







1. Rules of the Scheme

The scheme is governed by a set of rules submitted to and approved by the Registrar 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

Membership is open to any person or group of persons, except where the member ceases to be a permanent resident in the Republic of South Africa.

2.1 Registration of dependants

A member may apply for the registration of his/her dependants at the time of applying for membership. The following persons can qualify as a dependant:

- A spouse or partner
- Dependant children under the age of 21
- Dependant children over the age of 21 but under the age of 25 and who are full time students at a recognised tertiary educational institution
- Immediate family for which the member is liable for family care and support (proof of legal duty required)
- Disabled/Mentally challenged children

2.2 Students and children older than 21 years

Children above the age of 21 years are regarded as adult dependants, unless they are studying full-time at a recognised secondary or educational institution. A member should submit annual proof of registration for their dependants who are still studying full-time at an educational institution. The dependant will be regarded as a child dependant.

A student over the age of 25 years will be regarded as an adult dependant.

A dependant child's membership status will change to adult dependant at the beginning of the month following the dependant's 21st birthday, if proof has not been received that he/she is not a full-time student at a recognised secondary or educational institution. This does not apply for disabled or mentally challenged dependants.

2.3 Waiting periods

Prospective members are required to disclose to the scheme, on the application form, details of any sickness or medical condition for which medical advice, diagnosis, care or treatment was recommended and/or received prior to the 12 month period ending on the date on which application for membership was made.

The scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application:

- a general waiting period of up to three months
- a condition-specific waiting period of up to 12 months
- a concurrent waiting period on PMB's

The scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application:

- a condition specific waiting period of up to 12 months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits
- a general waiting period of up to 3 months

2.4 Membership card

Every member shall be furnished with a membership card. This card must be exhibited to the supplier of a service on request. It remains the property of the scheme and must be returned to the scheme on termination of membership. Members will receive cards for each adult dependant registered. Members may apply for additional membership cards or replacement cards.

2.5 Change of address

A member must notify the scheme within 30 days of any change of address including his/her domicilium citandi et executandi (address at which legal proceedings may be instituted). 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.

2.6 Termination of membership

2.6.1 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.

2.6.2 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 3 months written notice. All rights to benefits cease after the last day of membership.

2.6.3 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, the child dependant/s.



2.7 Late joiner penalties

A "Late joiner" is an applicant or the adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is thirty five years of age or older but excludes beneficiaries who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without a break in coverage exceeding three consecutive months since 1 April 2001.

Premium penalties may be applied to a late joiner. Such 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 following formula shall be applied to determine the applicable penalty band:

A = B minus (35 + C) where:

A = number of years to determine appropriate penalty band

B = age of the late joiner at time of application

C = number of years of creditable coverage which can be demonstrated

Should a late joiner penalty already have been imposed and evidence of creditable coverage is produced thereafter, the penalty shall be recalculated and such revised penalty shall be applied from the time that such evidence was provided.

If an applicant is unable to obtain documentary proof to substantiate periods of creditable coverage, he/she shall be entitled to produce a sworn affidavit declaring such detailed information and that reasonable efforts to obtain documentary evidence of such periods of creditable coverage were unsuccessful.

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.

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.

4. Members' portions

Members' portions arise when health care 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 cheque/electronic payment, 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 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 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 financial 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-rating 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 the following year members will qualify for the full annual benefit.

6. How to claim

6.1 Electronic claims

Most suppliers i.e. Hospitals, Pharmacies and General Practitioners, etc. submit claims electronically and members do not have to submit such claims. It remains however the member's responsibility to ensure that the claim reaches the scheme within four months from treatment date and to check remittance advices for accuracy and validity of the supplier's claim.

6.2 Paper claims

Claims must be submitted within 4 months from date of service to:

Private Bag X49, Rivonia, 2128





6.3 Payment of claims

Compcare Wellness has two payment runs per month (mid month and at month end) to suppliers and to members. Members can track the payment of their claims on the scheme's website (www.compcarewellness.co.za). Members will receive a monthly statement after each payment run containing details of all payments made to suppliers.

6.4 Specialists

A referral must be obtained from a General Practitioner for first time visits to Specialists, with the exception of services provided by an ophthalmologist or gynaecologist.

6.5 OTC (Over the counter Medicines)

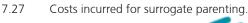
Most options have a benefit available where a member can go directly to a pharmacy and have the pharmacist prescribe medication for minor ailments that do not necessarily require a GP consultation and will also alleviate a long wait in a doctors consulting room. Please consult your benefit guide for OTC rules and limits around this benefit. This benefit includes homeopathic medicines.

7. Exclusions

The following exclusions will apply to a member and/or his dependants unless that particular exclusion is covered under the statutory prescribed minimum benefits (PMB's).

