Old Mutual Gap

Policy 2026

Section 1: General Terms & Conditions

Gap cover is not a Medical Scheme, and the cover is not the same as that of a Medical Scheme. This Policy is not a substitute for Medical Scheme membership. This Policy only covers the shortfall between the Medical Scheme Tariff and the actual cost the attending medical practitioner charges.

Important Information about the Policy

- This Policy is underwritten by GENRIC Insurance Company Limited (FSP: 43638), an Authorised Financial Services Provider and licensed non-life Insurer and is administered by Kaelo Risk (Pty) Ltd, an Authorised Financial Service Provider - Registration No. 2008/019335/07 (FSP No 36931). Old Mutual Gap Cover is distributed by Old Mutual Life Assurance Company (South Africa) Limited, Registration Number 1999/004643/06, a licensed FSP and Life Insurer.
- The Policyholder's Gap Policy will remain active for as long as the Premium is received (this is called the Period of Insurance).
- The cover provided is always subject to all the terms and conditions explained throughout this Policy document.
- The general terms and conditions apply to every section of the Policy. Some terms and conditions apply to specific sections under the Policy. The Policyholder must ensure they understand all sections of the Policy document and contact Us should they have any questions.
- Waiting periods will apply from the Policy Start Date.
- The main purpose of Gap Cover is to provide cover for the shortfall between what a Medical Practitioner charges and what the Policyholder's Medical Scheme pays for the Covered Events as set out in the Policy.
- We apply the principles of TCF in all our business functions. To this end, the Policy Schedule attached to this document demonstrates all the information required for benefits, premiums payable, and any limitations applicable within the terms of the Policy.
- The PPR published under the Short-term Insurance Act is a fundamental business practice, and all care and thought to go into any information, advertising, and interaction both directly and indirectly with Policyholders and intermediaries at all times.
- This Policy wording is effective as of **01st January 2026**. Please note that this policy wording replaces any previous Policy wording regarding the product. As such, claim events occurring as of **01st January 2026** will be assessed strictly in accordance with these terms. We may change the Policy wording at any time, giving You **31** days' notice.
- All Compensation Limits and Premiums include VAT at the standard rate. In accordance with the Commissioner's directive under Section 20(7) of the VAT Act, this Policy document, together with proof of payment of the insurance Premium, serves as a valid tax invoice. All monetary amounts, including Premiums and any payouts to the Policyholder, are stated in South African Rand.

Helpful Definitions

The following definitions apply throughout the Policy and all relevant documentation. The definitions specific to the Policy Section can be found at the start of the section.

- In this Policy, all words and expressions signifying the singular shall include the plural and vice versa.
- Words and expressions which denote any gender include all genders.
- Where age is mentioned in the Policy, it will be the age attained.

Definition	Meaning
Benefit(s)	The Benefit amount payable to the Policyholder in relation to a Covered Event as defined, as calculated in terms of the Policy document.
Certificate of Membership	An official document issued by the Policyholder's Medical Scheme indicating all relevant Dependents, Waiting Periods and/or contributions/premiums applicable to the Medical Scheme cover.
Compensation Limit	The maximum amount for which the Insured Person is covered, as stated in the Policy Schedule.
Covered Events	The Events that the Insured Person are covered for as shown in the Policy Section of this Policy document.
Insured Person	• A Principal Insured Person or an Eligible Spouse of a Principal Insured Person or an Eligible Child of a Principal or Spouse Insured Person. Such persons must be covered by a registered Medical Scheme and must not already be insured for similar cover at another insurer. • Such other person as the Insurer may from time to time deem eligible. • The Insured Person may also be referred to as "You", "Your" or "Yourself".
Insurer	GENRIC Insurance Company Limited, Reg No. 2005/037828/06, FSP No. 43638 an Authorised Financial Services Provider and licensed non-life Insurer. Also referred to as "We", "Us", "Our", or "Ourselves".
Medical Scheme	A Medical Scheme as registered under the Medical Schemes Act and registered with the Council of Medical Schemes.
Medical Schemes Act	The Medical Schemes Act No. 131 of 1998 as amended and includes the Regulations thereto.
Medical Scheme Option	The Medical Scheme Option of the Principal Insured Person immediately before the Covered Event.
Medical Scheme Option Reimbursement Rate	The Medical Scheme Tariff as indicated by the rules of the Medical Scheme.
Overall Annual Limit (OAL)	The total value of the compensation allowed for all aggregated claims as defined within the Schedule, per Insured Person registered on the Policy. The Overall Annual Limit (OAL) for claims is aggregated to a maximum of **R223 000** from **1 April 2026 to 31 March 2027**, unless specified, per beneficiary per annum. The number of claims that can be submitted against this Policy is unlimited, except if the Benefit category defines otherwise or until the maximum Overall Annual Limit is reached.
Period of Insurance	The period from the Start Date of this Policy to midnight before the same day of the month one month later. The Period of Insurance is shown in the Policy Schedule.
Policy	The formal contract issued by the Insurer, which contains the terms and conditions of the Non-Life insurance cover. It serves as the legal evidence of the insurance agreement and is signed by the duly authorised person(s).
Policy Schedule	This sets out the type of cover selected by the Policyholder, the Insured Persons, the Period of Insurance, the Benefit amounts and the Premium payable. Any changes to the Policy will be shown in the Policy Schedule.
Policy Section	The part of this Policy document that relates specifically to the cover provided under this Policy.

