SANLAM GAP COMPREHENSIVE POLICY DOCUMENT 2027

Sanlam

Gap Cover

INSURED BY
CENTRIQ
INSURANCE
A LICENSED NON-LIFE INSURER

Statutory notice:

This 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.
Sanlam Gap is administered by Essential Medical (Pty) Ltd, an authorised financial services provider (FSP 42980).
AfroCentric Health (RF) (Pty) Ltd holds preference shares in Centriq Insurance Company Limited.
Insurance Products are insured by Centriq Insurance Company Limited ("Centriq") a licensed non-life insurer and authorised Financial Services Provider (FSP 3417).

Financial Planning | Retirement | Insurance | Health | Investments | Wealth | Credit

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Centriq is committed to protecting the personal information of our stakeholders in accordance with the Centriq Privacy Notice.pdf

Disclaimer

This Policy replaces all previous versions of your previous Sanlam Gap Policy. All terms and conditions in this Policy are applicable to Insured Parties on the Policy.

All definitions throughout the Policy are indicated with bold font and with the first letter of each word capitalised. Important points are indicated with a bold and blue font type.

Processing of insurance information is done in accordance with the applicable legislation, as well as our Privacy Policies which can be found on our websites:

- www.centriq.co.za

A. Your Insurer

The insurance cover is underwritten by your Insurer: Centriq Insurance Company Limited registration number 1998/007558/06, FSP 3417, a licensed non-life insurer, and is the insurance company providing the Benefits as detailed in this Policy. The cover provided is subject to all the terms and conditions explained throughout your Policy.

B. Your Underwriting Manager

Your **Underwriting Manager** is responsible for all administrative matters relating to your **Policy** which include:

- Issuing of your **Policy**.
- Assessing and processing your claims.
- Collection of your **Premium**.

You can reach Essential Medical (Pty) Ltd on: 0861 111 167 or email: info@sanlamgap.com

C. Definitions

Any words and expressions used in this Policy can refer to either singular or plural and to either gender.

The words and expressions utilised are defined as follows:

C1. **"Accidental Injury"**: Refers to bodily injury caused by violent, unintentional, external and physical means.

C2. **"Balance Billing"**: This is a practice where a **Medical Practitioner** or other healthcare service provider charges a separately identifiable fee that is over and above the **Tariff** fee (or set of such fees) that relates to a Medical Procedure/s or Treatment/s and is billed together on one statement or invoice and is not considered as a refundable Benefit by a Medical Scheme.

C3. **"Basic Dentistry"**: Refers to any of the following dental treatments: cleaning, extractions (including wisdom teeth), fillings, inlays, bonding, root canal treatment and treatment for pain and abscesses.

C4. **"Benefit or Benefits"**: It is the benefits as listed on the **Benefit Schedule** that are payable to the Insured Party following an Insured Event.

C5. **"Benefit Schedule"**: Refers to Annexure A: Detailed Benefits attached to this policy which sets out the benefits covered and their maximum limits payable.

C6. **"Condition-Specific Waiting Period"**: A period during which an **Insured Party** may not claim **Benefits** in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received before the **Insured Party's Effective Date** of cover.

C7. **"Consumables"**: Consumables are medical supplies needed for sample collection, wound or surgical site dressing changes, medication administration, and other procedures. They consist of, among other things, gloves, bandages, syringes, needles, and catheters that are thrown away after only one use.

C8. **"Deductible"** or **"Co-payment"**: The **Benefit** payable is equal to the fixed value **Deductible** or **Co-payment** amount, as defined in the rules of the **Insured Party's Medical Scheme** and relating to the defined **Diagnostic Procedure**. This means a fixed amount imposed by the **Insured Party's Medical Scheme**, in terms of its registered rules, in respect of a diagnostic procedure.

C9. **"Designated Service Provider"** or **"DSP"**: A healthcare service provider chosen by a **Medical Scheme** as one of their preferred suppliers. This means a fixed amount imposed by the **Insured Party's Medical Scheme**, in terms of its registered rules, in respect of a diagnostic procedure.

C10. **"Effective Date"**: The first day of the month on which cover starts for the **Insured Party** as noted in the Policy Schedule.

C11. **"Eligible Child"**:

- A child born to either the Policyholder or Eligible Spouse of this Policy.
- An Eligible Child includes a legally adopted child or stepchild of a Policyholder. In the event that the Eligible Child reaches the age of 27 years, the child will no longer be an Eligible Child and will therefore no longer be covered under this Policy. On turning 27 and within 30 days of doing so, the Eligible Child may take up a new Policy in their own capacity without any additional waiting periods or exclusions being applied. The age limitation will not be applicable to a Special Needs Child.

C12. **"Eligible Spouse"**:

- The partner of the **Policyholder**, whether by means of South African law or religious belief.
- The partner by common law who shares a home with the **Policyholder** and has done so for at least six months.

C13. **"Emergency"**: A serious, unexpected, and dangerous situation requiring immediate action.

C14. **Essential Medical (Pty) Ltd registration number 2011/116999/07**, who is appointed to administer this Policy on behalf of the Insurer and is registered to do so in terms of the Short-Term Insurance Act No 53 of 1998.

C15. **"Family"**: Collectively it refers to the **Policyholder**, Eligible Spouse, Eligible Children and/or Special Needs Child as defined in the **Policy**.

C16. **"General Waiting Period"**: The period in which an **Insured Party** may not claim any **Benefits**, except for **Benefits** directly arising from **Accidental Injury**.

C17. **"Hazardous Sport"**: It includes, but is not limited to, participation in or use of any of the following:

- All forms of motorised racing, speed tests or aerobatics, whether by land, sea or air;
- Mountaineering, trekking or hiking above an altitude of 4 000 metres;
- Hunting, shooting or deploying firearms in any manner other than for self-defence purposes.

