Sanlam

GAP COVER DETAILED BENEFITS 2022

UNDERWRITTEN BY
CENTRIQ INSURANCE

www.sanlam.co.za

Financial Planning | Investments | Insurance | Retirement | Wealth

Confidence comes from knowing you're in control

Financial confidence is a feeling of certainty. Knowing you are prepared for the challenges that may come your way - including poor health. While no one can promise you a disease-free future, we can promise you peace of mind with Sanlam Gap Cover. Regardless of your current Medical Scheme, Sanlam Gap Cover provides you with the security that today is a good day and the faith that tomorrow will be even better.

Comprehensive cover **made simple for you**

Sanlam Gap Cover is a short term insurance product that provides an extra layer of financial protection for those who already have medical aid. It helps to cover certain shortfalls between what your medical aid scheme will pay and the rates charged by in-**Hospital** medical specialists.

Why choose **Sanlam Gap?**

The high cost of specialist **Treatments** and above-inflation increases means that more people are at risk of being left behind and excluded from the quality medical care they need and deserve. **Sanlam Gap** gives you the freedom to choose whichever Doctor or specialist will give you the best care, regardless of your **Medical Scheme**, regardless of rates. We have you covered for the best care, without the stress of having to worry about additional bills.

Core Benefits 2022

Health Service	Benefit	Limit
Core Benefits*	The following **Benefits** are defined as Core **Benefits**: • **Tariff** Shortfalls • **Co-Payments** and **Deductibles** • Shortfalls from Sub-Limits • Oncology **Tariff** Shortfalls • Oncology Sub-Limits Oncology • **Co-Payments** • Out-of-Hospital Tariff shortfalls • Penalty **Co-Payment** • Innovative Oncology Medicines • Dental Reconstruction **Benefit** **Prescribed Minimum Benefits** (PMB) procedures are covered under Core **Benefits** and are subject to clinical review by our Specialist third party, MedClaim Assist.	**Core Benefit Limit:** The maximum **Benefit** payable by the **Insurer** for all Core **Benefit** clauses (as defined) combined shall be limited to R177 800 per **Insured Party Per Annum**.
Tariff Shortfalls	**Benefits** relating to this clause will only be paid in respect of services occurring during a **Hospital Episode** that are rendered and charged for by an individual **Medical Practitioner**. This **Benefit** requires your **Medical Scheme** to pay their portion of the claim from your hospital/risk **Benefit**. **Core 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'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 R10 000 which is five (5) times the **Medical Scheme Tariff** (500%). The maximum **Benefit** payable by this **Policy** for this procedure is therefore: R10 000 – Fee charged by the specialist LESS R2 000 – **Benefit** paid by **Medical Scheme** = R8 000 – The gap cover **Benefit**.	The **Benefit** provided is for charges above the **Medical Scheme Tariff** limited to an additional five times (500%) that of the **Medical Scheme Tariff**, subject to the **Core Benefit Limit**

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

Core Benefits 2022

Health Service	Benefit	Limit
Co-Payments and Deductibles	**Benefits** relating to this clause will only be paid in respect of the defined diagnostic procedures listed in Table One and which occur during an **Insured Event**. 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 listed in Table One.	Subject to the **Core Benefit Limit**.

Table One - Defined Diagnostic Procedures

Cystourethroscopy	Gastroscopy
Colonoscopy	Cystoscopy or Hysteroscopy
Proctoscopy	CT Scan
Sigmoidoscopy	MRI or PET Scan

Benefits relating to this clause will only be paid in respect of the Defined **Medical Procedures** listed in Table Two and which occur during a **Hospital Episode**.

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 **Medical Procedure** listed in Table Two.

Table Two - Defined Medical Procedures

Conservative Back and Neck **Treatment**	In-patient **Basic Dentistry**
Myringotomy	Hernia Repair
Tonsillectomy	Varicose Vein Surgery
Adenoidectomy	Percutaneous Radiofrequency Ablations
Facet Joint Injections	Rhizotomies
Arthroscopy	Confinement
Functional Nasal Procedures	Circumcision
Non-Malignant Hysterectomy	Hymenotomy
Confinement	Spinal Fusion or Major Joint Replacement
Laparoscopy	Nissen Fundoplication
Hysteroscopy	Spinal Fusion or Major Joint Replacement

Core Benefits 2022

Health Service	Benefit	Limit
Shortfalls from Sub-Limits	**Benefits** relating to this clause will only be paid in respect of a service, provided during a **Hospital Episode**, where the charges relating to the service supplied has exceeded a relevant **Benefit** sub-limit of the **Insured Party's Medical Scheme** plan type.	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 R57 500 subject to the **Core Benefit Limit**.
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 (malignant neoplasm) and which occurs during an **Insured Event**. 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 by this **Policy** for this procedure is therefore: R100 000 – Oncology **Treatment** Cost LESS R20 000 – **Benefit** paid by **Medical Scheme** = R80 000 – Your gap cover **Benefit**.	The **Benefit** provided is for charges above the **Medical Scheme Tariff** limited to an additional five times (500%) that of the **Medical Scheme Tariff**, subject to the **Core Benefit Limit**.

