Medical Gap Cover

Policy Terms and Conditions
Effective 2016

Table of Contents

Welcome

Thank you for choosing Instant Life Medical Gap Cover, underwritten by Guardrisk Insurance Company Limited as your preferred gap cover provider.

Our commitment to you is that we will offer you excellent service and provide you with a cost effective and comprehensive product which meets your gap cover needs.

It is very important that you understand how your gap cover works. For this reason, please read through your policy documentation, which has been written in plain language. If however, you require any additional information, you are welcome to contact the Instant Life call centre on 087 806 1413 and one of our helpful and knowledgeable call centre operators will be happy to assist you.

Please note that Guardrisk Insurance Company Limited has adopted English as its official language and all correspondence will therefore be in English.

To help us in making sure that we provide you with excellent service delivery, please ensure that all of the information you have provided is correct and please remember to update Instant Life should there be any changes to this information.

Instant Life

1. Important information

The below information applies to your policy with us. Please ensure that you read these terms and conditions carefully and that you fully understand them as they affect your cover under this policy. This policy and its terms and conditions of cover apply with effect from «./Policy/StartDate» and replace all prior policy wordings issued by us.

2.1 How gap cover works

2.1.1 You will only qualify for cover under this policy if you are a member of a registered medical scheme.

2.1.2 Gap cover is written under a Short Term Insurance licence as an Accident and Health product.

2.1.3 A gap cover policy is not tax deductible and we do not issue tax deduction (IT3) certificates for the premiums that you pay in respect of this policy.

2.1.4 The main purpose of gap cover is to provide cover for the shortfall between what a medical practitioner charges and what your medical aid pays, for any in-hospital surgical procedure or for certain out-of-hospital surgical procedures.

2.1.5 Gap cover also insures against co-payments or deductibles which may be levied against you by your medical aid, for certain procedures.

2.1.6 Gap cover does not replace or act as a substitute for your medical aid cover, nor does it cover you for every shortfall between what you are charged and what your medical aid pays.

2.2 Summary of benefits

A summary of the benefits offered are detailed below:

2.2.1 Benefit for shortfalls including prescribed minimum benefits

2.2.2 Benefit for co-payments applied by your medical aid for certain procedures

2.2.3 Benefit for co-payments on oncology treatment programmes

2.2.4 Benefit for shortfalls in internal prosthesis costs

2.2.5 Lump sum benefit for first time cancer diagnosis

2.2.6 Lump sum benefit for personal accidental death and disability

2.2.7 Lump sum benefit for long-term hospitalisation

2.2.8 Fixed benefit for tooth repairs as a result of accidental injury

2.2.9 Hello Doctor benefit

2. The Policy

2.1. General conditions

2.1.1. If you pay us the premium due in respect of this policy, we will pay you the benefits that you are entitled to in terms of this policy.

2.1.2. This policy wording and your Policy Schedule sets out the terms and conditions of your policy with us. It is a legal contract between you and us and it is based on the information given to us when you applied for the cover.

2.1.3. Our duty in terms of this policy is to provide the cover and pay the benefits, which are explained in this policy wording and which is detailed on the Policy Schedule that we send to you. Your Policy Schedule confirms your personal details, the period of time that you are covered for and the monthly premium payable for this cover.

2.1.4. Your duty in terms of this policy is to pay the premium and act in accordance with all of the terms and conditions of this policy wording.

2.1.5. If you do not carry out your duty in terms of this policy, we may reject a claim or even cancel your contract with us.

2.1.6. Your cover with us will begin on the cover start date that is reflected on the Policy Schedule that we issue to you. Cover can only begin on the 1st day of a calendar month and it can only terminate on the last day of a calendar month.

2.1.7. If we find that you have:

- not disclosed or incompletely disclosed anything that may affect our acceptance of your application for cover or
- submitted a claim that is false or overstated,

We may refuse to pay a claim under this policy or we may cancel the policy from the date on which we make this finding. If this happens you will not be entitled to a refund of premiums paid and we may also take legal action against you. If we have already paid a claim you will be required to pay back any amounts we paid in respect of this claim.

2.1.8. We will only cover you if you are living in the Republic of South Africa.

2.1.9. You are only covered for procedures and treatment which take place in the Republic of South Africa and where you have used the services of a South African registered medical services provider.

