PLUS GAP COVER 2017

1. INTRODUCTION

This policy is underwritten by **Sirago Underwriting Managers (Pty) Ltd** under contract from the **Insurer** as indicated on your Schedule of Insurance.

This is a Short-term Insurance stated benefit policy regulated by the Financial Services Board under auspices of the Short-term Insurance Act 53 of 1998.

2. PRODUCT DESCRIPTION

This product is a Short-term Insurance stated benefit product that consists of the following components:

2.1. GAP COVER

2.1.1. This benefit covers the difference between your Medical Scheme Rate paid and private rates charged by a **Registered Medical Professional** for **in-hospital treatment**.
2.1.2. Gap Cover will settle up to a total of **500%** (five hundred percent) of your Medical Scheme Rate.
2.1.3. This stated benefit will be added to the scheme tariff paid by your Medical Scheme, but will not exceed a total of **600%** (six hundred percent) of the Medical Scheme Rate.

2.2. COPAY & ADMISSION AND PENALTY FEE COVER

2.2.1. This benefit will cover a fixed amount **Co-payments** (Oncology benefits are catered for in a separate benefit category) and **Admission fees** imposed in terms of your Medical Scheme rules.
2.2.2. **Co-payments** are the excesses payable for specified procedures or tests and **Admission Fees** are the amounts payable before you are admitted to a treatment facility, regardless of what you are admitted for.
2.2.3. Your **Co-payment cover is unlimited.**
2.2.4. Your **Admission and Penalty Fees** will be covered, up to a maximum amount of **R5, 000.00** (five thousand rand) per insured per incident.

2.3. OUT-PATIENT AND EMERGENCY ROOM COVER

2.3.1. This benefit will cover your **Gap Cover** component (as defined above) for any **Out-Patient Surgical Procedure** that would normally be performed on an **In-Patient** basis.
2.3.2. This policy also covers any In Room procedures where the insured elects to use these facilities as an alternative to Acute Hospitals
2.3.3. Your **Out-Patient** surgery will be covered, up to a maximum amount of **R3, 500.00** (three thousand five hundred rand) per insured per incident. A maximum of **3** (three) claims per insured person will be payable per annum.
2.3.4. An overall annual limit of **R10, 000.00** (ten thousand rand) per policy applies to this benefit.
2.3.5. In addition, this benefit covers **Emergency Treatment** when you visit the emergency room in a medical emergency as a result of an accident or trauma incident only.
2.3.6. An overall annual limit of **R4, 500.00** (four thousand five hundred rand) per policy applies to this section for accident and trauma cover only.

2.4. PMB COVER

2.4.1. This benefit will cover your **Gap**, **CoPay** and **Admission Fee** components for the use of a non- **Designated Service Provider** for **Prescribed Minimum Benefit treatment.**
2.4.2. Cover is not available for emergency or involuntary **PMB treatment** as this is regulated by the Medical Schemes Act 131 of 1998 and must be paid in full by the Medical Scheme

2.5. CANCER COVER

2.5.1. This benefit will pay you a lump sum of **R5, 000.00** (five thousand rand) upon the **initial diagnosis** of **Cancer** as defined in paragraph 26.8)**.**
2.5.2. An overall annual limit of **R200, 000.00** (two hundred thousand rand) per policy applies to this section of cover.
2.5.3. Cancer Cover incorporates Co-payment cover, benefit for Co-payment and biological drugs as per formulary and is limited to R200 000 (two hundred thousand rand) per annum for the following oncology treatments with a sublimit of R40, 000 (forty thousand rand) for cancer cover co-payments.
2.5.4. Treatment for any cancers which have been previously diagnosed have to be in remission for a minimum of **5** (five) years either prior to the policy inception or during cover.
2.5.5. This Product Option gives you a benefit that will cover your Oncology related **Co-payments** for treatment of **Cancer** once you have reached the Oncology limit your Medical Scheme prescribes.
2.5.6. The benefit payable is equal to the co-payment applied by your Medical Scheme in terms of your benefit entitlement.
2.5.7. Your Medical Scheme must require you to pay a **Co-payment** for this benefit to be accessed
2.5.8. The following medicines are available through the formulary: Herceptin, Mylotarg, Nexavar, Imavac, Sprycel, Faslodex, Velcade, Tarceva, Alimta, Zevalin, Avastin, Erbitux, Sutent, Fludara, Mabthera Bendamustine Sandostatin, Lanreotide related to:

2.5.8.1. Specific oncological condition and/or specific sub-groups of cancers limited to the sub-groups of the following Cancer Categories: HER 2 + Breast cancer, Acute myeloid leukemia, Advanced hepatocellular carcinoma, Acute lymphoblastic leukemia, Chronic myeloid leukemia, Chronic lymphocytic leukemia, Non-Hodgkins lymphoma, Advanced renal cell carcinoma, Hairy cell leukemia, Myelodysplasia, HER-ve breast cancer, Gastrointestinal stromal tumor, Multiple myeloma, Non-small cell lung cancer, Metastatic colorectal cancer and Head and neck cancer

2.6. SPECIALIST OUT-PATIENT CONSULTATION FEE

2.6.1. This benefit will cover your **Gap cover** component above scheme tariff for out-patient consultation fee with a **Medical Specialist**.
2.6.2. Your **Specialist Consultation Fee Gap** claim will be covered, up to a maximum amount of **R 750.00** (seven hundred and fifty rand) per insured per incident. A maximum of **3** (three) claims per insured person will be payable per annum.
2.6.3. An overall annual limit of **R3, 000.00** (three thousand rand) per policy applies to this section of cover.

