SANLAM GAP COMPREHENSIVE POLICY DOCUMENT 2025

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.

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

Contents

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. 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:

B1. **"Accidental Injury"**: Refers to bodily injury caused by violent, unintentional, external and physical means.

B2. **"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.

B3. **"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.

B4. **"Benefit or Benefits"**: It is the benefits as listed on the **Benefit Schedule** that are payable to the Insured Party following an Insured Event.

B5. **"Benefit Schedule"**: Refers to Annexure A: Detailed Benefits attached to this policy which sets out the benefits covered and their maximum limits payable.

B6. **"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.

B7. **"Core Benefits"**: This is a list of benefits defined as Core Benefits in the **Benefit Schedule** and which benefits are subject to the Overall Annual Limit.

B8. **"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**.

B9. **"Designated Service Provider"** or **"DSP"**: A healthcare service provider chosen by a Medical Scheme as one of their preferred suppliers.

B10. **"Effective Date"**: The first day of the month on which cover starts for the **Insured Party** as noted in the Policy Schedule.

B11. **"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.

B12. **"Eligible Special Dependant"**:

- A dependant who is neither an Eligible Spouse nor a Special Needs Child nor an Eligible Child of the Policyholder but who is a dependant on the Policyholder's Medical Scheme and has been accepted by the Insurer for such cover under this Policy.
- If no such acceptance is provided by the Insurer, such special dependants are not covered even though they are dependants on the Policyholder's Medical Scheme.

B13. **"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.

B14. **"Emergency"**: A serious, unexpected, and dangerous situation requiring immediate action.

B15. **"Family"**: Collectively it refers to the **Policyholder**, Eligible Spouse, Eligible Children, Special Needs Child and/or Eligible Special Dependants as defined in the **Policy**.

B16. **"General Waiting Period"**: The period in which an **Insured Party** may not claim any **Benefits**, except for **Benefits** directly arising from **Accidental Harm**.

B17. **"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.

B18. **"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 mental health institutions.
- Provides 24 hour 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.
- 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.

B19. **"Hospital Episode"**: The period of time between admission to **Hospital** of an **Insured Party** until the time of discharge from the **Hospital** / network clinic that serves patients for **Major Affective Disorders** including major depression & bipolar of the same **Insured Party** for the same **Insured Event**.

B20. **"Hospital Network"**: A list of **Hospitals** or network clinic that serves patients for **Major Affective Disorders** including major depression & bipolar specified by the **Insured Party's Medical Scheme**, as the **Designated Service Provider** of one or more plan types of the **Medical Scheme**.

B21. **"Illness"**: Any physical disease or sickness which presents itself in an **Insured Party** which can be diagnosed by a Medical Practitioner using factual evidence and has been diagnosed.

In other words it must be capable of diagnosis and have been diagnosed.

B22. **"Innovative Oncology Medicines"**: As described by the Insured Party's Medical Scheme in the Oncology Innovative benefit.

B23. **"Insurer"**: Centriq Insurance Company Limited, registration number 1998/007558/06; FSP 3417.

B24. **"Insured"** or **"Insured Party"**: Refers to the **Policyholder**, **Eligible Spouse, Eligible Child** or **Eligible Special Dependant**, as defined in this **Policy**.

B25. **"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**.

B26. **"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.

B 27. **"Medical Practitioner"**: A person who is suitably qualified and registered with the Health Professions Council of South Africa to practice medicine.

B28. **"Medical Procedure"**: A medical procedure is a course of action intended to achieve a result in the delivery of healthcare. A medical procedure with the intention of determining, measuring, or diagnosing a patient's condition.

B29. **"Medical Scheme"**: A Medical Scheme as registered under the Medical Schemes Act.

B30. **"Medical Schemes Act"**: to the **Medical Schemes** Act No. 131 of 1998.

B31. **"Overall Annual Limit"**: The maximum amount payable per **Insured Party Per Annum** in respect of Core Benefits.

B32. **"Per Annum"**: The period from 1 January to 31 December of any year.

B33. **"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.

B34. **"Permanent Disability"**: Any **Accidental Harm** or physical **Illness** that renders a person permanently unable to work in their own or other occupation for which they are suited by training, education or experience.

B35. **"Policy"**: Consists of this policy document as well as the Policy Schedule **Policy Schedule**.

B36. **"Policy Exclusions"**: The list of services, conditions and events that are not covered on the **Policy**.

B37. **"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.

B38. **"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.

B39. **"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.

B40. **"Premium or Premiums"**: The monthly amount due to the **Insurer** payable by, or on behalf of the **Policyholder**.

B41. **"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.

B42. **"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.

B43. **"Split Billing"**: A practice where a **Medical Practitioner** or other healthcare service providers 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**.

B44. **"Tariff"**: Either the scheme rate or a specific **Tariff** registered by a **Medical Scheme** to determine the rate at which its **Benefit** are payable.

B45. **"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.

C. Claims

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

- Notify **Centriq** of any claim in writing as soon as possible but not later than **six months** after the end of the **Insured Event**. Claims submitted more than **six months** after the end of the Insured Event may not be covered.
- 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. 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** unless you are claiming for a **Benefit** with different qualifying criteria such as a Family Protector or a defined **Co-payment**.