C18. **"Hospital"**: Any institution in South Africa which meets all of the following criteria:

- Provides surgical and medical diagnostic and therapeutic facilities for **Treatment** and care of sick or injured persons under the supervision of **Medical Practitioners**. This includes registered mental health institutions.
- Provides 24 hour registered nursing services to sick or injured persons within the aforementioned facilities.
- Is not an institution that primarily cares for persons who are mentally disabled, blind, deaf, mute or in any other way physically disabled.
- Is not a nursing home or home for the elderly.
- Is not a place of rest or recuperation.
- Is not an institution that primarily treats people for drug addiction, alcoholism, eating disorders or any other form of addictive behaviour.
- Is not a health hydro or alternative therapy clinic or other similar establishment.
- Is not a Step-Down Facility.

C19. **"Hospital Episode"**: The period of time between admission to **Hospital** of an **Insured Party** until the time of discharge from the **Hospital**.

C20. **"Hospital Network"**: A list of **Hospitals** specified by the **Insured Party's Medical Scheme**, as the **Designated Service Provider** of one or more plan types of the **Medical Scheme**.

C21. **"Illness"**: Any physical disease or sickness diagnosed by a Medical Practitioner using objective clinical evidence.

C22. **"Innovative Oncology Medicines"**: As approved and defined by the Insured Party's Medical Scheme.

C23. **"Insurer"**: Centriq Insurance Company Limited, registration number 1998/007558/06; FSP 3417.

C24. **"Insured"** or **"Insured Party"**: Refers to the **Policyholder**, **Eligible Spouse, Eligible Child**, or **Special Needs Child**, as defined in this **Policy**.

C25. **"Insured Event"**: Any one or more of the following:

- **Accidental Injury, Illness** or other health incidents that cause an **Insured Party** to be admitted to a **Hospital** and to undergo **Treatment** or **Medical Procedures** during the **Hospital** Episode.
- Chemotherapy, radiotherapy or other drug regimens, approved by an **Insured Party's Medical Scheme**, that is administered to an **Insured Party** for treating a tumour, growth or other body tissue that has cancer (malignant neoplasm).

- An **Insured Party** receives kidney dialysis for the **Treatment** of acute or chronic renal failure.
- **Accidental Injury** that directly causes an **Insured Party** to receive Emergency Treatment at the out-patient casualty or **Trauma** ward of a **Hospital**.

C26. **"Key Benefits"**: This is a list of benefits defined as Key Benefits in the **Benefit Schedule** and which benefits are subject to the Overall Annual Limit.

C27. **"Medical Expense Shortfall Policy"**: An Accident and Health policy, as defined in Category 1 of section 7.2(1) of regulations to the Short-term Insurance Act, No 53 of 1998.

C28. **"Medical Practitioner"**: A person who is suitably qualified and registered with the Health Professions Council of South Africa to practice medicine or a suitably qualified healthcare practitioner registered with the applicable statutory professional council.

C29. **"Medical Procedure"**: Any medical, surgical or diagnostic procedure undertaken by or under the supervision of a **Medical Practitioner** or other appropriately registered healthcare practitioner for the purpose of diagnosing, investigating, monitoring, preventing or treating a patient's medical condition or injury.

C30. **"Medical Scheme"**: A Medical Scheme as registered under the Medical Schemes Act.

C31. **"Medical Schemes Act"**: refers to the **Medical Schemes** Act No. 131 of 1998.

C32. **"Mentally Disabled"**: A person who has a condition that significantly limits their cognitive functioning, intellectual development, or ability to adapt to everyday life.

C33. **"Overall Annual Limit"**: The maximum amount payable per **Insured Party Per Annum** in respect of Key Benefits.

C34. **"Per Annum"**: The period from 1 January to 31 December of any year.

C35. **"Penalty"**: Any **Co-payment**, **Deductible**, exclusion or reduction, applied against the **Benefits** of an **Insured Party's Medical Scheme**, that would otherwise not have been applied had the authorisation rules of that **Medical Scheme** been adhered to or the **Benefits** had been attained from the **Designated Service Provider** or **Hospital** Network of that **Medical Scheme** plan type.

C36. **"Permanent Disability"**: Any **Accidental Injury** 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.

C37. **"Policy"**: Consists of this policy document as well as the **Policy Schedule**.

C38. **"Policy Exclusions"**: The list of services, conditions and events that are not covered on the **Policy**.

C39. **"Policy Schedule"**: It is the document that forms part of the insurance contract between you and the Insurer that lists the Insured Parties that are covered, their Effective Date of cover, the monthly Premium payable and General and Condition-Specific Waiting Periods that may apply.

C40. **"Policyholder"**: The owner of this Policy and the person responsible for Premium payments, who is also referred to as you or your in the Policy.

C41. **"Premature Birth"**: The natural or surgically assisted birth of one or more infants that occurs more than 41 days before the originally expected natural birth date of 40 weeks as verified by the clinical records of the mother's attending physician.

C42. **"Premium or Premiums"**: The monthly amount due to the **Insurer** payable by, or on behalf of the **Policyholder**.

C43. **"Prescribed Minimum Benefits (PMBs)"**: Are a set of defined benefits provided to beneficiaries of **Medical Schemes** to ensure that all **Medical Scheme** members have access to certain minimum health services.

C44. **"Special Needs Child":** Any child, including a legally adopted child or stepchild of the **Policyholder**, who on account of either a physical or mental disability, is unable to financially support him/herself and remains reliant on the **Policyholder** for support and care.

C45. **"Split Billing"**: A practice where a **Medical Practitioner** or other healthcare service provider charges a separately identifiable fee that is over and above the **Tariff** fee (or set of such fees) that relates to a **Medical Procedure/s or Treatment/s** and is billed separately from the **Tariff** fees on two or more statements or invoices, and is not considered as a refundable **Benefit** by a **Medical Scheme**.

