Dr. Pikkie Kok
FINANCIAL & HEALTHCARE ADVISOR

SIRAGO GOV-GAP COVER 2019

1. INTRODUCTION

This policy is underwritten by **Sirago Underwriting Managers (Pty) Ltd** (Sirago) under contract from GENRIC Insurance Company Limited (GENRIC) (FSP 43638). GENRIC is an Authorised Financial Services Provider and registered Short- Term Insurer - the Insurer as indicated on your Schedule of Insurance.

The Overall Annual Limit (OAL) for claims is aggregated to a maximum of **R150 000.00** (one hundred and fifty thousand rand), unless specified, per beneficiary per annum. The number of claims that can be submitted against this policy are unlimited, except if the benefit category defines otherwise or until the maximum overall limit is reached.

This is a Short-term Insurance accident and health policy regulated by the Financial Sector Conduct Authority (FSCA) and Prudential Authority (PA) under auspices of the Short-term Insurance Act 53 of 1998 and the Insurance Act 18 of 2017.

All fees, commissions, benefits and premium values quoted are inclusive of Value Added Tax (VAT).

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, however in order to activate this policy, a copy of your current certificate of membership from your medical scheme is required Your medical scheme must be registered in terms of the Medical Schemes Act 131 of 1998. This policy will only be activated and valid if purchased as a complimentary product to an approved and registered medical scheme in South Africa.

1.1. **Open Enrolment:** This policy is subject to Open enrolment which allows all eligible members to join a health insurance solution of their choice without facing any form of unfair discrimination

1.2. **Community Rating:** This policy is subject to Community rating which requires health insurance providers to offer health insurance policies within a given territory at the same price to all persons regardless of their health status.

1.3. **Cross Subsidisation:** This policy is subject to cross subsidisation which is applied on the premium rating basis where the risk pool of policyholders is big enough to cater for a cross subsidisation element .

1.4. **Discrimination:** This policy does not discriminate on the basis of race, age, gender, marital status, ethical or social origin, sexual orientation, pregnancy, disability, state of health, geographical location or any other means. We may however charge a different premium dependent on your age at the time of inception or apply waiting periods if applicable.

1.5. **Treating customer fairly (TCF):** Sirago applies the principles of TCF in all of its business functions. To this end the policy schedule attached to this document demonstrates all the information required to benefits, premiums payable and any limitations applicable within the terms of the policy.

1.6. **Policyholder Protection Rules:** The Policyholder Protection Rules published under the Short-Term Insurance Act is a fundamental business practise within Sirago and all care and thought goes into any information, advertising, interaction both directly and indirectly with policyholders and intermediaries at all times.

Effective – 01 January 2019, please note that this policy wording replaces any previous policy wording regarding this product. As such, claim events occurring as of 01 January 2019 will be assessed strictly in accordance with these terms.

Please note that this policy wording is available in Afrikaans on request.

2. WAITING PERIODS

2.1. **General waiting Periods:**

2.1.1. A 3 (three) month general waiting period is applicable on any newly incepted policies and / or additional dependents to the current policy, except in the event of an **accident.**

2.1.2. In the event that the policyholder has held a Sirago policy for 12 (twelve) months without a break in cover and wants to upgrade to a higher option, all additional benefits will be subject to a 3 (three) month waiting period.

2.1.3. If the policyholder has held a Sirago policy for less than 12 (twelve) months and intends to upgrade to a higher option, the balance of the relevant waiting periods in the higher option per benefit category are applicable.

2.1.4. A 10 (ten) month waiting period on pre-existing conditions, diseases or illness.

2.2. **Policy Specific Waiting Periods applicable to certain procedures:**

The following conditions are excluded within the first 6 (six) months of the policy cover inception. Thereafter, benefits will be payable at a rate of:

2.2.2. 50% (fifty percent) of benefits available from month 7 (seven) to 10 (ten).

2.2.3. From month 11 (eleven), the policy benefits will be fully available except where there are condition policy / specific exclusions and when a new beneficiary joins the policy and is subject to underwriting terms as follows:

2.2.3.1. Myringotomy and Grommets;
2.2.3.2. Adenoidectomy;
2.2.3.3. Tonsillectomy;
2.2.3.4. Hysterectomy (except where malignancy can be proven);
2.2.3.5. Spinal, Back, Neck and joint related procedures (repairs, scopes, joint replacement) except in the case of an **accident.**

2.3. Specific Waiting Periods applicable to certain benefit categories and certain conditions and or relevant options:

2.3.1. 10 (ten) month waiting period for pregnancy and confinement.
2.3.2. The following benefits, Accidental Death, Total Permanent Disability and Premium Waivers are always subject to a 6 (six) month waiting period.
2.3.3. Initial Cancer diagnosis is subject to a 3 (three) month waiting period.
2.3.4. A 12 (twelve) month waiting period on all pre-existing Cancer related treatments.

3. PRODUCT DESCRIPTION

This is a Short-term Insurance accident and health policy regulated by the FSCA and PA under auspices of the Short-term Insurance Act 53 of 1998 and the Insurance Act 18 of 2017 that consists of the following benefit categories provided that all costs for both planned and emergency treatments incurred against this policy are obtained within the borders of South Africa and by a registered medical professional with a valid practise number issued by the HPCSA (Health Professions Council Of South Africa):

3.1. GAP COVER (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL)

3.1.1. This benefit covers the difference between your Medical Scheme Rate paid and private rates charged by a **Registered Medical Professional** for in-hospital treatment as defined by this policy document.
3.1.2. Gap Cover will settle claims up to **500%** (five hundred percent) **of** your Medical Scheme Plan / Option rate limited to a maximum of **600%** or at the stated benefit value as determined within your scheme policy.
3.1.3. This stated benefit for Gap Cover claims, will be added to the scheme tariff paid by your Medical Scheme.

