

Admed

The heart beat of Gap

2020 POLICY WORDING

Underwritten by Guardrisk Insurance Company Limited
A member of Momentum Metropolitan

Gap cover is not a medical scheme and the cover is not the same as that of a medical scheme. Only active medical scheme members are eligible for cover on Admed.

This policy is not a substitute for medical scheme membership, nor does it cover every shortfall between what an Insured Person is charged and what their medical scheme pays. No day-to-day benefits are covered on this policy (e.g. doctor visits, optometry, dentistry, medication).

It is a condition of continued cover that an insured remains a member or dependent of a registered South African medical scheme at all times during the term of this policy

Table of Contents

General Conditions

1. Important information
2. How this policy works
3. Protection of your personal information
4. Definitions
5. Who is covered
6. Starting your cover
7. The premium
8. General exclusions
9. Waiting Periods
10. Changes, cancelling or continuing your cover
11. Changing your cover option
12. How to claim
13. How to complain

Section A: Medical Expense Shortfall Benefits

14. Benefit for shortfalls in Medical Practitioner costs
15. Benefit for co-payments and deductibles levied by your medical scheme
16. Benefit for co-payments levied by your medical scheme on oncology Treatment programmes
17. Oncology extender benefit
18. Benefit for shortfalls in internal prosthesis costs
19. Accidental and Emergency casualty benefit

Section B: Lump Sum Benefits

20. Lump sum benefit for first time, minimum severity cancer diagnosis
21. Lump sum benefit for Accidental death or Accidental Permanent and Total Disability
22. Violent Crime benefit
23. Premium waiver benefit
24. Trauma counselling benefit
25. Baby bump benefit

General Conditions

The below information applies to your cover with us. Please ensure that you read these terms and conditions carefully and that you fully understand them, as they affect your cover under this policy. The terms and conditions of this annual policy apply from 1 January 2020 to 31 December 2020.

1. Important information

- 1.1 Gap cover is written under a Short Term Insurance licence as a Short Term Personal Lines - Accident and Health product.
- 1.2 A gap cover policy is not tax deductible and we do not issue tax deduction (IT3) certificates for the premiums that you pay or benefits that you receive in respect of this cover.
- 1.3 These terms and conditions apply to your cover if you are the Policyholder or if your employer, or an Associated Group is the Policyholder, and you are covered as a Member of your employer's or Associated Group's Group Scheme policy.
- 1.4 You will only qualify for cover under this policy if you are an active Member of a registered medical scheme.

2. How this policy works

If you pay us the premium due in respect of this policy, we will pay you the following benefits that you are covered for in terms of this policy, provided that the claim for the benefit falls within the scope of cover and is not excluded. The benefits that you will be entitled to, will depend on your selection of either the Supreme Gap or Primary Gap product option.

A summary of the benefits offered under each product option is provided in the table below.

	Supreme Gap	Primary Gap
Section A: Medical Expense Shortfall Benefits		
<i>(Under this section, a maximum of R165 000 can be paid per Insured Person per policy year)</i>		
Benefit for shortfalls	Covered	Covered
Benefit for co-payments applied by your medical scheme for certain Procedures	Covered	Covered
Benefit for co-payments on oncology Treatment programmes	Covered	Not covered
Oncology extender benefit	Covered	Not covered
Benefit for shortfalls in internal prosthesis costs	Covered	Not covered
Accidental and Emergency casualty benefit	Covered	Not covered
Section B: Lump Sum Benefits		
Lump sum benefit for first time, minimum-severity cancer diagnosis	Covered	Not covered
Lump sum benefit for personal Accidental Death and Permanent and Total Disability	Covered	Not covered
Violent Crime benefit	Covered	Not covered
Premium waiver benefit	Covered	Not covered
Trauma counselling benefit	Covered	Not covered
Baby bump benefit	Covered	Not covered

- 2.1 This policy wording and your Certificate of Cover sets out the terms and conditions of your cover with us. It is a legal contract between you (or your employer, if the policy is owned by your employer; or your Associated Group, if the policy is owned by your Associated Group) and us and it is based on the information given to us when you applied for the cover.
- 2.2 If the policy is owned by your employer or an Associated Group, your employer, or the Associated Group has no right to any benefits under this policy and all benefits to which you are entitled belong to you, irrespective of whether you pay the premium or your employer or Associated Group pays the premium on your behalf. You may not give your rights up to anyone else.
- 2.3 Our duty in terms of this policy is to provide the cover and pay the benefits which are explained in this policy and which is detailed on the Certificate of Cover that we send to you. Your Certificate of Cover confirms your personal details, the period of time that you are covered for and the monthly premium payable for this cover. Your Certificate of Cover is issued by us to you on your cover start date and on your renewal date every year thereafter.
- 2.4 If your cover with us begins after 1 January, your first period of cover may be less than 12 months. This is because we may align your renewal with the medical scheme industry's annual renewal period of 1 January to 31 December each year and enable you to enjoy our new benefits from 1 January each year. This also means that your premium may change on 1 January each year and not 12 months after your cover with us begins.
- 2.5 Your duty in terms of this policy is to pay the premium and act in accordance with all of the terms and conditions of this policy.
- 2.6 If you do not carry out your duty in terms of this policy, we may reject a claim or cancel your cover with us.
- 2.7 Your cover with us will begin on the cover start date that is reflected on the Certificate of Cover that we issue to you.
- 2.8 Cover can only begin on the 1st day of a calendar month and it can only terminate on the last day of a calendar month.
- 2.9 If we find that you have deliberately:
- not disclosed or incompletely disclosed anything that may affect your application for cover; or
 - submitted a claim that is false or overstated,
- we may refuse to pay a claim under this policy or we may cancel your cover from the date on which we make this finding. If this happens you will not be entitled to a refund of premiums paid and we may also take legal action against you. If we have already paid a claim you will be required to pay back any amounts we paid in respect of this claim.
- 2.10 We will only cover you if you are living in the Republic of South Africa.
- 2.11 You are only covered for Procedures and Treatment which take place in the Republic of South Africa and where you have used the services of a South African registered Medical Practitioner.
- 2.12 If you leave the Republic of South Africa to work in another country for your South African employer for more than 3 consecutive months, you will no longer be eligible for cover under this policy. Your dependents however, will be covered while they remain here in South Africa, provided your medical scheme and your policy with us remain active during this time.
- 2.13 In this case it is your responsibility to notify us of this in writing before you leave the country for the first time, as well as to provide us with a written nomination, authorising one of your dependents to submit and sign claim forms on your behalf while you are out of the country. If the above happens, when you return to South Africa you can continue your cover with us on the same terms and conditions and without having to serve new Waiting Periods with us, as long as you once again become eligible for cover under your medical scheme.
- 2.14 If before you left South Africa, your cover with us was a condition of your employment with your employer (in other words, it was compulsory), you must once again begin your cover with us on the same day that you begin your cover with the medical scheme.
- 2.15 If however, your cover was voluntary, you will have 90 days from the date of your re-joining the medical scheme to re-apply for cover with us.
- 2.16 It is agreed that only the laws of the Republic of South Africa apply to this policy, and as a result any legal proceedings in connection with this policy will only take place in the courts of the Republic of South Africa.
- 2.17 It is agreed that if any terms of this policy contradict the law of the Republic of South Africa, the terms of the law will take priority over the policy.

3 Protection of your personal information

- 3.1 We are committed to maintaining the confidentiality of your personal information and complying with the Protection of Personal Information Act of 2013 when processing your personal information. We will therefore keep your information and your dependents' information confidential and we have data security measures in place to do this, including access control to restrict disclosure of personal information to only authorised individuals.
- 3.2 Personal information refers to information that identifies you or relates specifically to you or your dependents, such as an identity number, name or email address.
- 3.3 We will collect, process, store and disclose your and your dependents' personal information in order to administer your cover with us.
- 3.4 You confirm that when you provide us with your personal information, your dependents and/or beneficiaries have provided you with the appropriate permission to disclose their personal information to us for the purpose of administering their cover with us.
- 3.5 You have the right to request a copy of the personal information we hold about you. If you do this, we will take all reasonable steps to confirm your identity before providing details of your personal information.
- 3.6 You have the right to contact and ask us to update, correct or delete your personal information.
- 3.7 You authorise us to retain your personal information until such time as you ask us to destroy it (unless we are obliged by law to retain it, regardless of your request).
- 3.8 You have the right to object to the processing of your personal information.

4 Definitions

To ensure a clear understanding of the cover offered under this policy, we explain the meaning of certain words, in more detail below. Where we have done this, the meaning that we have given will apply to that word.