C46. **"Tariff"**: Either the scheme rate or a specific **tariff** registered by a **Medical Scheme** to determine the rate at which its **Benefit** are payable.

C47. **"Treatment"**: Any form of medical advice, diagnosis, care or treatment provided by a **Medical Practitioner** for treating or monitoring the medical condition of an Insured Party.

D. Claims

Following an **Insured Event**, the **Insured Party,** will at their own expense:

- Claims must be submitted to the **Insurer** within **six (6) months** from the date of discharge from **Hospital** or, where no **Hospital** admission occurred, within **six (6) months** from the date on which the relevant **Medical Procedure** or **Treatment** was performed.

  This does not relate to claims for valid Gap cover shortfalls or benefit which may be recieved and automatically processed for memebrs of qualifying Medscheme Administered Schemes.

- Supply written proof, copies of medical accounts or other information as may reasonably be required for **Centriq** to process the claim or to ensure the validity of the claim. These documents include: a completed **Claims Form, Doctor's Accounts, Hospital Account; Claims Transaction History Report**. There may be additional information requested, such as medical reports as required and determined on a case-by-case basis.

- Allow **Centriq** to inspect as often as is necessary all current or past medical information or clinical records including the results of any diagnostic tests and submit to medical examination on behalf of and at the expense of **Centriq**.

- Where the **Insured Party** is not the **Policyholder**, the **Policyholder** will provide or obtain permission or consent from the Insured Party to comply with the above condition, failing which the processing of the relevant claims will be suspended until the required permissions or consent are obtained.

- **Assessing claims**. Claims are assessed on a line-by-line basis. Each line has a code on your healthcare or service provider's account, and this accounts for the total amount charged. These codes describe the Medical Procedure/s or Treament/s that was performed or the service that was provided. In respect of Key Benefits, your **Medical Scheme** must pay a portion of the cost of a coded line from your hospital or risk benefit in order for that claim line shortfall to be covered by your **Gap Cover**.

  Any claim excluded by your **Medical Scheme** cannot be covered by gap cover

  If you are in your waiting period, your claim may be rejected.

  If your incident is prior to your policy start date your claim may be rejected.

  You may only be able to claim for an eligible dependent if you are on a Family policy.

Your claim will be assessed according to your cover and plan type and in accordance with your Sanlam Gap benefits.

Please note that you may be required to complete a pre-existing questionnaire if you are within your waiting period.

Claims flagged as **Prescribed Minimum Benefit** (PMB) **Medical Procedures** or claims with a high values may be investigated with your **Medical Scheme** or discussed with your service provider for possible discount negotiation. PMB's are a set of defined benefits that **Medical Schemes** are required to cover by law. This means that as a **Medical Schemes** member, you shouldn't incur any out-of-pocket medical expenses related to a PMB.

Any **Benefit** payable in respect of an **Insured Event** will become payable after the completion of the **Treatment** relating to that **Insured Event**. At the **Insurer's** sole discretion, interim **Benefit** payments may be made after a period of **31 days** during the **Insured Event**.

All **Benefits** payable will be paid to you or your legal representative whose receipt of the **Benefits** will be a full discharge of liability.

If you die, any **Benefit** due will be payable to the surviving **Eligible Spouse**, failing which the **Benefit** will be paid to the **Eligible Children** (or their legal guardians in the event of them being minors) or failing any of the above, the **Benefit** will be paid to your estate.

No **Benefit** payable shall carry interest.

Any discount accrued by an **Insured Party** against the amount owing to any healthcare provider will be included in the calculation of the **Benefits** of this **Policy**.

If the Insurer rejects any claim, or disputes the quantum of a claim, the **Insured Party** has **90 days** to send a written statement to the **Insurer**, challenging this decision. Should you decide to approach the Ombudsman for assistance, you must do so within **180 days** of being advised that your representations to the Internal Complaints Department of Centriq have been unsuccessful.

Finally, we remind you of the policy condition, which requires you to institute legal action within **180 (one hundred and eighty)** days after the expiration of the **90 (ninety) day** period referred to above, failing which you will forfeit your claim and no liability can arise in terms of such claim.

Payment of any **Benefit** depends on the **Insured Party** supplying such medical evidence as is required by the Insurer to assess the validity of the claims or for an **Insured Party** to undergo any medical examination if requested and paid for by the **Insurer**.

E. Premiums

Premium refunds - more than one Gap policy

- If cover is cancelled or reduced because an **Insured Party** is covered under more than one medical expense shortfall (Gap) policy, any **Premium** refund is limited to **12 (twelve) months** and may be reduced by **Benefits** already paid for that period. The refund, if any, will be paid to the party that paid the **Premium**.

Individuals

- All **Premiums** are **payable either monthly in advance or arrears as agreed with the Policyholder and as stated on the Policy Schedule ("Payment Terms")**. Non-payment of **Premiums** may lead to the rejection of a claim or cover being suspended and any **Benefit** payable will be suspended until all **Premiums** have been received by **Centriq**.
- If the **Premium** is not paid on the payment date, you have a **30 day grace period** after which we will automatically deduct the outstanding **Premiums** from the same account to ensure continuous cover. If this **Premium** is also not paid you **will have no cover for the period for which you did not pay**.
- Should your **Premium** remain **outstanding after the third month** your cover will be **cancelled as of the last day of the month** in which you made your last successful payment.
- Should you cancel or stop your debit order, it will be deemed that you have cancelled your cover and you will not enjoy the **30 day grace period**. In the event that you reinstate your **Policy** thereafter, your **Policy** will be treated as a new **Policy** and the grace period will only apply from the second month of cover thereafter.
- Your **cover starts on the first calendar day of a particular month** and cannot be backdated.
- Your **Premium** will be **reviewed annually**.
- The **Insurer may adjust the Premiums by giving at least 31 days written notice**.
- If a premium is not received by the due date, the **Policy** and all claims under the **Policy** will be suspended from the date on which the premium remains unpaid.
- If the premium remains unpaid during the second consecutive month, the **Policy** and any claims will remain suspended. The **Policyholder** will have until the third consecutive monthly premium collection date to bring the account fully up to date.
- Where all outstanding premiums are paid before the third consecutive monthly premium collection date, cover may be reinstated and any valid claims that were suspended during the period of non-payment will continue to be processed, subject to the **Policy** terms and conditions.
- If the outstanding premiums are not received by the third consecutive monthly premium collection date, the **Policy** will be terminated and lapsed.
- Following lapse, there will be a break in cover for the period during which no premiums were received. No claims arising during, or relating to, the period of non-payment and lapse will be covered or payable.
- Should the **Policyholder** wish to obtain cover after the **Policy** has lapsed, a new policy application may be required. Any new policy issued will be subject to the applicable terms and conditions, including any waiting periods, exclusions, and underwriting requirements. The **Insurer** will not be liable for claims arising during any period for which no premium was received.