3.2. CO-PAYMENTS (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL)

3.2.1. Limited to a maximum of **R40 000.00** (forty thousand rand) per policy per annum.
3.2.2. This benefit will cover a fixed amount for **Co-payments** (Oncology benefits are catered for in a separate benefit category) imposed in terms of your Medical Scheme rules.
3.2.3. **Co-payments** are the excesses imposed by your medical scheme payable to a maximum rand limit for specified procedures or tests.
3.2.4. If your medical scheme defines your co-payment as a percentage of the benefit, your co-payment benefit under this policy will be limited to a maximum payment of **R5 000.00** (five thousand rand) per claim.
3.2.5. Your **Co-payment benefit is subject to your available OAL.**

3.3. DAY HOSPITALS / CLINIC AND OR IN ROOM SURGICAL PROCEDURES COVER (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL)

3.3.1. This benefit will cover your **Gap Cover** component for any **Day hospital / clinic and or in room procedures** in the event that a policyholder elects to have the treatment performed as an **Out-Patient** that would normally be performed on an **In-Patient** basis.
3.3.2. This policy also covers any **In Room Procedures** where the insured elects to use these facilities as an alternative to **Acute Hospitals.**
3.3.3. The policy will cover you for **Out-Patient Surgical Procedures** that your **Registered Medical Professional** would normally have performed as an **In-Patient**. This includes, but is not limited to, for example, gastroscopies, colonoscopies, wisdom teeth extractions, home-birth and stent insertions.
3.3.4. Procedures and admissions that would not normally require admission into hospital, this includes but is not limited to, for example, placing of crowns, minor extractions and excisions, diagnostic tests and minor biopsies.
3.3.5. Admissions where no Clinical/Medical reason for admission can be provided, will not be covered.

3.4. EMERGENCY ROOM COVER (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL)

3.4.1. The sub-limit for this benefit category is **R7 500.00** (seven thousand five hundred rand) per policy per annum.
3.4.2. Emergency Room – Accident and Trauma treatment - when you visit an emergency room in a medical emergency as a result of an accident or trauma incident only. A Sub-limit of **R5 500.00** (five thousand five hundred rand) per policy applies per annum.
3.4.3. Emergency Room - Illness Treatment – when you visit an emergency room in a medical emergency that requires immediate medical attention as a result of illness, the Gap portion of your claim will be paid to a maximum of **R2 000.00** (two thousand rand) per annum.
3.4.4. We will cover a GP's ER facility where no hospital ER is available, if there is no ER available within a 30km radius within the above stated benefit limits.

3.5. PRESCRIBED MINIMUM BENEFIT (PMB) COVER (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL)

This benefit will cover your **Gap** components for the use of a **non-Designated Service Provider** for **Prescribed Minimum Benefit treatment except in the event of an emergency. R30 000.00** (thirty thousand rand) per claim.

3.6. CANCER BOOST BENEFIT (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL)

Limited to **R100 000.00** (one hundred thousand rand) per beneficiary per annum and subject to the OAL of **R150 000.00** (one hundred and fifty thousand rand) per beneficiary per annum.

This benefit is restricted to policyholders whose medical scheme option has a rand value limit for cancer cover. The Cancer Boost benefit can only be claimed once your rand limit on your Medical Scheme Oncology benefit has been reached and you require further treatment. This benefit is dependent upon the insured having already been registered on the Medical Scheme's Oncology Programme.

The Cancer Boost benefits are limited to those that were determined within the approved medical scheme treatment plan which must be submitted to Sirago upon application for this benefit.

3.7. DAY TO DAY SPECIALIST CONSULTATION FEE (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL)

3.7.1. A sub-limit of **R3 600.00** (three thousand six hundred rand) per policy applies to this section of cover.

3.7.2. This benefit will cover your **Gap cover** component above scheme tariff for day to day specialist consultation fee with a **Medical Specialist**.
3.7.3. Your Gap component for the **Day to Day Consultation Fee** will be covered, up to a maximum amount of **R800.00** (eight hundred rand) per claim.
3.7.4. A maximum of **2** (two) claims per beneficiary will be payable per annum.

3.8. HOSPITAL ACCOUNT SHORTFALLS (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL)

3.8.1. A **sub-limit** of **R5 000.00** (five thousand rand) per policy applies to this section of cover.
3.8.2. This benefit will cover your Non-medical expense cover as a result of **Hospitalisation** Account Shortfall incurred when your Medical Scheme short-pays your hospital facility account.
3.8.3. Your Hospital Account Shortfall claim will be covered, up to a maximum amount of **R1 250.00** (one thousand two hundred and fifty rand) per claim.
3.8.4. A maximum of 2 (two) claims per beneficiary per annum.
3.8.5. Hospital Account shortfalls in the event of a PMB related admission will result in no benefit.

3.9. SUB-LIMIT ENHANCER BENEFIT (PAID TO THE MAXIMUM AVAILABLE SUB-LIMITS WITHIN YOUR OAL)

3.9.1. **Sub-limit** of **R45 000.00** (forty- five thousand rand) per policy per annum with a limit of **R15 000.00** (fifteen thousand rand) per claim.
3.9.2. Maximum of 2 (two) claims per beneficiary with a maximum of 3 (three) claims per policy per annum.
3.9.3. **Sub-limit Enhancer** applies when exceeding the benefit limit imposed by your medical scheme on Internal Prosthesis, MRI & CT scans only.
3.9.4. Cover is not available when the sub-limit or annual limit is reached at the time of the event and your medical scheme does not contribute any portion towards this benefit.

3.10. VALUE ADDED BENEFITS

Provides a lump sum benefit and/or waiver of premium for a defined period in the event of accidental death or total permanent disability. **Value Added Benefits do not form part of the aggregated OAL of R150 000** (one hundred and fifty thousand rand).

