Sanlam

COMPREHENSIVE GAP COVER BENEFITS 2024

FEDHEALTH
Create your aid.

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 is an authorised financial services provider (FSP 36931).
Kaelo Risk (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).

INSURED BY
CENTRIQ
INSURANCE
A LICENSED NON-LIFE INSURER

www.sanlam.co.za

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

Bridging the gap with confidence

Financial confidence is a feeling of certainty; knowing you are prepared for the challenges you may face – including poor health. We can't promise you a life free of disease however, with Sanlam Gap Cover, we can promise you peace of mind knowing that we can provide you with security regardless of your current medical scheme.

Why choose **Sanlam Gap?**

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

Comprehensive cover **made simple for you**

Sanlam Gap Cover is a non-life 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 Scheme** will pay and the rates charged by in-hospital medical specialists.

MEDICLINIC

Close the Gap even further with the **new Mediclinic Extender Benefit**

You can close the gap even more, thanks to the **Mediclinic Extender Benefit**.

The Mediclinic Extender Benefit offers additional cover for **Medical Scheme** co-payments, private ward cover, and a cancer lump sum benefit, etc. These benefits ensure that you enjoy personalised treatment at all Mediclinic hospitals and is the perfect add-on to your **Sanlam Gap Cover.**

» **See page 5 for more**

Monthly premiums 2024

Individuals younger than 60 years

R248

ADD MEDICLINIC EXTENDER FOR ONLY

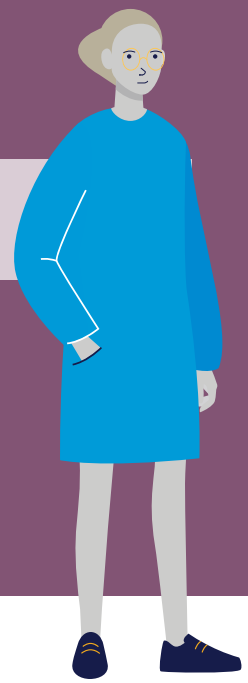
R46

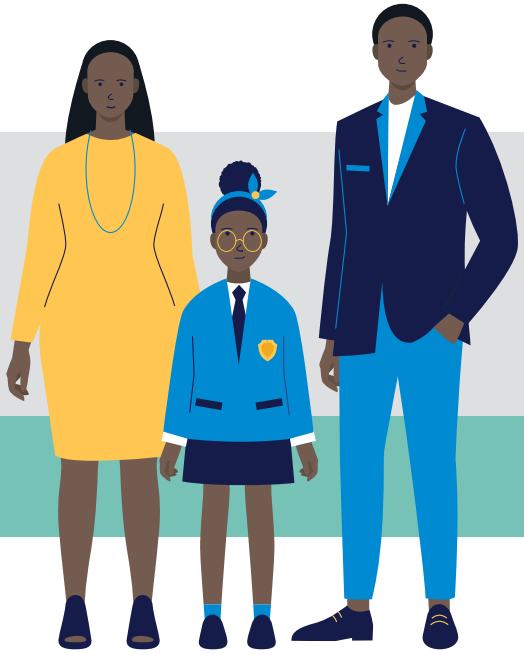
Individuals older than 60 years

R495

ADD MEDICLINIC EXTENDER FOR ONLY

R85





Families younger than 60 years

R433

ADD MEDICLINIC EXTENDER FOR ONLY

R104

Families older than 60 years

R868

ADD MEDICLINIC EXTENDER FOR ONLY

R176

Key Benefits 2024 for Fedhealth

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** Prescribed Minimum Benefits (PMBs) procedures are covered under Core Benefits and are subject to clinical review by our specialist third party, MedClaim Assist.	**Key Benefit Limit:** The overall maximum **Benefit** payable for the Key **Benefit** clauses of this **Policy** will be limited to the statutory maximum of **R198 660 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 a fixed or upfront rand value deductible or co-payment amount as defined in the rules by the **Insured Party's Medical Scheme**. This **Benefit** will include cover for defined, fixed value co-payments applied by the **Medical Scheme**.	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 **R64 500**.
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 000 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**.
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 **R13 780**.
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**.