Core Benefits 2022

Health Service	Benefit	Limit
Oncology Sub-Limits	**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 (malignant neoplasm) and which occurs during an **Insured Event**. **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. The **Benefit** payable is equal to the charged amount, less the amount paid by the **Insured Party's Medical Scheme**.	Subject to the **Core Benefit Limit**.
Oncology Co-Payments	**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 (malignant neoplasm) and which occurs during an **Insured Event**. The **Benefit** payable is equal to the **Co-payment** applied once related costs have exceeded the specific threshold defined by the **Medical Scheme**.	The maximum **Benefit** payable shall be limited to a 20% **Co-payment**, subject to the **Core Benefit Limit**.
Out-of-Hospital Tariff Shortfalls	**Benefits** relating to this clause will only be paid in respect of the defined out-patient procedures or **Treatment** listed in Table three that are rendered and charged for by an individual **Medical Practitioner**. This **Benefit** requires your **Medical scheme** to pay their portion of the claim from your hospital/risk **Benefit**. Table Three – Defined Out-Patient Procedures / **Treatment** **Diagnostic:** • Cystourethroscopy, • Colonoscopy, • Proctoscopy, • Sigmoidoscopy, • Gastroscopy, Cystoscopy or Hysteroscopy • In-Patient Basic dentistry	Any **Benefit** provided for charges above the **Medical Scheme Tariff** shall be limited to an additional five times (500%) of the **Medical Scheme Tariff**, subject to the **Core Benefit Limit**.

Core Benefits 2022

Health Service	Benefit	Limit
Out-of-Hospital Tariff Shortfalls	**General Surgery:** • Drainage of Superficial Abscess (e.g. Carbuncle, Suppurative • Hidradenitis, Cutaneous or Paronychia, Perineal Abscess Etc) • Dialysis **Treatment** • Removal Foreign Body • Anoscopy • Colposcopy of the Cervix Including Upper / AdjacentVagina; With Loop Electrode Conisation of Cervix / Biopsy • Cauterisation of Warts • Breast Biopsy or Vacuum Assisted Biopsy Destruction (e.g., Laser, Electrosurgery, Cryosurgery, Chemosurgery, Surgical Curettement) of Benign Lesions other than Skin Tags or Cautaneous Vascular Lesions • Nasal Cautery - Cautery and / or Ablation, Mucosa of Inferior Turbinates, Unilateral or Bilateral Any Method • Home Births • Puncture Aspiration of Cyst of Breast • Circumcision • Cone Biopsy • Pap Smears • Sigmoidoscopy for Diagnostic or Removal Foreign Body or Tumours • Insertion Mirena In Rooms **Dental:** • Drainage of Abscess, Cyst, Haematoma from Dentoalvelar Structures • Drainage of Abscess, Cyst, Haematoma, Vestibule of Mouth • Root Canal • Surgical Extraction of Wisdom Teeth **Ophthalmology:** • Meibomian Cyst Excision • Excision of Chalazion; • Blepharotomy, Drainage of Abscess, Eyelid	Any **Benefit** provided for charges above the **Medical Scheme Tariff** shall be limited to an additional five times (500%) of the **Medical Scheme Tariff**, Subject to the Core Benefit limit.