- 4.1 **"Accident"** means a sudden, unexpected, violent and visible external event, which is inflicted on you by something other than yourself at an identifiable time and place and that independently of any other cause, directly results in Bodily Injury;
- 4.2 **"Associated Group"** means a registered body or group of people who share a common purpose or interest and who are organised with varying degrees of formality, including but not limited to unions, societies, church groups, medical schemes, and loyalty programmes;
- 4.3 **"Beneficiary"** means you or your dependents covered on this Policy, irrespective of whether you have contracted directly with us as an individual Policyholder or if you are a Member of your employer's or Associated Group's Group Scheme;
- 4.4 **"Bodily Injury"** means physical damage of the function of a body part, organ or brain and it includes cuts, abrasions, bruises, burns and disfigurements;
- 4.5 **"Certificate of Cover"** means the certificate that is issued to you confirming the details of your cover under this policy;
- 4.6 **"Claims Negotiator"** means MedClaim Assist (Pty) Ltd, a third party service provider that has been appointed by us to negotiate claim settlements with medical schemes in respect of Prescribed Minimum Benefit claims, as well as with Medical Practitioners in respect of excessive fees that may have been charged;
- 4.7 **"Complaint"** means an expression of dissatisfaction relating to a policy or service offered or provided by us, which indicates that we have:
 - Contravened or failed to comply with an agreement, a rule, a law or a code of conduct that we are bound to as an insurer;
 - Caused harm, prejudice, distress or substantial inconvenience due to our or our appointed administrator's willful negligence, maladministration, or failure to act; or
 - Treated a customer unfairly.
- 4.8 **"Counsellor"** means a person who is legally qualified as a Counsellor, registered with the Health Professions Council of South Africa (HPCSA) and authorised to practice in the Republic of South Africa;

- 4.9 **“Day Clinic”** (also known as an unattached operating theatre) means a facility which is licensed with the Department of Health as a Day Clinic and allows for a patient to be discharged on the very same day a Procedure is done;
- 4.10 **“Dental Implant”** means an artificial tooth root that is placed into your jaw to hold a replacement tooth or bridge;
- 4.11 **“Disease”** refers to an abnormal condition affecting an organism of the body. This abnormal condition could be due to infection, degeneration of tissue, injury/trauma, toxic exposure, development of cancer, etc. This is what needs to be ‘cured’, especially if it’s life-threatening;
- 4.12 **“Due Date”** means the date on which your premium is due or the date your employer has deducted the premium from your salary;
- 4.13 **“Emergency”** means the necessity to immediately visit a casualty facility due to a Bodily Injury caused by an Accident as defined in the Policy, and when failure to do so, may result in loss of life, limb or significant complications;
- 4.14 **“External Prosthesis”** means an artificial device which is used to replace external body parts which don’t work or are no longer there (for example, artificial limbs);
- 4.15 **“Group Scheme”** means a scheme or arrangement which provides for the entering into of one or more policies, where the Insured Person is a Beneficiary nominated by the Policyholder and the Policyholder has no insurable interest in the policy;
- 4.16 **“Hospital”** means any institution in the Republic of South Africa that:
- Provides diagnostic (problem solving) and therapeutic (healing) facilities for surgical and medical analysis, Treatment and care of sick or injured people by or under the supervision of qualified and registered Medical Practitioners; and
 - Provides 24 hour nursing services by nurses registered with the South African Nursing Council (SANC) to sick or injured people within these facilities.
- A Hospital does not include:
- A casualty ward; or
 - A Day Clinic or operating theatre; or
 - A mental institution or home for recovery; or
 - A place of rest or care facility for the elderly (including Hospice); or
 - An institution that provides long-term care for people that are mentally disabled, blind, deaf, mute or in any other way physically handicapped; or
 - An institution that Treats people for drug addiction, alcoholism, eating disorders or any other form of addictive behaviour; or
 - A health hydro, natural cure or alternative therapy clinic; or
 - A step-down facility (also called a medical rehabilitation centre);
- 4.17 **“ICD-10 code”** means an alphanumeric code that is used to inform medical schemes about what condition their Members were Treated for so that claims can be settled correctly. ICD-10 stands for International Classification of Diseases and Related Health Problems (10th revision) and it is a coding system developed by the World Health Organisation (WHO), that translates the written description of medical and health information into standard codes;
- 4.18 **“Illness”** means the symptoms that might come with having a Disease. Symptoms like pain, fatigue, weakness, discomfort, distress, confusion, dysfunction, or the like – the reasons people seek healthcare;
- 4.19 **“Infirmary”** means a bodily weakness or fragility, especially one brought on by old age;
- 4.20 **“Insured Person”** means you and any person that is registered as a dependent on your medical scheme and is eligible for cover on this policy;
- 4.21 **“Major Medical Benefit”** means that part of your medical scheme cover that is specific to the medical scheme Plan Option that you are on and covers you in the event that you are Hospitalised or are required to undergo Treatment or a Procedure;

- 4.22 **“Medical Savings Account”** means an amount that your medical scheme provides you at the start of the year. You can use this to pay for day-to-day medical costs like doctor visits, X-rays and dentist visits. Any money in your Medical Savings Account which you haven’t used by the end of the year is carried over to the next year;
- 4.23 **“Medical Scheme Tariff”** (also called Medical Scheme Tariff or “MST”) means a specific amount that your medical scheme has committed to paying for a specific Procedure. Your medical scheme calculates this amount based on what it can afford to pay for the Procedure, not on the actual costs to the Medical Practitioner for performing the Procedure. Your medical scheme will have a tariff for every Procedure that it covers and these tariffs can be requested from your medical scheme;
- 4.24 **“Medical Practitioner”** means a person who is legally qualified as a Medical Practitioner, registered with the Health Professions Council of South Africa (HPCSA) and authorised to practice in the Republic of South Africa;
- 4.25 **“Member”** means a person belonging to a particular group such as a Medical Scheme, an employer or an Associated Group;
- 4.26 **“Modifier”** means a four-character code that a Medical Practitioner can add to a regular Service Code to indicate a service or Procedure that has been altered by special circumstance, but for which the basic code description itself has not changed. A Modifier can be used when a Procedure has been increased or reduced, where only part of a Procedure was performed, where a Procedure was performed more than once, when a Procedure was performed by more than one Medical Practitioner (for example, with an assistant) and the physical status of a patient for the administration of anaesthesia;
- 4.27 **“Obesity”** means an abnormal or excessive fat accumulation that may impair health. Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify Obesity in adults and adults that have a BMI greater than or equal to 30 are considered Obese;
- 4.28 **“Permanent and Total Disablement”** means being completely unable to perform any occupation whatsoever, unable to perform any normal daily living tasks (such as eating, dressing, bathing, walking, etc.) yourself and in the opinion of a Medical Practitioner, unlikely to ever recover from Disability;
- 4.29 **“Plan Option”** means a medical scheme Plan Option which provides a specific set of benefits, terms and conditions for a defined contribution;
- 4.30 **“Policyholder”** means :
- You, if you have contracted directly with us and we have issued a policy in your name;
 - Your employer, if your employer has contracted directly with us, we have issued a policy in your employer’s name and you are a Member of that policy; or
 - Your Associated Group, if the Associated Group has contracted directly with us, we have issued a policy in the Associated Group’s name and you are a Member of that Associated Group;
- 4.31 **“Pre-Authorisation Letter”** means a formal document from a medical scheme which a Medical Practitioner must obtain prior to performing Treatment and/or a Procedure, and which pre-approves the cost of such Treatment and/or Procedure;
- 4.32 **“Pre-existing Medical Condition”** means any physical defect, Bodily Injury, Disease, Illness, Infirmity or health condition that existed and was known by You or your dependent, or for which You or your dependent received or should reasonably have received medical advice and/or Treatment prior to cover under this policy commencing;
- 4.33 **“Prescribed Minimum Benefits”** (PMB’s) means, “a set of defined benefits to ensure that all medical scheme Members have access to certain minimum health services, regardless of the option they have chosen”. This means that there are approximately 270 listed conditions that according to the Medical Schemes Act 131 of 1998, your medical scheme should provide you with cover for. This list is updated once a year and can be found on the Council for Medical Schemes’ website at www.medicalschemes.com;
- 4.34 **“Procedure”** means any medical or surgical Procedure which is listed in the National Health Reference Price List (NHRPL) and it includes follow ups after the Procedure, by the Medical Practitioner that performed the Procedure, while you are still admitted into Hospital;
- 4.35 **“Service Code”** means the specific code used by Medical Practitioners in charging for each of their services and recognised by medical schemes in capturing and processing claims for payment. A Procedure may have one or multiple Service Codes, each of which relates to a specific sub-Procedure of the primary Procedure. When processing a claim, medical schemes will apply their Medical Scheme Tariff (MST) to each of these Service Codes individually – more often than not, the charge applied by the Medical Practitioner to a Service Code will be higher than the Medical Scheme Tariff applied by your medical

scheme to the same Service Code, resulting in a shortfall. Likewise, when processing this shortfall, we will also apply our calculation to each of the Service Codes for which you are claiming;

- 4.36 **“Treat”/“Treatment”** means to give medical care or attention to in order to try to heal or cure;
- 4.37 **“Violent Crime”** means an act which is harmful to an individual and punishable by law;
- 4.38 **“Waiting Period”** means a period of time during which you have to pay your monthly premium but you cannot claim from the policy for specific events that happen during this period. A Waiting Period is calculated from (and includes) the first day on which your cover begins with us or is reinstated by us. Any costs not paid by your medical scheme for specific Procedures or Treatments which take place during this period cannot be claimed (either during or after the Waiting Period has finished). A Waiting Period protects all Insured Persons by ensuring that individuals are not able to make a large claim shortly after joining and then cancelling their cover. This would unfairly result in increased premiums for all Members and Policyholders;
- 4.39 **“We”** (that is wherever we say ‘us’, ‘our’ or ‘we’) means Guardrisk Insurance Company Limited (Reg. No. 1992/001639/06, FSP No. 75) who is the insurer of this policy;
- 4.40 **“You”** means the person (or persons), who has cover under this insurance policy, and it includes every person who qualifies as a Beneficiary for cover under this policy.

