Sanlam

INSURED BY CENTRIQ INSURANCE
A LICENSED NON-LIFE INSURER

This document is only a summary. For a comprehensive list of benefits, limits and exclusions that apply.

Sanlam Gap Cover

Understanding your Sanlam Gap Comprehensive Cover policy

What is **Gap Cover?**

Gap Cover is additional protection against shortfalls to complement your Medical Scheme cover. Shortfalls occur when your healthcare provider charges higher rates than what your Medical Scheme will pay.

These shortfalls expose you to out-of-pocket expenses that could lead to exorbitant debts.

What is the purpose of **Gap Cover?**

Gap cover is essential for Medical Scheme Members* due to the high cost of specialist treatments and above inflation increases, meaning that more people are at risk of being left behind and excluded from the quality medical care they need and deserve.

Many medical disciplines are increasing their charges at a rate much higher than that of inflation, some up to 500% of Medical Scheme rates. Patients and their families are required to meet the cost shortfalls that exist between what their Medical Scheme covers and the actual charge of the specialist. Gap cover helps you cover these cost shortfalls in line with statutory and Policy limits, terms and conditions.

*You must be a member of a Registered Medical Scheme

What does my **Gap Cover include?**

Gap Cover is for certain cost shortfalls for in-hospital treatment as well as certain defined out-of-hospital procedures which can be categorised as follows:
Core Benefits and **Additional Benefits as per the brochure and policy document**. For detailed information and whether these **Benefits** are applicable to your plan, access your **Policy** and **Detailed Benefits and Services** documents.

Key Benefits

- Tariff Shortfalls
- Co-Payments and Deductibles
- Shortfalls from Sub-Limits
- Oncology Lump Sum
- Oncology Tariff Shortfalls
- Oncology Sub-Limits
- Oncology Co-Payments
- Out-of-Hospital Tariff shortfalls
- Penalty Co-Payment
- Innovative Oncology Medicines
- Dental Reconstruction Benefit
- Major Affective Disorders including major depression & bipolar

Benefit Extenders

- Family Booster
- Child Casualty Illness
- Accidental Casualty
- Hospital Booster
- Family Protector
- Medical Aid Contribution Waiver
- Gap Premium Waiver

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.

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).

Understanding your Waiting Periods

The waiting periods for Sanlam Gap are as follows:

- 3 Month General Waiting Period
- 12 Month Condition-Specific Waiting Period

Moving from another Gap provider?

You can easily move from your previous Gap cover to Sanlam Gap. In order to ensure that the waiting periods are applied fairly and in line with the below, we suggest that you do not allow for a break in your cover.

If there is no break in cover, then the unexpired portion of the waiting periods from the previous policy will be applied to your Sanlam Gap Policy when you move over and if you already completed your waiting periods on your previous Gap cover, no waiting periods will apply on Sanlam Gap.

What are the waiting periods for Employer Groups joining Sanlam Gap?

- Waiting periods are determined at take on - waiting periods will either be applied; waived or reduced.
- Policyholders who join Sanlam Gap on a voluntary basis through their employer group will receive full waiting periods.
- Compulsory groups will have all waiting periods waived.

What is offered in terms of waiting period concessions?

- We will waive the 3-month General Waiting Period.
- 12-month condition specific exclusions will still apply.
- Waiting period concessions are negotiated with Centriq, the administrator.

Centriq will advise you when a concession period has been opened. Concessions are only applicable to employer groups.

Exclusions

For a detailed outline of all Policy Exclusions, please refer to section I of your Policy document.

Claims caused by or related to any of the following, will not be covered:

- Any claim that is excluded or rejected by the Policyholder's Medical Scheme, this means that, if your Medical Scheme has not paid their portion toward any particular line item charged, it will not be covered by your Sanlam Gap Cover Policy.
- 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.
- Any fee charged by a Medical Practitioner, Hospital, or other healthcare provider that constitutes Split Billing. This exclusion does not apply to Balance Billing.
- Any Treatment or Medical Procedure for infertility.
- Any Treatment or Medical Procedure where such treatment occurred outside of the period of an Insured Event.
- External prosthesis
- Any appliances including, but not limited to, wheelchairs, beds or convalescing equipment.
- All dental procedures classified as Specialised Dentistry, 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.
- 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
- Rehabilitation, frail care or hospice services
- Step-Down Facilities
- TTO (To-Take-Out) medicines

Benefits apply only for services rendered within the territory of the Republic of South Africa. Any services provided outside of the borders of South Africa are excluded from cover.