2.7. HOSPITAL ACCOUNT SHORTFALLS

2.7.1. This benefit will cover your **Hospitalisation** Account Shortfall incurred when your Medical Scheme short-pays your hospital facility account.
2.7.2. Your Hospital Account Shortfall claim will be covered, up to a maximum amount of **R 500.00** (five hundred rand) per insured per incident. A maximum of **3** (three) claims per insured person will be payable per annum.
2.7.3. An overall annual limit of **R3, 000.00** (three thousand rand) per policy applies to this section of cover.

2.8. ADDITIONAL CARE COVER

2.8.1. This benefit will cover your **Gap Cover** component for any of the listed procedures/diagnoses or **treatment** outlined in paragraph 28.
2.8.2. Your Additional **Care Cover Gap** claim will be covered, up to a maximum amount of **R1,000.00** (one thousand rand) per insured per **incident**.
2.8.3. An overall annual limit of **R3, 000.00** (three thousand rand) per policy applies to this section of cover.

2.9. VALUE ADDED BENEFITS

Provides a lump sum benefit and/or waiver of premium for a defined period in the event of death, or accidental death or total permanent disability.

These benefits form part of the standard policy product premium

2.9.1. Health Premium Waiver only in event of Death and or Disability. R2,000.00 (two thousand rand) per month for 6 (six) month period.
2.9.2. Accidental Death – R5,000.00 (five thousand rand) premium principal insured, R5,000.00 (five thousand rand) adult dependant and R3,000.00 (three thousand rand) child dependant per policy per life

3. HOW THE POLICY WORKS

The headlines in this document are for ease of reference only. Please read the entire clause to understand its full meaning. Check your Schedule of Insurance which, along with any relevant endorsements, explains the cover you have. The benefit amount is not related to the specific cost of any medical **treatment** or **hospitalisation.**

4. WHAT MAKES UP YOUR POLICY OF INSURANCE?

Your Policy consists of:

- The Schedule of Insurance;
- Policy Wording (Terms and Conditions);
- Correspondence and amendments sent to your last known address.

Please ensure that you are familiar with the contents of all the documents and that all the detail noted on the Schedule of Insurance is correct in every respect

5. WHO IS THE INSURED?

We cover the persons who are listed on the policy documents as Principal or Dependants (Referred to as "You", "Your", Policy Holder or "Insured Person" in the policy terms).

6. WHO IS COVERED BY THIS POLICY?

This policy will cover the Policyholder and dependants who are listed on the schedule of Insurance.

Child dependent is up to the age of 21 (twenty one), however cover can be extended to the age of 27 (twenty seven) for full time students *(Documented proof is required to evidence dependents over the age of 21 (twenty-one)).*

- Family Cover is limited to members on the medical scheme of the Principal insured person **OR** no more than **2**(two) Adults and **3** (three) Child dependants on different Medical Schemes.
- Individual cover is limited to no more than 1 (one) individual.

7. WHEN WILL A CLAIM (BENEFIT) BE PAID?

As soon as:

7.1. We have confirmed validity of your policy and dependants;
7.2. We confirm your premium payments are up to date;
7.3. We have validated your claim using sub contracted administrators if required;
7.4. We have confirmed benefits for the claim ICD-10 Coding;
7.5. All policy conditions have been met;
7.6. All required documents have been received.

8. TO WHOM WILL THE POLICY BENEFITS BE PAID?

Only you or the persons indicated on the Schedule of Insurance will be entitled to claim and receive benefits under this policy. The applicable benefit will be paid directly into your account. All payments are subject to the limit and benefits available as stated in the policy documents.

9. WHEN DOES THE POLICY BECOME ACTIVE?

The policy incepts on the inception date reflected on your Schedule of Insurance and is ratified once we have received your first monthly premium. All policy terms will apply from the actual date of inception of the policy.

No policy will become active if premium is not received and such a policy is viewed as not taken up.

Any change of policy option benefits will have a **3** (three) month waiting period applied to the enhanced benefits only.

Additional dependants added after policy inception will be subject to individual waiting periods and underwriting.

10. HOW LONG DOES THIS POLICY LAST?

The policy is in force for as long as your premiums are paid up to date or until your policy is cancelled by you, or by us, giving **1** (one) calendar month notice.