Policyholder/ Principal Member	The person who entered into this Policy agreement and who is a paid-up member of a Medical Scheme.
Premium(s)	The monthly amount payable by or on behalf of the Policyholder to the Insurer as defined in the Policy Schedule applicable to this Policy.
Premium Payer	Refers to the Policyholder and/or person responsible for paying the monthly Premiums for this Policy and who has agreed to the monthly Premium deductions from their nominated bank account.
Start Date:	Cover will start on the first day of the calendar month for which the Premium has been paid by or on behalf of the Insured Person, subject to all the terms and conditions of this Policy.
Waiting Period	The period during which an Insured Person is not entitled to claim any Benefits under the Policy in accordance with the underwriting terms and conditions at the Start Date of the Policy.

Policyholder's Responsibilities

- The Policyholder is responsible for making sure that all information given to Us, including any important details, is correct. Important (or material) information refers to anything a reasonable person would see as necessary for the Insurer to evaluate the risk accurately. When assessing this risk, We may decide whether to provide cover under this Policy, determine the appropriate Premium, and consider if any extra terms or conditions should be applied.

  ! All information provided by the Policyholder will be validated at the claims stage.

  Examples of material information: Previous and current illnesses, diseases and operations.

- If the information provided by the Policyholder or an Insured Person is incorrect, it could be interpreted as a misrepresentation, omission or non-disclosure, dishonesty and/or fraud, and We can:
  - reject the Policyholder's claim;
  - declare the Policy invalid from the Start Date of the Policy;
  - cancel the Policy;
  - recover any compensation to the Policyholder in the settlement of previous claims; or
  - refund Premiums paid by the Policyholder/Premium Payer, where applicable (less cost incurred by Us during the Period of Insurance and subject to a maximum backdated refund period of **12** months).
- The Policyholder must inform the Insurer immediately if any information We have on record for an Insured Person is incorrect or has changed.
- Where material information of the Policy has changed and a refund is due as per the rules set out above, the refund is subject to a maximum backdated refund period of **12** months.

Country In Which The Policy Applies

The Policy applies to South Africa only. Any services provided outside the borders of South Africa are excluded from cover.

What To Do In The Event Of A Claim

- Following a Covered Event the Policyholder or an Insured Person will at their own expense:
  1. Inform Us of any claim by completing the online claims process. No claim shall be payable if the completed claim form, together with all supporting documentation, is not received within **6** months of the Medical Scheme's payment date or within **6** months of the termination of this Policy, whichever occurs first.
  2. Supply written proof, copies of medical accounts or other information as may reasonably be required for Us to process the claim or to ensure the validity of the claim.
  3. Permit Us to review, as needed, all current or past medical information, clinical records, and the results of any diagnostic tests.
  4. If required, undergo a medical examination, arranged and paid for by the Insurer.

The Policyholder must get a claim number from Us to confirm that the claim has been recorded. Without this claim number, it means We have no record of the claim.

- If the Insured Person is not the Policyholder, they must either provide the necessary permission or obtain consent from the Policyholder to meet the above requirement. If this is not done, the processing of the relevant claims will be suspended until the required permissions or consents are obtained.
- Any Benefit related to a Covered Event will only be paid once the Treatment for that Covered Event has been completed.
- Interim Benefit payments may be made to the Policyholder after a **31-**day period during a Covered Event, at the Insurer's sole discretion.
- All Benefits due will be paid to the Policyholder or their legal representative, and the receipt of these Benefits will fully release Us from any further liability.
- In the event of the death of the Policyholder, any Benefit due will be payable to the surviving Spouse, failing which the Benefit will be paid to the Dependent Children (or their legal guardians in the event of them being minors) or, failing any of the above, the Benefit will be paid to the Policyholder's estate.
- No Benefit payable will carry interest.
- Any discount accrued by an Insured Person, against the amount owing by the Insured to any Medical Provider, will be factored into the calculation of the Benefits of this Policy.

How We Compensate

- If We approve your claim, the payment will be made in cash to the same bank account used for Premium deductions, unless you specify a different account on the claim form.
- The Policy Section reflects the Overall Annual Limit and sub-limits applicable to this Policy.
- You will only receive compensation for a valid claim if the Hospital Stay, Treatment, or Medical Procedure related to the Covered Event begins before the Policy's cancellation date.
- The Insurer may negotiate with the Insured Person's Medical Provider any discount and pay the Benefit payable in terms of this Policy directly to the Medical Provider, should a discount be granted.

Claim Disputes

- We may accept or reject all or part of a claim. After a claim has been rejected, We will allow the Policyholder **90** days to make representations to Us about Our decision. If We rejected a claim or a part of it, and You want to contest Our decision, the Policyholder must do so in writing and outline reasons for the dispute. We will provide the Policyholder with a written response within **31** days.
- Should the Policyholder not agree with the outcome of the appeal, they must escalate the dispute to GENRIC at the Insurer's complaints department.
- The Policyholder may also refer a dispute regarding an outcome of a claim to the National Financial Ombud Scheme or serve legal process on Us within **90** days after the time We allow for representations, on disputed claims.
- Should the Policyholder not enforce these rights, the claim will be deemed prescribed/abandoned.
- The Policyholder is afforded an additional **6** months in addition to the **90** days to take legal action.
- Should the Policyholder have any questions or concerns about this Policy or the handling of a claim they must provide Us with their concerns or questions in writing to:

  Complaints Department Tel: 086 144 4462
  Email: complaints@genric.co.za
- Please visit Our website or contact Our offices for Our Complaints Resolution Policy.
- If GENRIC is not able to resolve the complaint satisfactorily, the Policyholder may lodge a further complaint to the National Financial Ombud Scheme, or FAIS Ombud details, which are contained within the Policy Schedule.