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This Policy is not a substitute for Medical Scheme membership.

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Key Benefits 2025

Health Service	Benefit	Limit
Key Benefits*	The following **Benefits** are defined as Key **Benefits**: • Tariff Shortfalls • **Co-payments** and **Deductibles** • Shortfalls from Sub-Limits • Oncology Lump Sum • Oncology Tariff Shortfalls • Oncology Sub-Limits • Oncology **Co-payments** • Out-of-**Hospital** Tariff shortfalls • **Penalty Co-payment** • **Innovative Oncology Medicines** • Dental Reconstruction **Benefit** • Major Affective Disorders	**Key Benefit Limit:** The overall maximum **Benefit** payable for the Key **Benefit** clauses of this **Policy** will be limited to the statutory maximum of **R210 580 per Insured Party per annum.** **Prescribed Minimum Benefits** (PMB) procedures are covered under Key **Benefits** and are subject to clinical review by our Specialist third party, MedClaim Assist.
Tariff Shortfalls	This **Benefit** provides an additional six times **(600%)** for charges above the **Medical Scheme** rate, covering shortfalls for healthcare service providers such as surgeons, radiologists, pathologists and physiotherapists. It also includes cover for **Prescribed Minimum Benefits** (PMBs).	An additional six times **(600%)** for charges above the **Medical Scheme** rate subject to the overall annual limit.
Co-Payments and Deductibles	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**. *Examples include co-payments applied to:* • *Da Vinci Robotic Surgery* • *Scopes and Scans*	Unlimited subject to the overall annual limit **per Insured per Policy**.
Shortfalls from Sub-Limits	This **Benefit** will apply 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 charged amount, less the amount paid by the **Insured Party's Medical Scheme**, subject to a maximum limit per **Insured Event** of **R66 400**.
Oncology Lump Sum	**Oncology Lump Sum Pay Out-Benefits** relating to this clause will only be paid if cancer is confirmed by the oncologist or pathologist as at least the medical equivalent of "Stage 2" or higher cancer. 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.	Limit **R15 500 per Insured Party** over the **Policy** lifetime.
Oncology Tariff Shortfalls	**Benefits** relating to this clause will only 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. This **Benefit** requires your **Medical Scheme** to pay their portion of the claim from your hospital/risk benefit.	Any **Benefit** provided for charges above the **Medical Scheme Tariff** shall be limited to an additional five times **(500%)**, subject to the overall annual limit **per Insured per Policy**.
Oncology Sub-Limits	**Benefits** relating to this clause will only be paid in respect of services, where the charges relating to the services supplied, have exceeded the **Benefit** sub-limit that applies to oncology **Treatment** of 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 subject to the overall annual limit **per Insured per Policy**.
Oncology Co-Payments	The **Benefit** payable is equal to the **Co-payment** applied once related costs have exceeded the specific threshold defined by the **Medical Scheme**.	Limited to the 20% oncology related co-payment applied by your **Medical Scheme**.

*The Benefit names listed throughout this document are for reference purposes only and will not form part of any Benefit definition.