11. YOUR RESPONSIBILITIES TOWARDS THE POLICY

In order to have cover you need to:

11.1. Pay your premiums;
11.2. Provide us with true and complete information when you apply for cover, submit a claim or make changes to your policy. This also applies when anyone else acts on your behalf;
11.3. Advise us of any changes to your health state between the point of application and actual inception of your policy;
11.4. Not admit any fault, nor make any offer or settlement, without our written agreement;
11.5. Agree to comply with all our reasonable requests;
11.6. Use all reasonable care and take all reasonable precautions to prevent or minimize loss, damage, liability, **injury** or death;
11.7. Inform us immediately of any changes to your circumstances that may influence whether we provide cover, the conditions of cover or the premium we charge. This includes any changes to any information on the Schedule of Insurance or in regards to convictions for offences by any person covered under this facility relating to dishonesty, reckless and negligent driving or driving under the influence.

12. INSURANCE POLICY CHANGES

You have to advise us when your contact details change. If you wish to cancel your insurance you must do so in writing by giving **30** (thirty) days' notice for cancellation. Should you wish to cancel the policy with "immediate effect", we may, at our discretion, accept the immediate cancellation and refund the premium related to the month in which the cancellation was requested, less all administrative expenses liable, to you.

You may make changes to your Insurance policy at any time.

Confirmation of the change will be sent to you In writing. We may amend your policy by giving you 1(one) calendar month notice. Notice can be given by fax. E-mail or post/mail to the last known contact details we have on record.

13. YOUR RESPONSIBILITY TOWARDS PREMIUM PAYMENTS

Your policy is an annual policy, payable in **12** (twelve) equal increment payments. Your policy will only become active once we receive your first monthly premium. Thereafter you must pay the full monthly premium increment, in advance, on the agreed payment dates as stated on your Schedule of Insurance.

If we do not receive the premium for your policy on the agreed payment date we will allow a **30** (thirty) day period of grace. During this grace period you may pay your premium either by cash deposit or electronic transfer into the **Insurer**s bank account to keep your cover active.

Please use the banking details indicated on your Schedule of Insurance for the payment of premiums.

Should your premium not be paid, a double debit is due on the next debit date. For debit order payments a double debit will be submitted to your bank. If this debit is also unpaid, the policy will be cancelled with effect from 24h00 on the last day of the month for which premium was received.

Please note that you will not have any cover unless all premiums are paid up to date.

Any revocation of premium debit authority will result in the immediate cancellation of your debit order instruction and you will be required to pay the premium in cash, in advance, as of this point.

It remains the sole responsibility of the policy holder to ensure that full premiums are paid on the due date.

14. REFUNDS

Premiums will only be refunded for a maximum period of 3 (three) months if approved by the **Insurer**.

No refunds of premium will be made in respect of:

- Any claim that, for whatever valid reason, is repudiated;
- Any policy that, for whatever valid reason, is cancelled by the **Underwriter**.
- Any policy that you cancel of your own accord (cancellation instruction must be in writing).
- Any cost difference resulting from changes to your policy option.

15. CLAIMS

15.1. You need to report your claim to us as soon as possible but not later than **30** (thirty) days after any **Health Event**. This includes events for which you do not want to claim but which may result in a claim in the future. Should you be incapacitated and not be able to make contact, you may get someone to contact us on your behalf.

15.2. In order for you to prove a claim, all required relevant documents must be submitted to us within 90 (ninety) days after your Medical Scheme paid their portion of the claim. **We shall not be liable for claims where the documentation is received outside of this period.**

15.3. Claims can only be assessed for payment once your completed claim information is received. This information consists of the following:

- 15.3.1. Fully completed and signed claim form for each event;
- 15.3.2. All hospital and related accounts substantiating your claim;
- 15.3.3. Your Medical Scheme Statement showing all the payments made by you or your Medical Scheme for the health event.
- 15.3.4. Completed Medical Reports substantiating the clinical information or any other documentation as requested by the **Underwriter.**
- 15.3.5. Pre-authorisation letter from your Medical Scheme for Copayment claims.

16. DISPUTED CLAIMS

After we inform you of our decision on a claim, we will allow you **90** (ninety) days to make representations to us about our decision. If we do not compensate you for a claim or a part of it, and you want to contest our decision, you must do so in writing and outline your reasons for the dispute. We will provide you with a written response within **30** (thirty) days. If you do not agree with the outcome of the appeal, you may refer the dispute to the Ombudsman for Short-term Insurance or serve legal process on us within **90** (ninety) days after the time we allow for representations on disputed claims. Should you not enforce these rights your claim will be deemed **prescribed**/abandoned.

17. FRAUD, MISREPRESENTATION, NON-DISCLOSURE & DELIBERATE ACTS

Your fully completed application form with the relevant disclosures (including changes to your health state that happens after application but before policy inception) provided by you or on your behalf forms the basis of our contract.

This policy can be re-underwritten, declared null and void or terminated if any misrepresentation or non-disclosure is made regarding any detail that is material to this insurance. Any incorrect information may affect the validity of this contract.

We will not compensate you for a claim where you or anybody who acts on your behalf, deliberately causes a loss, damage or injury. All cover under this policy will be forfeited if you submit a fraudulent claim, or anyone acts fraudulently on your behalf to obtain compensation.

