SANLAM GAP COMPREHENSIVE POLICY DOCUMENT 2023

Sanlam

Gap Cover

UNDERWRITTEN BY CENTRIQ INSURANCE

Statutory notice:

This is not a **Medical Scheme** and the cover is not the same as that of a **Medical Scheme**.

This **Policy** is not a substitute for **Medical Scheme** membership.

Sanlam Gap is administered by Kaelo Risk (Pty) Ltd, an authorised financial services provider (FSP 36391).

Insurance Products are underwritten by Centriq Insurance Company Limited ("Centriq") a licensed non-life insurer and authorised Financial Services Provider (FSP 3417).

Financial Planning | Retirement | Insurance | Health | Investments | Wealth | Credit

Contents

Centriq is committed to protecting the personal information of our stakeholders in accordance with the Centriq Privacy Notice.pdf

Disclaimer

This Policy replaces all previous versions of your previous Sanlam Gap Policy. All terms and conditions in this Policy are applicable to Insured Parties on the Policy.

All definitions throughout the Policy are indicated with bold font and with the first letter of each word capitalised. Important points are indicated with a bold and blue font type.

Processing of insurance information is done in accordance with the applicable legislation, as well as our Privacy Policies which can be found on our websites:

- www.kaelo.co.za and
- www.centriq.co.za

A. Your Insurer

The insurance cover is underwritten by your Insurer: Centriq Insurance Company Limited, FSP 3417, a licensed non-life insurer. The cover provided is always subject to all the terms and conditions explained throughout your Policy.

B. Your Underwriting Manager

Your **Underwriting Manager** is responsible for all administrative matters relating to your **Policy** which include:

- Issuing of your **Policy**.
- Processing of your claims.
- Collection of your **Premium**.

C. Definitions

Any words and expressions used in this Policy can refer to either singular or plural and to either gender.

The words and expressions utilised are defined as follows:

C1. **"Accidental Harm"**: bodily injury caused by violent, unintentional, external and physical means.

C2. **"Balance Billing"**: a practice where a **Medical Practitioner** or other healthcare service provider charges a separately identifiable fee that is over and above the **Tariff** fee (or set of such fees) that relates to a Medical Procedure (or Procedures) and is billed together on one statement or invoice and is not considered as a refundable Benefit by a Medical Scheme.

C3. **"Basic Dentistry"**: is defined as any of the following dental treatments: cleaning, extractions (including wisdom teeth), fillings, inlays, bonding, root canal treatment and treatment for pain and abscesses.

C4. **"Benefit or Benefits"**: the Benefit amount payable to the Insured Party in relation to an Insured Event, as stated in the **Benefit Schedule**.

C5. **"Benefit Schedule"**: The cover and Benefits detailed in this Policy under Addendum A.

C6. **"Condition-Specific Waiting Period**": a period in which an **Insured Party** is not entitled to claim **Policy Benefits** in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within a 12-month period prior to the cover **Inception Date**.

C7. **"Core Benefits"**: are the list of benefits defined as Core Benefits in the **Benefit Schedule** and which benefits are subject to the Overall Annual Limit.

C8. **"Deductible"** or **"Co-payment"**: the fixed, defined Rand amount that is deducted from the Insured Party's overall Medical Scheme Benefit entitlement by the Insured Party's Medical Scheme.

C9. **"Designated Service Provider"** or **"DSP"**: a medical service provider designated by a Medical Scheme as one of their preferred suppliers.

C10. **"Eligible Child"**: a child born to either the Policyholder or Eligible Spouse of this Policy. An Eligible Child includes a legally adopted child or stepchild of a Policyholder. In the event that the Eligible Child reaches the age of 27 years, the child will no longer be an Eligible Child and will therefore no longer be covered under this Policy. On turning 27 and within 30 days of doing so, the Eligible Child may take up a new Policy in their own capacity without any additional waiting periods or exclusions being applied. The age limitation will not be applicable to a Special Needs Child.

C11. **"Eligible Special Dependant"**: a dependant who is neither the Eligible Spouse nor an Eligible Child, nor a Special Needs Child of the Policyholder but who is an eligible dependant on the Policyholders's Medical Scheme and has been explicitly accepted by the Insurer for such cover under this Policy. In the event that no such explicit acceptance is provided by the Insurer, such special dependants are not covered even though they are dependants on the Policyholder's Medical Scheme.

C12. **"Eligible Spouse"**:

- the partner of the **Policyholder** with whom a spousal union exists, whether by virtue of South African law or religious tenet.
- the partner that shares a home with the **Policyholder** in a common law spousal union and has done so for at least six months.

C13. **"Emergency"**: a serious, unexpected, and dangerous situation requiring immediate action.

C14. **"Family"**: collectively the **Policyholder**, Eligible Spouse, Eligible Children, Special Needs Child and/or Eligible Special Dependants as defined in the **Policy**.

C15. **"General Waiting Period"**: the period in which an **Insured Party** may not claim any **Policy Benefits**, except for **Benefits** directly arising from **Accidental Harm**.

C16. **"Hazardous Sport"**: includes, but is not limited to, participation in or use of any of the following:

- All forms of motorised racing, speed tests or aerobatics, whether by land, sea or air;
- Mountaineering, trekking or hiking above an altitude of 4 000 metres;
- Hunting, shooting or deploying firearms in any manner other than for self-defence purposes.

C17. **"Hospital"**: any institution in South Africa which meets all of the following criteria:

- Provides surgical and medical diagnostic and therapeutic facilities for **Treatment** and care of sick or injured persons under the supervision of **Medical Practitioners**.
- Provides 24 hour nursing services to sick or injured persons within the aforementioned facilities.
- Is not an institution that primarily cares for persons who are mentally handicapped, blind, deaf, mute or in any other way physically handicapped.
- Is not a convalescent home or home for the elderly.
- Is not a place of rest or recuperation.
- Is not an institution that primarily treats people for drug addiction, alcoholism, eating disorders or any other form of addictive behaviour.
- Is not a health hydro or alternative therapy clinic or other similar establishment.
- Is not a step-down facility.