Core Benefits 2022

Health Service	Benefit	Limit
Penalty Co-Payment	Notwithstanding exclusion related penalties, the **Insurer** will pay a fixed value Penalty **Co-payment** or **Deductible**, or a percentage penalty **Co-payment** that does not exceed 30%, for the voluntary use by an **Insured Party** of a Hospital that is not part of a **Hospital Network**. 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.	A maximum of Two such events are covered under this **Benefit Per Annum** and up to a maximum amount of R16 500 **Per Event,** subject to the **Core Benefit Limit**.
Dental Reconstruction Benefit	**Benefits** relating to this clause are only payable in respect of Dental Reconstruction Surgery being required as a direct result of Accidental Harm or from Oncology **Treatment** that occurred after the Inception of this **Policy**. 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 only payable during an **Insured Event**. **Dental Reconstruction Example:** Mrs X is involved in a Motor Vehicle accident which damaged his teeth. Mrs X is required to have Dental Reconstruction as a result of this. Mrs X was admitted to hospital for his surgery. **The total cost for Mrs X's Treatment was R10 500.00**. Mrs X's **Medical Scheme** paid **R3 000** toward the Dental Surgeon's account from his Hospital **Benefit**. Sanlam Gap will calculate the **Benefit** payable to Mrs X as: **R10 500.00 (Charged Amount)** **Less R3 000.00 (Paid by Medical Scheme) =** **R7 500.00**	A maximum of Two such events are covered under this **Benefit Per Annum** and up to a maximum amount of R49 900 **Per Annum** subject to the **Core Benefit Limit**.
Innovative Oncology Medicines	Benefits relating to this clause will only be paid in respect of defined Innovative Oncology Medicines. Approval for any innovative drugs will be required by your **Medical Scheme**.	A value equal to the lesser of 25% of the total drug cost or R12 000 as it relates to **Innovative Oncology Medicines** subject to the **Core Benefit Limit**.

Benefit Extender

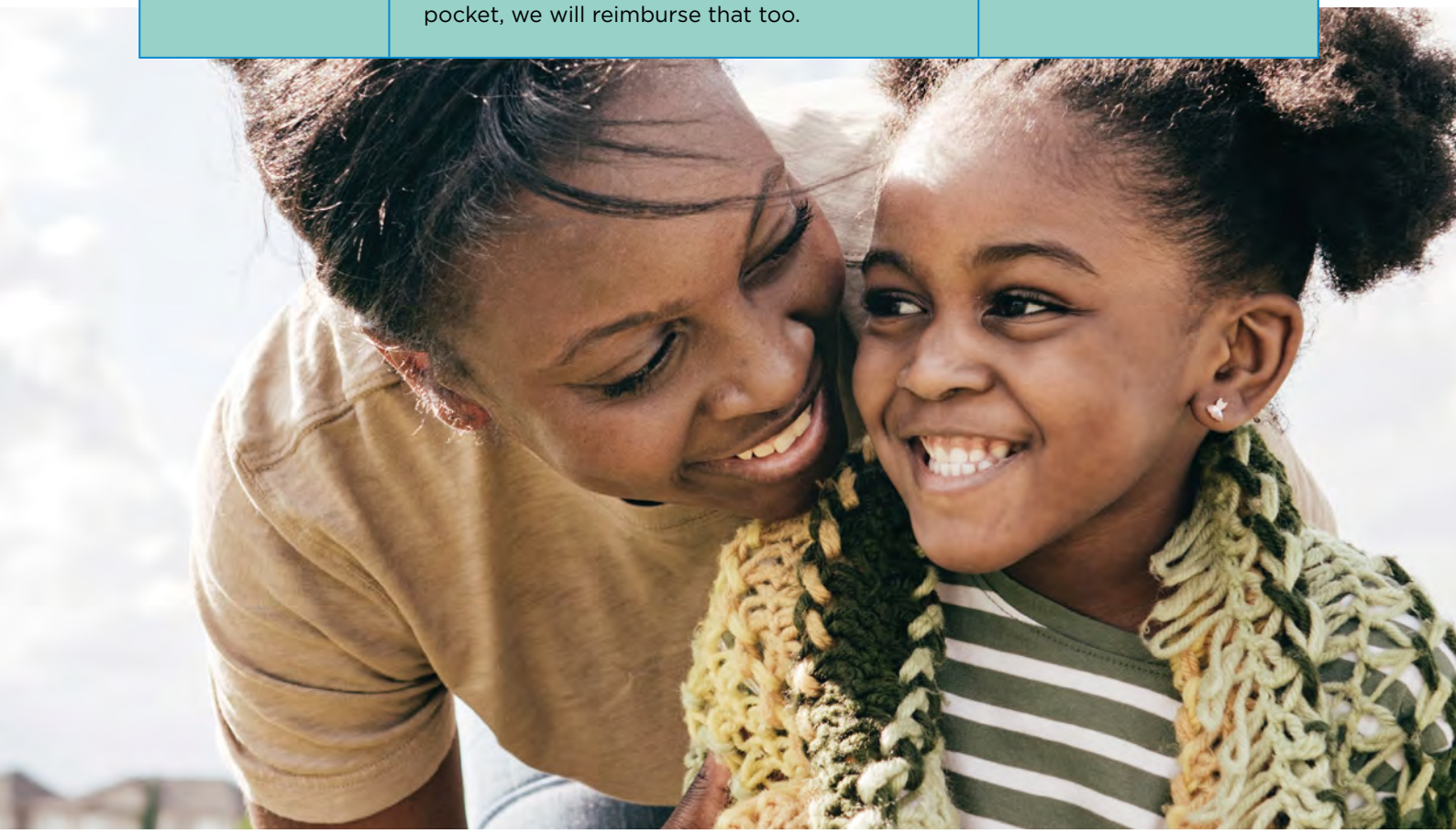
Health Service	Benefit	Limit
Accidental Casualty	**Benefits** relating to this clause will only be paid in respect of **Emergency** out-patient services that are a direct result of **Accidental Harm** and are provided within a casualty ward of a **Hospital**. The **Benefit** payable is equal to the total 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. No **Benefit** is payable under this clause for services that are related to an **Illness** or that are not delivered within a casualty ward of a **Hospital**, as defined.	Subject to a maximum of **R16 500 Per Event.**
Family Booster	A lump sum **Benefit** is payable when a Premature Birth occurs.	Lump sum **Benefit** is **R15 000.**
Hospital Booster	The following daily lump sum **Benefits** are payable where an **Insured Party** is admitted to a Hospital, and such an **Insured Event** occurred as a direct result of either Accidental Harm or Premature Birth, as defined, in your **Policy**. For the purposes of the above **Benefit** calculation, the first day is defined as commencing at the time of admission to Hospital and ending 24 hours later. All subsequent days are defined as commencing and ending on the same start and end times as the first day. The following **Benefit** limitations apply to this clause: If more than one **Insured Party** in the **Family** (if you have selected to pay the Family **Policy Premium**) is hospitalised as a result of the same event, only the **Insured Party** with the longest **Hospital Episode** will attract a **Benefit** under this clause. No **Benefit** is payable under this clause after day 30 of any **Hospital Episode**.	A maximum of two **Hospital Episodes** are covered under this **Benefit Per Annum**, up to a maximum amount of R27 690 **Per Annum**. The **Benefit** is payable from day one of the **Hospital Episode**: **R450 per day** from the 1st to the 13th day (inclusive). **R820 per day** from the 14th to the 20th day (inclusive). **R1 610 per day** from the 21st to the 30th day (inclusive). Max **R27 690.00 Per Annum**.
Family Protector	The lump sum **Benefit** is payable upon the Death or Permanent Disability of an **Insured Party** due to Accidental Harm.	Limited as follows: Children **below six years: R20 000** All other **Insured Parties: R30 000**