18. COMPLAINT PROCEDURE

Any complaint should be directed in writing to the office of Sirago Underwriting Managers (Pty) Ltd at:

- P.O. Box 1115, Bromhof, 2154, or
- Emailed to complaints@sirago.co.za

Any complaint received will be acknowledged and responded to, in writing, within **30** (thirty) days.

19. JURISDICTION

This agreement shall be governed, interpreted and construed in accordance with the laws of the Republic of South Africa. Any legal action or proceedings arising out of or in connection with this policy which is to be instituted in a court of law shall be brought in the High Court of South Africa and irrevocably submitted to the exclusive jurisdiction of such court.

20. TERRITORIAL LIMITS

Cover for this policy is only valid within the borders of the Republic of South Africa and covers only expenses incurred within the borders.

21. GUARANTEE CLAUSE

This is a Short-term Insurance stated benefit policy under auspices of the Short-term Insurance Act 53 of 1998. The stated benefit amount payable is not related to the specific cost of any medical **treatment** or hospitalisation.

Only a Medical Scheme Product can guarantee payment of full medical costs associated with a **health event**.

22. CONSENT CLAUSE

The sharing of claims information and underwriting information (including credit information) by Insurers is essential to:

- enable the insurance industry to underwrite policies;
- assess risks fairly;
- reduce the incidence of fraudulent claims;
- protect the public interest in terms of limiting excessive premium increases.

You hereby waive any right to privacy of any insurance information provided by you or on your behalf, in respect of any insurance policy or claims you lodge. You also consent to this information being disclosed to any other insurance company and/or verified against other legitimate sources or databases.

23. POLICY SPECIFIC EXCLUSIONS

You will have no benefit, and we will not compensate you for any illness, condition, disease or **injury**, or the consequences of **treatment** of, or resulting from, or associated with:

23.1. Medical Scheme exclusions, stated benefit limits or sub limits and any claims or claim portions rejected or not authorised by your Medical Scheme unless the benefits fall within the stated benefit entitlement as per this policy wording of the Gap Cover benefits.

23.2. The first **100%** (one hundred percent) of the Medical Scheme Tariff/ Rate (This will normally be covered by your Medical Scheme).

23.3. The following conditions are excluded within the first 6 (six) months of the policy cover inception. Thereafter, benefits will be payable at a rate of 50% (fifty percent) of benefits available from month 7 (seven) to 12 (twelve) after inception of the policy. From month 13 (thirteen), the policy benefits will be fully available except where there are specific exclusions and when a new beneficiary joins the policy and is subject to underwriting terms;

23.3.1. Myringotomy and Grommets;

23.3.2. Adenoidectomy;

23.3.3. Tonsillectomy
23.3.4. Hysterectomy's (except where malignancy can be proven)
23.3.5. Spinal, Back, Neck and joint related procedures (repairs, scopes, joint replacement etc.) except in the case of an **accident**
23.3.6. Death, total permanent disability and premium waiver are subject to a 6 (six) month waiting period.
23.3.7. 10 (ten) month waiting period for pregnancy and confinement

23.4. Claims that exceed the utilisation or benefit limit per annum applicable to this policy.
23.5. **Out-patient treatment** other than defined as covered under this policy.
23.6. Any claim less than a minimum amount of **R50.00** (fifty rand) due to client in final assessment.

24. GENERAL POLICY EXCLUSIONS

You will have no benefit, and we will not compensate you for any illness, condition, disease or **injury**, or the consequences of **treatment** of, or resulting from, or associated with:

24.1. An event not covered by this policy and/or falling outside of the policy's intention.
24.2. Any claim that must be paid in terms of alternate proclaimed legislation, such as the Compensation for Occupational Injuries Act 90 of 1993, the Road Accident Fund Act 56 of 1996 etc.
24.3. Any pre-existing condition, disease, disorder or illness, for **12** (twelve) months. This will include any condition which existed prior to inception, whether diagnosed or not, or for which an insured person has sought or received medical advice, received **treatment** by a **Registered Medical Professional** or exhibited symptoms, before actual inception of the policy.
24.4. Claims that occur within the first **3** (three) months after inception of cover, except in the event of an **accident.**
24.5. Claims for regular or routine medical **treatment** and advice on an on-going basis and routine physical examinations or procedures of a purely **diagnostic** nature , except as listed under the Additional Care Cover
24.6. Any illness, injury or consequence from alcohol, drug or substance intoxication, use, abuse, or addiction, directly or indirectly traceable to the insured being affected, permanently or temporarily. Claims may be considered where registered drugs are administered and prescribed by a **Registered Medical Professional**.
24.7. Any **Psychiatric or Psychological Condition** or emotional or nervous conditions including, but not limited to, depression, insanity, psychosis, stress-related and affective disorders.
24.8. Suicide, attempted suicide or any intentional or deliberate self-injury and/or self-exposure to danger or risk except in an attempt to save a human life.
24.9. Medication, drugs, prescriptions, consumables and equipment use and any internal or external appliances, prosthesis, implantations or devices, such as braces, crutches, dental implants, lenses, pacemakers, artificial joints etc, as defined.
24.10. **Cosmetic Surgery** as well as those **elective procedures** related to Cosmetic Surgery where no clinical indication for **treatment** is present, including any **treatment** and costs resulting from these procedures unless specified as part of the benefit entitlement to this policy.
24.11. Investigations, treatment or surgery for eating disorders, obesity or weight management, including any consequence of such **treatment** as well as any additional fees charged by a **Registered Medical Professional** for the management of overweight or underweight patients with reference to the **Body Mass Index (BMI),** other than defined as covered under the **Additional Care Cover Benefits.**
24.12. Investigations, treatment or surgery related to infertility, artificial insemination, hormone treatment for infertility, or any other form of assisted reproduction, other than those procedures defined under the Additional Care Cover **Benefit.**
24.13. Any illness, injury or condition resulting from or associated with:
24.13.1. Participation in any form of race or speed test (other than on foot or not involving any mechanically propelled vehicles or crafts).
24.13.2. Participation in a sport or hobby that is defined by Underwriters as **hazardous** or dangerous except for **scholars** taking part in school activities.
24.13.3. Participation as a **professional sports person**.