Dual Insurance

- No Insured Person can be covered by more than one Gap Policy simultaneously. If We determine that the Insured Person are covered under multiple policies, they must choose which one to claim under. The Policyholder is not allowed to claim under more than one policy for the same event.
- If We agree to refund the Policyholder a proportion of this Policy's Premium as a result of dual insurance, We will deduct any cost incurred by Us during the Period of Insurance from the refund. The maximum backdated Premiums considered for the refund will be limited to **12** months.

Policy Changes

- The Policyholder can make changes to the Policy at any time. However, the Policyholder must ensure that We confirm the change in writing, and that the change will take effect from the agreed date and time.
- The Insurer may change the terms, conditions and the Premiums of this Policy by giving the Policyholder **31** days' written notice to the email address provided by the Policyholder. Any changes will only come into effect after this **31-**day notice period has lapsed.

Policy Cancellations

- The Insurer may cancel this Policy by giving 31 days' written notice to the email address provided by the Policyholder.
- The Policyholder may cancel this Policy at any time in writing, and this cancellation will take effect at midnight from the day of this cancellation. We will not charge any administrative costs for processing the cancellation, and no Premium refunds will be made for a cancellation with less than **31** days' notice where the Premium has already been collected.
- If the Policyholder cancels this Policy and the Premium has not been collected, but already submitted for collection, the Premium will be refunded after We deduct any cost incurred by Us during the period of Insurance.
- If an Insured Person commits any fraudulent act, We have the right to immediately cancel this Policy and/or take legal action to recover any losses incurred. There is no cash value to this Policy if it is cancelled.
- If the Policyholder passes away and their Spouse or another Dependent remains an active member of the same Medical Scheme, they can choose to continue with this Policy. To do so, they must notify Us in writing within **90** days of the Policyholder's death. No waiting period will apply if the cover is transferred to the Policyholder's Spouse or Dependent.
- If the Policy is voided by Us, We will refund the Premiums paid (less cost incurred by Us during the period of cover).

Premium Payments

- Cover starts on the **1st** of each month, and the Premium Payer are responsible for paying the Premium each month for that specific month of cover. For example, if the Policyholder selected the **25th** as the debit order payment date, the debit order collected on the **25th** of January will be for the cover month of January.
- The Policy will automatically renew each month as long as the Premium Payer pays the monthly Premium on the agreed date. It is the Premium Payer's responsibility to ensure there are enough funds in their bank account for the debit order to be processed on the agreed date, as outlined below: **Debit Date**: This is the day of the month the Premium Payer has selected on the debit order authority letter for Us to collect the monthly Premium from their bank account (e.g., the 25th of each month).
- Debit orders are processed as per the bank-approved debit order collections methods, based on the Premium Payer's agreed mandate, to collect the Premium. These methods may include:

1. Utilising an authenticated debit order collection process which allows the Premium Payer to electronically confirm their debit order details with the bank and Us at the start of the Policy or when there are any changes to the mandate conditions.
2. Utilising Electronic Funds Transfer (EFT) Debit Order Services should the Premium Payer's bank not allow for authenticated debit order collections.

- These services may include a process to help ensure that there are sufficient funds in the Premium Payer's bank account for the Premium deduction. This is done to ensure that the monthly Premiums are paid on time, keeping the Policy active.
- The Policy will only be activated once the **1st** month's Premium has been received. If the required Premium is not received, the Start Date of the Policy will be adjusted to the next available Debit date. We will attempt to collect the Premium from the Premium Payer's bank account again. Should the Premium are still not received, the Policy will be terminated.
- If the Premium is not paid, We will automatically attempt to collect a double Premium in the following month. If We are still unable to collect the Premium, the Policy will be cancelled with effect from the last day of the month for which the last Premium was received.
- There is no cover under this Policy for any Period of Insurance for which We did not receive the required Premium.
- Should the agreed Debit Date fall on a public holiday or a non-banking day, the Premium will be collected on the next available banking day.
- If the Premium Payer request their bank to stop the payment of the Premium, the Policy will be automatically cancelled from the last day of the month for which the last Premium was received.
- We will charge a non-refundable recollection fee of **R50.00** for each failed Premium collection, regardless of the amount, due to any of the following reasons for the debit order rejection:
  1. Insufficient funds in the Premium Payer's account;
  2. The Premium Payer cancelled the debit order authorisation; or
  3. The Premium Payer provided incorrect banking details when the Policy was taken out by the Policyholder.
- We will not charge interest on late Premium payments.

Cooling-off Period

New Policy And Reinstatement Cooling-Off Period

The Policyholder may request to cancel this Policy within **31** days of receiving the Welcome or reinstatement pack. If no claims have been made and no Benefits paid, We will refund any Premiums received before the cancellation request, within **31** days of receiving the cancellation instruction. However, if the Policyholder cancels the Policy after the **31-**day cooling-off period or has already made a claim, We will not refund any Premiums paid.