Corporates (On Behalf of The Policyholder)

- All **Premiums** are **payable monthly in arrears** by the last working day of each month.
- Non-payment of **Premiums** may lead to the rejection of a claim or cover being suspended and any Benefit payable will be suspended until all outstanding **Premium** have been received by **Centriq**.
- Your **cover starts on the first calendar day of a particular month** and cannot be backdated.
- Your **Premium** will be **reviewed annually**.
- The **Insurer may adjust the Premiums by giving at least 31 days written notice**.
- Where premiums are paid by a **Corporate** on behalf of a **Policyholder**, any queries relating to outstanding premiums, non-payment of premiums, premium arrears, suspension, lapse, termination, or reinstatement of cover will be addressed directly with the **Corporate** responsible for the payment of premiums.
- Where a **Corporate** requests the backdated termination of a **Policy** or an insured member's cover, any premium refunds arising from such termination will be paid to the **Corporate** against whose account the premiums were originally received.
- Should any claims have been paid for a period that is subsequently subject to a backdated termination, the **Insurer** reserves the right to recover such claim amounts from the **Corporate**. Any recovery of amounts from the affected **Policyholder** or member will be the responsibility of the **Corporate**, and the **Insurer** shall have no obligation to pursue such recoveries on behalf of the **Corporate**.

- The Insurer shall not be liable for any claims arising during a period for which premiums were not received or for which cover has been retrospectively terminated at the request of the **Corporate**.

F. General Terms and Conditions

Jurisdiction and Currency

This **Policy** shall be subject to the jurisdiction of the courts of the **Republic of South Africa and South African law will apply**. The payment of all **Premiums** and **Benefits** shall be made in the currency of the **Republic of South Africa**.

No **Benefit** will be payable under this **Policy** where the same **Insured Event**, **Treatment** or expense has been claimed from, paid by, or is payable under another medical expense shortfall (Gap) insurance policy.

More than one Gap cover

An **Insured Party** may not be covered under more than one Gap insurance product administered by the **Administrator** at the same time. If an **Insured Party** is covered under more than one Gap policy, the **Policyholder** must disclose this to the Insurer at the time of claim. The **Policyholder** must nominate which policy will respond to the claim, and no duplicate or additional benefit may be claimed or paid in respect of the same **Insured Event**, **Treatment** or expense.

The **Insurer** reserves the right to suspend assessment or payment of the claim until sufficient information is received to determine whether another Gap policy applies.

Commencement of Cover

Cover will begin on the first day of the calendar month for which the **Premium** has been paid, subject to all the terms and conditions of this **Policy**.

Cover and Benefits

- Cover will only be in force or effect if the **Insured Party** is a member of a registered **Medical Scheme**.
- Cover will also be provided to the Family (where Family cover is purchased) regardless of whether or not they are covered under the same or separate **Medical Scheme** options. Under such circumstances, proof of the familial relationship may be required when claiming under this **Policy**.
- This **Policy** and any schedules and correspondence sent to you, your application for insurance, and any written or spoken statement made by you or on your behalf forms the contract between you and the **Insurer**.
- The Insurer **may change** the **Policy Exclusions**, **Benefits** or how the **Benefits** are calculated by giving **31 days written notice**.

General

Once the Premium has been paid on or before the Effective Date, **Insured Parties** are **covered for an Insured Event** subject to applicable terms, conditions, exclusions and limits as stated in the **Policy**.

Eligible Spouse

Should you have more than one spouse who could qualify as an **Eligible Spouse** then you must make an irrevocable nomination of one spouse as the **Eligible Spouse**. **Benefits** will only be paid to the nominated **Eligible Spouse**.

Should you die, the nominated **Eligible Spouse** may transfer the **Policy** of cover into their own name within 30 days without any additional waiting periods or exclusions being applied.

Eligible Child

Once the **Eligible Child** reaches the age of 27 years, the child will no longer be an **Eligible Child** and will therefore no longer be covered under this **Policy**. On turning 27 and within 30 days of doing so, the **Eligible Child** may take up a new **Policy** in their name with no additional waiting periods.

G. Termination of Cover

You may cancel this cover at any time, by giving a calendar months, prior written notice.

A calendar months' notice will be considered from the 1st of the month to the 31st of the same month.

If the **Insurer** decides to stop offering this type of insurance cover, the Insurer will give the **Policyholder** at least **90 (ninety) days**' written notice before this **Policy** ends.

If any fraudulent act is committed by any **Insured Party** or any service provider, the Insurer reserves the right to immediately cancel this cover and/or institute legal action against the relevant party to recover any losses.

If the **Insured Party**, or any person acting on behalf of the **Insured Party**, has misrepresented, inaccurately described or not provided all the details that affect the risk insured under this **Policy**, the **Insurer** may declare that the whole of this **Policy** or any part thereof is invalid. In such an event, the Insurer can reject any claim under this **Policy** and/or void this **Policy** from the **Policy Effective Date**.