25. STANDARD SHORT- TERM POLICY EXCLUSIONS

You will have no benefit, and we will not compensate you for any illness, condition, disease or **injury**, or the consequences of **treatment** of, or resulting from, or associated with:

25.1. Any claim arising directly or indirectly from active involvement in war, invasion, act of a foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or political risk of any kind, or any act of any person acting on behalf of or in connection with any organisation, group or activity aimed at overthrowing any government by force or any deliberate act of terrorism or violence.
25.2. Any riot, strike or public disorder (including civil commotion, labour disturbances or lock-out) or any act or activity resulting in or calculated to bring about riot, strike or such disorder.
25.3. Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers.
25.4. The act of any lawfully established authority, police force, security force or any other local, provincial or national body, in controlling, preventing, suppressing or in any other way dealing with any event referred to in the clauses above.
25.5. Compensation in terms of the War Damage Insurance Act 85 of 1976.

25.6. Nuclear weapons or nuclear material, ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception combustion shall include any self-sustaining process of nuclear fission.
25.7. Any loss arising from any contractual liability.
25.8. Any consequential loss or damage whatsoever.
25.9. Any attempt by you to commit an unlawful act.

26. DEFINITIONS AND EXPLANATIONS

26.1. **Accident:** An event that occurs unintentionally and usually results in harm, injury, damage or loss. Policy cover only extends to accidents occurring after inception of the policy.
26.2. **Accidental Death:** an event that results in an accidental death
26.3. **Acute:** A condition which is generally unforeseen, of rapid onset in nature, is severe and treatable, but does not last for a prolonged period and is therefore not chronic.
26.4. **Acute Hospital:** a hospital that treats all major and minor conditions
26.5. **Admission Fee**: The fixed amount you have to pay in terms of your Medical Scheme Rules when you are admitted to hospital as an **In-Patient.**
26.6. **Appliances:** An instrument or device designed for a particular medical use.
26.7. **Body Mass Index (BMI):** A measurement tool to establish the ideal weight of a person based on weight and height. Additional fees are charged for management of patients who fall outside the prescribed **BMI**.
26.8. **Cancer**: Diseases in which abnormal cells divide without control and are able to invade other tissues. This definition includes leukaemia, lymphoma and Hodgkin's disease but specifically **excludes** benign, pre-cancerous / in-situ tumours or growths as well as all stage zero **cancer** diagnoses. Any cancer that is diagnosed and treated through primary biopsy and not requiring additional intervention such as radiation therapy- or chemotherapy shall not be deemed as **cancer** and will not have any benefit paid. Cover under **cancer** benefits will not be available for any person diagnosed with **cancer** prior to the inception of this policy. Treatment for any cancers which have been previously diagnosed have to be in remission for a minimum of 3 years either prior to the policy inception or during cover.
26.9. **Contraceptive Devices:** Devices used to prevent pregnancy, including the diaphragm, condom, and intrauterine devices.
26.10. **Co-Payment:** The fixed amount excess imposed in terms of your Medical Scheme Rules for undergoing a specific procedure whether in or out of hospital. This will include, for example MRI, CT and Ultrasound Scans and scopes.
26.11. **Cosmetic Surgery:** Procedures performed to repair, change or restore body parts to look normal, or to change a body part to look better.
26.12. **Designated Service Provider (DSP):** The hospital/ specialists/ network providers prescribed by your Medical Scheme Rules where you can obtain diagnosis and **treatment** benefits without **co-payments** or penalties. A penalty or **co-payment** may be applied by your Scheme if you choose not to use the **Designated Service Provider.**
26.13. **Diagnostic**: A procedure or test which is performed to find out what is wrong with a patient. Diagnostic procedures do not aim to treat or cure a condition but is informative and exploratory in nature. This includes, for example, any examination, such as laboratory diagnostic or x-ray examination that does not result in a bona fide **hospitalisation** for **treatment** purposes (Other than covered under Preventative Care Benefit)
26.14. **Elective procedures**: **Treatment** that is not clinically essential such as *surgery* to correct a cosmetic condition that is not life-threatening.
26.15. **Emergency treatment**: A serious situation or occurrence that happens unexpectedly and demands immediate medical attention in the Emergency Room.
26.16. **Excess:** The first portion of any claim payable by you before cover commences.
26.17. **Formulary**: a list of stated prescription medicines.
26.18. **Hazardous/Dangerous (Sport):** Participation in any hobby, adventure or extreme sports including but not limited to Abseiling; Mountaineering; Rock climbing; Hang gliding; Micro-lighting; Base jumping; Parachuting; Skiing; Hunting; Kite surfing; Underwater activity involving the use of artificial breathing apparatus and all other forms of racing or speed trial or contest;
