery • Septoplasty	No co-payment
Arthroscopy	No co-payment
Minor gynaecological laparoscopic procedures e.g. Hysteroscopy, endometrial ablation and diagnostic laparoscopy.	No co-payment
Dental	R8 970 <13 years R3 480

Joint replacements Arthroplasty	No co-payment
Conservative back and neck treatment - spinal cord injections	No co-payment
Laminectomy and spinal fusion	No co-payment
Nissen fundoplication Reflux surgery	No co-payment
Hysterectomy (Except for cancer and prophylactic hysterectomy)	No co-payment
Laparoscopic hemicolectomy and inguinal hernia repair	No co-payment
Adenoidectomy, myringotomy - grommets, tonsillectomy • Hospital • Day clinic	No co-payment No co-payment

Other Co-Payments In Day-to-Day Benefits

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

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

Chronic Conditions Covered

- Addison's disease
- Allergic rhinitis
- Angina
- Ankylosing spondylitis
- Anorexia nervosa
- Asthma
- Attention deficit disorder
- Barrett's oesophagitis
- Bechet's disease
- Benign prostatic hyperplasia
- Bipolar mood disorder
- Bronchiectasis
- Bulimia nervosa
- Cardiac arrhythmias
- Cardiomyopathy
- Chronic renal failure
- Congestive cardiac failure
- Conn's syndrome
- Chronic obstructive pulmonary disease
- Chronic bronchitis
- Connective tissue disorder
- Coronary artery disease
- Crohn's disease
- Cushing's syndrome
- Cystic fibrosis
- Deep vein thrombosis
- Depression medication - R180 pbpm
- Diabetes insipidus
- Diabetes mellitus type 1 & 2
- Emphysema
- Epilepsy
- Generalised anxiety disorder
- Glaucoma
- Gastro-oesophageal reflux disease
- Gout/hyperuricaemia
- Haemophilia
- HIV/AIDS
- Hormone replacement therapy
- Huntington's disease
- Hypercholesterolaemia/ Hyperlipidaemia
- Hypertension
- Hypoparathyroidism
- Hypothyroidism
- Ischaemic heart disease
- Migraine
- Motor neuron disease
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Narcolepsy
- Obsessive compulsive disorder
- Osteoarthritis
- Osteoporosis
- Paget's Disease of the Bone
- Panic disorder
- Paraplegia/quadriplegia
- Parkinson's disease*
- Pemphigus
- Peripheral arteriosclerotic disease
- Polyarthritis nodosa
- Post-traumatic stress syndrome
- Psoriasis/psoriatic arthritis
- 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

List of Exclusions

Please Note that Exclusions are Subject to PMB.

Procedures

- Bariatric surgery / treatment relating to obesity
- Breast reduction / Gynaecomastia surgery
- Elective Caesarean sections for non-medical reasons
- Cochlear implants, auditory brain implants (Bone-anchored Hearing Aids) - **Limits apply**
- Cosmetic surgery - blepharoplasty; septoplasty, nasal tip reconstruction and otoplasty, as well as any cosmetic preparations
- Excimer Laser / Refractive surgery - **Limits apply**
- Gender reassignment surgery, medicines and treatment
- Infertility -AI; IVF; GIFT; ZIFT and ICSI
- 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) - **Limits apply**
- Removal of port-wine stains, scars and tattoos
- Reversal of Vasectomy or tubal ligation
- Robotic assisted surgery
- Spinal surgery and related orthopaedic prosthesis (Instrumentation, implantable devices and spinal cages) - **Limits apply**
- 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 - **Limits apply**
- 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
- APS/TENS machines
- Chair seats / backrests and cushions (Excluding wheelchairs backrests and cushions)
- 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 - **Limits apply**
- Wigs - **Limits apply**
- CPAP machines - **Limits apply**
- Apnoea monitors for infants <1 year - **Limits apply**

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

Sub-Limits
for Surgical Prosthesis, Electronic and Nuclear Devices and Appliances