H. Waiting Periods

Waiting Periods apply to **Insured Parties** as set out below:

A General Waiting Period of three months, except for a Benefit directly arising from Accidental Injury.

A Condition-Specific Waiting Period of 12 months. Where this is applied, a pre-existing questionnaire will be requested at claim stage.

Waiting periods will be applied to the cover of the relevant **Insured Party** from their **Effective Date** of cover.

A 3 month **General Waiting Period** applies to the Mediclinic Extender when it is first added to this **Policy**, whether at inception or mid-term.

I. Waiver of Waiting Periods

If you previously had a **Medical Expense Shortfall Policy**, not longer than **90 days** before the **Policy Start Date / or Inception Date**, then waiting periods on this **Policy** will be waived for all **Insured Parties**. The **General and Condition-Specific Waiting Periods** will be reduced by the expired portion of the waiting periods served under the previous policy. If a **dependant** is added after the **Policy Start Date / or Inception Date** then waiting periods may apply.

Waiting periods will not be applied to a **Newborn, Eligible Child, Special Needs Child or Eligible Spouse** if they are registered with **Centriq** 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 **Centriq** within **90 days**, full waiting periods will apply to the **dependant**. The Insurer reserves the right to waive the waiting periods for the **Insured Parties**. Any waiting periods waived will be shown on the **Policy Schedule**.

If cover for the Mediclinic Extender Benefit is included, the specific 3 month general waiting period for this benefit will apply and cannot be waived, regardless of previous gap cover or **Waiting Periods** served.

J. Policy Exclusions

The **Insurer** will not be liable for any claim caused by or related to any of the following:

- Any **Treatment** or **Medical Procedure** related to obesity.
- All costs related to ward fees, theatre fees and other **Hospital** expenses including materials and medication on the **Hospital** account. Consumables, disposable medical supplies, and sundry items.
- Cosmetic surgery except in the case where reconstructive cosmetic surgery is necessitated, in the sole opinion of the Insurer, as a direct result of **Accidental Injury** or other essential non-elective **Treatment** or **Medical Procedure**.
- Suicide, attempted suicide or wilful injury to oneself.
- Abortion, attempted abortion or any complications related thereto unless **Treatment** is, in the sole opinion of the **Insurer**, of a non-elective nature.
- Any procedure or examination where there is no factual indication of impairment in normal health.
- The consumption of any drug or narcotic, whether legal or illegal, unless legally prescribed by and taken following the instructions of a **Medical Practitioner**.
- The failure of an **Insured Party** to follow any medical advice given by a Medical Practitioner.
- Any incident, **Illness, Accidental Injury**, or event directly or indirectly caused by the continuous and excessive consumption of alcohol or where the **Insured Party** suffers from alcoholism.
- Any incident, **Illness, Accidental Injury** or event directly or indirectly attributable to the **Insured Party** having a blood alcohol content of more than thirty milligrams per one hundred millilitres of blood.
- Nuclear weapons, nuclear material, ionising radiations or contamination by radioactivity from any nuclear fuel, or any nuclear waste, or from the combustion of nuclear fuel which includes any self-sustaining process of nuclear fission.

- Participation or attempted participation by any **Insured Party** in any of the following:
    - Defence force, police force, medical rescue service, firefighting service, correctional services facility or the disarming of explosives;
    - Aviation activities where any medical expense incurred in relation to such activities are insured by any other party (excludes fare-paying passengers in a licensed passenger carrying aircraft);
    - **Hazardous Sport**, regardless of whether activities are performed privately, socially, during practice sessions, while participating in organised events, as an amateur or a professional.
- Any acts or attempted acts, including participation or attempted participation by any **Insured Party**, of any of the following:
    - Civil commotion, labour disturbances, riot, strike, lock-out or public disorder or any activity which is calculated or directed to bring about any of the following:
    - War, invasion, act of a foreign enemy, hostilities, civil war or warlike operations (regardless of whether war is declared or not);
    - Mutiny, military rising or usurped power, martial law or state of siege, or any other event or cause which determines the proclamation or maintenance of martial law or state of siege, insurrection, rebellion or revolution;
    - Any act (whether on behalf of an organisation, body, person or group of persons) calculated or directed to overthrow or influence any state or government or any provincial, local or tribal authority with force or using fear, terrorism or violence;
    - Any act calculated or directed to bring about loss or damage to further any political aim, objective or cause, or to bring about any social or economic change, or in protest against any state or government, or any provincial, local or tribal authority, or for inspiring fear in the public, or any section thereof;
    - Terrorism. An act of terrorism means the use or threat of violence for political, religious, personal or ideological reasons. This may or may not include an act that is harmful to human life. It could be committed by any person or group of persons, acting alone, on behalf of or with any organisation or government. It includes any act committed to influence any government or inspire fear in the public;
    - The act of any lawfully established authority in controlling, preventing, suppressing or in any other way dealing with any event referred to above.
- Any claim that is excluded or rejected by the **Insured Party's Medical Scheme**.
- Any claim that does not form part of the registered **Benefits** of the **Insured Party's Medical Scheme** but has been paid on an ex gratia basis.
- The following procedures, items, services, **Service Providers** or events:
    - External prosthesis;
    - Any appliances including, but not limited to, wheelchairs, beds or convalescing equipment;
    - All specialised dental procedures including, but not limited to, crowns, bridges, dental implant related procedures, orthognathic surgery, temporomandibular joint ("TMJ") surgery labial frenectomy, bone augmentations, bone or tissue regeneration. This definition also applies to exclusions related to any procedure or treatment related to basic dentistry.
    - Harvesting and/or preserving of human tissues, including but not limited to stem cell regeneration;
    - Breast enlargement;
    - Gastroplasty, lipectomy or otoplasty;
    - Gender reversal procedures;
    - Therapeutic massage therapists;
    - Institutions that primarily care for persons who are mentally disabled, blind, deaf, mute or in any other way physically disabled;
    - Nursing homes or homes for the elderly;
    - Places of rest or recuperation;
    - Rehabilitation (drug addiction, alcoholism, eating disorders or any other form of addictive behaviour), frail care or hospice services,
    - Health hydro or alternative therapy clinics;
    - Step-Down Facilities;
    - TTO (To-Take-Out) medicines.