C18. **"Hospital Episode"**: the period of time between admissions to **Hospital** of an **Insured Party** until the time of discharge from the **Hospital** of the same **Insured Party** for the same **Insured Event**.

C19. **"Hospital Network"**: a list of Hospitals specified by the **Insured Party's Medical Scheme**, as the Designated **Service Provider** of one or more plan types of the **Medical Scheme**.

C20. **"Illness"**: any physical disease or sickness which manifests in an **Insured Party** but is not a disease or sickness which is of such a nature as to be incapable of diagnosis by objective evidence or which, even though capable of diagnosis by such evidence, has not been diagnosed as such.

In other words it must be capable of diagnosis and have been diagnosed.

C21. **"Inception Date"**: the first day of the month on which cover commences for the **Insured Party** as noted in the **Policy Schedule**.

C22. **"Innovative Oncology Medicines"**: medicines as defined by the Insured Party's underlying Medical Scheme's oncology innovative benefit.

C23. **"Insurer"**: Centriq Insurance Company Limited, (reg 1998/007558/06),a licensed non-life insurer an authorised Financial Services Provider(FSP 3417)

C24. **"Insured"** or **"Insured Party"**: the **Policyholder**, **Eligible Spouse, Eligible Child or Eligible Special Dependant**, as defined in this **Policy**.

C25. **"Insured Event"**: any one or more of the following:

- **Accidental Harm, Illness** or other health incidents that cause an **Insured Party** to be admitted to a **Hospital** and to undergo **Treatment** or **Medical Procedures** during the **Hospital** Episode.
- Chemotherapy Radiotherapy or other drug regimens, approved by an **Insured Party's Medical Scheme**, that is administered to an **Insured Party** for the purposes of treating a tumour, growth or other body tissue that has cancer (malignant neoplasm).
- An **Insured Party** receives kidney dialysis for the **Treatment** of acute or chronic renal failure.
- **Accidental Harm** that directly causes an **Insured Party** to receive Emergency medical treatment at the out-patient casualty or **Trauma** ward of a **Hospital**.

C26. **"Kaelo Risk"**: Kaelo Risk (Pty) Ltd (registration no: 2008/019335/07), hereinafter referred to as "Kaelo Risk", who is appointed to administer this Policy on behalf of the Insurer and is registered to do so in terms of the Short-Term Insurance Act No. 53 of 1998.

C27. **"Medical expense shortfall policy"**: means an accident and health policy, as defined in Category 1 of section 7.2(1) of regulations to the Short-Term Insurance Act, No 53 of 1998.

C28. **"Medical Practitioner"**: a person who is suitably qualified and registered with the Health Professions Council of South Africa to practice medicine.

C29. **"Medical Procedure"**: any procedure defined under the National Health Reference Price List (NHRPL). If the procedure is not defined, the Insurer will calculate, at their sole discretion, an appropriate Benefit to be paid to the Policyholder.

C30. **"Medical Scheme"**: A Medical Scheme as registered under the Medical Schemes Act.

C31. **"Medical Schemes Act"**: to the **Medical Schemes** Act No. 131 of 1998.

C32. **"Multiple"**: the percentage cover of the **Tariff** of the plan type of the **Policyholder's Medical Scheme**, which may differ for different **Benefit** categories of that plan type, and which constitutes a key component of the **Benefit** calculation as defined in the **Benefit Schedule**.

C33. **"National Health Reference Price List"** or **"NHRPL"**: the Benefit **Tariff** set annually by the Department of Health as a guideline for charges by healthcare service providers or any replacement of the NHRPL effected by a change in law or statute or the generally accepted industry equivalent thereof.

C34. **"Overall Annual Limit"**: is the maximum amount payable per **Insured Party Per Annum** in respect of Core Benefits.

C35. **"Per Annum"**: the period from 01 January to 31 December of any year

C36. **"Penalty"**: any **Co-payment**, **Deductible**, exclusion or reduction, applied against the **Benefits** of an **Insured Party's Medical Scheme**, that would otherwise not have been applied had the authorisation rules of that **Medical Scheme** been adhered to or the **Benefits** had been attained from the Designated **Service Provider** or **Hospital** Network of that **Medical Scheme** plan type.

C37. **"Permanent Disability"**: any **Accidental Harm** or physical **Illness** that renders a person permanently unable to work in their own or other occupation for which they are suited by training, education or experience.

C38. **"Policy"**: this **Policy** as well as the Detail of Services and Benefits annexure and the **Policy Schedule**.

C39. **"Policy Exclusions"**: the list of services, conditions or events detailed in the "**Policy** Exclusion" section of this **Policy** which are excluded from cover at all times.

C40. **"Policy Schedule"**: the schedule attaching to and forming part of this Policy that defines the Product option, Cover Type, Policyholder, Inception Date, monthly Premium and Waiting Periods and other information that pertains to the cover provided under this Policy

C41. **"Policyholder"**: the Insured Party who applied for cover under this Policy for himself/herself and his designated Family (if you have selected to pay the Family Policy Premium) on inception of this Policy, who has been accepted by the Insurer to be eligible for the insurance cover provided by this Policy.

C42. **"Premature Birth"**: the natural or surgically assisted birth of one or more infants that occurs more than 41 days before the originally expected natural birth date of 40 weeks as verified by the clinical records of the mother's attending physician.

C43. **"Premium"**: the monthly amount due to the **Insurer** payable by, or on behalf of, the **Policyholder**.

C44. **"Prescribed Minimum Benefits (PMBs)"** are a set of defined benefits provided to beneficiaries of **Medical Schemes** to ensure that all **Medical Scheme** members have access to certain minimum health services. This amount is payable on a **visit to a specialist** where the specialist charges more than what your **Medical Scheme** will cover. This **Benefit** is applicable to all beneficiaries include - **Specialist Benefit** is an amount payable on a **visit to a specialist** where the specialist charges more than what your **Medical Scheme** will cover. This **Benefit** is applicable to all beneficiaries covered on your **Medical Scheme**.