2.1.10. If you leave the Republic of South Africa to work in another country for your South African employer for more than 3 consecutive months, you will no longer be eligible for cover under this policy.

2.1.11. If this happens, when you return to South Africa you can continue your cover with us on the same terms and conditions, as long as you once again become a member of a medical aid.

2.1.12. Under no circumstances will we confirm the value of a benefit that we will pay before you have undergone treatment or a procedure. This is because the amount that we will pay can only be calculated once your treatment or procedure has been undertaken, you have received all of the necessary documentation from your medical aid and service providers and your actual shortfall can be calculated.

2.1.13. It is agreed that only the laws of the Republic of South Africa apply to this policy, and as a result any legal proceedings in connection with this policy will only take place in the courts of the Republic of South Africa.

2.1.14. It is agreed that if any terms of this policy contradict the law of the Republic of South Africa, the terms of the law will take priority over the policy.

2.2. Definitions

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

2.2.1. **"Accident"** means a sudden, unexpected, violent and visible external event, which is inflicted on you by something other than yourself at an identifiable time and place and that independently of any other cause, results in bodily injury.

2.2.2. **"Bodily Injury"** means physical damage of the function of a body part, organ or brain and it includes cuts, abrasions, bruises, burns and disfigurements;

2.2.3. **"Disease"** refers to an abnormal condition affecting an organism of the body. This abnormal condition could be due to infection, degeneration of tissue, injury/trauma, toxic exposure, development of cancer, etc. This is what needs to be 'cured', especially if it's life-threatening;

2.2.4. **"Due Date"** means the date on which your premium is due as reflected in your debit order mandate;

2.2.5. **"Hospital"** means any institution in the Republic of South Africa that:

- Provides diagnostic (problem solving) and therapeutic (healing) facilities for surgical and medical analysis, treatment and care of sick or injured people by or under the supervision of medical practitioners; and
- Provides 24 hour nursing services by nurses registered with the South African Nursing Council (SANC) to sick or injured people within these facilities.

A hospital does not include:

- A casualty ward; or
- A day clinic or operating theatre that is not attached to a hospital; or
- A mental institution or home for recovery; or
- A place of rest or care facility for the elderly (including Hospice); or
- An institution that provides long-term care for people that are mentally disabled, blind, deaf, mute or in any other way physically handicapped; or
- An institution that treats people for drug addiction, alcoholism, eating disorders or any other form of addictive behaviour; or
- A health hydro, natural cure or alternative therapy clinic; or
- A step-down facility (also called a medical rehabilitation centre).

2.2.6. **"Illness"** means the symptoms that might come with having a disease. Symptoms like pain, fatigue, weakness, discomfort, distress, confusion, dysfunction, or the like – the reasons people seek healthcare.

2.2.7. **"Insured person"** means any person that is registered as a dependant on your medical aid and is eligible for cover on this policy;

2.2.8. **"Medical aid tariff"** (also called Medical Scheme Tariff or "MST") means a specific amount that your medical aid has committed to paying for a specific procedure. Your medical aid calculates this amount based on what it can afford to pay for the procedure, not on the actual costs to the

medical practitioner for performing the procedure. Your medical aid will have a tariff for every procedure that it covers and these tariffs can be requested from your medical aid.

2.2.9. **"Medical practitioner"** means a person who is legally qualified as a medical practitioner, registered with the Health Professions Council of South Africa (HPCSA) and authorised to practice in the Republic of South Africa;

2.2.10. **"Permanent and totally disablement"** means being completely unable to perform any occupation whatsoever, unable to perform any normal daily living tasks (such as eating, dressing, bathing, walking, etc.) yourself and in the opinion of a medical practitioner, unlikely to ever recover from disability;

2.2.11. **"Policy Schedule"** means the schedule that is issued to you confirming the details of your cover under this policy.

2.2.12. **"Prescribed minimum benefits"** (PMB's) means, "a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the option they have chosen". This means that there are approximately 270 listed conditions that according to the Medical Schemes Act 131 of 1998, your medical aid should provide you with cover for. This list is updated once a year and can be found on the Council for Medical Schemes' website at www.medicalschemes.com.