Premium Waivers: The Premium waiver benefit consists of two sub-benefit categories:

3.10.1. **Gap Cover Premium Waiver -** In event of Death and or Total Permanent Disability of the premium payer of the gap policy. The premium waiver is directly linked to your policy premium per month as indicated in your schedule of insurance. This benefit is not paid in cash, but held as a credit against the policy for the applicable 6 (six) month period. Should there be any premium adjustments within the 6 (six) month period, the credit balance available for the rest of the waiver period, will be adjusted accordingly. This benefit cannot be transferred, ceded or converted to cash.
3.10.2. **Medical Scheme Premium Waiver** – Payable in event of Death and or Total Permanent Disability of the premium payer of the medical scheme. **R2 500.00** (two thousand five hundred rand) per month for a 4 (four) month period will be paid towards your medical scheme payments, provided the Medical Scheme membership is active. A Certificate of Membership from your medical scheme must be presented monthly for authentication of current membership.
3.10.3. **Accidental Death – R5 000.00** (five thousand rand) principal insured, **R5 000.00** (five thousand rand) adult dependant and **R3 000.00** (three thousand rand) per child dependant per policy per life provided the policy is active.
3.10.4. **Cancer – Initial Diagnosis:** This benefit will pay you a lump sum of **R5 000.00** (five thousand rand) upon the **initial diagnosis** of **Cancer** as defined.
3.10.5. **Sira-Go' Baby**: A branded Sirago Welcome gift will be couriered to your physical address as per your application form upon receipt of the instruction to add the newborn child. The instruction must be submitted within 30 (thirty) days of the birth of the child to the policy. Subject to availability. Please allow 6 weeks for delivery.

4. HOW THE POLICY WORKS

The headers in this document are for ease of reference only. Please read the entire clause to understand its full meaning. Check your Schedule of Insurance which, along with any relevant endorsements, explains the cover you have. The benefit amount is not related to the specific cost of any medical **treatment** or expense shortfall or non-medical expense cover as a result of **hospitalisation.**

Claims will be assessed in accordance with best practice clinical guidelines and protocols as determined by Sirago from time to time and does not require notification to policyholders.

5. WHAT MAKES UP YOUR POLICY OF INSURANCE?

Your Policy consists of:

5.1. The Schedule of Insurance;
5.2. Policy Wording (Terms and Conditions);
5.3. Correspondence and amendments sent to your last known address.

Please ensure that you are familiar with the contents of all the documents and that all the detail noted on the Schedule of Insurance is correct in every respect. **Please note it is the policyholder's specific responsibility to keep all their personal details up to date and accurate at all times.**

6. WHO IS THE INSURED?

We cover the persons who are listed on the policy documents as Principal or Dependents (Referred to as "You", "Your", "Policyholder" or "Insured Person" in the policy terms).

7. WHO IS COVERED BY THIS POLICY?

This policy will cover the Policyholder and dependents who are listed on the schedule of Insurance.

7.1. Principal policyholders must be in the full- time employment of The State and be in possession of a valid and current Persal number in order for a Gov-Gap policy documents to be issued.
7.2. Cover is limited to all dependants under the main member or spouses medical aid.
7.3. **In order to validate this policy we will need a Certificate of Membership (COM) as issued by your selected government medical scheme.**
7.4. If on more than 2 (two) medical aids / options, family cover will be limited to 2 (two) adults and 3 (three) children up to 21 (twenty-one), and age 27 (twenty-seven) if full time students.

7.5. Individual cover is limited to no more than 1 (one) individual.
7.6. Child dependent is defined as a beneficiary up to the age of 21 (twenty-one), however cover can be extended to the age of 27 (twenty-seven) for full-time students. Documented proof of a full-time student is required to evidence dependents over the age of 21 (twenty-one). However, if the child dependent is a dependent on the family's medical aid, this rule will not be applicable. If the child dependent reaches adult age then this rule does not apply.
7.7. Gov-Gap has a policy cease age of 65. The policy will cease at the end of the benefit year in the year that the policyholder turns 65.
7.8. Sirago has two different age based premium tables. The benchmark for premium determination is 65 (sixty -five) years old. The effect of this rule is as follows: - any current policyholder who is 60 (sixty) years old but below 65 at the inception of the policy, will be charged the 60 to 65 (sixty -five) premium.
7.9. Any prospective policyholder who incepts a policy as from the 1st January 2019 and any other period during 2019 who is 60 (sixty) years old but below 65 years or older will be charged the 60 (sixty) to 65 years old premium.
7.10. Premiums are applicable for the duration of the relevant period of cover. Benefits do not change during this period and nor does any underwriting criteria.

8. WHEN WILL A CLAIM (BENEFIT) BE AUTHORISED FOR PAYMENT?

As soon as:

8.1. We have confirmed validity of your policy and dependents;
8.2. We confirm your premium payments are up to date;
8.3. We have validated your claim using sub contracted administrators if required;
8.4. We have confirmed benefits for the claim ICD-10 Coding;
8.5. All policy conditions have been met;
8.6. Upon confirmation of a valid HPCSA practise number
8.7. All required documents have been received;
8.8. Sirago reserves the right to initiate direct claims settlement with providers on behalf of policyholders in order to negotiate quicker and discounted claims settlement with providers;
8.9. Depending on the benefit design of your chosen Medical Scheme option:
8.9.1. **Hospital Plan** – Benefits will be paid in the event that your option pays a portion of the claim.
8.9.2. **Savings Plan** – Benefits will be paid in the event that your option pays a portion of the claim. However, the value settled by the Insurer will be limited to the Gap portion after the scheme has defrayed the scheme rate of the claim provided that there was an accumulated or allocated savings balance at the time of claim.
8.9.3. **Traditional Medical Scheme Option** – Benefits will be paid in the event that your option pays a portion of the claim.

9. TO WHOM WILL THE POLICY BENEFITS BE PAID?

Only you or the persons indicated on the Schedule of Insurance will be entitled to claim and receive non- bereavement related benefits under this policy. These applicable benefits will be paid directly into the principal policyholder's account.

In the event of a death related claim the Insurer will pay the benefit into the policyholder or nominated beneficiaries account.

The beneficiary must be noted on the policy prior to any loss. We will require the full name, surname and ID to note the beneficiary. At the time of a claim we will require the beneficiary's ID and proof of bank

Should there be no beneficiary noted on the policy prior to the loss or should we be unable to confirm the identity of the beneficiary, payment will always be made into the principal policyholders account or to the estate of the principal policyholder.

All payments are subject to the limit and benefits available as stated in the policy documents.

10. WHEN DOES THE POLICY BECOME ACTIVE?

The policy inception date is reflected on your Schedule of Insurance and is ratified once we have received your first monthly premium. All policy terms will apply from the actual date of inception of the policy.