The **Underwriter** reserves the right to add to this list from time to time.
26.19. **Health Event:** An event relating to the health of the body of the insured person, adversely affected by illness or injury and necessitating bona-fide **In-Patient hospitalisation** and Out-patient procedures or other **treatment** approved by the **Underwriter.**
26.20. **Hospitalisation:** Confinement in a hospital as a resident **In-Patient** under the professional care of a **Registered Medical Professional** as defined below and approved by the **Underwriters.**
26.21. **ICD-10 Coding:** The International Classification of Diseases is a diagnostic coding standard that was adopted by the South African National Department of Health in 1996.
26.22. **Incident:** Any single discrete occurrence of a health event / claim incident, including all costs related to the original event.
26.23. **Initial Diagnosis:** The very first clinically confirmed diagnosis of any form of cancer, specifically excluding preliminary, tentative or other diagnosis not supported by clinical evidence of malignancy This definition excludes any incidence of cancer/pre-cancer prior to inception of the policy.
26.24. **Injury:** Damage to a body part sustained in an unforeseen future event, caused solely and directly by violent, accidental, external and visible means independent of and untraceable to any other cause.
26.25. **In-patient:** A patient who is "admitted" as a resident to the hospital as an "in-patient" and who spends time in a hospital ward admitted as such.
26.26. **In Room Procedures**: is defined as a procedure in a surgical suite that meets the requirements of a restricted area and is designated and equipped for performing surgical operations or other invasive procedures that require an aseptic field which would ordinarily be undertaken in an Acute facility.
26.27. **Insurance Company / Insurer:** The Insurance Company, indicated on your Schedule of Insurance, which offers insurance policies in return for premiums.
26.28. **Medical Scheme Rate:** It means the set fee that your scheme pays the service provider (doctor, hospital).
26.29. **Medical Specialist:** A practitioner who has completed advanced education and clinical training in a specific area of medicine, which includes but are not limited to Cardiologists, Gastroenterologists, Gynaecologists, Oncologists, Ophthalmologists, Orthopaedic surgeons, Physicians, Paediatricians & Urologists.

For purposes of this policy the definition specifically excludes all Basic and Specialised Dentistry, Optometry, Orthodontics, Orthotics, Physiotherapy, Psychiatry, Supplementary and Complementary Medical Practitioners as well Pathology and Radiology.

26.30. **Oncology Co-Payment:** The percentage excess /co-payment your Medical Scheme imposes on claims paid after you reach your annual Oncology Limits. (**Oncology Co-payments** are only covered under the Cancer Benefit).

26.31. **Out-Patient:** Any consultation, investigative test or surgical procedure that a Registered Medical Professional performs whilst you are not admitted as a hospital in-patient or any intervention that would not clinically require in-patient admission to a hospital.

26.32. **Penalty Fee**: The amount you have to pay in terms of your Medical Scheme Rules when you are admitted to hospital that is not a **DSP** as provided for in your Medical Scheme Rules**.**

26.33. **Pre-existing conditions:** Any illness, injury, condition or disorder which existed before this policy incepted.

26.34. **Premium Waiver**: means the Insurer **waives** the policyholder's obligation to pay any further **premiums** should he or she become seriously ill or disabled for a defined period

26.35. **Prescribed:** A claim that is deemed prescribed in line with the Prescription Act 68 of 1969.

26.36. **Prescribed Minimum Benefits (PMB):** A set of benefits as defined in the Medical Schemes Act and Regulations which ensures that all scheme members have access to certain minimum health benefits, regardless of your Medical Scheme Option. This includes a requirement for Medical Schemes to pay the full cost of diagnosis and treatment of a list of medical conditions, unless you choose to use a provider that is not a **DSP.**

26.37. **Professional sport:** This is a sport which is registered where an individual derives their livelihood (income) from fulltime participation in said sport.

26.38. **Psychiatric or psychological condition:** Any kind of mental illness and disability. This includes all forms of major affective disorders, anxiety disorders, psychiatric conditions and all other mental disorders outlined under **ICD-10 Coding** *F01:F99–Mental, Behavioural & Neurodevelopmental disorders.*

26.39. **Corrective procedures:** In relation to Cosmetic procedures that aim to correct function or structural defect. To be read in conjunction with paragraph 26.8**.**

26.40. **Registered Medical Professional:** A person legally licensed and duly qualified to practice medicine and surgery (other than the Insured or a member of the Insured's immediate family). This includes people legally licensed, duly qualified and registered in the Specialist Register of the Health Professional Board of the Republic of South Africa and recognised as such by the Underwriter.