2.2.13. **"Procedure"** means any medical or surgical procedure which is listed in the National Health Reference Price List (NHRPL) and it includes follow ups after the procedure, by the medical practitioner that performed the procedure, while you are still admitted into hospital;

2.2.14. **"Treat"** means to give medical care or attention to in order to try to heal or cure;

2.2.15. **"Waiting period"** means a period of time during which you have to pay your monthly premium but you cannot claim from the policy for specific events that happen during this period. A waiting period is calculated from (and includes) the 1st day on which your cover begins with us or is reinstated by us and any costs not paid by your medical aid for specific procedures or treatments which take place during this period cannot be claimed (either during or after the waiting period has finished). A waiting period protects all policyholders by ensuring that individuals are not able to make a large claim shortly after joining and then cancelling their cover. This would unfairly result in increased premiums for all policyholders.

2.2.16. **"We"** (that is wherever we say 'us', 'our' or 'we') means Guardrisk Insurance Company Limited (Reg. No. 1992/001639/06, FSP No. 5) who is the insurer of this policy.

2.2.17. **"You"** means the person who has cover under this insurance policy and it includes every person who qualifies for cover under this policy. Only you have rights in terms of this policy and may claim against this policy. You may not give your rights up to anyone else.

2.3. Who is covered

2.3.1. You may only apply for, be granted cover under and continue to remain covered under this policy if you are and remain an active member of a medical aid (also known as a medical scheme). The medical aid that you are a member of must be registered in the Republic of South Africa by the Registrar of Medical Schemes and in terms of the Medical Schemes Act No. 131 of 1998 or it must be registered as a sick fund in terms of the Labour Relations Act No. 66 of 1995.

2.3.2. If you are not covered by a medical aid at any time, you will not qualify for cover under this gap policy during that time. If this happens, it is your responsibility to let us know so that we can cancel your policy with us.

2.3.3. You may not incept this policy if you are younger than 18 years unless you are registered as the principal member on a medical aid.

2.3.4. Dependants who are 65 years old or older at policy inception will not be covered under this policy.

2.3.5. If you are already covered by us when you turn 65 years, you will continue to enjoy cover with us provided you continue to remain an active member of a medical aid. If you cancel your policy with us or your policy lapses after the age of 65, you will not be able to reinstate your cover with us.

2.3.6. Any child, spouse or extended adult dependant that is registered as a dependant on your medical aid is also covered under this policy.

2.3.7. A child dependant can include your natural child, your stepchild or a child that you have legally adopted. Your child must be registered as an active member on your medical aid to qualify for cover under this policy.

2.3.8. A spouse can mean a person that you are married to in terms of South African law, a customary union, or a religious union. Your spouse must be registered as an active member on your medical aid to qualify for cover under this policy.

2.3.9. Only one spouse can be covered under this policy. If you have more than one spouse registered as a dependant on your medical aid, you must tell us in writing which spouse will be covered under your policy with us before your cover with us begins.

2.3.10. An extended adult dependant can include your parent, your brother or your sister. Your adult dependant must be registered as an active member on your medical aid before the age of 65 and for at least 12 months to qualify for cover under this policy. In addition, you must tell us in writing about any dependants over the age of 65 that are already eligible for cover under this policy.

2.3.11. When your child, your spouse or your extended adult dependant is no longer registered as an active member on your medical aid, they will also no longer qualify for cover under this policy. Their cover will end at exactly the same time as their cover under your medical aid ends.

2.3.12. If you die and your spouse or any other dependant remains an active member of the medical aid that you belonged to, your spouse or the dependant will have the option to continue cover under this policy by letting us know in writing within 60 days from the date of your death. To continue cover means that no waiting periods will be applied to the policy when it is changed to your spouse's or dependant's name and the cover will apply from the date of your death. Your current dependants will also continue to remain covered.

2.3.13. You cannot be covered under more than one gap policy with us at the same time. If we discover that you have more than one policy with us we will cancel the other policies and refund you the premium you have paid for these policies.

2.4. The premium

2.4.1. Your monthly premium is payable to us on your due date. The premium includes a commission of R24.72, an outsourcing administration fee R55.05 and a binder fee of R19.71, inclusive of VAT.