No policy will be activated if premium is not received and such a policy is viewed as not taken up (NTU).

Any change of policy option benefits will have a **3** (three) month waiting period applied to the additional benefits only.

Additional dependents added after policy inception will be subject to individual underwriting and waiting periods unless it is a new-born whose details are provided to the Insurer within 90 (ninety) days of birth.

11. HOW LONG DOES THIS POLICY LAST?

The policy is in force for as long as your premiums are paid up to date or until your policy is cancelled by you, or by the Insurer giving **31 (thirty-one)** days 'notice.

This policy will be cancelled as at the 31st December of the same year that the principal policyholder turns 65 years old.

12. YOUR RESPONSIBILITIES TOWARDS THE POLICY

In order to have cover you need to:

12.1. Pay your premiums;
12.2. Provide us with true and complete information when you apply for cover, submit a claim or make changes to your policy. This also applies when anyone else acts on your behalf;
12.3. **Advise us of any changes to your health status between the point of application and actual activation of your policy;**
12.4. Not admit any fault, nor make any offer or settlement on our behalf without our written agreement;
12.5. Agree to comply with all our reasonable requests;
12.6. Use all reasonable care and take all reasonable precautions to prevent or minimize loss, damage, liability, **injury** or death;
12.7. Inform us immediately of any changes to your circumstances that may influence whether we provide cover, the conditions of cover or the premium we charge. This includes any changes to any information on the Schedule of Insurance or in regards to convictions for offences by any person covered under this facility relating to dishonesty, reckless and negligent driving or driving under the influence.

Methods of Payment. Our preferred method of payment is by Persal.

13. INSURANCE POLICY CHANGES

You have to advise us when your contact details change. If you wish to cancel your insurance you must do so in writing by giving **30** (thirty) days' calendar notice for cancellation. Should you wish to cancel the policy with "immediate effect", we may, at our discretion, accept the immediate cancellation and refund the premium related to the month in which the cancellation was requested, less all administrative expenses liable, to you.
You may make changes to your Insurance policy at any time.
Confirmation of the change will be sent to you in writing. We may amend your policy by giving you 31 (thirty-one) days' notice. Notice can be given by fax, e-mail or post/mail to the last known contact details we have on record as provided by the policyholder.

If for any reason the Insurer decides to discontinue and / or cancel this particular product line, all policyholders will be given the benefit of a 90 (ninety) day notice period of this decision prior to termination.

14. YOUR RESPONSIBILITY TOWARDS PREMIUM PAYMENTS

Your policy is an annual policy, payable in **12** (twelve) equal increment payments. Your policy will only be activated once we receive your first monthly premium. Thereafter you must pay the full monthly premium, in advance, on the agreed payment dates as stated on your Schedule of Insurance.

If we do not receive the premium for your policy on the agreed payment date we will allow a **31** (thirty-one) days' period of grace. During this grace period, you may pay your premium either by cash deposit, electronic transfer (EFT) and /or through requesting a forced debit from your bank account into the **Insurer**s bank account to keep your cover active.

14.1. **Cooling Off Period:** A policyholder may, where a policy has a term longer than a month and no benefit has yet been paid or claimed or an event insured against under the policy has not yet occurred, within 14 (fourteen) days after the date of receipt of the schedule of insurance, cancel the policy entered into with the insurer by way of a written cancellation notice to the insurer.

All premiums or moneys paid by the policyholder to the insurer up to the date of receipt of the notice received at any date thereafter in respect of the cancelled or varied policy must be refunded to the policyholder, subject to a 20% handling fee for administration services.

Please use the banking details indicated on your Schedule of Insurance for the payment of premiums.

Should your premium not be paid, a double debit is due on the next debit date. For debit order payments a double debit will be submitted to your bank. If this debit is also unpaid, the policy will be cancelled with effect from 24h00 on the last day of the month for which premium was received.

In the event that the policy owner requests a reinstatement of a cancelled policy, this will be considered at the Insurers discretion and will need to have a signed health declaration document in support of the request. Considerations for reinstatement will be limited to a maximum of 90 (ninety) days after the cancelation date of the policy. Any requests that exceed the 90 (ninety) day period are subject to a new policy application and all relevant terms and conditions will apply.

Please note that you will not have any cover unless all premiums are paid up to date. Any revocation of premium debit authority will result in the immediate cancellation of your policy unless you pay the premium in cash, in advance, as of this point.

It remains the sole responsibility of the policyholder to ensure that full premiums are paid on the due date.

15. REFUNDS

Premiums will only be refunded for a maximum period of 3 (three) months if approved by the **Insurer**.

No refunds of premium will be made in respect of:

15.1. Any claim that, for whatever valid reason, is repudiated;
15.2. Any policy that, for whatever valid reason, is cancelled by the **Underwriter**;
15.3. Any policy that you cancel of your own accord (cancellation instruction must be in writing);
15.4. Any cost difference resulting from changes to your policy option.

16. CLAIMS

16.1. You need to report your claim to us as soon as possible but not later than **30** (thirty) days after any **Health Event**. This includes events for which you do not want to claim but which may result in a claim in the future. Should you be incapacitated and not be able to make contact, you may get someone to contact us on your behalf.
16.2. In order for you to prove a claim, all required relevant documents must be submitted to us within 90 (ninety) days after your Medical Scheme paid their portion of the claim. **We shall not be liable for claims where the documentation is received outside of this period.**
16.3. Claims can only be assessed for payment once your completed claim information is received. This information consists of the following:
  16.3.1. Fully completed and signed claim form for each event;
  16.3.2. All hospital and related accounts substantiating your claim;
  16.3.3. Your Medical Scheme Statement showing all the payments made by you or your Medical Scheme for the health event;
  16.3.4. Completed Medical Reports substantiating the clinical information or any other documentation as requested by the **Underwriter;**
  16.3.5. Pre-authorisation letter from your Medical Scheme for Co-payment claims as well as the proof of payment or receipt of payment;
  16.3.6. As part of our claims validation process we use the services of a contracted third party in order to authenticate medical scheme membership, plan option type, relevant beneficiaries and agreed medical scheme option tariffs amongst other relevant information to validate the claim;
  16.3.7. In the event of a Value-Added Benefit claim all supporting documentation and certification are required by the Insurer, which would include a death certificate and /or a permanent disablement certificate or reports from a registered Medical practitioner;
  16.3.8. We reserve the right to call for additional information of a clinical nature. In the event that Sirago requests a PMA (Post Medical Assessment) from your doctor as part of the claims assessing and authentication process, Sirago will cover the cost of the PMA (Post Medical Assessment) to a maximum cost of **R250.00** (two hundred and fifty rand) per event.;