5 Who is covered

- 5.1 You may only apply for, or be granted cover under and continue to remain covered under this policy if you are and remain an active Member of a medical scheme (also known as a medical aid). The medical scheme that you are a Member of must be registered in the Republic of South Africa by the Registrar of Medical Schemes and in terms of the Medical Schemes Act No. 131 of 1998.
- 5.2 If you are not covered by a medical scheme at any time, you will not qualify for cover under this policy during that time. If this happens, it is your responsibility to let us know so that we can cancel your cover with us.
- 5.3 You will not be accepted for cover on this policy if you are younger than 18 years unless you are registered as the principal Member on a medical scheme.
- 5.4 If you cancel your cover with us or your cover lapses after the age of 65, you will be able to reinstate your cover with us, however the premium applicable to your cover, may be different to that which was available to you prior to the cancellation.
- 5.5 Any child, spouse or adult dependent that is eligible for cover under this policy and is registered as a dependent on your medical scheme can also be covered under this policy.
- 5.6 A child dependent can include your natural child, your stepchild, a child that you have legally adopted or a child for whom you are financially responsible. This child must be registered as an active dependent on your medical scheme or on your ex-spouse’s medical scheme in terms of a divorce decree, to qualify for cover under this policy.
- 5.7 Any child dependent that reaches the age of 21 years may remain covered as a dependent as long as the child is still registered as a dependent on your medical scheme and financially dependent on you due to being a full-time student, or mentally or physically disadvantaged. In this case, we reserve the right to request proof that this child is dependent on you.
- 5.8 Any child born into cover (in other words, the mother’s cover is active with us on the date that the child is born) is covered from the date of birth without any Waiting Periods.
- 5.9 A spouse can mean a person that you are married to in terms of South African law, a customary union, a religious union or that you have shared a home with as if you are a married couple for at least 6 months prior to being covered on the policy. Your spouse must be registered as an active dependent on your medical scheme to qualify for cover under this policy.
- 5.10 Only one spouse can be covered under this policy and this spouse must be on the same medical scheme as you. If you have more than one spouse registered as a dependent on your medical scheme, you must tell us in writing which spouse will be covered under this policy with us before your cover with us begins.
- 5.11 If you and your spouse are employed by the same employer and it is a condition of employment that you both apply for cover with us, we will issue the policy to the older of the two of you and the younger will be named as a dependent on the policy.
- 5.12 An adult dependent can only include your parent or parent-in-law.

- 5.13 If it is a compulsory condition of your employment that you are a Member of your employer's group policy with us and you have a parent or parent-in-law registered as a dependent on your medical scheme when your cover transfers to us, this adult dependent will also qualify for cover under this policy.
- 5.14 If you join cover as a Member of your employer's voluntary group policy or as an individual Policyholder and your parents that are under the age of 65 have been registered as dependents on your medical scheme for more than 12 months, they will also be eligible for cover under this policy.
- 5.15 If you join cover as a Member of your employer's voluntary group policy or as an individual Policyholder and your parents that are over the age of 65, have joined cover from another insurer and have been registered as dependents on your medical scheme for more than 12 months, they will be eligible for cover under this policy.
- 5.16 If any adult dependent does not meet the above eligibility requirements, they may not be covered as a dependent on your membership, but they can elect to purchase their own cover with us on an individual Policyholder basis.
- 5.17 When your child, your spouse or your adult dependent is no longer registered as an active dependent on your medical scheme, they will also no longer qualify for cover under this policy. Their cover will end at exactly the same time as their cover under your medical scheme ends.
- 5.18 If you die and your spouse or any other dependent remains an active Member of the medical scheme that you belonged to, your spouse or the dependent will have the option to continue cover under this policy by letting us know in writing within 60 days from the date of your death. To continue cover means that no new Waiting Periods will be applied to the cover when it is changed to your spouse's or dependent's name and the cover will apply from the date of your death. Your current dependents will also continue to remain covered.
- 5.19 If you are a Member of your employer's policy on the date of your death and your employer agrees to it, your spouse will continue to enjoy the same terms and conditions of cover as well as the group-rated premium that you enjoyed. If your employer does not agree to it, your spouse can still continue the same terms and conditions of cover on an individual policy with us, but the premium will change to the applicable individual policy premium.
- 5.20 You cannot be covered under more than one gap policy with us at the same time. If we discover that you have more than one policy with us we will cancel the last issued policies and refund you the premiums you have paid for the additional policies up to a maximum of 12 months of premiums.

6 Starting your cover

- 6.1 If it is a condition of your employment that you are a Member of your employer's group policy, your cover must begin on the date of your appointment with your employer.
- 6.2 If you have the choice to apply for cover with us through your employer's group policy and you apply within 90 days of your date of appointment with your employer the 3-month general Waiting Period will be waived and only the 9-month and 12-month Pre-existing Medical Condition Waiting Periods will apply (where applicable) to your and your dependents' cover.
- 6.3 If you have the choice to apply for cover with us through your employer's group policy and you apply more than 90 days after the date of your appointment with your employer, a 3-month general Waiting Period, the 9-month and the 12-month Pre-existing Medical Condition Waiting Periods will apply (where applicable) to your and your dependents' cover.
- 6.4 If for any reason, you join your employer's medical scheme more than 90 days after your date of appointment with your employer, you may also apply for cover with us on the same cover start date as your medical scheme. If this happens, you will need to give us proof of your medical scheme cover start date before we will give you cover.
- 6.5 We may also agree with your employer that we give you the opportunity to apply for cover at certain other times during the year and during this time we waive the 3-month general Waiting Period. This is called a "window" period and must be agreed between us and your employer. Window periods are usually granted for 1 month during the annual policy renewal. In most cases this date will be during January, unless we have agreed another date or period of time with your employer.
- 6.6 The granting of a window period is entirely at our discretion. The number of months for which a window period may be granted also remains entirely at our discretion and a previously granted window period does not guarantee that future window periods will also be granted.
- 6.7 If you join cover prior to the granting of a window period and you are subject to a Waiting Period, and thereafter we grant a window period to your employer, you will not be allowed to terminate your cover with us and re-apply for cover within the window period, with no Waiting Periods.

- 6.8 If you have retired from employment and you have continued your cover (as a pensioner) through the employer's policy with us, you will continue to enjoy the same benefits with us that you had while you were employed.
- 6.9 Unless your cover is a compulsory condition of employment with your employer, your cover will start on the first day of the month, following the date we receive your application. No backdating of cover will be accepted.

7 The premium

- 7.1 Your monthly premium is payable to us on the Due Date.
- 7.2 This policy will renew on the 1st of January each year (unless we have specifically agreed to another date) and at this time we will calculate a new premium and we may revise the policy terms and conditions. When we do this, we will give you, your employer or your Associated Group at least 30 days' notice of the new terms, conditions and premium payable.
- 7.3 If we do not receive your first premium on the first Due Date on which the premium is payable, your cover will not start and you will not be entitled to any benefits under this policy.
- 7.4 It is your responsibility to ensure that we receive your first premium or that your first premium is deducted and paid over to us.
- 7.5 It is also your responsibility to ensure that you continue to pay your premium for you to remain covered on this policy.
- 7.6 Where your employer or Associated Group pays your premiums to us on your behalf, with effect from the second month of cover:
- If we do not receive your premiums within 15 calendar days after the Due Date, we will let your employer know that your cover is in a grace period and that you have 30 calendar days from the Due Date in which to pay us your outstanding premium.
 - If we do not receive your outstanding premium by midnight on the 30th calendar day after your Due Date, we will cancel your cover and it will terminate with effect from midnight of the last day of the month for which we have received a premium.
- 7.7 If we collect your premium via a debit order deduction from your bank account:
- Your premium will be payable monthly on your agreed premium Due Date.
 - We will always try to collect your premium on the agreed premium collection date. If for any reason we are unable to collect your premium on this date – for example, due to your deduction date falling on a weekend or a public holiday – we will collect your premium as close as possible to this date. All bank charges are for your account.
 - It is your responsibility to ensure that there are available funds in your account on the date on which we submit your debit order.
 - If we are unable to collect your premium by the Due Date, we will try to double deduct your premium during the following monthly debit order run.
 - If we are once again unable to collect your outstanding premium, we will cancel your cover and your cover will terminate with effect from midnight on the day before your outstanding premium was due.
 - If you cancel the direct debit that pays your premium for this policy, your cover will automatically be cancelled from the date that your premium was due to be paid.
- 7.8 If your cover is in a grace period this means that you are a month behind your premium payments to us and if you submit a claim during this period, we will not process your claim until you have paid us the premium owed to us. Once you have paid us this outstanding premium, we will process your claim.
- 7.9 Your premium can only be paid to us in South African currency that is, South African Rands.
- 7.10 If we decide to change the benefits or premiums for our products, we will give you, your employer or your Associated Group 30 days' written notice.