2.4.2. Your policy will renew annually on your policy renewal date (unless we have specifically agreed to another date) and at this time we will calculate a new premium and we may revise the policy terms and conditions. When we do this, we will give you at least 30 days' notice of the new terms, conditions and premium payable.

2.4.3. If we do not receive your first premium on the first due date on which premium is payable, your policy will not start and you will not have any cover.

2.4.4. It is your responsibility to ensure that we receive your first premium.

2.4.5. It is also your responsibility to ensure that you continue to pay your premium for you to remain covered on this policy.

2.4.6. If we collect your premium via a debit order deduction from your bank account:

- Your premium will be payable monthly on your agreed premium due date.
- We will always try to collect your premium on the agreed premium collection date. If for any reason we are unable to collect your premium on this date – for example, due to your deduction date falling on a weekend or a public holiday – we will collect your premium as close as possible to this date. All bank charges are for your account.
- It is your responsibility to ensure that there are available funds in your account on the date on which we submit your debit order.
- If we are unable to collect your premium by the due date, we will try to collect your premium during the following month or double deduct your premium during the following monthly debit order run.
- If we are once again unable to collect your outstanding premium, we will cancel your policy and your cover will terminate with effect from midnight on the day before your outstanding premium was due.
- If you cancel the direct debit that pays your premium for this policy, your policy will automatically be cancelled from the date that your premium was due to be paid.

2.4.7. If your policy is in a grace period this means that you are a month behind your premium payments to us and if you submit a claim during this period, we will not process your claim until you have paid us the premium owed to us. Once you have paid us this outstanding premium, we will process your claim.

2.4.8. Your premium can only be paid to us in South African currency that is, South African Rands.

2.4.9. If we decide to change the premiums for your cover under this policy, we will give you 30 days' written notice.

2.5. General exclusions

We will not cover you, under any circumstances, for any disease or bodily injury that is caused either directly or indirectly by, or is as a result of:

2.5.1. Your wilful participation in war, invasion, terrorist activity, rebellion, active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers;

2.5.2. Nuclear weapons, nuclear material, ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the burning of nuclear fuel, including any self sustaining process of nuclear fission (the splitting of an atomic nucleus into small parts);

2.5.3. Your taking of any legal drug unless it has been prescribed by a registered medical practitioner (other than you) and you are following the instructions of the medical practitioner in your taking of the drug. A legal drug is a substance that is used as a medicine and is registered in terms of the Medicines and Related Substances Control Act No. 101 of 1965;

2.5.4. Your taking of any illegal drug. An illegal drug is any chemical substance that affects a physical, mental, emotional or behavioral change in an individual and is listed in the South African Drugs and Drug Trafficking Act 140 of 1992;

2.5.5. Illegal behaviour or as a result of breaking the law of the Republic of South Africa;

2.5.6. Your attempted suicide, intentional self-injury or reckless exposure to danger;

2.5.7. Aviation except if you are on a commercial flight as a fare-paying passenger;

2.5.8. Participation in sports on a professional basis. Professional means that you are paid to participate in the sport;

2.5.9. Participation in hazardous (dangerous) sports, including:

- Hang-gliding
- Kite-surfing
- Mountaineering
- Para-gliding
- Scuba diving
- Skiing

2.5.10. Any form of race or speed test, other than on foot or involving any non-mechanically propelled vehicle, vessel, craft or aircraft.

2.6. Waiting periods

2.6.1. You have to serve a waiting period when your cover with us starts. The waiting periods that apply to your cover run concurrently. This means that they start together from your first day of cover. The applicable waiting periods and the cover you will have are as follows:

Type of waiting period	**Cover in month:**											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
All claims (3-month general)	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Specific procedures (9-month condition specific)	No	No	No	No	No	No	No	No	No	Yes	Yes	Yes
Birth related (10-month maternity)	No	No	No	No	No	No	No	No	No	No	Yes	Yes

2.6.2. During the 3-month general waiting period we will **not** pay you for any claim, except if your claim is as a result of an accident that causes bodily injury and the accident took place after your cover start date.

