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Optima Policy 2024

INSURED BY
CENTRIQ
INSURANCE
A LICENSED NON-LIFE INSURER

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CONTENTS

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OUR CONTRACT WITH YOU

This is the insurance contract between you, the Policyholder and Centriq Insurance Company Limited, your Insurer and replaces any previous versions. It contains the details of the Benefits provided and the terms, conditions and exclusions. All terms, conditions and exclusion in this Policy applies to all Insured Parties on the Policy.

Important points are written in bold.

Processing of insurance information is done in line with applicable legislation, as well as our Privacy Policy which can be found in our Compliance and Trust Centre on our website: www.kaelo.co.za and www.centriq.co.za.

SECTION A: YOUR INSURER

The insurance cover is underwritten by your Insurer: Centriq Insurance Company Limited registration number 1998/007558/06, FSP 3417, a licensed non-life insurer, and is the insurance company providing the Benefits as detailed in this Policy. The cover provided is subject to all the terms and conditions explained throughout your Policy.

SECTION B: YOUR UNDERWRITING MANAGER

Kaelo Risk (Pty) Ltd, registration number 2008/019335/07, an authorised Financial Services Provider (FSP 36931), is your Underwriting Manager.

The Underwriting Manager is responsible for administering your Policy which includes:

- Issuing your Policy
- Assessing and processing your claims
- Collection of your Premium.

You can reach Kaelo on 0861 493 587 or email kaelogap@kaelo.co.za

SECTION C: DEFINITIONS

All definitions used in the Policy are explained below and are marked with capital letters throughout the Policy.

Any words or expressions in the table below will have the same meaning wherever they appear in this Policy Wording unless stated otherwise.

Number	Definition	Meaning
C1	**Accidental Injury**	Refers to bodily injury caused by violent, unintentional, external and physical means.
C2	**Balance Billing**	This is a practice where a Medical Practitioner or other healthcare service provider charges a separately identifiable fee that is over and above the Tariff fee (or set of such fees) that relates to a Medical Procedure/s or Treatment/s and is billed together on one statement or invoice and is not considered as a refundable Benefit by a Medical Scheme.
C3	**Basic Dentistry**	Refers to any of the following dental treatments: cleaning, extractions (including wisdom teeth), fillings, inlays, bonding, root canal treatment and treatment for pain and abscesses.
C4	**Benefit or Benefits**	It is the benefits as listed on the Benefit Schedule that are payable to the Insured Party following an Insured Event.
C5	**Benefit Schedule**	Refers to Annexure A: Detailed Benefits attached to this policy which sets out the benefits covered and their maximum limits payable.
C6	**Condition-Specific Waiting Period**	A period during which an Insured Party may not claim Benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received before the Insured Party's Effective Date of cover.

Number	Definition	Meaning
C7	**Core Benefits**	This is a list of benefits defined as Core Benefits in the Benefit Schedule and which benefits are subject to the Overall Annual Limit.
C8	**Deductible or Co-payment**	This is a fixed, rand amount that the Medical Scheme applies to certain procedures according to your Medical Scheme plan option for hospital admissions.
C9	**Designated Service Provider or DSP**	A healthcare service provider chosen by a Medical Scheme as one of their preferred suppliers.
C10	**Effective Date**	The first day of the month on which cover starts for the Insured Party as noted in the Policy Schedule.
C11	**Eligible Child**	• A child born to either the Policyholder or Eligible Spouse of this Policy. • An Eligible Child includes a legally adopted child or stepchild of a Policyholder.
C12	**Eligible Special Dependant**	• A dependant who is neither an Eligible Spouse nor a Special Needs Child nor an Eligible Child of the Policyholder but who is a dependant on the Policyholder's Medical Scheme and has been accepted by the Insurer for such cover under this Policy. • If no such acceptance is provided by the Insurer, such special dependants are not covered even though they are dependants on the Policyholder's Medical Scheme.
C13	**Eligible Spouse**	• The partner of the Policyholder, whether by means of South African law or religious belief. • The partner by common law who shares a home with the Policyholder and has done so for at least six months.
C14	**Emergency**	A serious, unexpected, and dangerous situation requiring immediate action.
C15	**Family**	Collectively it refers to the Policyholder, Eligible Spouse, Eligible Children, Special Needs Child and/or Eligible Special Dependants as defined in the Policy.
C16	**General Waiting Period**	The period during which an Insured Party may not claim any Benefits, except for Benefits directly arising from Accidental Injury.
C17	**Hazardous Sport**	It includes, but is not limited to, participation in or use of any of the following: • All forms of motorised racing, speed tests or aerobatics, whether by land, sea or air; • Mountaineering, trekking or hiking above an altitude of 4 000 metres; • Hunting, shooting or deploying firearms in any manner other than for self-defence purposes.