Policy Changes Cooling-Off Period

The Policyholder may request to cancel any Policy change (such as adding or removing an Insured Person) within **31** days of receiving confirmation of the change. If no claims have been made and no Benefits paid, the Policy won't be cancelled, but We will refund any Premiums or partial Premiums received due to the change, after deducting the cost of the cover already provided. The Premium refund will be issued within **31** days of receiving the cancellation instruction. However, if the Policyholder cancels the change after the **31**-day cooling-off period or has made any claims, We will not refund the Premiums already paid

Jurisdiction

South African law applies to this Policy and only the courts of the Republic of South Africa may deal with any dispute in respect of this Policy. 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.

Processing of Insurance Information

Your privacy is of utmost importance to us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by You or which is collected from You is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored safely and securely.

You hereby agree to give honest, accurate and up-to-date Personal Information and to maintain and update such information when necessary.
You accept that Your Personal Information collected by Us may be used for the following reasons:

- to establish and verify Your identity in terms of the Applicable Laws;
- to enable Us to fulfil Our obligations in terms of this Policy;
- to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
- reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share Your information for further processing with the following third parties, which third parties have an obligation to keep Your Personal Information secure and confidential:

- Payment processing service providers, merchants, banks and other persons that assist with the processing of Your payment instructions;
- Law enforcement and fraud prevention agencies, and other persons tasked with the prevention and prosecution of crime;
- Regulatory authorities, industry ombudsmen, governmental departments, local and international tax authorities, and other persons that We, in accordance with the Applicable Laws, are required to share Your Personal Information with;
  - Credit Bureaus;
  - Our service providers, agents and subcontractors that We have contracted with, to offer and provide products and services to any policyholder in respect of this Policy; and
  - Persons to whom we cede Our rights or delegate Our authority, in terms of this Policy.

You acknowledge that any Personal Information supplied to Us in terms of this Policy is provided according to the Applicable Laws. Unless consented to by Yourself, We will not sell, exchange, transfer, rent or otherwise make available Your Personal Information (such as Your name, address, email address, telephone or fax number) to any other parties, and You indemnify Us from any claims resulting from disclosures made with Your consent.

You understand that if We have utilised Your Personal Information contrary to the Applicable Laws, You have the right to lodge a complaint with Us within **10** (ten) days. Should We not resolve the complaint to Your satisfaction, You have the right to escalate the complaint to the Information Regulator.

You also similarly give consent to the sharing of information regarding past insurance policies and claims that You have made. You also acknowledge that information provided by Yourself, or Your representative, may be verified against any legally recognised sources or databases.

By insuring or renewing Your insurance You not only consent to such information sharing but also relinquish any rights of confidentiality with regard to underwriting or claims information that You have provided or that has been provided by another person on Your behalf.

In the event of a claim, the information You have supplied with Your application, together with the information You supply about the claim, will be included on the system and made available to other insurers participating in the prevention of fraudulent and any criminal behaviour or activity.

Policy Exclusions

We shall not be liable for hospitalisation, bodily Injury, sickness or disease directly or indirectly caused by or related to or in consequence of:

- Nuclear weapons or nuclear material or by ionising radiation or contamination by radioactivity from any nuclear fuel or any nuclear waste from the combustion of nuclear fuel. For this exception, combustion shall include any self-sustaining process of nuclear fission.
- Any claim arising directly or indirectly from active involvement in a 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.
- Any participation in 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.
- Any participation in aviation activities where any medical expense incurred in relation to such activities (excludes fare-paying passengers in a licensed passenger carrying aircraft).
- Any participation in hazardous sport such as all forms of motorised/jet racing or motorised/jet aerobatics, whether by land, sea or air; mountaineering, scuba diving and hunting, shooting or deploying firearms in any manner other than for self-defence purposes. These sports are excluded regardless of whether these activities are performed privately, socially, during practice sessions, while participating in organised events or as an amateur or a professional.
- Any participation in any form of race or speed test (other than on foot or involving any non-mechanically propelled vehicle, vessel, craft or aircraft).
- Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riots, strikes, or the activities of locked-out workers.
- 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.
- Compensation in terms of the War Damage Insurance Act 85 of 1976.
- Any loss arising from any contractual liability.
- Any consequential loss or damage whatsoever.
- Any attempt by an Insured Person to commit an unlawful act.
- Any attempt by an Insured Person to commit suicide, intentional self-injury or reckless exposure to danger.
- Any claim payable in terms of alternate proclaimed legislation, such as the Compensation for Occupational Injuries Act 90 of 1993, and the Road Accident Fund Act 56 of 1996.
- An event not covered by this Policy and/or falling outside of the Policy's intention.
- Any claim that is not paid by a Medical Scheme.
- No Benefits shall be payable due to the Insured person's failure to comply with the Medical Scheme rules.
- No benefits shall be payable in the event of fraudulent submission by the claimant.

Section 2: Policy

Helpful Definitions

The following definitions apply throughout the Policy and all relevant documentation.

- In this Policy, all words and expressions signifying the singular shall include the plural and vice versa.
- Words and expressions which denote any gender include all genders.
- Where age is mentioned in the Policy, it will be the age attained.