2.6.3. The procedures that are subject to a 9-month waiting period are provided below. This means that if you have one of these procedures in the first 9 months of your cover with us, we will reject your claim:

- Joint surgery (except where the procedure is as a result of an accident after your cover start date which causes bodily injury);
- Arthroscopic (joint scope) procedures (except where the procedure is as a result of an accident after your cover start date which causes bodily injury);
- Spinal surgery, including spinal fusion (except where the procedure is as a result of an accident after your cover start date which causes bodily injury);
- Nasal (including sinus, adenoid and tonsil related) surgery (except where the procedure is as a result of an accident after your cover start date which causes bodily injury);
- Cataract and laser eye surgery;
- Hysterectomy (except where the procedure is necessary because you have been diagnosed with a gynaecologic cancer after your cover start date);
- Dentistry related claims (except where the procedure is reconstructive and is as a result of an accident after your cover start date which causes bodily injury);
- All hernia repairs (except where the procedure is as a result of an accident after your cover start date which causes bodily injury);
- All cardiac (heart) related surgery and procedures, including angioplasty and cardiac catheterization;
- Grommet surgery.

2.6.4. If you already have a gap cover policy through another insurer or you are covered as a dependant on another gap policy and you decide to replace that policy with ours, we will waive the waiting period that would apply to new policyholders, on the condition that:

a) there is no break in cover - if there is a gap of more than 1 calendar day between the termination of your cover with the other insurer and your cover start date with us, you will be subject to the normal waiting periods;

b) you were covered on the other insurer's policy for more than 10 months – if you were covered for less than 10 months, you will carry the remainder of the waiting period over to your new policy with us;

c) You are continuing cover on the same (or a similar) level of cover that you had with the other insurer; and

d) You provide us with confirmation of your cover period from the other insurer.

2.7. Changes, cancelling or continuing your cover

2.7.1. We may make changes to or cancel your policy by giving you 30 days' written notice.

2.7.2. You may cancel your policy with us at any time by giving us 30 calendar days' written notice.

2.7.3. Your cover and all benefits under this policy will be cancelled from the date of cancellation of your policy.

2.7.4. We will only pay you benefits that are payable in terms of the conditions and limitations of the policy.

2.7.5. We will also only cover you for events that have happened on or after your cover start date and before midnight on the date on which your cover is cancelled.

2.7.6. For any event to be covered, it must happen after any waiting period that applies to your cover.

2.7.7. There is no cash value to this policy if it is cancelled.

2.7.8. We will only refund the premiums you paid for this policy if you paid your premiums annually in advance and you have not claimed against your policy at any time. If this is the case, we will refund you the portion of the premiums that apply to the months after the date of cancellation of your policy with us.

2.7.9. If you change your mind about taking up the policy, you may let us know in writing within 30 days of the start date of the policy and we will cancel the policy and refund you your first (and only) premium paid.

2.7.10. If after cancelling your policy with us, you decide to continue with this policy, we will issue a new policy to you and we will apply the waiting periods again from the date on which your new policy starts.

2.7.11. You must let us know whenever your personal details change.

3. What you are covered for

3.1. Benefit for shortfalls in medical practitioner costs

3.1.1. In-hospital procedures

If after the expiry of any waiting period applied to your cover, you are admitted into hospital for a procedure to treat a disease, an illness or a bodily injury and this procedure is performed by a registered medical practitioner while you are in hospital, we will cover you for the shortfall between what the medical practitioner has charged you and what your medical aid has paid for the procedure.

The maximum amount that we will pay towards this shortfall is calculated as 5 times (or 500% of) the medical aid tariff less the amount payable (or actually paid, whichever is the higher) by your medical aid.

In most instances the medical practitioner will separate the primary procedure that they have performed into a number of smaller procedures on the account that they issue for payment. This is because they are required to detail every "sub-procedure" undertaken during your primary procedure for medical aid billing purposes. If the medical practitioner does this, we will also separate the shortfall for each sub-procedure in our calculation of the amount owing to you.

This means that we may pay the full shortfall on some sub-procedures, a portion of the shortfall on other sub-procedures (for example where a sub-limit has been reached) or no portion of the shortfall on certain sub-procedures (for example, whether your medical aid has not paid the first portion of a specific sub-procedure).

We will provide you with detail regarding how we have calculated the amount that we will pay you for each sub-procedure if you ask us to do so.

It is important for you to be aware that under this benefit we will only cover you for any shortfall if the procedure took place while you were admitted to, and staying in, hospital.