- An injury on duty recoverable from the Workman's Compensation Fund is excluded. Any expenses incurred as a result of an injury on duty that are subsequently recoverable by the relevant **Insured Party** from the Workman's Compensation Fund.
- Any **Co-payment**, **Deductible**, percentage Co-payment or percentage Deductible, and any Penalty applied by the **Insured Parties Medical Scheme** is excluded, unless expressly provided for in this **Policy's Benefit Schedule**.
- Shortfalls on claim lines that the **Insured Party's Medical Scheme** did not approve and pay from the hospital/risk benefit, including lines paid from a medical savings account, day-to-day benefits, an above-threshold benefit or a self-payment gap, are not covered under the **Key Benefits** of this **Policy**.
- Any fee charged by a **Medical Practitioner, Hospital** or other healthcare providers that constitutes **Split Billing** in this **Policy**. This exclusion does not apply to Balance Billing, in this **Policy**.
- Any criminal act or attempted criminal act by an **Insured Party** which includes 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.
- Expenses incurred for transport charges or for services rendered whilst being transported in any vehicle, vessel or craft whether or not such vehicle, vessel or craft is specifically designed for medical emergency transport.
- Any act by an **Insured Party** that wilfully exposed the **Insured Party** to danger (except where such an act is to save human life).
- Any **Treatment** or **Medical Procedure** that, in the sole opinion of the Insurer 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 Party**.
- Any **Hospital Episode, Treatment** or **Medical Procedure** relating to the **Insured Event** which begins after the cancellation of this **Policy**.
- Any **Treatment** or **Medical Procedure** where such treatment occurred outside of the period of cover.
- Any out-patient **Treatment** unless expressly provided for in this **Policy's Benefit Schedule**.



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AfroCentric Health (RF) (Pty) Ltd holds preference shares in Centriq Insurance Company Limited.

Insurance Products are insured by Centriq Insurance Company Limited ("Centriq") a licensed non-life insurer and authorised Financial Services Provider (FSP 3417).

2027 Benefits Schedule

Exclusive to members on Comprehensive

You must be on a South African Medical Scheme. The Benefits listed below 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.

Benefit	Benefit Description	Limit
Key Benefits*	The following **Benefits** are defined as Key **Benefits**: • In-Hospital Tariff Shortfalls • Out-of-Hospital Tariff Shortfalls • **Co-payments** and **Deductibles** • Penalty Co-payment • Shortfalls from **Sub-Limits** • Oncology Tariff Shortfalls • Oncology **Co-payments** • Oncology **Sub-Limits** • **Innovative Oncology Medicines** • Dental Reconstruction **Benefit** • Major Affective Disorders **Example:** The limit on 1 January 2027 is **R226 881**. If the CPI inflation rate for the preceding calendar year is 3%, this limit will increase to **R233 687** per Insured Party per annum on 1 April 2027. The increased limit applies to Insured Events from 1 April to 31 December 2027. **Key Benefits – Hospital/Risk Benefit requirement** For the Key Benefits, cover applies only where the Insured Party's Medical Scheme has approved the claim and paid its portion from the hospital/risk benefit. Amounts paid from a medical savings account, day-to-day benefits, an above-threshold benefit or a self-payment gap are not covered under Key Benefits.	**Overall Annual Limit for Key Benefits:** The overall maximum amount payable for the Key **Benefit** clauses of this **Policy** is **R226 881 per Insured Party per annum**, as applicable on 1 January 2027. This amount is defined as the Overall Annual Limit, which is the maximum amount payable **per Insured Party per annum** in respect of Key **Benefits.** **Automatic Escalation of Limit on 1 April:** The Overall Annual Limit will automatically increase on 1 April each year by the annual Consumer Price Index (CPI) inflation rate published by Statistics South Africa for the preceding calendar year. The increased limit applies to Insured Events from 1 April to 31 December of that Policy year. **Prescribed Minimum Benefits** (PMB) procedures are covered under Key **Benefits** and are subject to clinical review by our Specialist third party, MedClaim Assist.
In-Hospital Tariff Shortfalls	This **Benefit** provides cover for shortfalls on charges above the **Medical Scheme Tariff** for healthcare service providers (such as surgeons, radiologists, pathologists and physiotherapists) for procedures performed while admitted to hospital. The policy covers up to an additional six times (600%) above whatever Your Medical Scheme pays. The **Benefit** payable Is equal to the total cost of **Treatment** less the amount paid by the **Medical Scheme** from your hospital/risk benefit, subject to a maximum of 600% above the **Medical Scheme Tariff**. **Example:** If You are on a Medical Scheme plan that pays 100% of the Medical Scheme Tariff (e.g. R4 000 for a procedure), and the specialist charges R28 000 (700% of the Medical Scheme Tariff), Your Gap cover benefit would be: • R28 000 – Fee charged by the specialist • LESS R4 000 – Benefit paid by Medical Scheme • = R24 000 – The Gap cover benefit payable (subject to policy limits).	An Additional six times **(600%)** on charges above the **Medical Scheme Tariff** subject to the Overall Annual Limit.
Out-of-Hospital Tariff Shortfalls	This **Benefit** provides cover for shortfalls on charges above Medical Scheme Tariff for out-patient procedures. The policy covers up to an additional six times **(600%)** of whatever your **Medical Scheme** pays. The **Benefit** payable Is equal to the total cost of Treatment less the amount paid by the Medical Scheme from your hospital/risk benefit, subject to a maximum of 600% above the Medical Scheme Tariff. **Example:** If You are on a Medical Scheme plan that pays 100% of the Medical Scheme Tariff (e.g. R2 200 for a procedure), and the specialist charges R15 400 (700% of the Medical Scheme Tariff), Your Gap cover benefit would be: • R15 400 – Fee charged by the specialist • LESS R2 200 – Benefit paid by Medical Scheme • =R13 200 – Your Gap cover benefit payable (subject to policy limits).	An Additional six times **(600%)** on charges above the **Medical Scheme Tariff** subject to the Overall Annual Limit.