C45. **"Special Needs Child":** any child, including a legally adopted child or stepchild, of the **Policyholder**, who by virtue of either a physical or mental disability, is unable to financially support him/herself and remains reliant on the **Policyholder** for support and care.

C46. **"Split Billing"**: a practice where a **Medical Practitioner** or other healthcare service providers charges a separately identifiable fee that is over and above the **Tariff** fee (or set of such fees) that relates to a **Medical Procedure** (or Procedures), and is billed separately from the **Tariff** fees on two or more statements or invoices, and is not considered as a refundable **Benefit** by a **Medical Scheme**.

C47. **"Tariff"**: either the NHRPL Tariff or a specific Tariff registered by the **Medical Scheme** to determine the rate at which its **Benefits** are payable.

C48. **"Trauma"**: **Accidental Harm** to an **Insured Party** that gives rise an **Insured Event**.

C49. **"Treatment"**: any form of medical advice, diagnosis, care or treatment provided by a **Medical Practitioner** for the purpose of treating or monitoring the medical condition of an Insured Party.

D. Claims

Following an **Insured Event**, the **Insured Party** or the **Policyholder**, as the case may be, shall at his own expense:

- Notify **Kaelo Risk** of any claim in writing as soon as possible but not later than **six months** after the end of the **Insured Event**. Claims submitted more than **six months** after the end of the Insured Event are excluded from cover.
- Supply written proof, copies of medical accounts or other information as may reasonably be required for **Kaelo Risk** to process the claim or to ensure the validity of the claim. These documents include: a completed **Claims Form, Doctor's Accounts, Hospital Account; Claims Transaction History Report**. There may be additional information requested such as medical reports as required and determined on a case by case basis.
- Provide authority for **Kaelo Risk** to inspect as often as is necessary all current or past medical information or clinical records including the results of any diagnostic tests and submit to medical examination on behalf of and at the expense of **Kaelo Risk**.
- Where the **Insured Party** is not the **Policyholder**, the **Policyholder** shall provide or obtain the necessary permission or consent from the Insured Party to comply with the above condition failing which the processing of the relevant claims shall be suspended until such time as the requisite permissions or consents are obtained.
- **Assessing claims**. Claims are assessed on a line by line basis. Each line has a code on your healthcare or service provider's account and this accounts for the total amount charged. These codes describe the medical procedure that was performed or the service that was provided. Your **Medical Scheme** must pay a portion of the cost of a coded line from your hospital or risk benefit in order for that claim line shortfall to be covered by your **Gap cover** unless you are claiming for a **Benefit** with different qualifying criteria such as a Family Protector or a defined **Co-payment**.
- Claims flagged as **Prescribed Minimum Benefit** (PMB) **Medical Procedures** or claims with a high values may be investigated with your **Medical Scheme** or discussed with your service provider for possible discount negotiation. PMB's are a set of defined benefits that **Medical Schemes** are required to cover by law. This means that as a **Medical Schemes** member, you shouldn't incur any out-of-pocket medical expenses related to a PMB.

Any **Benefit** payable in respect of an **Insured Event** shall only become payable after the end of the **Treatment** relating to the **Insured Event** but at the sole discretion of the Insurer, interim **Benefit** payments can be made to the **Policyholder** after a 31 day period during an **Insured Event**.

All **Benefits** payable shall be paid to the **Policyholder** or his legal representative whose receipt of the **Benefits** shall in every case be a full discharge of liability.

In the event of the death of the **Policyholder**, any **Benefit** due shall be payable to the surviving **Eligible Spouse**, failing which the **Benefit** will be paid to the **Eligible Children** (or their legal guardians in the event of them being minors) or failing any of the above, the **Benefit** shall be paid to the **Policyholder's** estate.

No **Benefit** payable shall carry interest.

Any discount accrued by an **Insured Party**, against the amount owing by the Insured to any **Medical Provider**, shall be factored into the calculation of the **Benefits** of this **Policy**.

If the Insurer rejects any claim, or disputes the quantum of a claim, the **Insured Party** has **90 days** to make representation to the Insurer, challenging this decision. If the Insurer persists in rejecting the claim or disputing the quantum, the Insured Party has to have summons issued and served on the Insurer, within **six months (180 days)** after the expiry of the **90 days** period; failing which, the **Insured Party** will forfeit his claim and will have no further claim in terms of this **Policy**.

Payment of any **Benefit** is conditional on the **Insured Party** supplying such medical evidence as is required by the Insurer to adequately assess the validity of the claims or for an **Insured Party** to undergo any medical examination if requested and paid for by the Insurer.

E. Premiums

Individuals

- All **Premiums** are **payable monthly in advance or arrears by the last working day of the month**. Non-payment of **Premiums** may lead to the rejection of a claim or cover being suspended and any **Benefit** payable will be suspended until all **Premiums** have been received by **Kaelo Risk** or the Insurer.
- If the **Premium** is not paid on the payment date, you have a **30 day grace period** after which we will automatically deduct the outstanding **Premiums** from the same account to ensure continuous cover. If this **Premium** is also not paid you **will have no cover for the period for which you did not pay**.
- Should your **Premium** remain **outstanding after the third month** your cover will be **cancelled at midnight on the last day of the month** for which **Premium** has been received.
- Should you cancel or stop your debit order, it will be deemed that you have cancelled your cover and you will not enjoy the **30 day grace period**. In the event that you reinstate your **Policy** thereafter, your **Policy** will be treated as a new **Policy** and the grace period will only apply from the second month of cover thereafter.
- Your **cover starts on the first calendar day of a particular month** and cannot be backdated.
- Your **Premium** will be reviewed annually.
- The **Insurer may adjust the Premiums by giving at least 31 days written notice** thereof to the **Policyholder**.