3.1.2. Out-of-hospital procedures

If, after the expiry of any waiting period applied to your cover, you undergo a procedure to treat a disease or a bodily injury and this procedure is listed below and is performed by a medical practitioner outside of a hospital (in other words, on an outpatient basis in a registered day clinic), we will cover you for the shortfall between what the medical practitioner has charged you and what your medical aid has paid for the procedure.

Once again the maximum amount that we will pay towards this shortfall is calculated as 5 times (or 500% of) the medical aid tariff less the amount payable (or actually paid, whichever is the higher) by your medical aid.

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

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

Ear, nose, throat	Direct laryngoscopy
General surgery	Closure of colostomy
	Lymph node biopsy
	Needle biopsy of the liver
	Surgical biopsy of breast lump
Gastro-intestinal	Colonoscopy
	Endoscopy
	Gastroscopy
	Oesophagoscopy
Gynaecology	Cervical laser ablation
	Dilatation and curettage
	Hysteroscopy
	Incision and drainage of Bartholin's cyst
Obstetrics	Childbirth in a non-hospital setting
Oncology	Chemotherapy
	Radiotherapy
Ophthalmology	Cataract removal
	Pterygium removal
	Trabeculectomy
Orthopaedic	Carpal tunnel release
	Ganglion surgery
Radiology	Computer Axial Tomography (CAT) scan
	Magnetic Resonance Imaging (MRI) scan
	Positron Emission Tomography (PET) scan
Renal	Kidney dialysis
Respiratory	Bronchoscopy
Urology	Prostate biopsy
	Vasectomy

3.1.3. Specific conditions

3.1.3.1. This Medical Gap Cover includes cover for shortfalls arising from Prescribed Minimum Benefits.

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

- The medical aid option that you have selected includes cover under your major medical benefit for the procedure that you are claiming for; and
- Your medical aid pays the first portion of the claim from your major medical benefit; and
- You are paying for any shortfall from your medical savings account OR in cash.

3.1.3.3. If your medical aid cannot provide or it does not have, a medical aid tariff for any of the above procedures, we reserve the right to calculate an industry-related (Admed) tariff that will be applied to the calculation of the amount payable to you.

3.1.4. Specific exclusions

3.1.4.1. We will not pay your claim under this benefit if the medical aid option that you have selected does not include cover under your major medical benefit for the procedure that you are claiming for.

3.1.4.2. We will not pay your claim under this benefit if the medical aid option that you have selected excludes this procedure.

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

- Hospital fees including theatre charges, ward charges or any other hospital costs;
- Materials or medication used during your stay in hospital, at a day clinic or during your procedure (whether it is in-hospital or out-of-hospital);
- Any external prosthesis or dental implants. We define an external prosthesis as an artificial device which is used to replace external body parts which don't work or are no longer there (for example, artificial limbs), or to assist the body internally or externally to function better (for example, pacemakers). We define a dental implant as an artificial tooth root that is placed into your jaw to hold a replacement tooth or bridge;
- Out-of-hospital dental procedures;
- Home and private nursing;
- Procedures for cosmetic purposes (unless the cosmetic procedure is necessary because of an illness or an injury);
- Exploratory procedures or procedures that are paid for by your medical aid on an exception or ex-gratia basis;
- Procedures for obesity;
- Routine medical / physical examinations including laboratory tests, x-rays, electrocardiograms (ECG's), pap smears, annual check-ups, etc.;
- Procedures performed with the use of robotic machinery where any shortfall being claimed is directly related to the use of such robotic machinery by a medical practitioner and it has been charged for by a hospital;
- Anxiety disorders (such as phobias, excessive compulsive disorders, etc.), mood disorders (such as depression, bipolar disorder, etc.), psychotic disorders (such as schizophrenia, delusions, etc.), dementias (such as Alzheimers, substance-induced dementia, etc.) and eating disorders (such as anorexia nervosa, binge eating disorder, etc.);
- Transportation costs (including resuscitation) in an emergency vehicle or aircraft and emergency medical service costs.

3.2. Benefit for co-payments and deductibles levied by your medical scheme

Co-payments and deductibles are commonly applied to radiology scans (MRI, CAT, ultrasound) and specialist referral procedures. If your medical aid levies a co-payment or deductible for an in-hospital or out-of-hospital procedure which you need to pay upfront and out of your own pocket, we will cover this co-payment / deductible.