	Description	Frequency	Sub-limit
Overall internal prosthesis limit per family			**R65 210**
Coronary artery stents (Subject to the overall internal prosthesis limit)	Stents	Annual	Subject to the overall internal prosthesis limit and a sub-limit of R15 220 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		R37 390
	Renal stents		R7 060
	Aneurysm coils		R49 890
Heart valves etc. (Subject to the overall internal prosthesis limit)	Heart valves (Mitral etc)	Annual	R34 010
Orthopaedic prosthesis (Subject to the overall internal prosthesis limit)	Hip prosthesis	Annual	R35 000
	Knee prosthesis		R35 000
	Shoulder prosthesis		R51 620 per prosthesis if not supplied by network provider.
	Elbow prosthesis		R44 020
	Ankle prosthesis		R44 020
	Wrist prosthesis		R44 020
	Finger prosthesis		R27 170
	Spinal instrumentation – Sub-limit per level subject to the overall internal prosthesis limit and limited to 1 procedure per beneficiary per year.		R31 520 for the first level and R56 510 for two and more levels if not supplied by a network provider.
	Spinal cages		R38 040
	Spinal implantable devices		Subject to the overall internal prosthesis limit.
	Internal fixators for fractures		R35 100
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)	Intraocular lenses	Annual	R5 650 if not supplied by a network provider.
	Bladder sling		R10 760
	Hernia mesh		R11 090
	Vascular grafts		R35 640

	Description	Frequency	Sub-limit
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	R210 520
	Cochlear implants and Bone Anchored Hearing Aids (BAHA)	Annual	R276 810
	Insulin pumps	Every 5 years	R30 330
Appliances (Subject to day-to-day benefits)	**Overall limit**	**Annual**	**R69 770**
	Hearing aids (13 years and older)	3 year interval	R29 780
	Hearing aids (0 - 12 years)	3 year interval	R6 790
	Artificial eyes	5 year interval	R29 780
	BP monitor	3 year interval	R870
	Glucometer	3 year interval	R870
	Humidifier	3 year interval	R370
	Nebuliser	3 year interval	R710
	Breast pump	Per pregnancy	R3 480
	Moonboot	Annual	R2 940
	Elbow crutches	Annual	R880
	CPAP machines	3 year interval	R13 370
	Apnoea monitors for infants < 1yr	Once per beneficiary per lifetime	R13 040
	Braces and callipers	Annual	R970
	Rigid back brace	Annual	R7 060
	Sling clavicle brace	Annual	R710
	Wigs	Annual	R2 610
	Bras for breast prosthesis after mastectomies	2 per annum	R3 690
	Breast prosthesis	Annual	R4 400
	Commodes	3 year interval	R2 720
	Swivel Bath chairs	3 year interval	R5 430
	Wheelchairs	3 year interval	R2 260
	Walking frames	3 year interval	R1 360
	Rehabilitative foot orthotics	Annual	R4 400
Wearable devices	Wearable devices claimable only with a valid NAPPI code	Annual	PMSA
Stockings (Subject to day-to-day benefits)	Stockings: Elastic, Full length and anti-embolic stockings, including compression socks	Annual	R2 620

Your CompCare Cover
for Medical Emergencies

Ensuring you receive the care you deserve in critical moments.

At CompCare, we understand that medical emergencies can happen when you least expect them. That's why we're committed to providing the support and cover you need during urgent, life-threatening situations. Whether it's a heart attack, serious accident, or life-threatening allergic reaction, we take away the financial stress so you can focus on what matters most - getting the right care, fast.

What is Regarded as a Medical Emergency?

It is the sudden and unexpected onset of a health condition that demands immediate medical or surgical intervention. Without prompt treatment, it could lead to significant impairment of bodily functions, serious dysfunction of an organ or body part, or pose a severe risk to the person's life.

Examples of Medical Emergencies Include:

- Heart attacks
- Strokes
- Severe burns
- Poisoning
- Serious motor vehicle accident with life-threatening injuries
- Life-threatening allergic reactions (anaphylaxis)

What Does This Mean for You?

