

Member Guide 2010

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 may 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, 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 up to the age of 25 years.

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) A condition specific waiting period up to 12 months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.
- (b) In respect of any person contemplated in this subsection, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

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 "Later 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 however remains 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 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 institution 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, wiring 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 rebellion
- 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 in respect of injuries arising from professional sport, speed contests, speed trials, and the cost of injury and any other related costs as a result of scuba diving to depths below 40 meters and cave diving, except for PMB's.
- 7.21 All costs for such sickness conditions directly attributable to failure to carry out the instructions of a medical practitioner, subject to PMB's.
- 7.22 All costs relating to a treatment if the efficacy and safety of such treatment cannot be proved
- 7.23 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
- 7.24 Travelling expenses incurred by members, excluding benefits covered by Emergency Medical Services in the event of an emergency medical condition
- 7.25 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, brachithery 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 co-payment of R5 000 will be levied.
- 7.26 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
- 7.27 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
- 7.28 Costs incurred for surrogate parenting
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)

SUB-LIMITS:

Coronary Artery stents

Stents (max of 3)	R 11 000
Medicated stents (max 3 stents)	R 17 000

AAA Stents

Abdominal aortic aneurism stents	R 50 000
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Heart valves etc

Heart valves (Mitral etc)	R 22 000
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Orthopaedic prosthesis

Hip prosthesis	R 39 000
Knee prosthesis	R 33 000
Shoulder prosthesis	R 33 000
Spinal instrumentation (Per level, limited to 2 levels and one procedure per beneficiary per year)	R 22 000
Spinal cages	R 11 000

Artificial limbs

Through knee prosthesis	R 50 000
Below knee prosthesis	R 38 000
Above knee prosthesis	R 44 000
Partial foot prosthesis	R 19 000
Partial hand	R 12 000
Below elbow	R 35 000
Above elbow	R 40 000

Other prosthesis

Imported lenses	R 8 000
Intra ocular lenses (per eye)	R 5 000
Normal bladder sling	R 8 000

Electronic and Nuclear devices (Subject to PMB's)

Defibrillator	R 120 000
Single pace maker	R 45 000
Dual pace maker	R 55 000
Internal nerve stimulators	R 100 000
Cochlear implant	R 127 000
Insulin pumps	R 22 000

Surgical Appliances

Hearing Aids	
- Pinnacle	R 16 000
- Dynamix	R 10 500
- Symmetry	R 8 500
- Mumed	R 5 000
- Axis	No Benefits
- NetworX	No Benefits
External Fixators	R 15 800
Artificial eyes	R 12 000
BP Monitor	R 600
Glucometer	R 600
Humidifier	R 240
Nebuliser	R 880
Moonboot	R 1 000
Elbow crutches	R 380
CPAP machines	R 8 800
Foam walker	R 1 700
Walkers	R 300
Braces & callipers	R 600
Commodes	R 888
Sling Clavicle brace	R 188
Wigs	R 1 700
Bra's (prosthesis after mastectomies)	R 2 500
Wheelchairs	R 2 500

Stockings

Elastic Stockings	R 700
Stockings (Thigh)	R 650
Anti Embolic Stockings	R 1 000