Corporates (On Behalf of The Policyholder)

- All **Premiums** are **payable monthly in arrears** by the last working day of each month.
- Non-payment of **Premiums** may lead to the rejection of a claim or cover being suspended and any Benefit payable will be suspended until all arrears **Premium** have been received by **Kaelo Risk** or the **Insurer**.
- Your **cover starts on the first calendar day of a particular month** and cannot be backdated.
- Your **Premium** will be r**eviewed annually**.
- The **Insurer** may adjust the **Premiums** by giving at least **31 days written notice** thereof to the **Policyholder**.

F. General Terms and Conditions

Jurisdiction and Currency

This **Policy** shall be subject to the jurisdiction of the courts of the **Republic of South Africa and South African law will apply**. The payment of all **Premiums** and **Benefits** shall be made in the currency of the **Republic of South Africa**.

Commencement of Cover

Cover shall commence on the first day of the calendar month for which the **Premium** has been paid by or on behalf of the **Policyholder**, subject to all the terms and conditions of this **Policy**.

Cover and Benefits

- Cover shall only be in force or effective if the **Insured Parties** are also current and paid up beneficiaries of a registered **Medical Scheme**.
- Cover will also be provided to the **Insured Parties** regardless of whether or not they are covered under the same or separate **Medical Scheme** options. Under such circumstances, proof of the familial relationship may be required when claiming under this **Policy**.
- This **Policy**, Benefit Schedule, **Policy Schedule** and correspondence sent to the **Policyholder**, the **Policyholder's** application for insurance, and any written or spoken statement made by the **Policyholder** or on his/her behalf, forms the contract between the **Policyholder** and the **Insurer**.
- The Insurer **may alter the Benefits** and/or Policy Exclusions or the basis upon which **Benefits** are calculated under this Policy by giving **31 days written notice** thereof.

Eligible Spouse

Should a **Policyholder** have more than one spouse who could qualify as an **Eligible Spouse** then the **Policyholder** must make an irrevocable nomination of one spouse as the **Eligible Spouse**. **Benefits** will only be paid to the nominated **Eligible Spouse** or the **Eligible Special Dependant**.

On the death of the **Policyholder**, the nominated **Eligible Spouse** may transfer the **Policy** of cover into their own capacity within 30 days without any additional waiting periods or exclusions being applied.

G. Termination of Cover

You may cancel this cover at any time, by giving **a calendar months, prior written notice. The insurer may cancel this cover at any time, by giving you 31 days, prior written notice**.

In the event that any fraudulent act is committed by any **Insured Party** or any **Service Provider**, the Insurer reserves the right to immediately cancel this cover and/or to institute legal proceedings against the relevant party to recover any losses.

In the event that the **Insured Party**, or any person acting on behalf of the **Insured Party**, has misrepresented, inaccurately described or not provided all the details that affect the risk insured under this **Policy**, the Insurer may declare that the whole of this **Policy** or any part thereof is invalid. In such an event, the **Insurer** shall be entitled to reject any claim under this **Policy** and/or to void this **Policy** from the Policy Start Date.

H. Waiting Periods

The **Insurer** shall apply waiting periods to the cover of an **Insured Party** as outlined below:

During the first three months of being an Insured Party, a General Waiting Period shall apply except for Benefits directly arising from Accidental Harm.

During the first 12 months of being a Insured Party, a Condition-Specific Waiting Period shall apply. Where this is applied, a pre-existing questionnaire will be requested at claim stage, within the first 12 months. The requirement is that this questionnaire is completed by the diagnosing medical practitioner.

Waiting Periods shall be applied to the cover of the relevant **Insured Party**, from the time that such **Insured Party's** cover commences under this **Policy**.

In the event that an **Insured Party** previously had a similar **Medical Expense Shortfall Policy**, not longer than **90 Days** before the **Inception Date**, the period of the **General Waiting Period** and **Condition-Specific Waiting Period** shall be reduced by the expired portion of the **General Waiting Period** and **Condition-Specific Waiting Period** served under such previous policy.

Waiting periods will not be applied to a newborn, **Eligible Child, Special Needs Child** or **Eligible Spouse** if they are registered with **Kaelo Risk** within **90 Days** and added to the **Policy**, as a dependant, from the birth or marriage date. **Premiums** will be payable from the birth or marriage date.

Should the **Eligible Child** or **Eligible Spouse** not be registered with **Kaelo Risk** within **90 Days**, full waiting periods will be applied to the **Insured Party**.

The **Insurer** reserves the right to waive the Waiting Periods for the Insured Parties. Any such waiver applied will be indicated on the **Policy Schedule**.

I. Exclusions

The **Insurer** shall not be liable for any claim caused by or related to, whether such cause or related cause is as a direct or indirect consequence of any of the following:

- Any **Treatment** or **Medical Procedure** related to obesity.
- All costs related to ward fees, theatre fees and other **Hospital** expenses including materials and medication on the **Hospital** account.
- Cosmetic surgery except in the case where reconstructive cosmetic surgery is necessitated, in the sole opinion of the Insurer, as a direct result of **Trauma** or other essential non-elective **Treatment** or **Medical Procedure**.
- Suicide, attempted suicide or wilful injury to oneself.
- Abortion, attempted abortion or any complications related thereto unless **Treatment** is, in the sole opinion of the **Insurer**, of a non-elective nature.
- Any procedure or examination where there is no objective indication of impairment in normal health.
- The consumption of any drug or narcotic, whether legal or illegal, unless legally prescribed by and taken in accordance with the instructions of a **Medical Practitioner**.
- The failure of an **Insured Party** to follow any medical advice given by a Medical Practitioner.
- Any incident, **Illness, Accidental Harm**, or event directly or indirectly caused by the continuous and excessive consumption of alcohol or where the **Insured Party** suffers from alcoholism.