26.41. **Scholar:** An insured that is attending primary or secondary school. This definition specifically excludes any student or attendant of a tertiary institution.

26.42. **Sub**-Limit: A limitation on the amount of coverage available to cover a specific stated benefit. A sublimit is part of, rather than in addition to, the limit that would otherwise apply. It places a maximum on the amount available, rather than providing additional coverage.

26.43. **Surgical Procedure:** A course of action with the intention of treating, curing or restoring anatomical functions or structure and specifically excludes rehabilitation and other policy exclusions, not specifically defined as covered.

26.44. **Trauma:** Serious injury to the body, as from physical violence or an accident.

26.45. **Treatment:** Services provided to a patient, by a specialist or therapist approved by the Underwriter for acute, life-threatening medical conditions.

26.46. **Total Permanent Disability**: **means** that because of a sickness or injury, a person is unable to work in their own or any occupation for which they are suited by training, education, or experience.

26.47. **Underwriter / Sirago Underwriting Managers (Pty) Ltd:** Any person who or which issues a financial product to clients in the form of a Short-term Insurance policy as defined in the Short-term Insurance Act 53 of 1998 by virtue of an authority, approval or right granted to such person in terms of a written agreement entered into by such person with a Short-term Insurer, authorised to carry on Short-term Insurance business in the Republic of South Africa. An Underwriting Manager's sole remuneration is derived from such activities and such person is deemed to be an agent of the Short-term Insurer. The acts of an Underwriting Manager shall in all respects be and are fully binding upon the Short-term Insurer. Premiums received by an Underwriting Manager on behalf of the Short-term Insurer shall irrevocably be deemed to have been received by the Short-term Insurer.

27. OUT-PATIENT PROCEDURES

The policy will cover you for **Out-Patient Surgical Procedures** that your **Registered Medical Professional** would normally have performed as an **In-Patient**. This includes, but is not limited to, for example, gastroscopies, colonoscopies, wisdom teeth extractions, home-birth and stent insertions.

Procedures that would not normally require admission into hospital, and admissions where no Clinical/Medical reason for admission can be provided, will not be covered. This includes, but is not limited to, for example, placing of crowns, minor extractions and excisions, diagnostic tests and minor biopsies.

28. ADDITIONAL CARE COVER BENEFITS

The policy will cover your Gap Benefit for treatment or procedures related to the following preventative procedures:

28.1. Pap Smear
28.2. Cholesterol Test
28.3. Blood Glucose Test
28.4. Flu Vaccination
28.5. Childhood Immunisation (Department of Health Formulary)
28.6. Bone Density Scans
28.7. Prostate Specific Antigen Tests
28.8. Mammogram
28.9. Contraceptive Device Implantation

PLUS GAP COVER 2017

Your claim will be covered, up to a maximum amount of
R 1, 000.00 (one thousand rand) per insured per **incident**. An overall annual limit of **R3, 000.00** (three thousand rand) per policy applies to this section of cover.

Effective – 01 January 2017, please note that this policy wording replaces any previous policy wording regarding this product. As such, claim events occurring as of 1 January 2017 will be assessed strictly in accordance with these terms, regardless of when your policy originally incepted.

STATUTORY NOTICES

ABOUT THE INTERMEDIARY

Myfin Financial Services 1237 (Pty)Ltd – an

authorised financial services provider FSP 44462

Company registration: 2012/205235/07
Unit 8 Morninglen Office Park, Kelvin Drive Gallo

Manor Sandton 2192

PO Box 2124 Lonehill 2062

Telephone : 087 550 3200

Fax : 0860 271 4200

Email: info@4me.co.za

Website: www.my-fin.co.za

INTERMEDIARY COMPLIANCE OFFICERS

Our Compliance officers: Associated Compliance FSP 39822

Compliance Officer Telephone number: 011 431 1183 (Landline) **Fax number**: 086 656 2947 (Fax to Desktop)

POBOX 125 HoneyDew 2040 Email: peter@pvsi.co.za

This intermediary does not hold directly/indirectly more than 10% of the Insurer's shares or any equivalent substantial interest in the Insurer.

Contact the intermediary to determine whether more than 30% of their total remuneration is received from the

Insurer

Contact the intermediary to obtain details of their guarantee, professional indemnity and fidelity insurances.