The peace of mind that you are fully covered for medical emergencies. This means that if you or your loved ones experience a medical emergency, your treatment and care will be prioritised - no matter what your benefit option is.

CompCare Covers the Following:

- Emergency room
- Hospital account
- Radiology
- Pathology
- Specialists
- Blood transfusions
- Oxygen
- Any other related costs

The facility or admin fee is not covered.

Authorisations

Hospitalisation pre-authorisation is required, but with our 24-hour pre-authorisation call centre, you can easily secure approval at any time, day or night.

Remember:

Download your membership card from the Universal.one App for CompCare members, so you always have it on hand in an emergency.

For minor injuries or other ailments, costs will be covered from your available day-to-day benefits.

Ambulance Services: Call 082 911 for Netcare 911

They will dispatch an ambulance to you, even from another ambulance service should that be required. CompCare will cover any necessary emergency air lifts.

FAQ Your CompCare Questions, Answered

How do I Apply for Membership?

Individual members can visit the CompCare website to apply online in less than 10 minutes, speak to a broker or request a callback on the CompCare website. If you are joining through your employer, please follow your employer's application process.

When is My Monthly Contribution Due?

Your contribution must be paid by the **third day of each month,** and it is **paid upfront for the month ahead.**

How do I Add a Dependant?

- Contact CompCare or download the form from the CompCare website and email it to **membership@universal.co.za.**
- You may need a birth certificate, marriage certificate or affidavit.
- Newborn babies must be added within 30 days of birth.
- Students aged 18 to 21 must provide proof of studies.

Where can I Find my Membership Card?

Your digital membership card is available on the Universal.one App and can be used at healthcare providers.

How do I Update my Personal Details?

Complete a Member Update Information form, available on the CompCare website, or call **0861 222 777.** Remember to report changes within 30 days.

How do I Check my Available Benefits and Claims?

Log in to the Universal.one App to view your membership details, statements, claims, and medical scheme expenses. Alternatively, call **0861 222 777** for assistance.

How do I Submit a Claim?

Submit your claim through the Universal.one App or email it to **claims@universal.co.za** within four months of treatment. For benefit enquiries, email **compcare@universal.co.za.**

Where do I Find a Doctor or Healthcare Provider?

Use the Universal.one App to find a healthcare provider near you. If you are on a network option, select **Network Provider** when searching.

How do I Get Hospital Authorisation?

Request pre-authorisation through the Universal.one App, email **preauthorisation@universal.co.za,** or call **0861 222 777.** For planned admissions or procedures, apply at least 48 hours in advance to avoid a late notification co-payment.

Where do I Get my Certificates?

Download your membership certificate, tax certificate and statements from the Universal.one App, or call **0861 222 777** for help.

What Should I do if my Claim is Rejected?

Check the rejection reason on the Universal.one App or call **0861 222 777.** A consultant will explain what happened and what information may still be needed.

How do I Register on the Universal.one App?

Download the Universal.one App from the Apple App Store or Google Play Store. Register with your membership number and personal details to access your digital card, claims, benefits and more.

Terms Explained

Abbreviations

A	Adult Dependant
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
PF	Per Family
PMSA	Personal Medical Savings Account
PSA	Prostate-Specific Antigen blood test
RP	Reference Pricing or Medicine Reference Price
SAOA	South African Optometry Association
SPG	Self-Payment Gap
TTO	To-Take-Out (medicine taken on discharge from hospital)

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

Above Threshold Benefit (ATB): 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): 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.

Personal Medical Savings Account (PMSA): for the SelfCare and SaverCare options, a portion of the member's contribution is allocated to a savings account from which day-to-day medical expenses may be covered. The full savings amount is made available at the beginning of the financial year, it accumulates if not depleted and is carried over to the next year. A PMSA cannot be used to pay for PMB services.

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.

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.

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: **0861 123 267** 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 Universal.one 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.

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 2027 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. If you leave the Scheme before the year is up and have used all the funds in your savings account, you will owe the Scheme the advanced portion of the Medical Savings Account you have used, as it is a pro-rated benefit allocated in advance for the full benefit 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®