- Any incident, **Illness, Accidental Harm** or event directly or indirectly attributable to the **Insured Party** having a blood alcohol content exceeding thirty milligrams per one hundred millilitres of blood.
- Nuclear weapons, nuclear material, ionising radiations or contamination by radioactivity from any nuclear fuel, or from any nuclear waste, or from the combustion of nuclear fuel which includes any self-sustaining process of nuclear fission.
- Participation or attempted participation by any **Insured Party** in any of the following:
    - Defence force, police force, medical rescue service, firefighting service, correctional services facility or the disarming of explosives;
    - Aviation activities where any medical expense incurred in relation to such activities are insured by any other party (excludes farepaying passengers in a licensed passenger carrying aircraft);
    - **Hazardous Sport** as defined, regardless of whether activities are performed privately, socially, during practice sessions, while participating in organised events, as an amateur or a professional.
- Any acts or attempted acts, including participation or attempted participation by any **Insured Party**, of any of the following:
    - Civil commotion, labour disturbances, riot, strike, lock-out or public disorder or any act or activity which is calculated or directed to bring about any of the above
    - War, invasion, act of foreign enemy, hostilities, civil war or warlike operations (regardless of whether war is declared or not)
    - Mutiny, military rising or usurped power, martial law or state of siege, or any other event or cause which determines the proclamation or maintenance of martial law or state of siege, insurrection, rebellion or revolution
    - Any act (whether on behalf of an organisation, body, person or group of persons) calculated or directed to overthrow or influence any state or government or any provincial, local or tribal authority with force or by means of fear, terrorism or violence;
    - Any act calculated or directed to bring about loss or damage to further any political aim, objective or cause, or to bring about any social or economic change, or in protest against any state or government, or any provincial, local or tribal authority, or for the purpose of inspiring fear in the public, or any section thereof;
    - Terrorism. An act of terrorism means the use or threat of violence for political, religious, personal or ideological reasons. This may or may not include an act that is harmful to human life. It could be committed by any person or group of persons, acting alone, on behalf of or with any organisation or government. It includes any act committed with the intention to influence any government or inspire fear in the public;
    - The act of any lawfully established authority in controlling, preventing, suppressing or in any other way dealing with any event referred to above.
- Any claim that is excluded or rejected by the **Insured Party's Medical Scheme**.
- Any claim that does not form part of the registered **Benefits** of the **Insured Party's Medical Scheme** but has been paid on an ex gratia basis.
- The following procedures, items, services, **Service Providers** or events:
    - External prosthesis;
    - Any appliances including, but not limited to, wheelchairs, beds or convalescing equipment;
    - All dental procedures classified as specialised dentistry including, but not limited to, crowns, bridges, dental implant related procedures, orthognathic surgery, temporo-mandibular joint ("TMJ") surgery, labial frenectomy, bone augmentations, bone or tissue regeneration. The above definition does not include **Basic Dentistry**, as defined in this **Policy**); This exclusion is not applicable to the Dental Reconstruction Benefit in this **Policy**.
    - Harvesting and/or preserving of human tissues, including but not limited to stem cell regeneration;
    - Breast augmentation;
    - Gastroplasty, lipectomy or otoplasty;
    - Gender reversal procedures;
    - Therapeutic massage therapists;

- Institutions that primarily care for persons who are mentally handicapped, blind, deaf, mute or in any other way physically handicapped;
- Convalescent homes, or homes for the elderly;
- Places of rest or recuperation;
- Rehabilitation (drug addiction, alcoholism, eating disorders or any other form of addictive behaviour),
- Health hydro or alternative therapy clinics;
- Step-Down Facilities;
- TTO (To-Take-Out) medicines.

- Any expenses incurred as a result of an injury in a motor vehicle accident that are subsequently recoverable by the relevant **Insured Party** from the Road Accident Fund.
- Any expenses incurred as a result of an injury on duty that are subsequently recoverable by the relevant **Insured Party** from Workman's Compensation Fund.
- Any **Co-payment** or **Deductible** applied by the **Insured Party's** Medical Scheme against the **Benefits** to be received or paid out from the **Medical Scheme**, other than those specifically listed in the **Benefit Schedule** outlined in this **Policy**.
- Any **Penalty**, as defined in this **Policy**, applied by the **Insured Party's Medical Scheme**.
- Any fee charged by a **Medical Practitioner, Hospital** or other medical service provider that constitutes **Split Billing** as defined in this **Policy**. This exclusion does not apply to Balance Billing, also defined in this **Policy**.
- Any criminal act or attempted criminal act by an **Insured Party** which shall include the submission of any fraudulent information or the use of any fraudulent means to obtain any Benefit under this **Policy**.
- Any Treatment or **Medical Procedure** for infertility.
- Expenses incurred for transport charges or for services rendered whilst being transported in any vehicle, vessel or craft whether or not such vehicle, vessel or craft is specifically designed for the purposes of medical emergency transport.
- Any act by an **Insured Party** that wilfully exposed the **Insured Party** to danger (except where such act was necessitated in order to save human life).
- Any Treatment or **Medical Procedure** that, in the sole opinion the **Insurer** is of such a nature that it is not considered to be medically necessary, or where alternative conservative Treatment would provide a similar outcome, or is of such a nature that there is no likely improvement in the medical condition of the **Insured Party**.
- Any Hospital Episode, Treatment or **Medical Procedure** relating to the **Insured Event** which commences after the date of cancellation of this **Policy**.
- Any Treatment or **Medical Procedure** where such treatment occurred outside of the period of cover.
- A **Deductible** or **Co-payment** that is specified by the **Insured Party's Medical Scheme** as a percentage of costs. This does not apply to the 20% oncology Co-payment as per the oncology Co-payments or penalty Co-payments in this Policy.
- Any out-patient **Treatment** unless otherwise specified in this Policy.

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Sanlam

GAP COVER BENEFITS 2023

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This **Policy** is not a substitute for **Medical Scheme** membership.
Sanlam Gap is administered by Kaelo Risk (Pty) Ltd, an authorised financial services provider (FSP 36391).
Insurance Products are underwritten by Centriq Insurance Company Limited ("Centriq") a licensed non-life insurer and authorised Financial Services Provider (FSP 3417).