Benefit Extender

Health Service	Benefit	Limit
Medical Scheme Contribution Waiver	The following lump sum **Benefit** is payable upon the death or **Permanent Disability** of the **Policyholder** due to **Accidental Harm** and where the **Policyholder** is the Principal Member of the **Medical Scheme**. The **Benefit** amount will only apply (become payable) where there are dependants registered on the **Medical Scheme**, who are being paid for by the **Policyholder**. The **Benefit** payable is equal to the monthly **Medical Scheme** contribution applicable after the qualifying event above, multiplied by **six** and subject to an overall maximum limit. This **Benefit** is limited to **one event** over the **Policy** lifetime. In addition, the **Sanlam Gap** Cover **Premium** will be waived for **six months**.	The **Benefit** payable is subject to an overall maximum limit of R35 500.

Benefit Extender

Health Service	Benefit	Limit
RAF Claims	An end-to-end legal service is provided by the nominated Service Provider of **Kaelo**, our administator to assist Insured Parties with legitimate claims against the Road Accident Fund (RAF). Service Providers are contracted to Kaelo Risk and not to the **Insurer:** Centriq Insurance Company Limited.	Included.
Child Casualty 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 R2 500 Per Event.** **Limited to children under age 12**.



How to Submit your Claim

Once you have established that you have a valid claim, you will be required to complete the **Sanlam Gap Cover claim form**, which you can request from **sanlaminfo@kaelo.co.za**.

Please note that this is not an automatic process, and you will be required to submit a separate claim form to the claim that has been submitted to your **Medical Scheme**.

When submitting the claim form, you will also need to provide a copy of the relevant specialists' accounts, hospital accounts and medical aid 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 first day that you were hospitalised 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 **sanlamclaims@kaelo.co.za**.

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**.

Sanlam Gap

https://www.kaelo.co.za/quick-links/

Contact **Information**

Sanlam Gap Cover
T 0861 111 167
E sanlaminfo@kaelo.co.za
www.sanlam.co.za

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

Kaelo Risk(Pty)Ltd an authorised financial services provider (FSP 36391)

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

This brochure which is also the Detail of Services and Benefits annexure to your Policy, should be read together with your Policy and Policy Schedule as they all form part of your agreement with the Insurer and the Underwriting Manager (UMA). Please ensure that you familiarise yourself with all the terms and conditions contained in all the documents you have received.

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