4.2.1 Specific conditions

- We will only cover co-payments that are levied by your medical aid, not co-payments that are levied by a medical practitioner, a hospital or a day clinic.

- We will cover co-payments that have been paid by you when using a designated (also called a network or associated) service provider (DSP) for the procedure. While details of designated (network or associated) service providers and non-designated (non-network or non-associated) service providers are available from your medical aid, for purposes of this policy a DSP is defined as a healthcare provider that has been selected by your medical aid as their preferred provider.

4.2.2. Specific exclusions

- The co-payment is in respect of costs relating to your procedure and not in respect of costs relating to your hospital stay. If a co-payment has been levied against you because you elected to have a private ward and your medical aid option only covers you for a general ward, we will not cover this co-payment.

4.3. Benefit for co-payments levied by your medical scheme on oncology treatment programmes

If you have been diagnosed as having cancer you will be required by your medical aid to register for oncology benefits or an oncology programme with them and the cost for your cancer treatment will be subject to an annual limit. Once you have reached this limit, your medical aid will levy a 20% co-payment on all cancer treatment costs for the remainder of that year.

We will cover this 20% co-payment up to a total amount of R250 000 per person covered on the policy per policy year.

4.3.1 Specific conditions

- You be will only be eligible for this benefit if you are registered on your medical aid's oncology treatment programme.

- We will only cover chemotherapy and radiotherapy cancer treatments.

4.3.2 Specific exclusions

- If no co-payment is applied by your medical aid (in order words, if your medical aid pays the costs in full) you will have no claim under this section of the policy.

- We will also not cover any co-payment that is applied by your medical aid if you have chosen to undergo your treatment with a non-designated service provider.

4.4. Benefit for shortfalls in internal prosthesis costs

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

4.4.1. Specific conditions

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

4.4.2. Specific exclusions

- Devices that are placed inside a body to assist with a functioning body part (for example, a pacemaker) are specifically excluded from cover.

- We will also only cover you for any shortfall under this benefit if the medical aid option that you have selected includes cover under your major medical benefit for the internal prosthesis that you are claiming for. If your medical aid option does not include cover for this, we will not provide cover for any shortfall either.

4.5. Lump sum benefit for first time cancer diagnosis

If you or anyone on your policy are diagnosed with cancer for the first time while covered on this policy, we will pay you a once-off lump sum benefit of R25 000.

4.5.1. Specific conditions

- You will be eligible for this benefit if:

  - you are diagnosed as having at least stage II / regional, malignant cancer (categorized by the uncontrolled growth and spread of malignant cells, and the invasion of the normal surrounding tissue) by a medical practitioner while you are covered under this policy, and

  - this is your first-time diagnosis of any cancer; and

  - this diagnosis of cancer can be proven with clinical, histological, radiological and laboratory evidence.

- This amount is payable once only in a lifetime, per person covered on the policy.

4.5.2. Specific exclusions

- Cancer includes Leukemia and Hodgkins Disease but excludes all skin cancers and all cancers diagnosed and treated by primary biopsy only, where it does not require any further surgical, medical or radio therapy.

4.6. Lump sum benefit for accidental death or accidental permanent and total disability

If you or a dependant dies or become permanently and totally disabled as a result of an accident while you are covered under this policy, we will pay your estate (on death) or you, a fixed amount of R25 000.

In addition to the above, there are additional extensions of cover under this benefit:

4.6.1. Emergency transportation / search and rescue – maximum of R25 000

- If as a result of an accident you are in danger of being or you have been injured, we will pay costs and expenses up to R25 000 (for each and every claim) for your necessary emergency transportation or for your search and rescue, including freeing and bringing you to a place of safety.

- We will not pay these costs if we find you in circumstances which are not as a result of an accident or if the accident is unlikely to result in injury to you.

4.6.2. Life support equipment – maximum of R25 000

- If as a result of an accident life support machinery, equipment or apparatus is needed, we will pay costs and expenses up to R25 000 (for each and every claim) for the hire of these.