8 General exclusions

We will not cover you, under any circumstances, for any Disease or Bodily Injury that is caused either directly or indirectly by, or is as a result of:

- 8.1 Your willful participation in war, invasion, terrorist activity, rebellion, active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers;
- 8.2 Nuclear weapons, nuclear material, ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the burning of nuclear fuel, including any self-sustaining process of nuclear fission (the splitting of an atomic nucleus into small parts);
- 8.3 Your taking of any legal drug unless it has been prescribed by a registered Medical Practitioner (other than you) and you are following the instructions of the Medical Practitioner in your taking of the drug. A legal drug is a substance that is used as a medicine and is registered in terms of the Medicines and Related Substances Control Act No. 101 of 1965;
- 8.4 Your taking of any illegal drug. An illegal drug is any chemical substance that affects a physical, mental, emotional or behavioral change in an individual and is listed in the South African Drugs and Drug Trafficking Act 140 of 1992;
- 8.5 Illegal behaviour or as a result of breaking any law of the Republic of South Africa;
- 8.6 Your suicide, attempted suicide, intentional self-injury or any form of exposure to danger;
- 8.7 Anxiety disorders (such as phobias, excessive compulsive disorders, etc.), mood disorders (such as depression, bipolar disorder, etc.), psychotic disorders (such as schizophrenia, delusions, etc.), dementias (such as Alzheimer's, substance-induced dementia, etc.) and eating disorders (such as anorexia nervosa, binge eating disorder, etc.);
- 8.8 Aviation except if you are on a commercial flight as a fare-paying passenger;
- 8.9 Participation in sports on a professional basis. Professional means that you are paid to participate in the sport;
- 8.10 Participation in hazardous (physically dangerous) sports or activity, including:
 - Hang-gliding
 - Kite-surfing
 - Mountaineering
 - Para-gliding
 - Scuba diving
 - Skiing
- 8.11 Participation in any form of race or speed test, other than on foot or involving any non-mechanically propelled vehicle, vessel, craft or aircraft.

9 Waiting Periods

A Waiting Period is a period of time during which you will have to pay your monthly premium, but no cover will be granted.

You or your dependents may have to serve a Waiting Period when your cover with us starts. Any Waiting Periods that apply to you or a dependent will be highlighted in the Certificate of Cover issued to you. In addition, any Waiting Periods that apply to your cover run concurrently. This means that they start together from your first day of cover. No cover will be granted during the Waiting Period and any claim event arising during the Waiting Period will not be covered.

No Waiting Period will apply to your cover if it is a condition of your employment that you be covered as a Member on your employer's group policy.

Failure to disclose Pre-existing Medical Conditions when you apply for cover may result in limited or excluded benefits.

9.1 3-Month General Waiting Period

9.1.1 A general Waiting Period of 3 months will apply to your cover if:

- you have voluntarily chosen to join as a Member of your employer's group policy and the policy has less than 35 employees covered with us; **OR**
- you have voluntarily chosen to join as a Member of your employer's group policy and the policy has more than 35 employees covered, but you are joining cover more than more than 90 days after your employment start date and outside of a window period; **OR**
- you are an individual Policyholder (not a Member of an employer group policy).

9.1.2 During the 3-month general Waiting Period we will **not** pay you for any claim event that takes place after your cover start date and before the end of the 3-month general Waiting Period.

9.2 12-Month Waiting Period for Cancer, Birth and Pregnancy

9.2.1 If on the first day of cover, you or any of your dependents:

- Have already been diagnosed with or received or been recommended for medical advice, care or Treatment for cancer of any type, **OR**
- Have given birth within 12 months before the first day of cover, **OR**
- are currently pregnant,

we will not cover any claims related to these events for the first 12 months after the cover starts.

9.2.2 This means that you or any of your dependents will not have cover for any claims related to these conditions for the first 12 months of your cover with us.

9.3 9-Month Waiting Period for Pre-existing Medical Conditions

9.3.1 If on the first day of cover, you or any of your dependents have any other Pre-existing Medical Condition(s) including a physical defect, Bodily Injury, Disease, Illness, Infirmary or health condition for which medical advice, diagnosis, care or Treatment was recommended or received within 12 months before the first day of cover and which would have caused a reasonable and prudent person to seek medical advice and/or Treatment, this physical defect, Bodily Injury, Disease, Illness, Infirmary or health condition will be excluded for 9 months after cover starts.

9.3.2 This exclusion applies whether you actually received any Treatment or not and/or whether you have actually been diagnosed with the condition or not.

9.3.3 Examples of Pre-existing Medical Conditions which will be subject to this 9-month Waiting Period are provided below, but do not represent all Pre-existing Medical Conditions which may be subject to this Waiting Period:

- Any bone or joint condition including ongoing back, shoulder, hip or knee problems, arthritis, rheumatism, fibromyalgia or any other musculoskeletal (back, bone and muscle) condition;
- High blood pressure, high cholesterol or lipids, ischaemic or coronary heart Disease, chest pains, irregular heartbeat, heart murmur, heart failure, myocardial infarction, angina, peripheral vascular Disease, valve lesions or any other heart-related medical condition;
- Ovarian cysts, hormone replacement therapy, endometriosis, abnormal pap smears or menstrual bleeding, uterine fibroids or prolapse;
- Stroke, spinal cord injury or any other brain, spinal or nerve condition;
- Gastric ulcers, hernias, poor digestion, gallstones, spastic colon, GORD (heartburn), inflammatory bowel Disease, intestinal polyps or any other abdominal condition;
- Cataracts, glaucoma, squint, blurry vision, blindness (partial or full), retinal detachment or any other disorder of the eye;

- Any condition of the ear, nose or throat, irrespective of whether it is congenital or developed later, including hearing problems, sinus or nasal problems, cochlear implants, tonsillitis or adenoiditis;
- Any condition of the mouth, teeth or gums including maxillo-facial Treatment or specialised dentistry;
- Diabetes, thyroid Disease (including hypo or hyperthyroidism), osteoporosis or any other metabolic-related condition;
- Cirrhosis, liver Disease or failure, cystic fibrosis or any other liver-related condition;
- Kidney and/or renal failure, kidney stones, recurrent urinary or bladder infections, dialysis, polycystic kidney Disease or any other renal or urinary condition;
- Any blood condition or Disease including deep vein thrombosis, anaemia, ITP (platelet deficiency), leukaemia, lymphoma, haemophilia and any other bleeding disorders;
- Any condition of the prostate including undescended tests or urinary incontinence;
- Any other medical condition not listed above that you or your dependent may know of, that may require Treatment or surgery within 12 months of the cover start date.

9.4 Replacement of gap cover

9.4.1 If you already have a gap cover policy through another insurer or you are covered as a dependent on another gap policy and you decide to replace that policy with ours, we will waive the Waiting Period that would apply to new Policyholders or Members, on the condition that:

- there is no break in cover of more than 90 calendar days between the cover termination date of your cover with the other insurer and your cover start date with us. If there is a break of more than 90 days, you will be subject to the normal Waiting Periods that apply to new Policyholders or Members;
- you were covered on the other insurer's policy for more than 12 months – if you were covered for less than 12 months, you will carry the remainder of any Waiting Period over to your new cover with us;
- You are continuing cover on the same (or a similar) level of cover that you had with the other insurer; and
- You provide us with written confirmation of your cover period from the other insurer.

9.4.2 The above will also apply separately to each dependent named on your cover with us.

10 Changes, cancelling or continuing your cover

- 10.1 We may make changes to your cover by giving you 30 days' written notice.
- 10.2 You may cancel your cover with us at any time by giving us 30 calendar days' written notice.
- 10.3 Your cover and all benefits under this policy will be cancelled at 23h59 on the last day of cover following your 30 calendar days' written notice to us.
- 10.4 We will only pay you benefits that are payable in terms of the conditions and limitations of the policy.
- 10.5 We will also only cover you for events that have happened on or after your cover start date and before midnight on the date on which your cover is cancelled.
- 10.6 For any event to be covered, it must happen after any Waiting Period that applies to your cover.
- 10.7 There is no cash value to this policy if it is cancelled.
- 10.8 We will only refund the premiums you paid for this cover if you paid your premiums annually in advance and you have not claimed against the policy at any time. If this is the case, we will refund you the portion of the premiums that apply to the months after the date of cancellation of your cover with us.
- 10.9 If you change your mind about taking up the cover, you may let us know in writing within 30 days of the start date of the cover and we will cancel the cover and refund you your first (and only) premium paid.