Number	Definition	Meaning
C18	**Hospital**	Any institution in South Africa which meets all of the following criteria: • Provides surgical and medical diagnostic and therapeutic facilities for Treatment and care of sick or injured persons under the supervision of Medical Practitioners. • Provides 24-hour nursing services to sick or injured persons within the facilities. • Is not an institution that primarily cares for persons who are mentally disabled, blind, deaf, mute or in any other way physically disabled. • Is not a nursing home or home for the elderly. • Is not a place of rest or recuperation. • Is not an institution that primarily treats people for drug addiction, alcoholism, eating disorders or any other form of addictive behaviour. • Is not a health hydro or alternative therapy clinic or other similar establishment. • Is not a Step-Down Facility.
C19	**Hospital Episode**	The period of time between admission to Hospital of an Insured Party until the time of discharge from the Hospital of the same Insured Party for the same Insured Event.
C20	**Hospital Network**	A list of Hospitals specified by the Insured Party's Medical Scheme, as the Designated Service Provider of one or more plan types of the Medical Scheme.
C21	**Illness**	Any physical disease or sickness which presents itself in an Insured Party which can be diagnosed by a Medical Practitioner using factual evidence and has been diagnosed.
C22	**Innovative Oncology Medicines**	As described by the Insured Party's Medical Scheme in the Oncology Innovative benefit.
C23	**Insurer**	Centriq Insurance Company Limited, registration number 1998/007558/06; FSP 3417.
C24	**Insured Party**	Refers to the Policyholder, Eligible Spouse, Eligible Child or Eligible Special Dependant, as defined in this Policy.
C25	**Insured Event**	Any one or more of the following: • Accidental Injury, Illness or other health incidents that cause an Insured Party to be admitted to a Hospital and to undergo Treatment or Medical Procedures during the Hospital Episode. • Chemotherapy, radiotherapy or other drug regimens, approved by an Insured Party's Medical Scheme, that is administered to an Insured Party for treating a tumour, growth or other body tissue that has cancer (malignant neoplasm). • An Insured Party receives kidney dialysis for the treatment of acute or chronic renal failure. • Accidental Injury that directly causes an Insured Party to receive Emergency Treatment at the outpatient casualty or trauma ward of a Hospital.