Definition	Meaning
Accidental Harm	Bodily injury caused by sudden, violent, unintentional, external and physical means.
Balance Billing	A practice where a Medical Practitioner or other medical service providers charges a separately identifiable fee that is over and above the Tariff fee (or set of such fees) relating to a Medical Procedure (or procedures) and is billed together on one statement or invoice, and is not considered as a refundable Benefit by a Medical Scheme.
Basic Dentistry	Means the following dental Treatment: cleaning, extractions (including wisdom teeth), fillings, inlays, bonding, root canal Treatment, and Treatment for pain and abscesses.
Deductible or Co-payment	A predetermined, fixed rand amount set by the Policyholder's Medical Scheme that is deducted from the Medical Scheme's Benefit entitlement when certain Medical Procedures or Covered Events occur. This definition specifically excludes any Deductibles or Co-payments calculated as a percentage of costs rather than as a fixed rand amount.
Dependent Child	The Policyholder's unmarried biological child, legally adopted child, or stepchild who is a dependent on their Medical Scheme. Cover under this Policy ends when the child turns **26** years old. However, the child may take out a new Policy in their own name within **31** days of turning **26** years, without any additional Waiting Periods or exclusions. This age limit does not apply to a Special Needs Child, as defined in this Policy, who continues to be covered under the Policyholder's Medical Scheme.
Designated Service Provider (DSP)	A medical service provider designated by a Medical Scheme as one of its preferred suppliers.
Family	Collectively, the Policyholder, their Spouse, and/or Dependent Child/Children as Family are defined in this Policy document.
Hospital	Any institution in the Republic of South Africa which provides facilities for medical and surgical diagnoses, Treatment and 24-hour nursing care for injured persons or people suffering from an Illness as defined in this Policy. This excludes day clinics or unattached surgical theatres.
Hospital Network	A list of Hospitals, specified by the Insured Person's Medical Scheme, as the Hospital Network Designated Service Provider of one or more Benefit options of the Medical Scheme.
Hospital Stay	The period between admission to the Hospital for an Insured Person until the time of discharge from the Hospital of the same Insured Person for the same Covered Event.
Illness	Any medically diagnosable and diagnosed disease or sickness (excluding self-illness diagnoses) that affects an Insured Person's body and warrants Treatment.
Medical Practitioner	A medically qualified professional who is registered with the Health Professions Council of South Africa and Authorised to practice medicine in the Republic of South Africa.

Medical Procedure	Any procedure listed in the National Health Reference Price List (NHRPL), including follow-up care provided by the Medical Practitioner who performed the procedure, while the Insured Person is still admitted to the Hospital.
Network	A healthcare service provider that has an agreement with a Medical Scheme to deliver cost-effective medical services to its members. Medical Schemes establish negotiated rates with a selected network of providers, including Hospitals, clinics, doctors, specialists, and pharmacies.
Overall Annual Limit (OAL)	The total value of the compensation allowed for all aggregated claims as defined within the Schedule, per Insured Person registered on the Policy. The Overall Annual Limit (OAL) for claims is aggregated to a maximum of **R223 000** from **1 April 2026 to 31 March 2027**, unless specified, per beneficiary per annum. The number of claims that can be submitted against this Policy is unlimited, except if the benefit category defines otherwise or until the maximum overall annual limit is reached.
Penalty	Any Co-payment, deductible, exclusion or reduction applied against the Benefits of the Policyholder's Medical Scheme that would otherwise not have been applied had the authorisation rules of the Medical Scheme been adhered to or the Benefits had been attained from the Designated Service Provider or Hospital Network of that Medical Scheme Benefit option.
Permanent Disability	Any Accidental Harm or physical Illness that renders a person permanently unable to work in their own or other occupation for which they are suited by training, education or experience.
Policy Exclusion	The list of services, conditions or events in the Policy which are not covered by this Policy.
Premature Birth	The natural or surgically assisted birth of one or more that occurs more than **41** days before the originally expected natural birth date. For this definition, the originally expected natural birth date is accepted as being **40** weeks, as verified by the clinical records of the mother's attending physician.
Prescribed Minimum Benefits (PMB)	A set of defined medical conditions that all Medical Schemes are legally required to cover, regardless of the plan option chosen by the member and according to the Medical Schemes Act 131 of 1998 as amended and the clinical criteria set out in the Rules of the medical schemes.
Special Needs Child	Any Child, including a legally adopted Child or Stepchild, of the Insured who, either by a physical or mental disability, is unable to financially support themselves and remains reliant on the Policyholder for support and care.
Split Billing	The practice where a Medical Practitioner or other medical service provider divides a bill for service into **2** or more portions, submitting one portion to the Medical Scheme and directing the remaining amount to the Policyholder to cover the shortfall in medical expenses.
Spouse	Means the person the Policyholder is married to by any law, custom or religion, or if the Policyholder is not married, the person he/she live with as a couple for at least **6** months (common-law relationship) and who is a spouse dependent on the Policyholder's Medical Scheme. If the Policyholder has more than one Spouse, they must make an irrevocable nomination of one Spouse and as defined in this Policy.
Stepchild	The biological or legally adoptive parent must, at any time after the birth of the Stepchild, have been married to the Policyholder. For this Policy, married means a marriage (including a customary marriage) or union recognised under South African law. The Child of the person you live with as a couple (common-law relationship) will not be regarded as the Policyholder's Stepchild.
Step-down/ Sub-acute Facility	An institution used after hospitalisation for supportive and rehabilitative healthcare for medical, post-surgical, post-traumatic, neurological, orthopaedic, musculoskeletal and other conditions.
Tariff	A specific Tariff registered by a Medical Scheme to determine the rate at which its Tariff Benefits are payable.

Trauma	Accidental Harm to an Insured Person that results directly in an Insured Event.
Treatment	Any form of investigation, examination, consultation, or Surgical Procedure by a Medical Practitioner to treat and/or monitor an Insured Person's medical condition arising out of an Insured Incident, but excludes any mental condition or insanity.