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The amounts used in these examples are for illustration only. Actual shortfalls may vary depending on provider charges and your Medical Scheme's payment. All benefits are subject to the policy's terms, conditions, and annual limits.

2027 Benefits Schedule

Exclusive to members on Comprehensive

You must be on a South African Medical Scheme. The Benefits listed below 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.

Benefit	Benefit Description	Limit
Co-Payments and Deductibles	This **Benefit** provides cover for **Co-Payments** and **Deductibles** applied by the **Medical Scheme** in respect of defined diagnostic procedures. The **Benefit** payable is equal to the fixed value **Deductible** or **Co-payment** amount, as defined in the rules of the **Insured Party's Medical Scheme** and relating to the defined diagnostic procedures as approved and covered by the medical scheme. *Examples include co-payments applied to:* • *Da Vinci Robotic Surgery* • *Scopes and Scans*	Unlimited number of events subject to the Overall Annual Limit
Penalty Co-Payment	This **Benefit** provides cover for penalty **Co-payments** or **Deductibles**, up to a maximum of 30%, for the voluntary use by an **Insured Party** of a non-Network Hospital. The **Benefit** payable is equal to the penalty **Co-payment** or **Deductible** amount, up to a maximum of 30%, as defined in the rules of the **Insured Party's Medical Scheme**. Any other liability arising against an **Insured Party** from a **Penalty**, as defined, that is not a fixed value **Penalty Co-payment** defined in the rules of the **Insured Party's Medical Scheme**, remains an exclusion.	Two events **per Family per Annum**, up to a maximum of 30% of the total cost, capped at **R19 300** per event, subject to the Overall Annual Limit.
Shortfalls from Sub-Limits	This **Benefit** provides cover for services provided during a **Hospital Episode**, where the charges relating to the service supplied have exceeded the Sub-limit benefit paid by the **Insured Party's Medical Scheme**. The **Benefit** payable is equal to the shortfall amount between the total cost charged and the sub-limit amount paid by the **Medical Scheme** from the hospital/risk benefit. No **Benefit** is payable if the **Medical Scheme** has paid no amount from the hospital/risk benefit toward that same service.	Maximum limit per **Insured Event** of **R71 300**, subject to the Overall Annual Limit.
Oncology Tariff Shortfalls	This **Benefit** provides cover for shortfalls on charges above the Medical Scheme Tariff for oncology and related **Treatments**, that have been approved by the **Medical Scheme** for purposes of treating cancer. This includes breast cancer reconstruction surgery for the affected breast following a mastectomy. The policy covers up to an additional six times (600%) of whatever your **Medical Scheme** pays. The Benefit payable is equal to the total cost of **Treatment** less the amount paid by the **Medical Scheme** from your hospital/ risk benefit, subject to a maximum of 600% above the **Medical Scheme Tariff**. Cover for Innovative Oncology Medicines is excluded from the Oncology Tariff Shortfalls Benefit. **Example:** If You are on a **Medical Scheme** plan that pays 100% of the **Medical Scheme Tariff** (e.g. R6 500 for oncology treatment), and the total cost is R45 000 (700% of the **Medical Scheme Tariff**), Your Gap cover benefit would be: • R45 000 – Oncology Treatment Cost • LESS R6 500 – Benefit paid by Medical Scheme • = R38 500 – Your Gap cover benefit payable (subject to policy limits).	Any **Benefit** provided for charges above the **Medical Scheme Tariff** shall be limited to an Additional six times **(600%)**, subject to the Overall Annual Limit.

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The amounts used in these examples are for illustration only. Actual shortfalls may vary depending on provider charges and your Medical Scheme's payment. All benefits are subject to the policy's terms, conditions, and annual limits.

2027 Benefits Schedule

Exclusive to members on Comprehensive

You must be on a South African Medical Scheme. The Benefits listed below 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.

Benefit	Benefit Description	Limit
Oncology Co-Payments	This **Benefit** provides cover for Oncology Co-Payments applied by the **Medical Scheme** once related costs have exceeded the specific threshold defined in the scheme rules.	Limited to the 20% oncology related co-payment applied by your **Medical Scheme,** subject to the Overall Annual Limit.
Oncology Sub-Limits	This **Benefit** provides cover for shortfalls on oncology related services, where the charges exceed the **Benefit** sub-limit defined by the **Insured Party's Medical Scheme** plan type. **Benefits** will be paid in respect of oncology and related treatment, that has been approved by the Insured **Party's Medical Scheme**, for the purposes of treating cancer (malignant neoplasm) and which occurs during an **Insured Event**.	Unlimited number of events, subject to the Overall Annual Limit.
Innovative Oncology Medicines	This **Benefit** provides cover for shortfalls on the cost of defined Innovative Oncology Medicines approved by the **Insured Party's Medical Scheme**. The Benefit payable is equal to the total cost of the Innovative Oncology Medicine less the amount paid by the Medical Scheme from the hospital/risk benefit, subject to applicable policy limits.	A value equal to the lesser of 25% of the total drug cost or **R20 000**, subject to the Overall Annual Limit.
Dental Reconstruction Benefit	The **Benefit** provides cover for shortfalls if dental reconstruction surgery is required as a direct result of **Accidental Injury**, or of oncology **Treatment**, that occurred after the **Effective Date**. The **Benefit** payable is equal to the total cost of **Treatment** less the amount paid by the **Medical Scheme** from your hospital/ risk benefit. **Example:** If You are on a Medical Scheme plan that pays R3,000 toward the dental surgeon's account from Your hospital/risk benefit, and the total cost for dental reconstruction is R10,500, your gap cover benefit would be: • R10 500 - Charged Amount • Less R3 000 - Paid by Medical Scheme • = R7 500 - Your Gap cover benefit payable (subject to policy limits).	The **Benefit** is subject to two events **per Family per Annum** and a maximum amount of **R52 000 per Annum**, subject to the Overall Annual Limit.
Major Affective Disorders including major depression & bipolar	This **Benefit** provides cover for services provided during a Hospital Episode for mental depression, where the charges relating to the service supplied have exceeded the Prescribed minimum benefit of 21 days covered by the **Insured Party's Medical Scheme**.	Subject to a maximum of five days to a limit of **R2 650** per day per **Insured Party per Annum**, subject to the Overall Annual Limit.