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Benefit Schedule

Addendum A: Detailed Benefits

Benefits Description Sanlam Gap Cover

The benefits listed below apply only for services rendered within the territory of the Republic of South Africa. Any services provided outside of the borders of South Africa are excluded from cover.

The benefits listed below are deemed as separate benefits and may qualify for coinciding yet distinct benefits, as the case may be.

Core Benefits 2023

Health Service	Benefit	Limit
Core Benefits*	The following **Benefits** are defined as Core **Benefits**: • Tariff Shortfalls • **Co-Payments** and **Deductibles** • Shortfalls from Sub-Limits • Oncology Tariff Shortfalls • Oncology Sub-Limits • Oncology **Co-Payments** • Out-of-**Hospital** Tariff shortfalls • **Penalty Co-Payment** • **Innovative Oncology Medicines** • Dental Reconstruction **Benefit**	**Core Benefit Limit:** The **Overall Annual Limit** is **R185 837 per Insured Party Per Annum**. which is the maximum combined **Benefit** payable by the Insurer for all Core **Benefit** clauses. However, this limit will increase on 1 April 2023, in line with the annual Consumer Price Index (CPI) inflation rate as published by Statistics South Africa, but it will not exceed **R200 000**. **Prescribed Minimum Benefits** (PMB) procedures are covered under Core **Benefits** and are subject to clinical review by our Specialist third party, MedClaim Assist.

*The Benefit names listed throughout this document are for reference purposes only and will not form part of any Benefit definition.

Core Benefits 2023

Health Service	Benefit	Limit
Tariff Shortfalls	**Benefits** relating to this clause will only be paid in respect of services occurring during a **Hospital Episode** rendered and charged for by a Medical Practitioner. This Benefit requires your **Medical Scheme** to pay their portion of the claim from your hospital/risk benefit. **Core Benefits Tariff Shortfalls Example** Mr S is on a **Medical Scheme** – plan A, which covers him to a maximum of 100% of the **Medical Scheme** Rate. This means that the **Medical Scheme** will pay all expenses towards Mr. S's **Treatment** costs. The **Medical Scheme** Rate for a total colonoscopy is R2 000 (100%) which means that the maximum that the **Medical Scheme** will pay is R2 000 (100%). The specialist performing the procedure charged R10 000 which is five (5) times the **Medical Scheme Tariff** (500%). The maximum **Benefit** payable by this **Policy** for this procedure is therefore: R10 000 – Fee charged by the specialist LESS R2 000 – **Benefit** paid by **Medical Scheme** = R8 000 – The gap cover **Benefit**.	The **Benefit** provided is for charges above the **Medical Scheme Tariff** limited to an additional five times (500%) that of the **Medical Scheme Tariff**, subject to the **Overall Annual Limit**.
Co-Payments and Deductibles	**Benefits** payable are for a standard **Co-payment** or an upfront **Deductible** amount for the cost of a diagnostic or **Medical Procedure**. The **Benefit** payable is equal to the fixed value **Deductible** or **Co-payment** amount, as defined in the rules of the I**nsured Party's Medical Scheme**. This **Benefit** excludes any **Deductible** or **Co-payment** that is specified by the **Insured Party's Medical Scheme** as a percentage of costs and not a specified **Rand** amount	Subject to the **Overall Annual Limit**.

Core Benefits 2023

Health Service	Benefit	Limit
Shortfalls from Sub-Limits	This **Benefit** will apply for services provided during a **Hospital Episode**, where the charges relating to the service supplied have exceeded the **Sub-limit** benefit paid by the **Insured Party's Medical Scheme**. The **Benefit** payable is equal to the charged amount, less the amount paid by the **Insured Party's Medical Scheme**, and subject to the **Benefit** limit.	**R60 900** subject to the **Overall Annual Limit**.
Oncology Tariff Shortfalls	**Benefits** relating to this clause will only be paid in respect of oncology and related **Treatment**, that has been approved by the **Insured Party's Medical Scheme**, for the purposes of treating cancer (malignant neoplasm) and which occurs during an **Insured Event**. This **Benefit** requires your **Medical Scheme** to pay their portion of the claim from your hospital/risk benefit **Oncology Tariff Shortfalls Example** Mr. T is on a **Medical Scheme** – Plan B which covers him to a maximum of 100% of the **Medical Scheme** rate. This means that the **Medical Scheme** will pay all expenses at the defined **Medical Scheme** rate towards Mr. T's **Treatment** costs. The **Medical Scheme** rate for the specific oncology **Treatment** is R20 000 (100%). This means that the maximum that the **Medical Scheme** will pay is R20 000. The total cost for the specific Oncology **Treatment** required by Mr. T is R100 000 which is five times the **Medical Scheme Tariff** (500%). The maximum **Benefit** payable by this **Policy** for this procedure is therefore: R100 000 – Oncology **Treatment** Cost LESS R20 000 – **Benefit** paid by **Medical Scheme** = R80 000 – Your gap cover **Benefit**.	The **Benefit** provided is for charges above the **Medical Scheme tariff**, limited to an additional five times (500%) of the **Medical Scheme tariff**, subject to the **Overall Annual Limit.**

Core Benefits 2023

Health Service	Benefit	Limit
Oncology Sub-Limits	**Benefits** relating to this clause will only be paid in respect of oncology and related **Treatment**, that has been approved by the **Insured Party's Medical Scheme**, for the purposes of treating cancer (malignant neoplasm) and which occurs during an **Insured Event**. **Benefits** relating to this clause will only be paid in respect of services, where the charges relating to the services supplied, have exceeded the **Benefit** sub-limit that applies to oncology **Treatment** of the **Insured Party's Medical Scheme** plan type. The **Benefit** payable is equal to the charged amount, less the amount paid by the **Policyholder's Medical Scheme**.	Subject to the **Overall Annual Limit**.
Oncology Co-Payments	**Benefits** relating to this clause will only be paid in respect of oncology and related **Treatment**, that has been approved by the **Insured Party's Medical Scheme**, for the purposes of treating cancer (malignant neoplasm) and which occurs during an **Insured Event**. The **Benefit** payable is equal to the **Co-payment** applied once related costs have exceeded the specific threshold defined by the **Medical Scheme**.	The maximum **Benefit** payable is limited to a 20% **Co-payment**, subject to the **Overall Annual Limit**.