Number	Definition	Meaning
C26	**Kaelo**	Kaelo Risk (Pty) Ltd, registration number: 2008/019335/07, hereafter referred to as Kaelo, who is appointed to administer this Policy on behalf of the Insurer and is registered to do so in terms of the Short-Term Insurance Act No. 53 of 1998.
C27	**Medical Expense Shortfall Policy**	An Accident and Health policy, as defined in Category 1 of section 7.2(1) of regulations to the Short-term Insurance Act, No 53 of 1998.
C28	**Medical Practitioner**	A person who is suitably qualified and registered with the Health Professions Council of South Africa to practice medicine.
C29	**Medical Procedure**	A medical procedure is a course of action intended to achieve a result in the delivery of healthcare. A medical procedure with the intention of determining, measuring, or diagnosing a patient's condition.
C30	**Medical Scheme**	A Medical Scheme registered under the Medical Schemes Act.
C31	**Medical Schemes Act**	The Medical Schemes Act No. 131 of 1998.
C32	**Overall Annual Limit**	The maximum amount payable per Insured Party Per Annum in respect of Core Benefits.
C33	**Per Annum**	The period from 1 January to 31 December of any year.
C34	**Penalty**	Any Co-Payment, Deductible, exclusion or reduction, applied against the benefits of an Insured Party's Medical Scheme, that would not have been applied had the authorisation rules of that Medical Scheme been adhered to or had the benefits been attained from the Designated Service Provider or Hospital Network of that Medical Scheme plan type.
C35	**Permanent Disability**	Any Accidental Injury or physical Illness that renders a person permanently unable to work in their own or other occupation for which they are suited by training, education or experience
C36	**Policy**	Consists of this policy document as well as the Policy Schedule.
C37	**Policy Exclusions**	The list of services, conditions and events that are not covered on the Policy.
C38	**Policy Schedule**	It is the document that forms part of the insurance contract between you and the Insurer that lists the Insured Parties that are covered, their Effective Date of cover, the monthly Premium payable and General and Condition-Specific Waiting Periods that may apply.
C39	**Policyholder**	The owner of this Policy and the person responsible for Premium payments, who is also referred to as you or your in the Policy.
C40	**Premature Birth**	The natural or surgically assisted birth of one or more infants that occurs more than 41 days before the originally expected natural birth date of 40 weeks as verified by the clinical records of the mother's attending physician.
C41	**Premium or Premiums**	The monthly amount due to the Insurer payable by, or on behalf of the Policyholder.

Number	Definition	Meaning
C42	**Prescribed Minimum Benefits**	Prescribed Minimum Benefits (PMBs) are a set of defined benefits provided to beneficiaries of Medical Schemes to ensure that all Medical Scheme members have access to certain minimum health services.
C43	**Special Needs Child**	Any child, including a legally adopted child or stepchild of the Policyholder, who on account of either a physical or mental disability, is unable to financially support him/herself and remains reliant on the Policyholder for support and care.
C44	**Split Billing**	A practice where a Medical Practitioner or other healthcare service provider charges a separately identifiable fee that is over and above the Tariff fee (or set of such fees) that relates to a Medical Procedure/s or Treatment/s and is billed separately from the Tariff fees on two or more statements or invoices and is not considered as a refundable benefit by a Medical Scheme.
C45	**Tariff**	Either the scheme rate or a specific Tariff registered by a Medical Scheme to determine the rate at which its benefits are payable.
C46	**Treatment**	Any form of medical advice, diagnosis, care or treatment provided by a Medical Practitioner for treating or monitoring the medical condition of an Insured Party.

SECTION D: CLAIMS

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

  1. Notify Kaelo of any claim in writing as soon as possible but not later than six months after the end of the Insured Event. Claims submitted more than six months after the Insured Event may not be covered.
  2. Supply written proof, copies of medical accounts or other information as may reasonably be required for Kaelo to process the claim or to ensure the validity of the claim. These documents include a completed Claims form, doctor's accounts, Hospital account; Claims Transaction History Report. There may be additional information requested, such as medical reports as required and determined on a case-by-case basis.
  3. Allow Kaelo to inspect as often as is necessary all current or past medical information or clinical records including the results of any diagnostic tests and submit to medical examination on behalf of and at the expense of Kaelo.
  4. Where the Insured Party is not the Policyholder, the Policyholder will provide or obtain permission or consent from the Insured Party to comply with the above condition, failing which the processing of the relevant claims will be suspended until the required permissions or consent are obtained.

- Claims are assessed on a line-by-line basis. Each line has a code on your healthcare or service provider's account, and this accounts for the total amount charged. These codes describe the Medical Procedure/s or Treatment/s that was performed or the service that was provided. Your Medical Scheme must pay a portion of the cost of a coded line from your hospital or risk benefit in order for that claim line shortfall to be covered by your Gap Cover unless you are claiming for a Benefit with different qualifying criteria such as a Family Protector or a defined Co-payment.