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

Additional Benefits 2024 for Fedhealth

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 **R15 900.**
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 **R2 860 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 6 months up to an overall maximum amount of **R35 500**. 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.**
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.

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

Mediclinic Extender Benefit

The Mediclinic Extender Benefits applies to members who have opted to include the option on their Sanlam Gap Comprehensive Policy. Confirmation thereof would reflect on the member's **Policy Schedule**.

	Health Service	Benefit	Limit
HEALTHCARE BENEFITS	Casualty Illness	**Benefits** relating to this clause will only be paid in respect of **Emergency** outpatient 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-hour emergency illness only at a Mediclinic for all **Insured Parties** covered **(Mondays to Fridays: 6pm – 8am. All-day Saturdays, Sundays & public holidays).**	Subject to a maximum of **two** such events **per Annum** and a maximum of **R2 650 per Insured Event.**
	Specialist Benefit	Specialist Benefit - Out-of-hospital This **Benefit** will become payable when your **Medical Scheme** has paid a portion of your out of hospital specialist claim. We will cover the shortfall thereof.	Up to **R5 200 per Insured Party per Annum**, subject to the Overall Annual Limit.
	Private Ward	Cover for the difference between the cost of a general ward and a private ward. Payable only in the event of confinement (childbirth) admissions. Only at a Mediclinic hospital (if available).	Subject to a maximum of **one** event **per Insured Party per Annum** and a maximum of **R5 200** subject to the Overall Annual Limit.
	Cancer 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 Insured Party** and is only payable on first-time diagnosis as a lump sum of **R10 600**.
CO-PAYMENT BENEFITS	Cashless Co-payment	**Benefits** relating to this clause will only be paid in respect of defined diagnostic procedures that occurred 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. **Benefit** is directly payable to the Mediclinic Pre-authorisation letter required.	Unlimited subject to the Overall Annual Limit. Only at a Mediclinic facility.
	Cashless 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 Mediclinic facility that is not part of their **Medical Scheme Hospital Network**.	Unlimited only at a Mediclinic facility subject to a maximum of **R17 500** per event and subject to the Overall Annual Limit.

***How to pre-authorise your cashless co-payments:**

Kindly complete a pre-authorisation form which can be found on the website:

https://documents.sanlam.co.za/2024_Sanlam_Gap-Mediclinic-Extender-Cashless-Form.pdf

and submit to sanlamauth@kaelo.co.za within a minimum of 48 working hours prior to your procedure or admission. In the event of an emergency,a pre-authorisation form needs to be completed post procedure within 3 working days.

***All other benefits claimable via the standard claiming process -**

click here

MEDICLINIC

Sanlam Gap Seamless Claims Process

SIMPLIFIED

PREVIOUS PROCESS		SEAMLESS PROCESS
Medical event occurs	1	Medical event occurs
Medical provider submits claims to medical scheme for payment	2	Medical provider submits claims to medical scheme for payment
Medical Scheme assesses claims and identifies shortfalls	3	Medical Scheme assesses claims and identifies shortfalls
Member receives statement noting payment shortfalls, requiring payment	4	Member receives statement noting payment shortfalls, requiring payment
Member completes paperwork and submits to Sanlam Gap (sanlamclaims@kaelo.co.za)	5	Member does not complete ANY PAPERWORK as all information is automatically sent by the medical scheme directly to Sanlam Gap for assessment, according to the policy benefits
Paperwork is received by Sanlam GAP and assessed, according to the policy benefits	6	
Once all documentation is received, claims shortfalls are paid within 7 to 14 working days	7	Claims shortfalls are paid within 7 to 14 working days
Member is paid and send a statement as confirmation	8	Member is paid and send a statement as confirmation

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

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 it forms 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.

Contact **Information**

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

Sanlam

Live with confidence

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

T +27 (0)21 947 9111
F +27 (0)21 947 8066

www.sanlam.co.za