OLDMUTUAL

2026

OLD MUTUAL HEALTH SOLUTIONS

ConnectGap Cover

CORPORATE

DO GREAT THINGS EVERY DAY

GENRIC Insurance

kaelo

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WHAT IS **GAP COVER**

Gap Cover is additional protection against shortfalls to complement your Medical Scheme cover. Shortfalls occur when your healthcare provider charges higher rates than what your Medical Scheme will pay. These shortfalls expose you to out-of-pocket expenses that could lead to exorbitant debts.

WHAT DOES IT **COVER?**

Medical Related Benefits	Other Benefits
• Tariff Shortfalls • Consumables • Oncology Co-Payments and Sub-Limits • Step-Down Facility • Dental Reconstruction Benefit • Accidental Casualty • Child Casualty Illness • Innovative Oncology Medicines	• Accidental Death and Disability Benefit - Policyholder and Dependants. • Oncology First-Time Diagnosis • Medical Scheme Contribution Waiver • ConnectGap Premium Waiver

The Benefits listed are only a summary of cover. For a comprehensive list of Benefits and limits that apply to your specific plan, please view your Policy document

YOUR INSURER

The insurance Policy is underwritten by Insurer:
GENRIC Insurance Company Limited (FSP: 43638). GENRIC is an Authorised Financial Services Provider and licensed non-life Insurer. The cover provided is subject to all the terms and conditions explained throughout your Policy.

YOUR UNDERWRITING MANAGER

Kaelo Risk (Pty) Ltd, registration number 2008/019335/07, an authorised Financial Services Provider (FSP 36931), is your Underwriting Manager.

The Underwriting Manager is responsible for administering your Policy which includes:
• Issuing your Policy
• Processing your claims
• Collection of your Premium.
• You can reach Kaelo on 0861 106 660 or email **connectgap@kaelo.co.za**

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BENEFITS

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

Medical Related Benefits				
Health Service	**Benefit**	**Core**	**Plus**	**Secure**
Overall Annual Limit	All core Benefits are limited to the Overall Annual Limit of **R223 000** per Insured Person per annum. This limit applies from **1 April 2026** to **31 March 2027**, while the current limit of **R219 845** applies from **1 January 2026** to **31 March 2026**.			
Tariff Shortfalls	Limited to an additional 6 times (600%) of the Medical Scheme Rate for treatment received whilst in-hospital, or outpatient procedures where the charges were paid by your medical aid from the risk/hospital benefit.	Subject to the Overall Annual Limit		
Standard Co-payments and Deductibles	Standard Co-payment or an upfront Deductible amount for the cost of a Medical or Surgical Procedure. The Benefit payable equals the fixed value, Deductible or Co-payment amount.	✗	Subject to the Overall Annual Limit	
Penalty Co-payments and Deductibles	The requirement in the rules of the Medical Scheme is that the Policyholder contributes a Penalty Co-payment, related to the use of a non-Designated Service Provider (DSP).	✗	Limited to 2 events and a maximum of **R11 130** per Policy Per Annum.	Limited to 2 events, maximum **R13 000** per Policy Per Annum.
Sub-Limit	The cost for Surgical Procedures or the cost of Internal Prosthesis above a sub-limitation in terms of the Medical Scheme rules.	✗	✗	Limited to a total Benefit of **R70 800** per Policy Per Annum
Consumables	Charges above the Medical Scheme Tariff related to shortfalls on medicine, materials and internal appliances on the doctor's account.	Limited to **R7 120** per Insured Party Per Annum.		
Oncology Co-Payments and Sub-Limits	A Benefit equal to charges above a sub limitation, a Co-payment or a Deductible imposed by the Medical Scheme on chemotherapy or radiotherapy, basic and specialised radiology, pathology, specialist consultations and Biological Cancer Drugs for treatment received whilst as an in-patient and/or outpatient after you have reached your Medical Scheme's oncology benefit limit.	✓	✓	✓
Step-Down Facility	A stated Benefit for admission as an in patient to a Step-Down or Sub-Acute Recovery Facility provided that such admission results in a minimum stay of three consecutive days.	Limited to **R8 350** and one event per Insured Party Per Annum.		Limited to **R11 660** and one event per Insured Party Per Annum.
Dental Reconstruction Benefit	This Benefit is for charges above the Medical Scheme Tariff for Treatment received as an in-patient, related to dental reconstructive surgery due to an accident, Trauma or cancer.	Limited to **R11 500** per Insured Party Per Annum.		Limited to **R23 500** per Insured Party Per Annum
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.	Limited to **R15 050** per Policy Per Annum.		Limited to **R19 180** per Policy Per Annum.
Casualty Emergency	The Benefit payable is equal to the total cost of Treatment less the amount paid by your Medical Scheme from your hospital/risk benefit, or if payment is made from your available Medical Savings Account, or your own pocket.	Subject to a maximum of one event per Policy Per Annum and **R2 600** per event. The Benefit applies to Insured Parties aged 13 and above and is subject to treatment being after-hours.		
Child Casualty Illness	· Paid in respect of emergency outpatient services that are provided within a casualty ward of a Hospital. · The Benefit is only payable in the event of after-hours Treatment in an Emergency. · After-hours are Mondays to Fridays between 18:00 and 08:00 and all day Saturdays, Sundays and South African public holidays.	Subject to two events and **R3 000** per event Per Annum. Limited to children under age 12.		
Maternity Booster	A stated Benefit for childbirth where additional medical expenses are incurred as a result of the childbirth.	✗	✗	Subject to one maternity event Per Annum and limited to **R4000**.
Innovative Oncology Medicines	Approval for any innovative drugs will be required by your Medical Scheme.	A value equal to the lesser of 25% of the total drug cost or **R14 000** as it relates to Innovative Medicines		