- Claims flagged as Prescribed Minimum Benefits (PMBs) or claims with high values may be investigated with your Medical Scheme or discussed with your service provider for possible discount negotiation. PMB's are a set of defined benefits that Medical Schemes are required to cover by law. This means that as a Medical Scheme member, you shouldn't incur any out-of-pocket medical expenses related to a PMB.
- Any Benefit payable in regards to an Insured Event will only become payable after the end of the Treatment relating to the Insured Event but at the sole discretion of the Insurer. Interim Benefit payments can be made to you after a **31-day** period during an Insured Event.
- All Benefits payable will be paid to you or your legal representative whose receipt of the Benefits will be a full discharge of liability.
- If you die, any Benefit due will be payable to the surviving Eligible Spouse, failing which the Benefit will be paid to the Eligible Children (or their legal guardians in the event of them being minors) or failing any of the above, the Benefit will be paid to your estate.
- No Benefit payable will carry interest.
- Any discount received by an Insured Party against the amount owing to any healthcare provider will be included in the calculation of the Benefits of this Policy.
- If the Insurer rejects any claim, or disputes the quantum of a claim, the Insured Party has **90 days** to send a written statement to the Insurer, challenging this decision. If the Insurer persists in rejecting the claim or disputing the quantum, the Insured Party can take legal action and have a summons issued and served on the Insurer, within **six months (180 days)** after the expiry of the **90 days** period; failing which, the Insured Party will forfeit his claim and will have no further claim in terms of this Policy.
- Payment of any Benefit depends on the Insured Party supplying such medical evidence as is required by the Insurer to assess the validity of the claims or for an Insured Party to undergo any medical examination if requested and paid for by the Insurer.

SECTION E: PREMIUMS

Individuals

- All Premiums are **payable monthly in arrears** by the **last working day of each month**. Non-payment of Premiums may lead to the rejection of a claim or cover being suspended and any Benefit payable will be suspended until all arrear Premiums have been received by Kaelo or the Insurer.
- If the Premium is not paid on the payment date, you have a **30-day grace period** after which we will automatically deduct the outstanding Premium from the same account to ensure continuous cover. If this Premium is also not paid you **will have no cover for the period for which you did not pay.**
- Should your Premium remain **outstanding after the third month** your cover will be **cancelled as of the last day of the month** in which you made your last successful payment.
- Should you cancel or stop your debit order, it will be deemed that you have cancelled your cover and you **will not enjoy the 30-day grace period**. If you reinstate your Policy thereafter, your Policy will be treated as a new Policy and the grace period will only apply from the second month of cover.
- Your **cover starts on the first calendar day** of a particular month and cannot be backdated.
- Your Premium will be **reviewed annually**.
- The Insurer **may change the Premium by giving you at least 31 days written notice.**

Corporates (On Behalf of the Policyholder)

- All Premiums are **payable monthly in arrears** by the last working day of each month.
- Non-payment of Premiums may lead to the rejection of a claim or cover being suspended and any Benefit payable will be suspended until all arrear Premiums have been received by Kaelo or the Insurer.
- Your **cover starts on the first calendar day of a particular month** and cannot be backdated.
- Your Premium will be **reviewed annually.**
- The Insurer **may change the Premium by giving you at least 31 days written notice.**

SECTION F: GENERAL TERMS AND CONDITIONS

Jurisdiction and Currency

This Policy is under the authority of the courts of the Republic of South Africa and South African law will apply. The payment of all Premiums and Benefits will be made in the currency of the Republic of South Africa.

Commencement of Cover

Cover will begin on the first day of the calendar month for which the Premium has been paid, subject to all the terms and conditions of this Policy.

Cover and Benefits

- Cover will only be in force or effect if the Insured Party is a member of a registered Medical Scheme.
- Cover will also be provided to the Family (where Family cover is purchased) regardless of whether or not they are covered under the same or separate Medical Scheme options. Under such circumstances, proof of the familial relationship may be required when claiming under this Policy.
- This Policy and any schedules and correspondence sent to you, your application for insurance, and any written or spoken statement made by you or on your behalf forms the contract between you and the Insurer.
- The Insurer **may change** the Policy Exclusions, Benefits or how the Benefits are calculated by giving **31 days written notice.**

General

Once the Premium has been paid on or before the Effective Date, Insured Parties are **covered for an Insured Event** subject to applicable terms, conditions, exclusions and limits as stated in the Policy.