- 10.10 If after cancelling your cover with us, you decide to continue with this cover, we will apply the Waiting Periods again from the date on which your new cover starts.
- 10.11 If you are a Member of your employer's group policy, when you resign from employment, your cover with us will also terminate. You may however, choose to continue your cover with us by applying in writing for continuation of your cover with us. We will ask you to complete a continuation form and return it to us within 90 calendar days of your last day of employment with your employer.
- 10.12 When we receive this continuation form we will transfer your cover to an individual policy and we will communicate the terms and conditions of this transfer. Any underwriting exceptions (for example waiving of certain Waiting Periods on your cover) that you may have benefited from through your employer will fall away and your premium with us will be adjusted from group-rated to non-group rated from the date of your transfer to private capacity. If your employer paid your premiums in arrears, once your policy is transferred, you will be required to pay your premiums in advance.
- 10.13 If you are a Member of your employer's policy and when you retire you want to continue your cover with us, you may do so by having your employer apply in writing for continuation of your cover with us. If this happens we will continue your cover on the same terms, conditions and premium that you had with us while you were still employed. If this does not happen, you may still continue your cover with us, but your premium will be adjusted from group-rated to non-group-rated from the date of your transfer to private capacity.
- 10.14 You must let us know whenever your personal details change.

11 Changing your cover option

- 11.1 If you are a Member of your employer's policy and your employer allows you to choose between the options, you may downgrade from Supreme Gap to Primary Gap at any time of the year, by letting us know in writing at least one calendar month before the date of change. If you do this, we will change your cover option with us at the end of the month in which you let us know, and not apply any new Waiting Periods to your new benefits. The new premium will be applicable from the date on which your new benefits begin. If you still have Waiting Periods applied to your cover when you choose to downgrade, the balance of these Waiting Periods will be applied to your new cover option.
- 11.2 You may only upgrade from Primary Gap to Supreme Gap once per year, on your renewal date.

12 How to claim

When you want to claim under the policy, you **must do the following or else we may not pay your claim:**

- 12.1 Tell us as soon as possible about your claim or at least within **180 days** from the date of:
- 12.1.1 Admission into Hospital – for co-payment claims;
 - 12.1.2 The Procedure – for shortfall (including internal prosthesis) and trauma counselling claims;
 - 12.1.3 Diagnosis – for lump sum cancer, baby bump, oncology co-payment and oncology extender claims; or
 - 12.1.4 Bodily Injury – for casualty, premium waiver, Accidental death, Accidental Disability and Violent Crime claims.
- 12.2 Complete all of the relevant sections of the claim form accurately, completely and truthfully so that we can quickly and easily process your claim. If we do not receive all of the required information and documentation from you, this may cause delays in the processing of your claim.
- 12.3 Submit your claim:
- Online at www.admedonline.co.za;
 - By emailing us at admed@guardrisk.co.za;
 - Via post to Admed Claims, PO Box 786015, Sandton, 2146; or
 - By facsimile to 011 263 1419.
- 12.4 Please ensure that your claim is submitted with all of the required documentation.
- 12.5 Once we have received your claim, we register it and provide you with a claim reference number. We will also keep you updated as to progress with your claim including once your claim has been captured, assessed and finalised.

- 12.6 We reserve the right to request personal medical information from your medical scheme or Medical Practitioner in order to assess the validity of any claim submitted by you.
- 12.7 We also reserve the right to request personal medical information from your medical scheme or Medical Practitioner should a claim in any Pre-existing Medical Condition Waiting Period or not in a Pre-existing medical Condition Waiting Period but submitted within the first 12 months of cover, indicate and/or relate to a possible Pre-existing Medical Condition.
- 12.8 In the event that further investigation is required in respect of any Prescribed Minimum Benefit or potential pre-existing medical condition claim, we reserve the right to extend the time in which we will process and finalise your claim, in order that we are able to fully complete the necessary investigation before such finalization. We will however, keep you updated as to progress of the investigation.
- 12.9 Under no circumstances will we confirm whether we will cover a specific Procedure, nor will we confirm the value of a benefit that we will pay before you have undergone Treatment or a Procedure. This is because the amount that we will pay can only be calculated once your Treatment or Procedure has been undertaken, you have received all of the necessary documentation from your medical scheme and Medical Practitioners, you have submitted this documentation to us with your claim form and your actual shortfall can be calculated.
- 12.10 We may have contracted with your medical scheme to facilitate a seamless gap claim process between the scheme and ourselves. If we have done this, your medical scheme will contact you to obtain your written consent before they share your or your dependents' confidential medical information with us. If you provide this consent we will engage directly with your medical scheme to process your claim.
- 12.11 We reserve the right to negotiate on your behalf and through an appointed Claims Negotiator, with your medical scheme in respect of any Prescribed Minimum Benefit claim that you submit to us.
- 12.12 We also reserve the right to negotiate on your behalf and through an appointed Claims Negotiator, for a discounted rate with the relevant Medical Practitioner to ensure you maintain a favourable risk profile. If successful, this discount will be applied to your claim and payment will be made directly to the respective Medical Practitioner's bank account.
- 12.13 Claimed amounts that are not paid directly to a Medical Practitioner will be paid to you (the Member), directly into a bank account in your name, and always in South African Rand.
- 12.14 We will pay your claim into the bank account that you nominate on the claim form. It is your responsibility to ensure that these are the correct banking details and we will not be held liable for the payment of any claim to an incorrect bank account, if that account is the one which has been nominated on the claim form.
- 12.15 You must provide us, at your own expense, with any information and assistance as we may reasonably require about any claim.
- 12.16 We will only process your claim after your Treatment or Procedure has been undertaken and if you were admitted into Hospital, once you have been discharged from Hospital.
- 12.17 Medical Practitioner quotations prior to a claim event will not be accepted by us as evidence of the charged amount at claim stage.
- 12.18 Even if you have already made a claim and there is information outstanding from you which is needed to finalise the claim, your claim is no longer valid after 12 months from the date of the event which caused your claim, unless it is part of a pending court case.
- 12.19 The most that we will pay for any claim is the amount calculated as payable in terms of this policy. We will not pay any interest on claim amounts paid to you under this policy. We will also not be responsible for any costs relating to the posting or faxing of your claim, the querying of your claim or any delays in processing your claim due to us not timeously receiving the necessary documentation required to process your claim.
- 12.20 If after we have paid your claim, your medical scheme recalculates and reduces the amount that it will pay for the Treatment or Procedure that you have claimed the shortfall on, you may claim the additional shortfall from us within 90 days of the date of recalculation by your medical scheme. This additional claim amount will still be subject to the maximum amount that we will pay under the shortfall benefit.
- 12.21 If however, your medical scheme recalculates and increases the amount that it will pay for the Treatment or Procedure that you claimed the shortfall on and we have overpaid you the first time around, it is your responsibility to refund the overpayment to us within 90 days of the date of recalculation by your medical scheme. If you do not repay us the overpayment within this time, we may take legal action against you.

- 12.22 If we don't pay your claim and you disagree with our decision or if you are not happy with the amount we agree to pay for your claim under this policy, you can write to us about your complaint within 90 days of the date on which we notify you of our decision regarding your claim. After the 90 days, you have a further 180 days in which you can take legal action against us.
- 12.23 If during the processing of your claim it can be determined that your claim does not qualify in terms of the policy, we will reject your claim without requesting any additional documentation from you.
- 12.24 We reserve the right to refer claims for forensic review as part of our governance protocols or in the event that any claim is determined by us to be suspicious or potentially fraudulent in nature.

13 How to Complain

We aim to resolve most of our Complaints within 15 working days of receipt, unless the complexity of a Complaint requires longer than this, in which case we will regularly keep you updated as to progress of your Complaint until it has been resolved.

- 13.1 If you need to submit a Complaint, you can contact us online at www.admedonline.co.za/complaints, at admedcomplaints@guardrisk.co.za or telephonically at 0860 333 350.
- 13.2 If you are not satisfied with the outcome of your Complaint, you can contact the Guardrisk Short Term Insurance arbitrator, Buyisiwe Hlatshwayo on buyisiwe.hlatshwayo@guardrisk.co.za.
- 13.3 If you are still dissatisfied with the outcome of your Complaint, you can contact the relevant Ombud, details of which are provided in the FAIS Disclosure provided to you at commencement of your cover and on renewal each year.