16.3.9. In the event that Sirago deems your claim or certain claim lines to be clinically inappropriate or falls outside of the policy terms, the whole claim or certain claim lines will be repudiated.;

16.3.10. On Initial Diagnosis of Cancer, we require the histology report confirming the dates of diagnosis.

17. DISPUTED CLAIMS

After we inform you of our decision on a claim, we will allow you **90** (ninety) days to make representations to us about our decision. If we do not compensate you for a claim or a part of it, and you want to contest our decision, you must do so in writing and outline your reasons for the dispute. We will provide you with a written response within **30** (thirty) days. If you do not agree with the outcome of the appeal, you may refer the dispute to the Ombudsman for Short-term Insurance You are afforded an additional 6 (six) months in addition to the 90 (ninety) days to take legal action. Should you not enforce these rights your claim will be deemed **prescribed**/abandoned.

18. FRAUD, MISREPRESENTATION, NON-DISCLOSURE & DELIBERATE ACTS

Your fully completed application form with the relevant disclosures (including changes to your health status that happens after application but before policy inception) provided by you or on your behalf forms the basis of our contract.

This policy can be re-underwritten, declared null and void or terminated if any misrepresentation or non-disclosure is made regarding any detail that is material to this insurance. Any incorrect information may affect the validity of this contract or claims submitted.

We will not compensate you for a claim where you or anybody who acts on your behalf, deliberately causes a loss, damage or injury. All cover under this policy will be forfeited if you submit a fraudulent claim, or anyone acts fraudulently on your behalf to obtain compensation.

19. COMPLAINT PROCEDURE

Any complaint should be directed in writing to the office of Sirago Underwriting Managers (Pty) Ltd at:

19.1. P.O. Box 1115, Bromhof, 2154, or

19.2. Emailed to complaints@sirago.co.za

Any complaint received will be acknowledged and responded to, in writing, within **30** (thirty) days.

If you are not happy with the feedback and decisions taken by Sirago in terms of your complaint, you may lodge a further complaint with the Ombudsman for Short-term Insurance, details of which are contained within your schedule of insurance.

20. JURISDICTION

This agreement shall be governed, interpreted and construed in accordance with the laws of the Republic of South Africa. Any legal action or proceedings arising out of or in connection with this policy which is to be instituted in a court of law shall be brought in the Court of South Africa and irrevocably submitted to the exclusive jurisdiction of such court.

21. TERRITORIAL LIMITS

Cover for this policy is only valid within the borders of the Republic of South Africa and covers only expenses incurred within the borders.

22. GUARANTEE CLAUSE

This is a Short-term Insurance accident and health policy regulated by the Financial Services Board under auspices of the Short-term Insurance Act 53 of 1998.

The stated benefit amount payable is not related to the specific cost of any medical expense shortfall or non-medical expense cover as a result of hospitalisation.

Only a Medical Scheme Product can guarantee payment of full medical expense shortfall costs associated with a **health event**.

23. CONSENT CLAUSE

The sharing of claims information and underwriting information (including credit information) by Insurers is essential to:

23.1. enable the insurance industry to underwrite policies;

23.2. assess risks fairly;

23.3. reduce the incidence of fraudulent claims;

23.4. protect the public interest in terms of limiting excessive premium increases;

23.5. to use your personal information to communicate with you in order to offer you additional services and solutions provided by the Insurer.

You hereby waive any right to privacy of any insurance information provided by you or on your behalf, in respect of any insurance policy or claims you lodge. You also consent to this information being disclosed to any other insurance company and/or verified against other legitimate sources or databases.

Any personal income or health information obtained shall not be used or sold commercially and data security measures are in place to ensure the confidentiality of data management, and contractual agreements. Sirago shall ensure that its staff also abides by the provisions of this clause and to do all things necessary to enforce such compliance. We collate age band, income band, demographics and race statistics and all information will be for statistical and reporting purposes only.

24. POLICY SPECIFIC EXCLUSIONS

You will have no benefit, and we will not compensate you for any illness, condition, disease or **injury**, or the consequences of **treatment** of, or resulting from, or associated with:

24.1. Medical Scheme exclusions, stated benefit limits and any claims or claim portions rejected or not authorised by your Medical Scheme unless the benefits fall within the stated benefit entitlement as per this policy wording.

24.2. The first **100%** (one hundred percent) of the Medical Scheme Tariff/ Rate (this will normally be covered by your Medical Scheme).

24.3. Claims that exceed the utilisation or benefit limit per annum applicable to this policy.

24.4. **Out-patient treatment** other than defined as covered under this policy.

24.5. Any and all experimental treatments and medication both in and out of hospital.

24.6. Any claim less than a minimum amount of **R100.00** (one hundred rand) due to client in final assessment per incident

25. GENERAL POLICY EXCLUSIONS

Unless the policy makes provision for a specific benefit and is evident within the specific policy entitlement, any claim submitted will automatically be rejected.