4.6.3. Trauma counselling – up to R750 per visit, with an annual limit of R25 000

- If you are subjected to, or a witness of, an act of violence or a traumatic accident, we will refund you for counselling fees paid by you as a result of the violence or traumatic accident.
- An act of violence includes events such as murder, assault, robbery, rape, kidnapping or hijack which is reported to the police and for which a case number has been obtained.
- The maximum that we will pay under this benefit is R750 per counselling session, up to R25 000 per policy per year.

4.7. Lump sum benefit for long-term hospitalisation

If you are admitted to and are required to remain in hospital by your medical practitioner for a period of 30 continuous days or more, we will pay you a lump sum amount of R25 000. We consider a day to mean 24 continuous hours.

4.7.1. Specific conditions

- You may only claim for this benefit after you have been discharged from hospital and once per person covered on the policy, per year.

4.7.2. Specific exclusions

- We will not pay a claim under this benefit for long-term hospitalisation of a newborn baby.

4.8. Fixed benefit for dentistry due to accidental injury

If you are required to undergo an emergency out-of-hospital dental procedure involving the repair of a tooth or teeth as a result of accidental injury to your mouth, we will pay you a fixed benefit of R2 000 per tooth repaired, up to a maximum number of 5 teeth (R10 000) per policy per year.

4.8.1. Specific conditions

- An emergency procedure is considered to be one that takes place within 72 hours of the accident causing the injury.
- This benefit will only pay out if the injury is as a result of an accident as defined previously in this policy wording.

4.8.2. Specific exclusions

- No benefit will be payable for routine out-of-hospital dental procedures or for any dental repairs or treatment that are not considered to be of an accidental nature.

4.9. Hello Doctor

Hello Doctor is a service provider that enables a policyholder to obtain personalised healthcare at anytime and anywhere through mobile, web, application and social media access.

This includes:

- General health content including health articles, videos and communication via social platforms (Facebook and Twitter); and
- Advice over the phone through text-based conversation with a doctor or a request for a doctor to call back.

4. How to claim

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

- Tell us as soon as possible about your claim or at least within 6 months from the date of admission into hospital, the procedure, the diagnosis or the bodily injury.
- Complete all of the relevant sections of the claim form accurately and truthfully so that we can quickly and easily process your claim. If we do not receive all of the required information and documentation from you, this may cause delays in the processing of your claim.

5.2 Please take note of these further important terms:

- If we do not receive any notification of your claim within 6 months from the date of admission into hospital, the procedure, the diagnosis or the bodily injury, we will reject your claim.
- When we settle claims we pay you (the policyholder) directly into a bank account in your name and always in South African Rand.
- We will not pay your claim into a bank account that is not yours unless that bank account belongs to your spouse who is nominated as your spouse on your policy and you have given us written instruction to pay your claim to that bank account.
- Under no circumstances will we pay your claim to a medical practitioner, hospital or any other medical service provider.
- You must provide us, at your own expense, with any information and assistance as we may reasonably require about any claim.
- We will only process your claim after your treatment or procedure has been undertaken and if you were admitted into hospital, once you have been discharged from hospital.
- Even if you have already made a claim and there is information outstanding from you which is needed to finalise the claim, your claim is no longer valid after 12 months from the date of the event which caused your claim, unless it is part of a pending court case.
- The most that we will pay for any claim is the amount calculated as payable in terms of this policy. We will not pay any interest on claim amounts paid to you under this policy.
- If after we have paid your claim, your medical aid recalculates and reduces the amount that it will pay for the treatment or procedure that you have claimed the shortfall on, you may claim the additional shortfall from us within 90 days of the date of recalculation by your medical aid. This additional claim amount will still be subject to the maximum amount that we will pay under the shortfall benefit.
- If however, your medical aid recalculates and increases the amount that it will pay for the treatment or procedure that you claimed the shortfall on and we have overpaid you the first time around, it is your responsibility to refund the overpayment to us within 90 days of the date of recalculation by your medical aid. If you do not repay us the overpayment within this time, we may take legal action against you.
- If we don't pay your claim and you disagree with our decision or if you are not happy with the amount we agree to pay for your claim under this policy, you can write to us about your complaint within 90 days of the date on which we notify you of our decision regarding your claim.
- After the 90 days, you have a further 180 days in which you can take legal action against us.