Sanlam

UNDERWRITTEN BY CENTRIQ INSURANCE

This document is only a summary. For a comprehensive list of benefits, limits and exclusions that apply, please contact your financial advisor.

Sanlam Gap Cover

Understanding your Gap Cover policy

What is **Gap Cover?**

Gap cover is a non-life insurance product that helps you cover certain cost shortfalls that your Medical Scheme does not cover in full. These medical shortfalls occur when your selected doctor or medical specialist charges rates that are more than what your Medical Scheme will pay for.

These shortfalls vary according to the fees charged by a medical specialist and the nature of the procedure required. Sanlam Gap provides security regardless of the Medical Scheme plan or option selected. This freedom allows patients to select the very best doctors without having to worry about whether the medical bills will be fully covered by the Medical Scheme.

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.

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 **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.

Core Benefits

- Tariff Shortfalls
- Co-Payments and Deductibles
- Shortfalls from Sub-Limits
- Oncology Tariff Shortfalls
- Oncology Co-Payments
- Penalty Co-Payment

*You must be a member of a Registered Medical Scheme

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.

In the event that an **Insured Party** previously had a similar **Medical Expense Shortfall Policy**, not longer than **90 Days** before the **Inception Date**, the period of the **General Waiting Period** and **Condition-Specific Waiting Period** shall be reduced by the expired portion of the **General Waiting Period** and **Condition-Specific Waiting Period** served under such previous policy.

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 negotiatied with Sanlam by your broker.

Your broker 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 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 as defined in this Policy. This exclusion does not apply to Balance Billing, also defined in this Policy
- 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 augmentation
- 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.

Core Benefits 2023

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 **Co-Payments** • **Penalty Co-Payment**	**Core Benefit Limit:** The overall maximum **Benefit** payable for the Core **Benefit** clauses of this **Policy** will be limited to the statutory maximum of **R185 837 per Insured Party per annum.** However, this combined benefit amount will increase on 1 April 2023, in line with the annual legislative limit published by the Minister, but will not exceed **R200 000**. **Prescribed Minimum Benefits** (PMB) procedures are covered under Core **Benefits** and are subject to clinical review by our Specialist third party, MedClaim Assist.
Tariff Shortfalls	This **Benefit** provides an additional five times **(300%)** 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 fives times **(300%)** 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 copayment amount as defined in the rules by the **Insured Party's Medical Scheme**.	Limited to **R10 000 Per insured Per Annum.**

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

Core Benefits 2023

Health Service	Benefit	Limit
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 **R30 000**.
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 **(300%)**, 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**. Up to a maximum of **R30 000**.
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.	One event covered per policy lifetime. Up to the maximum of **R11 000**.

Mediclinic Extender Benefit

The Mediclinic Extender Benefits applies to members who have opted to include the option on their Sanlam Gap 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 500 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 **R4 900 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 **R4 900** 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 000**.
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 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 **R16 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/2023_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

How to Submit your Claim

Access the claim form by clicking on this **link** and download the form. Kindly email your completed claim form with supporting documentation to **sanlamclaims@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 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 **sanlamclaims@kaelo.co.za**.

Claims can also be captured online: **www.kaelo.co.za/quick-links**

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

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