You will have no benefit, and we will not compensate you for any illness, condition, disease or **injury**, or the consequences of **treatment** of, or resulting from, or associated with:

25.1. An event not covered by this policy and/or falling outside of the policy's intention.
25.2. An event where pre-authorisation was not obtained from the Medical Scheme or where Medical Scheme rules were not adhered to.
25.3. Any claim that must be paid in terms of alternate proclaimed legislation, such as the Compensation for Occupational Injuries Act 90 of 1993, the Road Accident Fund Act 56 of 1996.
25.4. Any pre-existing condition, disease, disorder or illness, for **1**0 (ten) months. This will include any condition which existed prior to inception, whether diagnosed or not, or for which an insured person has sought or received medical advice, received **treatment** by a **Registered Medical Professional** or exhibited symptoms, before actual inception of the policy.
25.5. Any pre-existing Cancer condition, disease, disorder or illness, for **12** (twelve) months. This will include any condition which existed prior to inception, whether diagnosed or not, or for which an insured person has sought or received medical advice, received **treatment** by a **Registered Medical Professional** or exhibited symptoms, before actual inception of the policy.
25.6. Breast reconstruction performed as a second or subsequent reconstruction.
25.7. Claims for regular or routine medical **treatment** and advice on an on-going basis and routine physical examinations or procedures of a purely **diagnostic** nature, except as listed under the Preventative Care benefit.
25.8. Any illness, injury or consequence from alcohol, drug or substance intoxication, use, abuse, or addiction, directly or indirectly traceable to the insured being affected, permanently or temporarily. Claims may be considered where registered drugs are administered and prescribed by a **Registered Medical Professional**.
25.9. Any **Psychiatric or Psychological Condition** or emotional or nervous conditions including, but not limited to, depression, insanity, psychosis, stress-related and affective disorders.
25.10. Suicide, attempted suicide or any intentional or deliberate self-injury and/or self-exposure to danger or risk except in an attempt to save a human life.
25.11. Medication, drugs, prescriptions, consumables and equipment used. Devices, such as artificial joints, braces, crutches, dental implants, orthodontic, prosthodontic and all cosmetic dentistry including all forms of internal and external prosthesis as defined, **unless specified as part of the benefit entitlement of this policy.**
25.12. **Cosmetic Surgery** where no clinical indication for **treatment** is present, including any **treatment** and costs resulting from these procedures unless specified as part of the benefit entitlement to this policy.
25.13. Discounts negotiated by the / and insured person directly with a service provider where re-imbursement of a claim will / could enrich the insured person.
25.14. **Elective procedures** with no clinical / medical indication including any **treatment** and costs resulting from these procedures unless specified as part of the benefit entitlement to this policy.
25.15. Investigations, treatment or surgery for eating disorders, obesity or weight management, including any consequence of such **treatment.**
25.16. Investigations, treatment, medication or surgery related to any condition where the policyholder seeks advice, diagnosis and / or treatments outside the border of South Africa.
25.17. **BMI (Body Mass Index)**
25.17.1. The additional charge by a **Registered Medical Professiona**l for the management of overweight and underweight patients with reference to the **Body Mass Index** (**BMI**). The applicable BMI codes are 0018 and 0019 and are not covered on this policy.
25.17.2. The additional charge by a **Registered Medical Professiona**l for the management of overweight and underweight patients **Body Mass Index** (**BMI**), directly related to pregnancy and diseases that are non-lifestyle related and the policyholder is under medical care at claim stage, Sirago will pay those additional charges applicable.
25.17.3. Supporting documentation is required from the patient in order to validate the claim.
25.18. Investigations, treatment or surgery related to infertility, artificial insemination, hormone treatment for infertility, or any other form of assisted reproduction**.**
25.19. Any claim related to the treatment of Sterilisation and Contraceptive device implantation unless specified.
25.20. Robotic Surgery, specialised mechanical or computerised appliances and equipment.

25.21. **SPORT RELATED EXCLUSIONS:**

Any illness, injury or condition resulting from or directly associated with professional sport:

25.21.1. Participation in any form of race or speed test, other than on foot.
25.21.2. Involving any mechanically propelled vehicles or crafts.
25.21.3. Participation in a sport or hobby that is defined by Underwriters as **hazardous** or dangerous except for **scholars** taking part in school activities.
25.21.4. Participation as a **professional sports person**.

26. STANDARD SHORT-TERM POLICY EXCLUSIONS

You will have no benefit, and we will not compensate you for any illness, condition, disease or **injury**, or the consequences of **treatment** of, or resulting from, or associated with:

26.1. Any claim arising directly or indirectly from active involvement in war, invasion, act of a foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or political risk of any kind, or any act of any person acting on behalf of or in connection with any organisation, group or activity aimed at overthrowing any government by force or any deliberate act of terrorism or violence.
26.2. Any riot, strike or public disorder (including civil commotion, labour disturbances or lock-out) or any act or activity resulting in or calculated to bring about riot, strike or such disorder.
26.3. Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers.
26.4. The act of any lawfully established authority, police force, security force or any other local, provincial or national body, in controlling, preventing, suppressing or in any other way dealing with any event referred to in the clauses above.

26.5. Compensation in terms of the War Damage Insurance Act 85 of 1976.
26.6. Nuclear weapons or nuclear material, ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception combustion shall include any self-sustaining process of nuclear fission.
26.7. Any loss arising from any contractual liability.
26.8. Any consequential loss or damage whatsoever.
26.9. Any attempt by you to commit an unlawful act.