- 7.1 All costs of whatsoever nature incurred for treatment of sickness conditions or injuries sustained by a member or a dependant and for which any other party is liable.
- 7.2 Professional fees and expenses incurred by healthcare professionals:
 - After hours consultation according to members choice
 - Appointments not honoured by beneficiaries
 - Charges for interest by health care provider, if due to member negligence
 - Costs incurred for insurance medical purposes
 - Fees for medical reports and motivations by any service provider, unless required by Scheme
 - Discretionary conditions and services with hospital admissions not authorised
 - Telephonic consultations with healthcare providers
 - Travelling expenses incurred by healthcare providers
- 7.3 Costs for services rendered by persons not registered with a recognised professional body constituted in terms of an Act of Parliament of the Republic of South Africa; or any institution, nursing home or similar institution except a state or provincial hospital not registered in terms of any law of the Republic of South Africa.
- 7.4 Frail Care Accommodation and nursing services rendered in convalescent or old age homes or similar institutions catering for the aged or chronically ill.
- 7.5 Holidays for recuperative purposes, whether deemed medically necessary or not.
- 7.6 All costs for rehabilitation for any particular sickness or condition, except for PMB's.
- 7.7 Private nursing fees in respect of both mother and child in postpartum cases.
- 7.8 Cosmetic procedure see Scheme rules for more details

- 7.9 Dental procedures and treatments:
 - Dental extractions for non-medical purposes.
 - Bleaching of teeth that have not been root canal treated
 - High impact acrylic dentures
 - The cost of the use of gold in dentures
 - Discretionary procedures elective treatments and surgery for personal reasons and not directly caused and related to illness, accident or disease
- 7.10 The treatment of artificial insemination of a person as defined in the Human Tissues Act, 7983 (Act 65 of 7983) except for PMB's.
- 7.11 In respect of infertility (PMB Code 902M), the following services are excluded:
 - Assisted reproductive technology (ART) techniques including in-vitro fertilisation (IVF)
 - Gamete intrafallopian tube transfer (GIFT)
 - Zygote intrafallopian transfer (ZIFT)
 - Intracytoplasmic sperm injection (ICSI)
- 7.12 Circumcision and any contraceptive measures or devices will not be covered from the Hospital Benefit or Day-to-day Risk Benefits, but may be claimed from Savings where applicable/available.
- 7.13 Reversal of Vasectomies or tubal ligation (sterilisation).
- 7.14 All costs related to the treatment, medication or surgical procedures of obesity, including bariatric surgery, gastric stapling, wring of the jaw for weight loss purposes etc
- 7.15 Willfully self-inflicted injuries except for PMB's.
- 7.16 Attempted suicide that exceeds the Prescribed Minimum Benefit limits.
- 7.17 Injuries or conditions sustained during willful participation in a riot, civil commotion, war, invasion, terrorist activity or rehellion
- 7.18 Injuries resulting from narcotic or alcohol abuse, except for the PMB's.
- 7.19 Illegal behavior, negligence, or a breach of law.
- 7.20 All costs for such sickness conditions directly attributable to failure to carry out the instructions of a medical practitioner, subject to PMB's.
- 7.21 All costs relating to a treatment if the efficacy and safety of such treatment cannot be proved.
- 7.22 Medication not registered by the Medicine Control Council, unless otherwise specified, e.g. homeopathic medicines which are covered in certain medical scheme options and subject to limits.
- 7.23 Travelling expenses incurred by members, excluding benefits covered by Emergency Medical Services in the event of an emergency medical condition.
- 7.24 The utilisation of certain specialised technologies to perform a procedure, where an alternative, more cost effective method of performing the procedure is available e.g. endometrial ablation, brachytherapy and certain surgical endoscopic procedures such as hemi-colectomies, abdomino perinial resections and appendisectomies are excluded unless prior clinical motivation from the attending specialist practitioner is obtained more than 7 working days in advance, and subject to approval by the medical advisor of the medical scheme. If authorised a copayment of R5 000 will be levied.
- 7.25 Alternative and / or complementary health services that are not supported by evidence based medicine are excluded see the rules of the scheme for further details.
 7.26 Certain conditions relating to educational and / or
 - Certain conditions relating to educational and / or psychological performance and / or behaviour, except for the PMB's. See the rules of the scheme for further details.









8. Sub limits for surgical prosthesis, electronic and nuclear devices and surgical appliances (subject to PMB's, pre-authorisation and protocols and subject to the limit for these benefits on each option and subject to these benefits being covered on each option)