Section A: Medical Expense Shortfall Benefits

(Under this section, a maximum of R165 000 can be paid per Insured Person per policy year)

14 Benefit for shortfalls in Medical Practitioner costs (SUPREME GAP AND PRIMARY GAP)

14.1 In-Hospital Procedures

- 14.1.1 If, after the expiry of any Waiting Period applied to your cover, you are admitted into Hospital for a Procedure to Treat a Disease, an Illness or a Bodily Injury and this Procedure is performed by a registered Medical Practitioner while you are in Hospital, we will cover you for the shortfall between what the Medical Practitioner has charged you and what your medical scheme has paid for the Procedure.
- 14.1.2 The maximum amount that we will pay towards this shortfall is calculated as 3 times (or 300% of) the amount paid by your medical scheme, up to the value of the actual shortfall.
- 14.1.3 The amount that we will pay is calculated as follows, according to your medical scheme Plan Option:

Scheme covers	We cover	Total cover
100%	300% (3 x 100%)	400%
200%	600% (3 x 200%)	800%
300%	900% (3 x 300%)	1,200%

- 14.1.4 In most instances the Medical Practitioner will separate the primary Procedure that they have performed into a number of smaller Procedures on the account that they issue for payment. This is because they are required to detail every "sub-Procedure" undertaken during your primary Procedure for medical scheme billing purposes. If the Medical Practitioner does this, we will also separate the shortfall for each sub-Procedure in our calculation of the amount owing to you.
- 14.1.5 This means that we may pay the full shortfall on some sub-Procedures, a portion of the shortfall on other sub-Procedures (for example where a sub-limit has been reached) or no portion of the shortfall on certain sub-Procedures (for example, where your medical scheme has not paid the first portion of a specific sub-Procedure or if the sub-Procedure charge relates to a specific Admed policy exclusion).
- 14.1.6 Where the Medical Practitioner has applied a Modifier to your Treatment or Procedure, we will calculate the shortfall payable on the Modifier in accordance with your medical scheme's rules.
- 14.1.7 Once we have finished processing your claim we will provide you with detail regarding how we have calculated the amount that we will pay you for each sub-Procedure.
- 14.1.8 It is important for you to be aware that under this benefit we will only cover you for any shortfall if the Procedure took place while you were admitted to and staying in, Hospital and that your medical scheme has provided you with a Pre-Authorisation Letter for the admission.

14.2 Out-of-Hospital Procedures

- 14.2.1 If, after the expiry of any Waiting Period applied to your cover, you undergo a Procedure to Treat a Disease or a Bodily Injury and this Procedure is listed below and is performed by a Medical Practitioner outside of a Hospital (in other words, on an outpatient basis in a registered Day Clinic), we will cover you for the shortfall between what the Medical Practitioner has charged you and what your medical scheme has paid for the Procedure.
- 14.2.2 Once again the maximum amount that we will pay towards this shortfall is calculated as 3x (or 300% of) the amount paid by your medical scheme, up to the value of the actual shortfall.
- 14.2.3 The amount that we will pay is calculated as follows, according to your medical scheme Plan Option:

Scheme covers	We cover	Total cover
100%	300% (3 x 100%)	400%
200%	600% (3 x 200%)	800%
300%	900% (3 x 300%)	1,200%

14.2.4 In addition, if the Medical Practitioner separates the primary Procedure that they have performed into a number of smaller Procedures on the account that they issue for payment, we will also separate the shortfall for each sub-Procedure in our calculation of the amount owing to you.

14.2.5 We have listed below, all of the Procedures that we will cover you for, on an out-of-Hospital (outpatient) basis. If the Procedure that you are going for is not included in this list, we do not cover it:

Cardiovascular	Coronary angioplasty
	Coronary angiogram
Ear, nose, throat	Adenoidectomy
	Direct laryngoscopy
	Grommets
	Myringotomy
	Sinus surgery, limited to: <ul style="list-style-type: none"> - Frontal sinus - Functional endoscopic sinus surgery - Bilateral function endoscopic sinus surgery
	Tonsillectomy
General surgery	Closure of colostomy
	Hernia repairs, limited to: <ul style="list-style-type: none"> - Inguinal hernia - Femoral hernia - Umbilical hernia - Epigastric hernia - Spigelian hernia
	Lymph node biopsy
	Needle biopsy of the liver
	Surgical biopsy of breast lump
Gastro-intestinal	Closure of colostomy
	Colonoscopy
	Endoscopy
	Gastrosocopy
	Ischio-rectal abscess drainage
	Laparoscopy
	Oesophagoscopy
	Surgical haemorrhoidectomy (excluding sclerotherapy or band ligation)
Gynaecology	Cervical laser ablation
	Dilatation and curettage
	Hysteroscopy
	Incision and drainage of Bartholin's cyst
	Marsupialisation of Bartholin's cyst

	Laparoscopy
	Tubal ligation
Obstetrics	Childbirth in a non-Hospital setting
Oncology	Chemotherapy
	Radiotherapy
Ophthalmology	Cataract removal
	Laser eye surgery
	Pterygium removal
	Trabeculectomy
Orthopaedic	Arthroscopy
	Bunionectomy
	Carpal tunnel release
	Ganglion surgery
Radiology	Computer Axial Tomography (CAT) scan
	Magnetic Resonance Imaging (MRI) scan
	Nuclear radiology
	Positron Emission Tomography (PET) scan
	Varicose vein removal
Renal	Kidney dialysis
Respiratory	Bronchoscopy
Urology	Circumcision (due to medical necessity)
	Cystoscopy
	Orchidopexy
	Prostate biopsy
	Vasectomy

14.3 Specific conditions

14.3.1 We will only cover you for any shortfall if the following applies to your claim:

- The medical scheme Plan Option that you have selected includes cover under your Major Medical Benefit for the Procedure that you are claiming for; **and**
- Your medical scheme pays the first portion of each Service Code on the claim from your Major Medical Benefit; **and**
- You are paying for any shortfall from your Medical Savings Account OR in cash; **and**
- Your cover starts with us and the relevant Waiting Period has expired before the date of admission into Hospital during which the Procedure giving rise to your claim occurs.

14.4 Specific exclusions

14.4.1 We will not pay your claim under this benefit if the medical scheme Plan Option that you have selected does not include cover under your Major Medical Benefit for the Procedure that you are claiming for;

14.4.2 We will not pay your claim under this benefit if the medical scheme Plan Option that you have selected excludes this Procedure or if for any reason (other than the depletion of your Major Medical Benefit) your medical scheme does not pay the first portion of your claim from your Major Medical Benefit;

14.4.3 We will not pay your claim under this benefit if the Procedure or Treatment is not undertaken in a registered Hospital or Day Clinic as defined in the policy;

14.4.4 We will also not cover you for costs for any of the following:

- Hospital and Day Clinic fees including theatre charges, ward charges or any other Hospital or Day Clinic costs (not related to a levied co-payment or an internal prosthesis);
- Pre-admission consultation costs charged by a Medical Practitioner including consultations or Emergency Treatment that takes place in the Medical Practitioner's consulting rooms, irrespective of whether they are located on the Hospital premises or not;
- Out-of-Hospital consultation costs charged by a Medical Practitioner, unless these costs apply to one of the covered out-of-Hospital Procedures listed above and the consultation takes place on the same day as the covered out-of-Hospital Procedure;
- Materials or medication used during your stay in Hospital, at a Day Clinic or during your Procedure (whether it is in-Hospital or out-of-Hospital);
- Any External Prosthesis or Dental Implants;
- Any appliances including, but not limited to, wheelchairs, crutches, braces, beds, prescription glasses, hearing aids and any type of equipment used during the recovery of an Illness or Procedure;
- Out-of-Hospital dental Procedures;
- Home and private nursing;
- Procedures for cosmetic purposes including cosmetic Procedures that form a small part of a major non-cosmetic Procedure (unless the cosmetic Procedure is necessary because of an Illness or a Bodily Injury);
- Exploratory Procedures to determine diagnosis of a medical condition including laboratory / blood tests, pathology tests in-and-out of Hospital, x-rays in-and-out of Hospital, pap smears, electrocardiograms (ECG's) ultrasounds, etc;
- Procedures that are paid for by your medical scheme on an exception or *ex-gratia* basis, including any form of co-insurance arrangement agreed to between you and your medical scheme;
- Elective Procedures that are performed for religious or cultural reasons and not due to medical necessity (for example, ritual circumcision);
- Procedures performed specifically for the Treatment of Obesity as well as any costs levied by the Medical Practitioner as a direct result of the patient's Body Mass Index (BMI) or bodily weight (irrespective of whether or not the first portion of the cost is covered by the medical scheme);
- Hospice or step-down facilities including any other institutions that are not considered a Hospital as defined in this policy;
- Medical / physical examinations performed annually or routinely, or for purposes of insurance policy underwriting including laboratory / blood tests, pathology tests in-and-out of Hospital, x-rays in-and-out of Hospital, electrocardiograms (ECG's), pap smears, annual check-ups, ultrasounds etc.;
- Procedures performed with the use of robotic machinery where any shortfall being claimed is directly related to the use of such robotic machinery by a Medical Practitioner and it has been charged for by a Hospital;
- Transportation costs (including resuscitation) in an Emergency vehicle or aircraft and Emergency medical service costs;
- Any other cost charged for by auxiliary or para medical services, including but not limited to physiotherapy, speech therapy, audiology, chiropractic Treatment, podiatry and similar therapeutical services.