27. DEFINITIONS AND EXPLANATIONS

27.1. **Accident:** An event that occurs unintentionally and usually results in harm, injury, damage or loss. Policy cover only extends to accidents occurring after inception of the policy.
27.2. **Accidental Death:** An event that results in an accidental death.
27.3. **Acute:** A condition which is generally unforeseen, of rapid onset in nature, is severe and treatable, but does not last for a prolonged period and is therefore not chronic.
27.4. **Acute Hospital:** A hospital that treats all major and minor conditions.
27.5. **Admission Fee**: The fixed amount you have to pay in terms of your Medical Scheme Rules when you are admitted to hospital as an **In-Patient.**
27.6. **Appliances:** An instrument or device designed for a particular medical use.
27.7. **Beneficiary:** A person(s) other than the policyholder of an insurance policy who is entitled to receive benefits.
27.8. **Body Mass Index (BMI):** A measurement tool to establish the ideal weight of a person based on weight and height. Additional fees are charged for management of patients who fall outside the prescribed **BMI**.
27.9. **Cancer**: Diseases in which abnormal cells divide without control and are able to invade other tissues. This definition includes leukaemia, lymphoma and Hodgkin's disease but specifically **excludes** benign, pre-cancerous / in-situ tumours or growths as well as all stage zero **cancer** diagnoses. Any cancer that is diagnosed and treated through primary biopsy and not requiring additional intervention such as radiation therapy- or chemotherapy shall not be deemed as **cancer** and will not have any benefit paid. Cover under **cancer** benefits will not be available for any person diagnosed with **cancer** prior to the inception of this policy.
27.10. **Certificate of Membership (COM).** An official document issued by your medical scheme or Gap Cover Provider indicating all relevant beneficiaries, waiting periods and / or contributions / premiums applicable to the medical scheme / policy.
27.11. **Consumable medical supplies**: Non-durable medical supplies that:
    27.11.1. Are usually disposable in nature;
    27.11.2. Cannot withstand repeated use by more than one individual;
    27.11.3. Are primarily and customarily used to serve a medical purpose.
27.12. **Contraceptive Devices:** Devices used to prevent pregnancy, including the diaphragm, condom, and intrauterine devices.
27.13. **Co-Payment:** The fixed amount excess imposed in terms of your Medical Scheme Rules for undergoing a specific procedure whether in or out of hospital. This will include, for example MRI, CT and Ultrasound Scans and scopes.
27.14. **Council of Medical Schemes (CMS):** A statutory body established by the medical schemes act (131 of 1998) to provide regulatory supervision of private health financing through medical schemes.
27.15. **Corrective procedures:** In relation to Cosmetic procedures that aim to correct function or structural defect.
27.16. **Cosmetic Surgery:** Procedures performed to repair, change or restore body parts to look normal, or to change a body part to look better.
27.17. **Dependant**: Someone who is dependent upon the policy owner for access to the benefits available within this policy.
27.18. **Designated Service Provider (DSP):** The hospital/ specialists/ network providers prescribed by your Medical Scheme Rules where you can obtain diagnosis and **treatment** benefits without **co-payments** or penalties.
27.19. **Diagnostic**: A procedure or test which is performed to find out what is wrong with a patient. Diagnostic procedures do not aim to treat or cure a condition but is informative and exploratory in nature. This includes, for example, any examination, such as laboratory diagnostic or x-ray examination that does not result in a bona fide non-medical expense cover as a result of **hospitalisation** for **treatment** purposes (Other than covered under the Additional Care Cover).
27.20. **Elective procedures**: **Treatment** that is not clinically essential such as *surgery* to correct a cosmetic condition that is not life-threatening.
27.21. **Emergency treatment**: A serious situation or occurrence that happens unexpectedly and demands immediate medical attention in the Emergency Room.
27.22. **Excess:** The first portion of any claim payable by you before cover commences.
27.23. **Family:** This is defined as a group consisting of parents and children living together in a household.
27.24. **Family Size:** Is defined as a maximum of 2 adults and 3 child dependents only.
27.25. **Gap Cover Premium Waiver**: Only in event of Death and or Total Permanent Disability of the premium payer do we pay a benefit against the policy for a 6 month period. See benefit description.
27.26. **General Waiting Period:** A period in which a policyholder is not entitled to claim any, or may only claim certain, policy benefits.
27.27. **Hazardous/Dangerous (Sport):** Participation in any hobby, adventure or extreme sports including but not limited to:
Abseiling;
Mountaineering;
Rock climbing;
Hang gliding;
Micro-lighting;
Base jumping;
Parachuting;
Skiing;
Hunting;
Kite surfing;
Underwater activity involving the use of artificial breathing apparatus and all other forms of racing or speed trial or contest;
The **Underwriter** reserves the right to add to this list from time to time.
27.28. **Health Event:** An event relating to the health of the body of the insured person, adversely affected by illness or injury and necessitating bona-fide **In-Patient** non-medical expense cover as a result of **hospitalisation** and Out-patient procedures or other **treatment** approved by the **Underwriter.**
27.29. **Hospital:** An institution providing medical, surgical treatment and nursing care, for sick or injured people. **This definition includes day hospitals and clinics.**
27.30. Non-medical expense cover as a result **Hospitalisation:** Confinement in a hospital as a resident **In-Patient** under the professional care of a **Registered Medical**

Professional as defined below and approved by the **Underwriters.**

27.31. **ICD-10 Coding:** The International Classification of Diseases is a diagnostic coding standard that was adopted by the South African National Department of Health in 1996.

27.32. **Illness:** A disease or period of sickness affecting the body, which warrants treatment at an emergency facility.

27.33. **Incident:** Any single discrete occurrence of a health event / claim incident, including all costs related to the original event.

27.34. **Individual:** A single human being as distinct from a group or family.

27.35. **Initial Diagnosis:** The very first clinically confirmed diagnosis of any form of cancer, specifically excluding preliminary, tentative or other diagnosis not supported by clinical evidence of malignancy This definition excludes any incidence of cancer/pre-cancer prior to inception of the policy.

27.36. **Injury:** Damage to a body part sustained in an unforeseen future event, caused solely and directly by violent, accidental, external and visible means independent of and untraceable to any other cause.

27.37. **In-patient:** A patient who is "admitted" as a resident to the hospital as an "in-patient" and who spends time in a hospital ward admitted as such.

27.38. **In Room Procedures**: is defined as a procedure in a surgical suite that meets the requirements of a restricted area and is designated and equipped for performing surgical operations or other invasive procedures that require an aseptic field which would / could ordinarily be undertaken in an Acute facility.

27.39. **Insurance Company / Insurer:** The Insurance Company, indicated on your Schedule of Insurance, which offers insurance policies in return for premiums.

27.40. **Medical Scheme:** A medical scheme is a form of insurance where you pay a monthly amount, called a contribution in return for financial cover for medical treatment you may need as well as any related medical expenses.

27.41. **Medical Scheme Premium Waiver**: Only in event of Death and or Total Permanent Disability of the premium payer, will we contribute towards your medical scheme payments, provided the Medical Scheme membership is active for a 4 month period. See benefit description.

27.42. **Medical Scheme Rate:** It means the set fee that your scheme pays the service provider (doctor, hospital).