Key Benefits 2025

Health Service	Benefit	Limit
Out-of-Hospital Tariff Shortfalls	This **Benefit** provides an additional six times **(600%)** of the **Medical Scheme** rate for out-patient procedures, subject to the costs being funded from the risk/hospital benefit by the **Insured Party's Medical Scheme**.	Unlimited subject to the overall annual limit **per Insured per Policy**.
Penalty Co-Payment	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. 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** and a maximum of **R18 550** per event.
Innovative Oncology Medicines	**Benefits** will be paid in respect of defined Innovative Oncology Medicines approved by the **Insured Party's Medical Scheme**.	A value equal to the lesser of 25% of the total drug cost or **R14 250**.
Dental Reconstruction Benefit	The **Benefit** is payable where Dental reconstruction surgery is required as a direct result of Accidental Injury or from Oncology Treatment that occurred after the **Inception 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.	The **Benefit** is subject to two events **per Family per Annum** and a maximum amount of **R49 900 per Annum**.
Major Affective Disorders including major depression & bipolar	This **Benefit** will apply 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 by the **Insured Party's Medical Scheme**.	Subject to a maximum of five days to a limit of **R2 500** per day per **Insured Party per Annum**.

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Additional Benefits

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.

Health Service	Benefit	Limit
Family Booster	A lump sum **Benefit** is payable when a **Premature Birth** occurs.	Lump sum **Benefit** is **R16 400.**
Casualty - Child Illness	**Benefits** relating to this clause will only be paid in respect of **Emergency** out-patient services that are provided within a casualty ward of a **Hospital**. The **Benefit** is only payable in the event of after-hours **Treatment** in an **Emergency** situation. After-hours is Mondays to Fridays between 18:00pm and 08:00am and all-day Saturdays, Sundays and South African public holidays. The **Benefit** payable is equal to the total cost of **Treatment** less the amount paid by your **Medical Scheme** from your hospital/ risk benefit. If payment is made from your available Medical Savings Account, or from your own pocket, we will reimburse that too.	Subject to a maximum of **two** such events **per Annum** and a maximum of **R3 000 per Event**. Limited to children under age 12.
Accidental Casualty	Cover for **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 equal to the total cost of **Treatment** less the amount paid by your **Medical Scheme** from your hospital/ risk benefit. If payment is made from your available Medical Savings Account, or from your own pocket, we will reimburse that too.	Subject to a maximum of **R18 450 per Insured Event.**
Hospital Booster	A lump-sum payment, related to the length of the hospital stay, will be paid in the event of an **Accident** or **Premature Birth**.	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	The lump sum **Benefit** is payable upon the death or **Permanent Disability** of an **Insured Party** due to **Accidental Injury**.	Limited as follows: Children **below six years: R20 000** All other **Insured Parties: R30 000.**
Medical Aid Contribution Waiver	A lump sum **Benefit** is payable upon 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.
Gap Premium Waiver	In the event of the death or **Permanent Disability** of the **Policyholder** as a result of an accident, **Policy Premiums** will be waived. 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.

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How to Submit your Claim

An automated claims submission process has been introduced to allow for the automatic processing of your claims, and you will no longer be required to submit a separate claim form in addition to the claim that has been submitted to your Medical Scheme. The Sanlam Gap Team have developed an automated integration system for its members on selected schemes to seamlessly integrate with your Medical Scheme, healthcare providers and its contracted third parties to assist with the efficiency of the claims process.

Alternatively, you are able to decline this process and access the claim form by clicking on this **link** and download the form. Kindly email your completed claim form with supporting documentation to **Gapinfo@centriq.co.za**

Standard Claims Process

When submitting the claim form, you will also need to provide a copy of the relevant specialists' accounts, **Hospital** accounts and **Medical Scheme** statement showing the processing of the accounts and the shortfall. Please note that the claim will not be processed until all documents have been received. You have **6 months** from the end of the **Insured Event** to submit your claim and relevant documentation. Any claim received for the first time after the 6 month period has expired, will not be honoured.

Claims can be e-mailed to **Gapinfo@centriq.co.za**

Claims can also be captured online: **Sanlam Gap Claims form**

Once received, **your claim will be processed** and if all requirements have been met, the **Benefit** amount will be paid within **7 to 10 working days**.

Please also remember that this **Policy** does not form part of your **Medical Scheme** and your **Medical Scheme** call centre will thus not be able to assist you with any questions in this regard.

Please direct all queries to our
Customer Care Centre on **0861 111 167**

Contact **Information**

Sanlam Gap Cover
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