Covered Events

The following events are covered under this Policy:

- Accidental Harm, Illness or other health incidents that cause an Insured Person to be admitted to a Hospital and to undergo Treatment or Medical Procedures during the Hospital Stay;
- Any additional costs incurred as a result of childbirth in a Hospital ward (except where medically necessary), subject to a **12**-month Pregnancy Waiting Period; and
- Kidney dialysis for Insured Person's for the Treatment of acute or chronic renal failure.

Benefit	Description	Gap Benefit Limit
Core Benefits	The Core Benefits are deemed as individual Covered Events and may qualify for coinciding yet distinct Benefits, as the case may be. The headings below are for reference purposes only and will not form part of any Benefit definition. All core Benefits are limited to the Overall Annual Limit of **R223 000** per Insured Person per annum.	
In-Hospital Benefits		
Tariff Shortfalls	Benefits are payable for services provided by a Medical Practitioner during a Hospital stay. The Benefit payable is limited to a minimum of **100%** and a maximum of **500%** of the Medical Scheme Rate based on the Insured's Medical Scheme Plan. **Defined Medical Procedures:** • Maxillofacial surgery • Back and spinal surgery • Orthopaedic surgery	The Benefit payable is limited to **500%** of the Medical Scheme Rate. The Benefit for all anaesthetist-related costs is limited at a maximum of **200%** of the Medical Scheme Rate, regardless of the Medical Scheme Plan or the service provider involved. If a non-designated service provider is used under a Medical Scheme Plan that operates through a DSP network, the Benefit payable is limited to a maximum of **100%** of the Medical Scheme Rate, regardless of the specific Plan. For Treatment related to the specified Defined Medical Procedures, the Benefit payable is limited to a maximum of **100%** of the Medical Scheme Rate, regardless of the Medical Scheme Plan or the service provider used.
Co-Payments & Deductibles	Benefits are payable for the Defined Diagnostic Procedures listed, which occur during a Covered Event. The Benefit payable equals the fixed value Deductible or Co-payment amount, as defined in the rules of the Insured Person's Medical Scheme	The Benefit payable equals the fixed value, Deductible or Co-payment amount. Subject to the Core Benefit limit (OAL)

	and relating to the Defined Diagnostic Procedure listed below. **Defined Diagnostic Procedures:** • Cystourethroscopy, colonoscopy, proctoscopy, sigmoidoscopy, gastroscopy, cystoscopy or hysteroscopy. • CT scan, MRI scan or PET scan. Only the specified Medical Procedures listed under this clause, and performed during a Hospital Stay, will be eligible for compensation. The Benefit payable equals the fixed value Deductible or Co-payment amount, as defined in the rules of the Insured Person's Medical Scheme and relating to the Defined Medical Procedures listed below. **Defined Medical Procedures:** • Conservative back and neck Treatment, myringotomy, tonsillectomy, adenoidectomy, facet joint injections, arthroscopy, functional nasal procedures, non-malignant hysterectomy, laparoscopy, endometrial ablation, hernia repair, varicose vein surgery, percutaneous radiofrequency ablations, rhizotomies, confinement, circumcision, hymenectomy, Nissen fundoplication, spinal fusion or major joint replacement.	
Penalty Co-payment	The benefit payable is a fixed value, Penalty Co-payment or Deductible, as defined in this Policy, for the voluntary use by an Insured Person of a Hospital that is not part of the Medical Scheme's Hospital Network. Any other liability incurred by the Insured Person due to a Penalty, as defined, that is not a fixed-value Penalty Co-payment specified in the rules of the Insured Person's Medical Scheme, will continue to be excluded from this Policy.	Limited to **1** event per Policy per annum, up to a maximum of **R16 000** per event.
Shortfalls from Sub-Limits	Benefits are payable for services rendered during a Hospital Stay when the associated charges exceed the applicable sublimit of the Insured Person's selected Medical Scheme Benefit option. The Benefit payable equals the total charged amount minus the portion covered by the Insured Person's Medical Scheme.	Limited to a maximum of **R50 000** per Policy per annum.
Childbirth	Benefits are payable for services provided and billed by an individual Medical Practitioner during a Hospital stay (except in cases where the services are deemed medically necessary). The Benefit payable is limited to a minimum of **100%** and a maximum of **200%** of the Medical	Limited to a maximum of **R15 900** per Hospital event.