27.43. **Medical Specialist:** A practitioner who has completed advanced education and clinical training in a specific area of medicine, which includes but are not limited to Cardiologists, Gastroenterologists, Gynaecologists, Oncologists, Ophthalmologists, Orthopaedic surgeons, Physicians, Paediatricians & Urologists. For purposes of this policy the definition specifically excludes all Basic and Specialised Dentistry, Optometry, Orthodontics, Orthotics, Physiotherapy, Psychiatry, Supplementary and Complementary Medical Practitioners as well Pathology and Radiology unless defined.

27.44. **Oncology Co-Payment:** The percentage excess /co-payment your Medical Scheme imposes on claims paid after you reach your annual Oncology Limits. (**Oncology Co-payments** are only covered under the Cancer Benefit).

27.45. **Out-Patient:** Any consultation, investigative test or surgical procedure that a Registered Medical Professional performs whilst you are not admitted as a hospital in-patient or any intervention that would not clinically require in-patient admission to a hospital.

27.46. **Overall Annual Limit (OAL):** The total value of the compensation allowed for all aggregated claims as defined within this schedule, per beneficiary registered on the policy.

27.47. **Penalty Fee**: The amount you have to pay in terms of your Medical Scheme Rules when you are admitted to hospital that is not a **DSP** as provided for in your Medical Scheme Rules**.**

27.48. **Persal Number:** Means a unique system generated 8-digit number assigned to each employee who is appointed on the Persal System via The State.

27.49. **Policy:** The formal contract issued by the Insurer, which contains terms and conditions of the short-term insurance cover and serves as its legal evidence.

27.50. **Policy Owner / Policyholder:** If you own an insurance contract or policy, you are a policyholder, also known as the policy owner. As a policyholder, you may also be the person covered by the policy.

27.51. **Pre-existing Conditions:** Any illness, injury, condition or disorder which existed before this policy activated.

27.52. **Prescribed:** The expiry or lapsing of legal rights in terms of the policy.

27.53. **Prescribed Minimum Benefits (PMB):** A set of benefits as defined in the Medical Schemes Act and Regulations which ensures that all scheme members have access to certain minimum health benefits, regardless of your Medical Scheme Option. This includes a requirement for Medical Schemes to pay the full cost of diagnosis and treatment of a list of medical conditions**.**

27.54. **Prescribed Period:** A defined 12 (twelve) month benefit cycle determined from your date of inception.

27.55. **Principal:** The Signatory to the application for inception of the policy.

27.56. **Professional sport:** This is a sport which is registered where an individual derives their livelihood (income) from fulltime participation in said sport.

27.57. **Prosthesis (Internal or External):** Replacement or repair of tissues by prosthetic devices, permanent or temporary, weight bearing or non- weight bearing, free or fixed and the removable replacement of a missing body part, specifically through trauma, disease and or congenital conditions.

27.58. **Psychiatric or psychological condition:** Any kind of mental illness and disability. This includes all forms of major affective disorders, anxiety disorders, psychiatric conditions and all other mental disorders outlined under **ICD-10 Coding** *F01:F99–Mental, Behavioural & Neurodevelopmental disorders.*

27.59. **Registered Medical Professional:** A person legally licensed and duly qualified to practice medicine and surgery (other than the Insured or a member of the Insured's immediate family). This includes people legally licensed, duly qualified and registered in the Specialist Register of the Health Professional Board of the Republic of South Africa and recognised as such by the Underwriter.

27.60. **Scholar:** An insured that is attending primary or secondary school. This definition specifically excludes any student or attendant of a tertiary institution.

27.61. **Sub-limit:** A sub-limit is a defined benefit amount within the overall annual limit of this policy.

27.62. **Sub-limit Enhancer:** A benefit limitation applied in terms of your medical aid benefits for internal prosthesis, MRI & CT Scans on the amount of coverage available to cover a specific stated benefit within this insurance policy. It places a maximum on the amount available, rather than providing additional coverage.

27.63. **Surgical Procedure:** A course of action with the intention of treating, curing or restoring anatomical functions or structure and specifically excludes rehabilitation and other policy exclusions, not specifically defined as covered.

27.64. **Trauma:** Serious injury to the body, as a result of physical violence or an accident.

27.65. **Treatment:** Services provided to a patient, by a specialist or therapist approved by the Underwriter for acute, life-threatening medical conditions.

27.66. **Treatment Plan** – A plan developed and approved by your medical scheme in consultation with the relevant medical practitioner**.**

27.67. **Total Permanent Disability**: means that because of a sickness or injury, a person is unable to continue work in their own or any occupation for which they are suited by training, education, or experience.

27.68. **Underwriter / Sirago Underwriting Managers (Pty) Ltd:** Any person who or which issues a financial product to clients in the form of a Short-term Insurance policy as defined in the Short-term Insurance Act 53 of 1998 and the Insurance Act 18 of 2017. by virtue of an authority, approval or right granted to such person in terms of a written agreement entered into by such person with a Short-term Insurer, authorised to carry on Short-term Insurance business in the Republic of South Africa. An Underwriting Manager's sole remuneration is derived from such activities and such person is deemed to be an agent of the Short-term Insurer. The acts of an Underwriting Manager shall in all respects be and are fully binding upon the Short-term Insurer. Premiums received by an Underwriting Manager on behalf of the Short-term Insurer shall irrevocably be deemed to have been received by the Short-term Insurer.

Please note: Effective from 01 January 2019, please note that this policy wording replaces any previous policy wording regarding this product. As such, claim events occurring as of 01 January 2019 will be assessed strictly in accordance with these terms.

The below table demonstrates the commission calculations based on premiums that your appointed intermediary is entitled to earn. However the table does not cater for any additional section 8 (5) fees that might have been negotiated between you and your intermediary, prior to policy inception. This intermediary fee is optional and is paid to the intermediary on top of the statutory commission on your behalf.

PREMIUM		% COMMISSION
FROM R1.00 to R300	Is	20%
THEN R301 to R600	Is	15%
THEN R601 to R1200	Is	10%
THEREAFTER R1201 +	Is	5%