Client Rights: As a client, no provider may request or induce you in any manner to waiver any right or benefit conferred on you by, or in terms of ,any provision of the FAIS Act and Code of Conduct. Should you feel that your rights have been prejudiced, or you have been aggrieved in any way, you have the right to lodge a complaint. A copy of our complaints process is available upon request

The Company has a comprehensive Conflict of Interest policy in place and can be accessed via the internet on www.my-fin.co.za There are no conflicts in terms of the FAIS Act identified at present in any of the following areas of our operations

Complaints can be lodged to complaints@4me.co.za

The "**4me**" brand , products and services are governed by Myfin Financial Services

PLUS GAP COVER 2017

GAPWISE HAS THE FOLLOWING NON INSURANCE VALUE ADDED PRODUCTS AND SERVICES

A. MEDWYZE – managed for you Global Case Management

Dealing with one's medical scheme for the payment of medical accounts when either the member or someone in that member's family has been admitted to hospital is an emotional and stressful time. This stress is often aggravated by the non-payment by your medical scheme of some part of the in-hospital or specialists account.

Close on 30% of all complaints submitted to the Council for Medical Schemes (CMS) related to unpaid accounts on PMB's and a further 25% of the complaints related to PMB's/Formularies/Designated Service Providers. *(CMS Annual Report).* As a consumer knowing precisely what should be paid and what not is a maze of technical medical information and codes that the average consumer has no clue about. Medwyze is a unique service offering which has been designed to compel your medical scheme to pay the prescribed minimum benefits (PMB's) which they are bound by law to pay and as such removes the hassle factor from you as a consumer which can result in no claim against your Gap Cover.

B. ACCIDENT EXPERT FROM ROAD COVER - www.roadcover.co.za

To ensure that victims of motor vehicle accidents have immediate access to an effective Road Accident Fund (RAF) and Compensation of Occupational

Injuries & Diseases (COID) claims management system - with NO additional costs to the Policyholder.

ACCIDENT EXPERT strives to assist its Policyholders with all the necessary administrative support from a claims management and claim preparation perspective, for submission to the RAF and COID by:

· Managing the Policyholder's claims with the RAF & COID.

· Having qualified and registered attorneys interact on behalf of the Policyholder, with the doctors who treated the Policyholder, the hospital where the

Policyholder was treated or admitted.

Services include:

· COID Assistance:

COID remuneration is based on the degree of disablement or illness sustained on duty.
Policyholders will be helped to:

- Avoid penalties by submitting their annual Return of Earnings to COID in time
- Avoid the payment of excessive fees
- Reduce the claims waiting period for the payment

Road Accident Fund (RAF) Assistance:

PLUS GAP COVER 2017

The RAF is a public entity set up by the South African Government aimed at making compensation payments to people injured, or dependants killed, in road accidents within

South Africa as a result of third party negligence.

For the duration of the claim, the Policyholder receives:

- Legal representation
- Administration and claims management
- Required medico-legal reports
- Required loss of support reports
- Required actuarial reports for loss of earnings
- Accident Reconstruction

Legal Assistance (RAF & COID)

The Legal Assistance Helpline manned by qualified and registered attorneys, 365 days a year Provide assistance in respect of uninsured losses/damages which were caused by the negligence of a third party, including obtaining compensation in respect of excess payments, claims less than excess, car hire charges, damages to clothing and personal effects such as glasses, jewellery and even accommodation expenses, should an accident occur far from home

If the motor vehicle is insured under third party cover only, ACCIDENT EXPERT will assist in recovering the costs of repairing the vehicle and any storage charges. Recovery for the insurer on claims pd out based on a risk and reward model in addition to the above.

C. Medi Fin – www.medifin.co.za

Access to a Specialist Finance Product for healthcare expenses that are not typically covered by your medical aid or any other healthcare product. See multiple examples below. Simply complete the online application process with Medi Fin or call us or them for any further information.

Cosmetic Surgery Finance, Cosmetic Dentistry Finance, Hair Restoration Finance, General Surgery Finance, Orthodontics Finance, Hospital Stay Finance, Laser Eye Surgery Finance, Bariatric Surgery Finance, IVF (Fertility) Programs Finance, ENT (Ear, Nose, Throat) Surgery Finance, Health and Beauty Finance, Other Medical Procedures.

D: 4me Lifestyle Mall - www.4melifestyle.co.za.

The 4me lifestyle mall is a complimentary loyalty and lifestyle mall.

Randgo is making its presence felt as one of the top benefits and rewards businesses in South Africa. This highly skilled technology, travel, concierge,

PLUS GAP COVER 2017

loyalty and online rewards company offers your employees/customers benefits like discounts, preferential treatment and unbeatable stock offering from leading global and local brands.

How does Randgo work?

The Randgo team uses equal portions of passion and professionalism to ensure that all stakeholders benefit from our platforms and programs and knows that by creating these win-win associations, that long value and relationships will flow.

Service with a smile

We are focussed on providing the highest levels of service, an extremely important aspect of our business. Cutting edge technology

The latest technology and infrastructure housed at Internet Solutions powers our sophisticated in house developed platforms. We create technology that is market-leading, reliable and easy to use.

Mobile access

The entire platform has a mobile component to allow for the issuing and redemption of vouchers in real-time from any location. Growing and improving

The platforms are continually growing with new features and improved functionality to ensure the highest levels of stickiness, usability and user value. It's all clear

Randgo is completely transparent in its dealings and statistics. All clients, vendors and partners have complete access and knowledge of Randgo's statistics and revenue streams.