Core Benefits 2023

Health Service	Benefit	Limit
Out-of-Hospital Tariff Shortfalls	This **Benefit** provides additional cover of up to 500% of the **Medical Scheme** rate for out-patient procedures, subject to the costs being funded from the risk/hospital benefit by the **Insured Party's Medical Scheme**. **Out-of-Hospital Tariff Shortfalls Example** Mr. V is on a **Medical Scheme** – plan C which covers him to a maximum of 100% of the **Medical Scheme Rate**. This means that the **Medical Scheme** will pay all expenses at the defined **Medical Scheme Rate** towards Mr. V's treatment costs. Mr. V has opted to undergo an Arthroscopy of his shoulder out of hospital. The **Medical Scheme Rate** for a total Arthroscopy is R2000 (100%). This means that the maximum that the **Medical Scheme** will pay is R2000 (100%). The specialist performing the procedure charged R10 000 which is five times the **Medical Scheme** tariff (500%). The maximum **Benefit** payable by this **Policy** for this procedure is therefore: R10 000 – Fee charged by the specialist for the Arthroscopy LESS R2 000 – **Benefit** paid by **Medical Scheme** = R8 000 – Your gap cover **Benefit**.	The **Benefit** provided is for charges above the **Medical Scheme** tariff, limited to **five times (500%)** of the **Medical Scheme** tariff, and subject to the **Overall Annual Limit**.

Core Benefits 2023

Health Service	Benefit	Limit
Penalty Co-Payment	Notwithstanding exclusion related penalties, the **Insurer** will pay a fixed value **Penalty Co-payment** or **Deductible**, or a percentage **Penalty Co-payment** up to a maximum of 30%, for the voluntary use by an **Insured Party** of a **Hospital** that is not part of a **Hospital** Network. Any other liability arising against an **Insured Party** from a **Penalty**, as defined, that is not a fixed value **Penalty co-payment** defined in the rules of the **Insured Party's Medical Scheme**, remains an exclusion.	A maximum of **two** such events are covered under this **Benefit Per Annum** and up to a maximum amount of **R17 500 Per Event**, subject to the **Overall Annual Limit**.
Innovative Oncology Medicines	**Benefits** will be paid in respect of defined **Innovative Oncology Medicines** approved by the **Insured Party's Medical Scheme**.	The **Benefit** payable is equal to the total cost of the **Innovative Oncology Medicine** less the amount paid by the **Medical Scheme** from the **Insured Party's** hospital/risk benefit up to a maximum value equal to the lesser of 25% of the total cost or **R13 000**, subject to the **Overall Annual Limit**.
Dental Reconstruction Benefit	**Benefits** relating to this clause are only payable in respect of Dental Reconstruction Surgery being required as a direct result of **Accidental Harm** or from Oncology **Treatment** that occurred after the **Inception Date**. The **Benefit** payable is equal to the total cost of **Treatment** less the amount paid by the **Medical Scheme** from your hospital/risk benefit. The **Benefit** is only payable during an **Insured Event**. **Dental Reconstruction Example** Mr X is involved in a Motor Vehicle accident which damaged his teeth. Mr X is required to have Dental Reconstruction as a result of this. Mr X was admitted to **Hospital** for his surgery. The total cost for Mr X's Treatment was R10 500.00. Mr X's **Medical Scheme** paid **R3 000** toward the Dental Surgeon's account from his **Hospital Benefit**. Sanlam Gap will calculate the **Benefit** payable to Mr X as: R10 500.00 charged amount Less R3 000.00 paid by **Medical Scheme** = R7 500.00	A maximum of Two such events per are covered under this **Benefit Per Annum** and up to a maximum amount of **R49 900 Per Annum** subject to the **Overall Annual Limit**.

Additional Benefits

The benefits listed below apply only for services rendered within the territory of the Republic of South Africa. Any services provided outside of the borders of South Africa are excluded from cover. The benefits listed below are deemed as separate benefits and may qualify for coinciding yet distinct benefits, as the case may be.

Health Service	Benefit	Limit
Family Booster	A lump sum **Benefit** is payable when a **Premature Birth** occurs.	Lump sum **Benefit** is **R15 900.**
Casualty Child Illness	**Benefits** relating to this clause will only be paid in respect of emergency out-patient services that are provided within a casualty ward of a **Hospital**. The **Benefit** is only payable in the event of after-hours **Treatment** in an emergency situation. After-hours is Mondays to Fridays between 18:00pm and 08:00am and all-day Saturdays, Sundays and South African public holidays. The **Benefit** payable is equal to the total cost of **Treatment** less the amount paid by your **Medical Scheme** from your hospital/ risk benefit. If payment is made from your available Medical Savings Account, or from your own pocket, we will reimburse that too.	Subject to a maximum of **two** such events **Per Annum** and a maximum of **R2 700 Per Event**. Limited to children under age 12.
Accidental Casualty	**Benefits** relating to this clause will only be paid in respect of emergency out-patient services that are a direct result of **Accidental Harm** and are provided within a casualty ward of a **Hospital**. The **Benefit** payable is equal to the total cost of **Treatment** less the amount paid by your **Medical Scheme** from your hospital/ risk benefit. If payment is made from your available Medical Savings Account, or from your own pocket, we will reimburse that too. No **Benefit** is payable under this clause for services that are related to an **Illness** or that are not delivered within a casualty ward of a **Hospital**, as defined.	Subject to a maximum of **R17 400 Per Event.**