Other Benefits				
Health Service	**Benefit**	**Core**	**Plus**	**Secure**
Accidental Death and Disability Benefit - Policyholder	If the Insured Person passes away or suffers total and permanent disability due to an accident, a stated Benefit will be payable.	Limited to **R15 600** per Policy Per Annum.		
Accidental Death and Disability Benefit - Dependants	If a Dependant passes away or suffers total and permanent disability die to an accident, a stated benefit will be payable.	Limited to **R10 550** for any Dependant per Policy Per Annum.		
Oncology First-Time Diagnosis	· A stated Benefit for the first-time diagnosis of cancer to the medical equivalent of stage 2 or higher form of cancer. · It excludes any form of cancer that was previously identified or required Treatment.	Limited to **R15 000** per Insured Party per lifetime, and provided that the Insured Party is younger than 66 years (at time of diagnosis).		Limited to **R39 400** per Insured Party per lifetime, and provided that the Insured Party is younger than 66 years (at time of diagnosis).
Contribution Waiver	In the event of the death or Total and Permanent Disability of the Medical Scheme main member, a Benefit equal to the monthly Premium of the Medical Scheme contribution will be paid, provided that the Policyholder is younger than 66 years (at time of claim).	Limited to an amount of **R5 166** per amount. The benefit will be paid for a period of 6 months		
Premium Waiver	In the event of the death or Total and Permanent Disability or forced retrenchment of the Policyholder, Policy Premiums will be waived provided that the Policyholder is younger than 66 years (at time of claim).	Waived for **6 months** from the date of the event.		

Any stated Benefit listed in this content is considered to be a contribution to pre-estimated costs and expenses.

EXCLUSIONS (What we will not cover)

For a detailed outline of all Policy Exclusions, please refer to section J of your Policy document.
Claims caused by or related to any of the following, will not be covered:

- Any claim that is excluded or rejected by the Insured Party's Medical Scheme. This means that, if your Medical Scheme has not paid their portion toward any particular line item charged, it will not be covered by your Gap Cover Policy.
- Any costs related to consultations or services provided on an out-patient basis, or outside of the hospitalisation date except where provision for outpatient Treatment has been paid by your Medical Scheme from the risk/Hospital benefit.
- Investigations, treatment and surgery for obesity its consequence, gender reassignment, cosmetic surgery or surgery directly or indirectly caused by or related to or inconsequence of cosmetic surgery other than as a result of an Insured Event.
- Out-patient dentistry, orthodontic, prosthodontic, cosmetic dentistry or dental implants, other than dental implants relating to an accident, Trauma or cancer related reconstructive surgery.
- Emergency casualty admissions that are not an Emergency or not with a registered Hospital Emergency unit, or where the cost of such an admission has been paid from the in-hospital risk portion of your Medical Scheme.
- Any procedure or code not covered or declined or paid as an exception by your Medical Scheme unless specific cover has been provided in the Policy.
- All costs related to ward fees, theatre fees and other Hospital expenses, including materials and medication on the Hospital account, unless specific cover has been provided in the Policy.
- Admin fees, levies or doctor's co-payments paid directly to the doctor or Specialist and are not related to your Medical Scheme.
- Any cost or shortfall due to you exceeding your benefit limit on your Medical Scheme unless specific cover has been provided in the Policy.
- Any costs related to to-take-home medication (TTO) dispensed for aftercare and External Appliances.
- Cancer Treatment costs and biological medication not approved by your Medical Scheme as part of your initial or ongoing oncology Treatment plan.

WAITING PERIODS

The Insurer will apply waiting periods to the cover of an Insured Party as set out below:

- Three (3)-month General Waiting Period from the date of inception (unless due to an accident) and a ten (10)-month waiting period for maternity and/or any procedures related to childbirth.
- Six (6)-month procedure-specific waiting period for any event related to joint surgery, nasal and sinus surgery, tonsillectomy, adenoidectomy, grommets, endoscopic and arthroscopic procedures, hernia repairs, hysterectomy, cardiac surgery, spinal surgery, dentistry and cataract procedures (unless due to an accident). This specific waiting period applies where medical advice, diagnosis, care or treatment was recommended or received for the condition within twelve (12) months before the Policy started.
- Previously diagnosed cancer, will be regarded as a pre-existing condition and Oncology Cover will be excluded for twelve (12) months. The Oncology Diagnosis Benefit is for an Insured Party that has not previously been diagnosed with any form of cancer that required treatment.
- Waiting Periods will be applied to the cover of the relevant Insured Party from their Inception Date.
- If an Insured Party previously had a similar Medical Expense Shortfall Policy, not longer than 90 days before the inception of this Policy, the period of the General Waiting Period and Condition-Specific Waiting Period will be reduced by the expired portion of the General Waiting Period and Condition-Specific Waiting Period served under such previous Policy.
- Waiting periods will not apply to a newborn, Eligible Child, Special Needs Child or Eligible Spouse if they are registered with Kaelo within 90 days and added to the Policy, as a Dependant, from the birth or marriage date. Premiums will be payable from the birth or marriage date.
- Should the Eligible Child, Special Needs Child or Eligible Spouse not be registered with Kaelo within 90 days, full waiting periods will apply to the Dependant.
- Kaelo reserves the right to waive or amend the waiting periods for the Policyholder and Insured Parties of participating employers based upon pre-determined criteria. Waiting periods applied may differ as per the plan selected.
- Any waiting periods waived or amended will be shown on the Policy Schedule.

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HOW TO **SUBMIT A CLAIM**

1 SUBMIT

2 NOTIFIED

To claim from ConnectGap you will need to submit the following:

- A completed ConnectGap Claim form, (www.kaelo.co.za/connectgap).
- A copy of the specialist's account(s);
- Hospital accounts; and
- A copy of your Medical Scheme's statement showing the processing of the account and the shortfall.

Time frame to submit your claim:

You have **six** months from the end of the Insured Event to submit your claim. Any claim received after the **six** month period has ended, will not be accepted.

Time frame to process your claim:

Once all required documents have been received, your claim will be assessed and if valid, within 7 to 14 working days.

Member queries:

0861 106 660

connectgap@kaelo.co.za

www.kaelo.co.za/connectgap

For quotes or more information contact:

connectgap@oldmutual.com

www.oldmutual.co.za/healthsolutions

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