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The amounts used in these examples are for illustration only. Actual shortfalls may vary depending on provider charges and your Medical Scheme's payment. All benefits are subject to the policy's terms, conditions, and annual limits.

Additional Benefits for Comprehensive

You must be on a South African Medical Scheme. The Benefits listed below 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 Benefits listed below are deemed as separate Benefits and may qualify for coinciding yet distinct Benefits, as the case may be.

Benefit	Benefit Description	Limit
Accidental Casualty	**Benefits** will be paid in respect of **Emergency** out-patient services that are a direct result of **Accidental Injury** and are provided within a casualty ward of a **Hospital**. The **Benefit** payable is the total cost of **Treatment** less any amount paid by the **Medical Scheme**, including amounts paid from a medical savings account or by the **Insured Party**, up to the maximum limit per **Insured Event**. No **Benefit** is payable for services that are related to an Illness, or that are not delivered within a casualty ward of a **Hospital**.	Subject to a maximum of **R18 450 per Insured Event.**
Casualty - Child Illness	**Benefits** will be paid in respect of **Emergency** out-patient services provided within a casualty ward of a Hospital for an **Eligible Child** under the age of 12, in an **Emergency**, during after-hours **Treatment**. After-hours means Mondays to Fridays between 18:00 and 08:00, and all day on Saturdays, Sundays and South African public holidays. The **Benefit** payable is the total cost of **Treatment** less any amount paid by the **Medical Scheme**, including amounts paid from a medical savings account or by the **Insured Party**, up to the maximum limit per event. No **Benefit** is payable if the child is 12 or older, if the services are not delivered within a casualty ward of a **Hospital**, or if the **Treatment** is not after-hours as defined above.	Subject to a maximum of two such events **per Annum** and a maximum of **R3 000 per Event**. Limited to children under age 12.
Family Booster	This Benefit provides for an agreed **Benefit** amount payable when a **Premature Birth** occurs.	Agreed **Benefit** amount payable is **R16 900.**
Hospital Booster	This Benefit provides for an agreed benefit amount payable according to the length of the Hospital stay, should the **Insured Party** be admitted to Hospital in the event of an **Accidental Injury** or **Premature Birth**.	Agreed benefit amount payable: A maximum of two **Hospital Episodes** are covered under this **Benefit Per Annum**, up to a maximum amount of **R29 300 per Annum**. **R480 per day** from the 1st to the 13th day (inclusive). **R860 per day** from the 14th to the 20th day (inclusive). **R1 700 per day** from the 21st to the 30th day (inclusive). No **Benefit** is payable under this clause after day 30 of any **Hospital Episode**.
Family Protector	This **Benefit** provides for an agreed **Benefit** amount, payable upon the death or **Permanent Disability** of an **Insured Party** due to **Accidental Injury**.	Agreed benefit amount payable: Children **below six years: R20 000** All other **Insured Parties: R30 000.**
Gap Premium Waiver	This Benefit provides cover for the waiver of Policy Premiums in the event of the death or **Permanent Disability** of the **Policyholder** as a result of an accidental injury. The **Benefit** will apply where the **Policyholder** is the principal member of the **Medical Scheme** and only if there are dependents registered on the **Gap** policy who are being paid for by the **Policyholder**.	Waived for a period of six months from the date of the event. This **Benefit** is limited to one event over the **Policy** lifetime.
Medical Aid Contribution Waiver	This **Benefit** provides cover for the waiver of **Medical Scheme** contributions in the event of the death or **Permanent Disability** of the **Policyholder** due to **Accidental Injury** and where the **Policyholder** is the principal member of the **Medical Scheme**. The **Benefit** will apply where there are dependents registered on the **Medical Scheme**, who are being paid for by the **Policyholder**.	Contributions will be covered for six months up to an overall maximum amount of **R40 000**. This **Benefit** is limited to one event over the **Policy** lifetime.
Oncology Agreed Benefit	This **Benefit** provides for an agreed benefit amount payable if cancer is confirmed by an oncologist or pathologist as at least the medical equivalent of "Stage 2" or higher cancer. The **Benefit** is limited to **ONE claim per individual per cancer type** for the life of the **Policy** (a unique, new, primary source of cancer) and excludes any claim which in any way relates to a cancer type previously identified and for which cover was granted.	Agreed benefit amount payable of **R30 000 per Insured Party** over the **Policy** lifetime.
Breast Cancer Reconstruction Benefit	This **Benefit** provides for an agreed benefit amount payable for reconstruction of the unaffected breast following a mastectomy for breast cancer.	Agreed benefit amount payable is **R30 000 per Insured Party** over the **Policy** lifetime.

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2 Strand Road, Bellville 7530 I PO Box 1, Sanlamhof 7532, South Africa

T 0861 111 167
E info@sanlamgap.com

www.sanlamonline.co.za

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