Additional Benefits

Health Service	Benefit	Limit
Hospital Booster	The following daily lump sum **Benefits** are payable where an **Insured Party** is admitted to a **Hospital**, and such an **Insured Event** occurred as a direct result of either **Accidental Harm** or **Premature Birth**, as defined, in your **Policy**. For the purposes of the above **Benefit** calculation, the first day is defined as commencing at the time of admission to **Hospital** and ending 24 hours later. All subsequent days are defined as commencing and ending on the same start and end times as the first day. The following **Benefit** limitations apply to this clause: If more than one **Insured Party** in the **Family** (if you have selected to pay the Family **Policy Premium**) is hospitalised as a result of the same event, only the **Insured Party** with the longest **Episode** will attract a **Benefit** under this clause. No **Benefit** is payable under this clause after day 30 of any **Hospital Episode**.	A maximum of two **Hospital Episodes** per **Family** are covered under this **Benefit Per Annum**, up to a maximum amount of **R29 300 Per Annum**. The **Benefit** is payable from day one of the **Hospital Episode**: **R480 per day** from the 1st to the 13th day (inclusive). **R860 per day** from the 14th to the 20th day (inclusive). **R1 700 per day** from the 21st to the 30th day (inclusive).
Family Protector	The lump sum **Benefit** is payable upon the Death or **Permanent Disability** of an **Insured Party** due to **Accidental Harm**.	Limited as follows: Children below six years: **R20 000** All other **Insured Parties: R30 000.**
Medical Scheme Contribution Waiver	The following lump sum **Benefit** is payable upon the death or **Permanent Disability** of the **Policyholder** due to **Accidental Harm** and where the **Policyholder** is the Principal Member of the **Medical Scheme**. In the event of death, the **Benefit** amount will only apply (become payable) where there are dependants registered on the **Medical Scheme**, who are being paid for by the **Policyholder**. The **Benefit** payable is equal to the monthly **Medical Scheme** contribution applicable after the qualifying event above, multiplied by **six** and subject to an overall maximum limit. This **Benefit** is limited to **one event** over the **Policy** lifetime. In addition, the Sanlam Gap Cover **Premium** will be waived for **six months**.	The **Benefit** payable is subject to an overall **maximum limit of R35 500.**

Additional Benefits

Health Service	Benefit	Limit
Gap Premium Waiver	In the event of the death or **Permanent Disability** of the **Policyholder** as a result of an accident, **Policy Premiums** will be waived. In the event of death, the **Benefit** will only apply (become payable) where the **Policyholder** is the principal member of the **Medical Scheme** and only if there are dependants registered on the **Gap Policy** who are being paid for by the **Policyholder.**	Waived for a period of six months from the date the of event. This **Benefit** is limited to one event over the **Policy** lifetime.
RAF Claims	An end-to-end legal service is provided by the nominated Service Provider of Kaelo, our administator to assist Insured Parties with legitimate claims against the Road Accident Fund (RAF). Service Providers are contracted to Kaelo Risk and not to the **Insurer**: Centriq Insurance Company Limited.	Included.

Mediclinic Extender Benefit

The Mediclinic Extender Benefits applies to members who have opted to include the option on their Sanlam Gap Policy. Confirmation thereof would reflect on the member's **Policy Schedule**.

Health Service		Benefit	Limit
HEALTHCARE BENEFITS	Casualty Illness	**Benefits** relating to this clause will only be paid in respect of **Emergency** outpatient services that are provided within a casualty ward of a **Hospital**. The **Benefit** is only payable in the event of after-hours **Treatment** in an **Emergency** situation. After-hour emergency illness only at a Mediclinic for all **Insured Parties** covered **(Mondays to Fridays: 6pm – 8am. All-day Saturdays, Sundays & public holidays).**	Subject to a maximum of **two** such events **per Annum** and a maximum of **R2 500 per Insured Event.**
	Specialist Benefit	Specialist Benefit - Out-of-hospital This **Benefit** will become payable when your **Medical Scheme** has paid a portion of your out of hospital specialist claim. We will cover the shortfall thereof.	Up to **R4 900 per Insured Party per Annum**, subject to the **Overall Annual Limit**.
	Private Ward	Cover for the difference between the cost of a general ward and a private ward. Payable only in the event of confinement (childbirth) admissions. Only at a Mediclinic hospital (if available).	Subject to a maximum of **one** event **per Insured Party per Annum** and a maximum of **R4 900** subject to the **Overall Annual Limit**.
	Cancer Lump Sum Pay Out	**Benefits** relating to this clause will only be paid if cancer is confirmed by the oncologist or pathologist as at least the medical equivalent of "Stage 2" or higher cancer.	**Benefit** is limited to **one** claim per **Insured Party** and is only payable on first-time diagnosis as a lump sum of **R10 000**.
CO-PAYMENT BENEFITS	Cashless Co-payment	**Benefits** relating to this clause will only be paid in respect of defined diagnostic procedures that occurred during an **Insured Event**. The **Benefit** payable is equal to the fixed value **Deductible** or **Co-payment** amount, as defined in the rules of the Insured Party's Medical Scheme. **Benefit** is directly payable to Mediclinic. Pre-authorisation letter required.	Unlimited subject to the **Overall Annual Limit**. Only at a Mediclinic facility.
	Cashless Penalty Co-payment	Notwithstanding exclusion related penalties, the Insurer will pay a fixed value **Penalty Co-payment** or **Deductible**, or a percentage **Penalty Co-payment** that does not exceed 30%, for the voluntary use by an **Insured Party** of a Mediclinic facility that is not part of their **Medical Scheme Hospital Network**.	Unlimited only at a Mediclinic facility subject to a maximum of **R16 500** per event and subject to the **Overall Annual Limit**.

***How to pre-authorise your cashless co-payments:**

Kindly complete a pre-authorisation form which can be found on the website: **https://documents.sanlam.co.za/2023_Sanlam_Gap-Mediclinic-Extender-Cashless-Form.pdf** and submit to sanlamauth@kaelo.co.za within a minimum of 48 working hours prior to your procedure or admission. In the event of an emergency,a pre-authorisation form needs to be completed post procedure within 3 working days.

***All other benefits claimable via the standard claiming process - click here**

MEDICLINIC

Statutory notice:

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