	Scheme Rate based on the Insured Person's Medical Scheme Plan.	
Dental	Benefits are payable for Basic Dentistry as defined in the Policy, as well as for the specified specialised dentistry procedures, whether performed during an in-hospital stay, at a day clinic, or on an outpatient basis. **Specialised Dentistry Procedures:** • Surgical extractions of wisdom teeth.	Limited to a maximum of: • **R5 480** of Tariff Shortfall per Policy, per annum. • **R5 480** for Co-payments per Policy, per annum. • **2** events per Policy per annum. • Subject to the Core Benefit limit (OAL)
In-and Out-of-Hospital Oncology Benefits		
Oncology Tariff Shortfalls	Benefits are payable in respect of Oncology and related Treatment, which has been approved by the Insured Person's Medical Scheme, to treat cancer (malignant neoplasm) which occurs during a Covered Event. The Benefit payable is limited to a minimum of **100%** and a maximum of **500%** of the Medical Scheme Rate based on the Insured Person's Medical Scheme Plan.	The Benefit payable is limited to **500%** of the Medical Scheme Rate.
Oncology Co-Payments	Benefits are payable in respect of Oncology and related Treatment, which has been approved by the Insured Person's Medical Scheme, to treat cancer (malignant neoplasm) which occurs during a Covered Event. The Benefit payable equals the Co-payment applied by the Insured Person's Medical Scheme once related costs have exceeded the specific threshold.	Limited to **20%** of the Co-Payment, subject to the Core Benefit limit (OAL)
Oncology Sub-Limits	Benefits are payable in respect of Oncology and related Treatment, which has been approved by the Insured Person's Medical Scheme, to treat cancer (malignant neoplasm) which occurs during a Covered Event. Benefits are payable for services where the charges exceed the Oncology Treatment sub-limit applicable to the Insured Person's Medical Scheme Benefit option. The Benefit payable equals the total charged amount less the amount paid by the Insured Person's Medical Scheme.	Subject to the Core Benefit limit (OAL).
Out-of-Hospital Benefits		
Tariff Shortfalls	Benefits are payable for the Defined Outpatient Procedures and Treatments listed below, provided and charged by a Medical Practitioner.	The Benefit payable is limited to **500%** of the Medical Scheme Rate.

	Defined Outpatient Procedures and Treatments: • Cystourethroscopy, colonoscopy, proctoscopy, sigmoidoscopy, gastroscopy, cystoscopy or hysteroscopy. The Benefit payable is limited to a minimum of **100%** and a maximum of **500%** of the Medical Scheme Rate based on the Insured's Medical Scheme Plan.	If a non-designated service provider is used under a Medical Scheme Plan that operates through a DSP network, the Benefit payable is limited to a maximum of **100%** of the Medical Scheme Rate, regardless of the specific Plan.
Co-Payments & Deductibles	Benefits are payable for the Defined Diagnostic Procedures listed, which occur during a Covered Event. The Benefit payable equals the fixed value Deductible or Co-payment amount, as defined in the rules of the Insured Person's Medical Scheme and relating to the Defined Diagnostic Procedure listed below. **Defined Diagnostic Procedures:** • Cystourethroscopy, colonoscopy, proctoscopy, sigmoidoscopy, gastroscopy, cystoscopy or hysteroscopy. • CT scan, MRI scan or PET scan.	The Benefit payable equals the fixed value, Deductible or Co-payment amount. Subject to the Core Benefit limit (OAL)
Accidental Casualty	Benefits are payable for emergency outpatient services directly resulting from Accidental Harm, provided the services are rendered within the casualty ward of a Hospital. The Benefit payable equals the charged amount less the amount paid by the Insured Person's Medical Scheme risk pool benefits. No Benefit is payable for services related to Illness, or for services resulting from Accidental Harm that are not provided in the casualty ward of a Hospital.	Limited to a maximum of **R15 900** per Policy per annum.
External Appliances	Benefits are payable for the purchase of External Appliances as defined in this Policy.	Limited to a maximum of **R2 120** per Policy per annum.
Benefit Extender		
Family Booster	A lump sum Benefit payout in the event of a Premature Birth, as defined, occurs.	Limited to a maximum of **R15 000** per Policy per annum.
Dental Reconstruction	Benefits are payable for dental reconstruction surgery required due to Accidental Harm or as a result of Oncology Treatment(provided the incident occurred after the Policy Start Date). The Benefit payable equals the total charged amount less the amount paid by the Insured Person's Medical Scheme.	Limited to a maximum of **R40 000** per Policy per annum.
Medical Scheme	This Benefit becomes payable if the main member of the Medical Scheme, who must also be the Policyholder of this Gap Cover Policy,	Limit to a maximum of **R30 000** for a maximum of **6** months during the lifetime of the Policy.

Contribution Waiver	passes away or becomes Permanently Disabled, provided all Insured Persons are covered under a single Medical Scheme. In cases where there is dual Medical Scheme membership, the Benefit applies only to the Policyholder's Medical Scheme. • The payout is limited to the actual monthly contribution to the Medical Scheme, and is subject to both the Medical Scheme and this Policy's Premiums being fully paid at the time the claim is submitted. •	
Step-Down Facility	A one-time lump sum Benefit is paid if the main member of the Medical Scheme, who must also be the Policyholder, spends at least **10** consecutive days in a Step-Down or sub-acute facility, as defined in this Policy.	Limited to a maximum of **R5 000** per Covered Event, per Policy per annum. Limited to **1** Covered Event per Policy per annum.

Cover Exclusions

We shall not be liable for hospitalisation, bodily Injury, sickness or disease directly or indirectly caused by or related to or in consequence of:

- Any claim that is excluded or rejected by the Insured Person's Medical Scheme.
- Any claim that does form part of the registered Benefits of the Insured Person's Medical Scheme but has been compensated on an ex-gratia basis.
- All Prescribed Minimum Benefits conditions and Treatment related to Prescribed Minimum Benefits.
- Any external and internal prosthesis.
- Any appliances, including, but not limited to, wheelchairs, beds or convalescent equipment.
- All dental procedures, including, but not limited to, crowns, bridges, dental implant-related procedures, orthodontic surgery, temporomandibular joint ("TMJ") surgery, labial frenectomy, bone augmentations, bone or tissue regeneration. This excludes benefits specified under the "Dental Reconstruction Benefit".
- Harvesting and/or preserving of human tissues, including but not limited to stem cell regeneration.
- Abortion, attempted abortion or any complications related thereto unless treatment is, in Our sole opinion a non-elective nature.
- Breast augmentation.
- Gastroplasty, lipectomy or otoplasty.
- Any Treatment or Medical Procedure related to obesity.
- Cosmetic surgery, except in the case where reconstructive cosmetic surgery is necessitated, in Our sole opinion, a direct result of Trauma or other essential non-elective Treatment or Medical Procedure.
- Gender reversal procedures.
- Therapeutic massage therapists, health hydro or alternative therapy.
- Rehabilitation, frail care, hospice services or services provided at a convalescent home or home for the elderly.
- To-take-out (TTO) medicines
- Any Co-payment or Deductible applied by the Insured Person's Medical Scheme against the Benefits to be received or compensated by the Medical Scheme, unless specifically stated as included in this Policy.
- Any Penalty, as defined in this Policy, applied by the Insured Person's Medical Scheme, unless specifically stated as included in this Policy.

- Any fee charged by a Medical Practitioner, Hospital or other medical service provider that constitutes Balance Billing or Split Billing as described in this Policy.
- Any criminal act or attempted criminal act by an Insured Person, which will include the submission of any fraudulent information or the use of any fraudulent means to obtain any Benefit under this Policy.
- Any Treatment or Medical Procedure for infertility.
- Any act by an Insured that willfully exposes the Insured to danger (except where such an act was necessitated in order to save human life).
- Any Treatment or Medical Procedure that, in Our sole opinion, is of such a nature that it is not considered to be medically necessary, or where alternative conservative Treatment would provide a similar outcome, or is of such a nature that there is no likely improvement in the medical condition of the Insured Person.
- Any procedure or examination where there is no objective indication of impairment in normal health.
- The consumption of any drug or narcotic, whether legal or illegal, unless legally described by and taken under the instructions of a Medical Practitioner.
- The failure of an Insured Person to follow any medical advice given by a Medical Practitioner.
- Any incident, illness, Accidental Harm or event directly or indirectly caused by the continuous and excessive consumption of alcohol, drugs, substance abuse or where the Insured Person suffers from alcoholism or any form of addiction.
- Any incident, illness, Accidental Harm or event directly or indirectly attributable to the Insured Person having a blood alcohol content exceeding the statutory limit.
- Any Treatment or Medical Procedure unless such Treatment occurred during the period Period of Insurance.
- Shortfalls or Co-payments as a result of not following the Medical Scheme guidelines as per the Medical Scheme referral process.
- All costs related to consultations or services provided on an outpatient basis, unless specifically stated as included in this Policy.
- Any cost related to psychiatric or psychological conditions such as depression, insanity, emotional or mental illness or any stress-related conditions.
- Any cost incurred in an institution that primarily provides care for the elderly or persons who are mentally retarded, blind, deaf, mute or in any other way physically handicapped.
- All costs related to ward and theatre fees on the Hospital account.
- All costs related to admission fees, both in- and out-of-hospital.
- All costs related to exploratory procedures such as blood tests, pap smears, ultrasounds, etc.

Special Conditions

Age Of Insured Persons

- The Policyholder must be older than **18** years unless they are registered as the Principal Member on a Medical Scheme.

Waiting Periods

The following Waiting Periods apply to this Policy:

1. A **3**-month general Waiting Period applies to any newly incepted Policies and/or additional dependents to the current Policy.
2. A **12**-month Waiting Period on Pre-existing Conditions, diseases, or illnesses. These include any conditions, including Cancer, which existed before the Start Date of the Policy, or for which an Insured Person has sought or received medical advice or received Treatment by a Registered Medical Professional or exhibited symptoms before the Start Date of the Policy. Failure to disclose any Pre-existing Condition could render the Policy null and void.

3. A **12-**month Waiting Period for any pregnancy-related Incidents (if pregnant at the Start Date of the Policy).

- Waiting periods will run concurrently if **2** or more Waiting Periods apply to an Insured Person.
- Waiting periods will be applied to the cover of the relevant Insured Person, from the Cover Start Date for such Insured Person under this Policy.
- Waiting periods will apply from the date when dependents are added to the Policyholder's Medical Scheme.
- Should the Insured Person under this Policy have previously had a gap policy with materially similar Benefits, the period of the Pre-existing Condition Waiting Period and/or Pregnancy Waiting Period above will be reduced by the expired portion of the Pre-existing Condition Waiting Period and/or Pregnancy Waiting Period served under such previous policy.
- If there is no unexpired portion of the Pre-existing Condition Waiting Period of such previous policy, the Pre-existing Condition Waiting Period and/or Pregnancy Waiting Period of this Policy will be waived. Such waiver only applies if the break in cover between the previous policy and this Policy is **90** days or less.
- We reserve the right to waive the General, Pre-existing Condition Waiting Period and/or Pregnancy Waiting Period for the Insured Person based upon pre-determined criteria. Any such waiver applied will be indicated on the Policy Schedule of this Policy.

Medical Examination

- Payment of any Benefit is conditional on the Insured Person supplying such medical evidence as is required for Us to adequately assess the validity of the claims or for an Insured Person to undergo any medical examination if requested and compensated for by Us.

Family Member Limit

- The Benefits of this Policy are extended to a maximum of **7** Family members, as defined in this Policy and as registered on the same Mbedical Scheme of the Policyholder at the time of the Covered Event.