15 Benefit for co-payments levied by your medical scheme (SUPREME GAP AND PRIMARY GAP)

Co-payments are commonly applied to radiology scans (MRI, CAT, PET) and specialist referral Procedures. If your medical scheme levies a co-payment for an in-Hospital or out-of-Hospital Procedure which you need to pay upfront and out of your own pocket or from your Medical Savings Account, we will cover this co-payment and refund you.

15.1 Specific conditions

- 15.1.1 We will only cover co-payments that are levied by your medical scheme, not co-payments that are levied by a Medical Practitioner, a Hospital or a Day Clinic.
- 15.1.2 We will cover co-payments that have been paid by you in cash or from your Medical Savings Account when using a designated (also called a network or associated) service provider (DSP) for the Procedure. While details of designated (network or associated) service providers and non-designated (non-network or non-associated) service providers are available from your medical scheme, for purposes of this policy a DSP is defined as a healthcare provider that has been selected and communicated by your medical scheme as one of their preferred providers.
- 15.1.3 The value of any co-payment that is claimed must be clearly indicated on your medical scheme statement OR it must be reflected on your Pre-Authorisation Letter OR it must be publicly available on your medical scheme's Plan Option brochure for the year. In the event that the value of the co-payment reflected on the medical scheme statement does not match the Pre-Authorisation Letter or the medical scheme's Plan Option brochure, the value reflected on the Pre-Authorisation Letter will be used in the calculation of your claim.

15.2 Specific exclusions

We will not cover the following types of co-payments:

- 15.2.1 Co-payments that are imposed for the use of a non-Designated medical facility;
- 15.2.2 Co-payments that are levied by a Medical Practitioner, a Hospital or a Day Clinic;
- 15.2.3 Co-payments that are imposed due to you not having adhered to your medical scheme's Procedure protocols. This includes (but is not limited to) co-payments imposed by your medical scheme for not being referred to a specialist Medical Practitioner by your regular Medical Practitioner and co-payments applied for not obtaining a Pre-Authorisation Letter from your medical scheme prior to a medical Procedure or Treatment;
- 15.2.4 Co-payments for costs only related to your Hospital stay. This means that if a co-payment has been levied against you because you elected a private ward or any other special request not ordinarily covered by your medical scheme under your selected medical scheme Plan Option we will not cover this co-payment;
- 15.2.5 Co-payments that relate to a condition or a Procedure for which you are in a Waiting Period at the date of admission or on the date of the Procedure, whichever is applicable.

16 Benefit for co-payments levied by your medical scheme on oncology Treatment programmes (SUPREME GAP ONLY)

If you have been diagnosed with cancer you will be required by your medical scheme to register for oncology benefits through an oncology programme with them and the cost for your cancer Treatment will be subject to a "one-year" treatment cycle annual limit, commencing from the date of your diagnosis. Once you have reached this limit, your medical scheme will levy a 20% co-payment on all cancer Treatment costs for the remainder of that treatment cycle year.

We will cover this 20% co-payment for all persons covered on the policy.

16.1 Specific conditions

- 16.1.1 You will only be eligible for this benefit if you are registered on your medical scheme's oncology Treatment programme and if your medical scheme pays the remainder of the cost of each Treatment.
- 16.1.2 The maximum amount that we will pay towards this co-payment will be dependent on the amount available from your Plan Option's annual benefit cap of R165 000 for the policy year. This means that your treatment cycle and your annual benefit limit of R165 000 will not run concurrently, as your "one-year" treatment cycle will run from your diagnosis date, but your annual benefit limit will run from your cover start date to cover termination date for each policy year.

16.2 Specific exclusions

We will not pay your oncology co-payment claim under the following circumstances:

- 16.2.1 If no co-payment is applied by your medical scheme (in other words, if your medical scheme pays the costs in full or if once your benefit limit is reached your medical scheme will pay for no further Treatment) you will have no claim under this section of the policy. You may however, have a claim under the Oncology Extender Benefit detailed below;
- 16.2.2 Co-payments that are applied by your medical scheme prior to you reaching your medical scheme oncology Treatment benefit limit (in other words, sub-limits applied within your Treatment benefit limit);
- 16.2.3 Co-payments that are applied by your medical scheme if you have chosen to undergo your Treatment with a non-designated service provider.

17 **Oncology extender benefit (SUPREME GAP ONLY)**

If you have been diagnosed as having cancer you will be required by your medical scheme to register for oncology benefits through an oncology programme with them and the cost for your cancer Treatment will be subject to a "one-year" treatment cycle annual limit, commencing from the date of your diagnosis. If once you have reached this limit, and your medical scheme offers no further cover for cancer Treatment costs for the remainder of that treatment cycle year, we will pay the first 20% of your Treatment costs for the remainder of that treatment cycle year.

17.1 Specific conditions

- 17.1.1 You will only be eligible for this benefit if you are registered on your medical scheme's oncology Treatment programme.
- 17.1.2 You will only be eligible for this benefit if you have paid the remainder of the cost of each Treatment.
- 17.1.3 The maximum amount that we will pay towards this benefit will be dependent on the amount available from your annual benefit cap of R165 000 for the policy year. This means that your treatment cycle and your annual benefit limit of R165 000 will not run concurrently, as your "one-year" treatment cycle will run from your diagnosis date, but your annual benefit limit will run from your cover start date to cover termination date for each policy year.

17.2 Specific exclusions

We will not pay your oncology extender claim under the following circumstances

- 17.2.1 If co-payments are applied by your medical scheme once your benefit limit is reached or if your medical scheme pays the costs in full, you will have no claim under this section of the policy. You may however, have a claim under the benefit for oncology co-payments levied by your medical scheme detailed above;
- 17.2.2 We will not cover any Treatment cost until you have reached your medical scheme oncology Treatment benefit limit;
- 17.2.3 We will not cover any Treatment cost if you have not paid the remainder of the cost of each Treatment;
- 17.2.4 We will also not cover any Treatment costs if you have chosen to undergo your Treatment with a non-designated service provider.

18 **Benefit for shortfalls in internal prosthesis costs (SUPREME GAP ONLY)**

If you have an internal prosthesis fitted, your medical scheme may pay the full cost of the prosthesis or it may pay up to a fixed limit. If your medical scheme pays up to a fixed limit and there is a shortfall between the cost of the prosthesis and the fixed limit, we will cover this shortfall up to a maximum amount of R30 000 per family per year.

18.1 Specific conditions

- 18.1.1 An internal prosthesis is a device that is placed inside a body during a Procedure with the specific purpose of permanently replacing a body part. In other words, a body part is removed and permanently replaced with a prosthesis during surgery. Examples include joint replacements and spinal fusions.

18.2 Specific exclusions

We will not cover the following under this benefit:

- 18.2.1 Devices that are placed inside a body to assist with the functioning of a body part (for example, a pacemaker, stents, etc.) are specifically excluded from cover;
- 18.2.2 Any External Prosthesis or Dental Implant;
- 18.2.3 We will also only cover you for any shortfall under this benefit if the medical scheme Plan Option that you have selected includes cover under your Major Medical Benefit for the internal prosthesis that you are claiming for. If your medical scheme Plan Option does not include cover for this, we will not provider cover for any shortfall either.

19 Accidental and Emergency Casualty Benefit (SUPREME GAP ONLY)

If you or a dependent need to visit the Emergency casualty ward at a Hospital due to an Emergency which is as a result of an Accident which has caused Bodily Injury, we will pay up to R10 000 of the costs paid by you and which you cannot claim back from your medical scheme.

19.1 Specific conditions

- 19.1.1 This benefit is payable for up to three (3) casualty visits per family per year. Any benefit not paid during the first three (3) claim events will not carry over to any further casualty visits in the same or following policy year.
- 19.1.2 Eligibility to claim for this benefit is subject to verification that the event was an Emergency and due to an Accident (meaning a sudden, unexpected, violent and visible external event, which is inflicted on you by something other than yourself at an identifiable time and place and that independently of any other cause, directly results in Bodily Injury).
- 19.1.3 One (1) of these casualty ward visits may be due to an Emergency only, for a dependent that is five (5) years old or less on the date of the claim event. The benefit for this claim will be limited to R2 000 and it will accumulate to your three (3) claim events and R10 000 benefit limit per year.
- 19.1.4 Any portion of the total charges paid by your medical scheme will be deducted from the amount payable to you.

19.2 Specific Exclusions

We will not cover the following under this benefit:

- 19.2.1 Elective Procedures undertaken at a casualty ward;
- 19.2.2 Casualty ward visits due to Illness, unless it is due to an emergency and it is for a dependent that is 5 years or younger.