		PINNACLE	DYNAMIX	SYMMETRY	MUMED	AXIS	NETWORX
SURGICAL INTERNAL PROSTHESIS OVERALL LIMITS WITH SUB-LIMITS BELOW PER OPTION		R48 000	R40 000	R35 000	R30 000	R28 500	Subject to PMBs and Protocols and pre- authorisation
2.1 Coronary Artery stents(subject to overall limit)	Stents (max of 3)	Subject to overall annual limit and a limit of R11 000 per stent	Subject to overall annual limit and a limit of R11 000 per stent	Subject to overall annual limit and a limit of R11 000 per stent	Subject to overall annual limit and a limit of R11 000 per stent	Subject to overall annual limit and a limit of R11 000 per stent	
	Medicated stents (max 3 stents)	Subject to overall annual limit and a limit of R17 000 per stent	Subject to overall annual limit and a limit of R17 000 per stent	Subject to overall annual limit and a limit of R17 000 per stent	Subject to overall annual limit and a limit of R17 000 per stent	Subject to overall annual limit and a limit of R17 000 per stent	
2.2 AAA Stents (subject to overall limit)	Abdominal aortic aneurism stents	Subject to overall annual limit					
2.3 Heart valves etc (subject to overall imit)	Heart valves (Mitral etc)	R22 000					
2.4 Orthopedic prosthesis (subject to overall limit)	Hip prosthesis Knee prosthesis Shoulder prosthesis Spinal instrumentation (Per level, limited to 2 levels and one procedure per beneficiary per year)	Subject to overall annual limit					
	Spinal cages	R11 000					
2.5 Other prosthesis (subject to overall limit)	Imported lenses Intra ocular lenses (per eye)	R8 000 R5 000					
	Normal bladder sling	R8 000					
2.6 Electronic and Nuclear devices (Subject to PMB's)	Defibrillator Single pace maker Dual pace maker	Subject to overall annual limit					
	Internal nerve stimulators Cochlear implant Insulin pumps	R100 000 R127 000 R22 000	R100 000 R127 000 R22 000	EXCLUDED R127 000 R22 000	EXCLUDED EXCLUDED EXCLUDED	EXCLUDED EXCLUDED EXCLUDED	EXCLUDED EXCLUDED EXCLUDED
2.7 Artificial limbs (Not subject to overall limit)	Through knee prosthesis Below knee prosthesis Above knee prosthesis Partial foot prosthesis Partial hand Below elbow Above elbow	R50 000 R38 000 R44 000 R19 000 R12 000 R35 000 R40 000	R50 000 R38 000 R44 000 R19 000 R12 000 R35 000 R40 000	R50 000 R38 000 R44 000 R19 000 R12 000 R35 000 R40 000	R50 000 R38 000 R44 000 R19 000 R12 000 R35 000 R40 000	R50 000 R38 000 R44 000 R19 000 R12 000 R35 000 R40 000	No benefit, except for PMBs



Contact Details

	CONTACT COMPANY	CONTACT NUMBER	FAX NUMBER	E-MAIL ADDRESS	POSTAL ADDRESS	WEBSITE
Call centre	Universal Healthcare Administrators (Pty) Ltd	011 208 1010/20	011 803 6489 011 807 4496	admin@universal.co.za	Private Bag X49 Rivonia, 2128	www.compcarewellness.co.za
Membership	Universal Healthcare Administrators (Pty) Ltd	011 208 1000	011 803 7847	admin@universal.co.za	Private Bag X49 Rivonia, 2128	www.compcarewellness.co.za
Contributions	Universal Healthcare Administrators (Pty) Ltd	011 208 1000	011 803 6495	admin@universal.co.za	Private Bag X49 Rivonia, 2128	www.compcarewellness.co.za
Hospital pre- authorization and general queries	Universal Care (Pty) Ltd	General enquiries 011 208 1100 Preauthorisation 0860 111 090	086 295 7355	General enquiries admin@univesal.co.za Preauthorisation preauthorization@ universal.co.za	PO Box 1411 Rivonia 2128	www.universal.co.za
Disease Management	Universal Care (Pty) Ltd	011 208 1100 0860 111 900	086 295 7305	diseasemanagement@ universal.co.za	PO Box 1411 Rivonia 2128	www.universal.co.za
Maternity Management	Universal Care (Pty) Ltd	011 208 1100 0860 111 090	086 295 7355	admin@universal.co.za	PO Box 1411 Rivonia 2128	www.universal.co.za
HIV / AIDS Management	Universal Care (Pty) Ltd	011 208 1100 0860 111 900	086 295 7305	admin@universal.co.za	PO Box 1411 Rivonia 2128	www.universal.co.za
Trauma Expense Recovery (MVA)	Universal Care (Pty) Ltd	011 208 1100	086 295 7354 or 086 295 7353	admin@universal.co.za	PO Box 1411 Rivonia 2128	www.universal.co.za
Universal Lifestyle	Universal Lifestyle	086 155 LIVE (5483)	086 504 1545	lifestyle@universal.co.za	PO Box 1411 Rivonia 2128	www.lifestyle360.co.za
Chronic Medication pre- authorization and queries	Mediscor	Chroniline 0860 119 553 Helpdesk 0860 113 238	0866 151 509 012 647 8001	preauth@mediscor.co.za Mediscor@mediscor.co.za	PO Box 8796 Centurion South Africa 0046	www.mediscor.net
Diabetic Management	The Centre for Diabetes and Endocrinology	011 712 6000	086 560 5182		PO Box 2900 Saxonwold 2132	www.cdecentr.co.za
Chronic Medi- cine Dispensing	Chronic Medicine Dispensary	0860 633 420	011 388 1630	help@chronicmedicine.co.za	Postnet Suite # 128 Private Bag X65 Halfway House 1685	www.chronicmedicine.com