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** shall only become payable after the end of the **Treatment** relating to the **Insured Event** but at the sole discretion of the Insurer. Interim **Benefit** payments can be made to you after a 31-day period during an **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. If the Insurer persists in rejecting the claim or disputing the quantum, the Insured Party can take legal action and have a summons issued and served on the Insurer, within **six months (180 days)** after the expiry of the **90 days** period; failing which, the **Insured Party** will forfeit his claim and will have no further claim in terms of this **Policy**.

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.

D. Premiums

Individuals

- All **Premiums** are **payable monthly in advance or arrears by the last working day of the 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 **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**.

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 arrears **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**.

E. 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**.

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 unreversible nomination of one spouse as the **Eligible Spouse**. **Benefits** will only be paid to the nominated **Eligible Spouse** or the **Eligible Special Dependant**.

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.

F. Termination of Cover

You may cancel this cover at any time, by giving 31 days, prior written notice.

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**.

G. Waiting Periods

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

A General Waiting Period of three months.

A Condition-Specific Waiting Period of 12 months. Where this is applied, a pre-existing questionnaire will be requested at claim stage, within the first 12 months. The requirement is that this questionnaire is completed by the diagnosing Medical Practitioner.

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

A General Waiting period will be applied for all newly incepted Mediclinic Extender plans, irrespective of whether an existing member.

H. Waiver of Waiting Periods

If you previously had a **Medical Expense Shortfall Policy**, not longer than **90 days** before the **Policy Start 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** 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**.

A General Waiting period will be applied for all newly incepted Mediclinic Extender plans, irrespective of whether an existing member.

I. 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.
- 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. The definition does not include **Basic Dentistry**, this exclusion does not apply to the **Dental Reconstruction Benefit** in this **Policy**.
    - 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.

- 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** or **Deductible** applied by the **Insured Party's** Medical Scheme against the **Benefits** to be received or paid out from the **Medical Scheme**, other than those specifically listed in the **Benefit Schedule** outlined in this **Policy**.
- Any **Penalty**, applied by the **Insured Party's Medical Scheme**.
- 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.
- A **Deductible** or **Co-payment** that is specified by the **Insured Party's Medical Scheme** as a percentage of costs. This does not apply to the 20% oncology Co-payment as per the oncology Co-payments or Penalty Co-payments in this Policy.
- Any out-patient **Treatment** unless otherwise specified in this Policy.

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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).

Benefits Description Sanlam Gap Cover

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.

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). **Key Benefits Tariff Shortfalls Example:** Mr S is on a Medical Scheme – plan A which covers him to a maximum of 100% of the Medical Scheme rate. This means that the Medical Scheme will pay all expenses towards Mr S' Treatment costs. The Medical Scheme rate for a total colonoscopy is R2 000 (100%) which means that the maximum that the Medical Scheme will pay is R2 000 (100%). The specialist performing the procedure charged R12 000 which is six times the Medical Scheme Tariff (600%). The maximum Benefit payable by this Policy for this procedure is therefore: • R12 000 – Fee charged by the specialist • LESS R2 000 – Benefit paid by Medical Scheme • = R10 000 – The gap cover Benefit.	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**.

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Key Benefits 2025

Health Service	Benefit	Limit
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. **Oncology Tariff Shortfalls Example:** Mr T is on a Medical Scheme – plan B which covers him to a maximum of 100% of the Medical Scheme rate. This means that the Medical Scheme will pay all expenses at the defined Medical Scheme rate towards Mr T's Treatment costs. The Medical Scheme rate for the specific oncology Treatment is R20 000 (100%). This means that the maximum that the Medical Scheme will pay is R20 000. The total cost for the specific oncology Treatment required by Mr T is R100 000 which is five times the Medical Scheme Tariff (500%). The maximum Benefit payable for this procedure is therefore: • R100 000 – Oncology Treatment Cost • LESS R20 000 – Benefit paid by Medical Scheme • = R80 000 – Your gap cover 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**.

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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**. **Out-of-Hospital Tariff Shortfalls Example:** Mr V is on a Medical Scheme – plan C which covers him to a maximum of 100% of the Medical Scheme rate. This means that the Medical Scheme will pay all expenses at the defined Medical Scheme rate towards Mr V's Treatment costs. Mr V has opted to undergo an arthroscopy of his shoulder out of Hospital. The Medical Scheme rate for a total arthroscopy is R2000 (100%). This means that the maximum that the Medical Scheme will pay is R2000 (100%). The specialist performing the procedure charged R10 000 which is five times the Medical Scheme Tariff (500%). The maximum Benefit payable for this procedure is therefore: • R10 000 – Fee charged by the specialist for the arthroscopy • LESS R2 000 – Benefit paid by Medical Scheme • =R8 000 – Your gap cover Benefit.	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. **Dental Reconstruction Example:** Mr X is involved in a motor vehicle accident which damaged his teeth. Mr X is required to have dental reconstruction as a result of this. Mr X was admitted to Hospital for his surgery. The total cost for Mr X's Treatment was R10 500. Mr. X's Medical Scheme paid R3 000 toward the dental surgeon's account from his hospital benefit. Centriq will calculate the Benefit payable to Mr X as: • R10 500 (Charged Amount) • Less R3 000 (Paid by Medical Scheme) • = R7 500	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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