Section B: Lump Sum Benefits

20 Lump sum benefit for first time cancer diagnosis (SUPREME GAP ONLY)

If, while covered on this policy, you or any of your dependents covered on this policy, are diagnosed with minimum stage II, local and malignant cancer for the first time, we will pay you a once-off lump sum benefit of R5 000.

If however, you are diagnosed with minimum stage II, regional and malignant cancer (including leukemia and Hodgkin's Disease) for the first time, we will pay you a once-off lump sum benefit of R15 000.

In addition, if you are successful in claiming the R15 000 benefit and the extent of treatment that you need results in your medical scheme paying R200 000 or more for your oncology treatment within your first one-year treatment cycle, we will pay you a further R10 000.

20.1 Specific conditions

20.1.1 This benefit is payable once in a lifetime per person covered on the policy.

20.1.2 You will be eligible for the R5 000 benefit if:

- you are diagnosed as having at least stage II, local AND malignant cancer (categorized by the uncontrolled growth and spread of malignant cells, and the invasion of the normal surrounding tissue) by a Medical Practitioner while you are covered under this policy; and
- this is your first-time diagnosis of any cancer during your lifetime; and
- this diagnosis of cancer can be proven with clinical, histological, radiological and laboratory evidence; and
- you are registered on your medical scheme's oncology Treatment programme.

20.1.3 You will be eligible for the R15 000 benefit if:

- you are diagnosed by a Medical Practitioner, while you are covered under this policy, as having at least stage II malignancy that is regional (malignancy is no longer local) as it has spread beyond the original or primary tumour and it is categorized by the invasion of the normal surrounding tissue due to uncontrolled growth and spread of malignant cells,, and
- this is your first-time diagnosis of any cancer during your lifetime; and
- this diagnosis of cancer can be proven with clinical, histological, radiological and laboratory evidence; and
- you are registered on your medical scheme's oncology Treatment programme.

20.1.4 You become eligible for the second R10 000 of this benefit if:

- you successfully claim the above R15 000 lump sum benefit; and
- your Treatment costs paid by your medical scheme in the first one-year treatment cycle exceed R200 000.

20.1.5 Eligibility for payment of both amounts must occur in the same one-year treatment cycle and not across 2 treatment cycles.

20.2 Specific exclusions

We will not pay your claim for:

20.2.1 Any cancer diagnosis that does not meet the minimum eligibility criteria;

20.2.2 Any cancer diagnosis that is not a first time diagnosis;

20.2.3 All skin cancers and all cancers diagnosed and Treated by primary biopsy only, where it does not require any further surgical, medical or radiotherapy Treatment.

21 Lump sum benefit for Accidental death or Accidental Permanent and Total Disability (SUPREME GAP ONLY)

If you or a dependent dies or become permanently and totally disabled as a result of an Accident while you are covered under this policy, we will pay your estate (on death) or you, a fixed amount of R50 000.

21.1 Specific conditions

- 21.1.1 The death or Disability must be as a direct result of an Accident, meaning “a sudden, unexpected, violent and visible external event, which is inflicted on you by something other than yourself at an identifiable time and place and that independently of any other cause, directly results in Bodily Injury”.
- 21.1.2 We reserve the right to request medical evidence that the death or Disability is as a result of an Accident before we process the claim.
- 21.1.3 Permanent and Total Disablement means “being completely unable to perform any occupation whatsoever, unable to perform any normal daily living tasks (such as eating, dressing, bathing, walking, etc.) yourself and in the opinion of a Medical Practitioner, unlikely to ever recover from Disability.
- 21.1.4 Permanent and Total Disablement must be diagnosed by the Medical Practitioner within 4 months of the Accident.
- 21.1.5 This benefit can only be paid once per Insured Person in a lifetime. This means that an Insured Person cannot be paid a benefit for both Accidental Permanent and Total Disability and thereafter, receive a benefit for Accidental death.
- 21.1.6 Any Accidental death benefit payable to a minor child under the age of 6 years of age will be capped at R10 000 and to a minor child between 6 years and 13 years of age 9 (inclusive), will be capped at R30 000.

21.2 Specific exclusions

We will not pay your claim for:

- 21.2.1 Death or Disability that is not due to an Accident as defined in the policy.
- 21.2.2 Disability that does not meet the criteria of Permanent and Total Disability, as defined in the policy.

22 Violent Crime Benefit (SUPREME GAP ONLY)

If you or a dependent successfully claims the lump sum benefit for Accidental death or Accidental Permanent and Total Disability AND the claim event was due to a Violent Crime, we will double the amount that we pay to your estate (on death) or you for this benefit.

22.1 Specific conditions

- 22.1.1 The lump sum benefit for Accidental death or Accidental Permanent and Total Disability must have been successfully claimed in order for this benefit to become payable.
- 22.1.2 The claim event must have been as a result of a Violent Crime as defined in the policy.
- 22.1.3 A criminal case must have been opened by the South African Police Department and a case number must have been issued.
- 22.1.4 This benefit can only be paid once per Insured Person in a lifetime.
- 22.1.5 In the event of Accidental Death relating to a minor child, the benefit caps referred to in clause 21.1.6 will apply to this benefit.

22.2 Specific exclusions

We will not pay your claim for:

- 22.2.1 Accidental death or Accidental Permanent and Total Disability claims which have been rejected.
- 22.2.2 Death or Disability that is not due to a Violent Crime as defined in the policy.

23 Premium Waiver Benefit (SUPREME GAP ONLY)

If you or a dependent who pays the monthly premium due on this policy, dies or become Permanently and Totally Disabled as a result of an Accident while covered under this policy, we will assist your dependents in covering the cost of their monthly medical scheme contributions and gap cover premium by paying them the equivalent of R5 000 per month for 6 months. The full amount of R30 000 however, will be paid when processing the claim, and not in instalments over the 6-month period.

23.1 Specific conditions

- 23.1.1 This benefit is only payable upon the death or Disability of the premium payer, who must also be named as an Insured Person on this policy on the claim event date. This means that the premium must have been paid from the bank account or salary of the deceased or disabled Insured Person for whom the claim is being made.
- 23.1.2 The death or Disability must be as a direct result of an Accident, meaning “a sudden, unexpected, violent and visible external event, which is inflicted on you by something other than yourself at an identifiable time and place and that independently of any other cause, directly results in Bodily Injury”.
- 23.1.3 We reserve the right to request medical evidence that the death or Disability is as a result of an Accident before we process the claim.
- 23.1.4 Permanent and Total Disablement means “being completely unable to perform any occupation whatsoever, unable to perform any normal daily living tasks (such as eating, dressing, bathing, walking, etc.) yourself and in the opinion of a Medical Practitioner, unlikely to ever recover from Disability.
- 23.1.5 Permanent and Total Disablement must be diagnosed by the Medical Practitioner within 4 months of the Accident.
- 23.1.6 This benefit can only be paid once per Insured Person in a lifetime. This means that an Insured Person cannot be paid a benefit for both Accidental Permanent and Total Disability and thereafter, receive a benefit for Accidental death.

23.2 Specific exclusions

We will not pay your claim for:

- 23.2.1 Death or Disability that is not due to an Accident as defined in the policy.
- 23.2.2 Death or Disability of an Insured Person that is not the premium payer of the policy.
- 23.2.3 Disability that does not meet the criteria of Permanent and Total Disability, as defined in the policy.

24 Trauma Counselling Benefit (SUPREME GAP ONLY)

If you are subjected to, or a witness of, an act of violence or a traumatic event and you need to undergo trauma counselling, we will pay you a fixed amount for each counselling session that you attend.

24.1 Specific conditions

- 24.1.1 An act of violence includes events such as murder, assault, robbery, rape, kidnapping or hijack which is reported to the police and for which a case number has been obtained.
- 24.1.2 We will pay R750 per counselling session, up to R25 000 per family per year.

24.2 Specific exclusions

We will not pay your claim for:

- 24.2.1 Any cost of counselling that is not related to an act of violence or a traumatic Accident.
- 24.2.2 Any counselling not undertaken by a Counsellor as defined in the policy.

25 Baby Bump Benefit (SUPREME GAP ONLY)

If you are diagnosed as pregnant by your Medical Practitioner while covered on the policy, we will pay you a fixed amount of R2 000 to assist you with unexpected pregnancy costs.

25.1 Specific conditions

- 25.1.1 Diagnosis of pregnancy must be proven either through a quantitative (beta hCG) blood test OR you must have been registered on your medical scheme's maternity programme,
- 25.1.2 Where pregnancy is confirmed with the beta hCG blood test, the test must have been administered by a registered Medical Practitioner and pregnancy must be confirmed in writing by the Medical Practitioner.
- 25.1.3 In pregnancy involving twins, triplets or more, this benefit will be payable per fetus.
- 25.1.4 This benefit is payable for all Insured Persons named on the policy.

25.2 Specific exclusions

We will not pay your claim for:

- 25.2.1 Any pregnancy diagnosis which occurs before your cover with us begins.
- 25.2.2 Any pregnancy diagnosis which is not confirmed with the required blood test or evidence of registration on your medical scheme's maternity programme.