Eligible Spouse

Should you have more than one spouse who could qualify as an Eligible Spouse then you must make an unreversible nomination of one spouse as the Eligible Spouse. Benefits will only be paid to the nominated Eligible Spouse or the Eligible Special Dependant.

Should you die, the nominated Eligible Spouse may transfer the Policy of cover into their own name within 90 days without any additional waiting periods or exclusions being applied.

Eligible Child

Once the Eligible Child reaches the age of 26 years, the child will no longer be an Eligible Child and will therefore no longer be covered under this Policy. On turning 26 and within 90 days of doing so, the Eligible Child may take up a new Policy in their name with no additional waiting periods.

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SECTION G: TERMINATION OF COVER

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

If any fraudulent act is committed by any Insured Party or any service provider, the Insurer reserves the right to immediately cancel this cover and/or institute legal action against the relevant party to recover any losses.

If the Insured Party, or any person acting on behalf of the Insured Party, has misrepresented, inaccurately described or not provided all the details that affect the risk insured under this Policy, the Insurer may declare that the whole of this Policy or any part thereof is invalid. In such an event, the Insurer can reject any claim under this Policy and/or void this Policy from the Policy Effective Date.

SECTION H: WAITING PERIODS

Waiting Periods apply to Insured Parties as set out below:

A General Waiting Period of three months.

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

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

SECTION I: WAIVER OF WAITING PERIODS

If you previously had a **Medical Expense Shortfall Policy**, not longer than **90 days** before the Policy Start Date, then waiting periods on this Policy will be waived for all Insured Parties. The General and Condition-Specific Waiting Periods will be reduced by the expired portion of the waiting periods served under the previous policy. If a Dependant is added after the Policy Start Date then waiting periods may apply.

Waiting periods will not be applied to a newborn, Eligible Child, Special Needs Child or Eligible Spouse if they are registered with Kaelo within **90 days** and added to the Policy, as a Dependant from the birth or marriage date. Premiums will be payable from the birth or marriage date.

Should the Eligible Child, Special Needs Child or Eligible Spouse not be registered with Kaelo within **90 days**, full waiting periods will apply to the Dependant.

The Insurer reserves the right to waive the waiting periods for the Insured Parties. Any waiting periods waived will be shown on the Policy Schedule.

SECTION J: POLICY EXCLUSIONS

- The Insurer will not be liable for any claim caused by or related to any of the following:
  - Any Treatment or Medical Procedure related to obesity.
  - All costs related to ward fees, theatre fees and other Hospital expenses including materials and medication on the Hospital account.
  - Cosmetic surgery except in the case where reconstructive cosmetic surgery is necessitated, in the sole opinion of the Insurer, as a direct result of Accidental Injury or other essential non-elective Treatment or Medical Procedure.
  - Suicide, attempted suicide or wilful injury to oneself.
  - Abortion, attempted abortion or any complications related to it unless Treatment is, in the sole opinion of the Insurer, of a non-elective nature.
  - Any procedure or examination where there is no factual indication of impairment in normal health.
  - The consumption of any drug or narcotic, whether legal or illegal, unless legally prescribed by and taken following the instructions of a Medical Practitioner.

- The failure of an Insured Party to follow any medical advice given by a Medical Practitioner.
- Any incident, Illness, Accidental Injury, or event directly or indirectly caused by the continuous and excessive consumption of alcohol or where the Insured Party suffers from alcoholism.
- Any incident, Illness, Accidental Injury or event directly or indirectly attributable to the Insured Party having a blood alcohol content of more than thirty milligrams per one hundred millilitres of blood.
- Nuclear weapons, nuclear material, ionising radiations or contamination by radioactivity from any nuclear fuel, or any nuclear waste, or from the combustion of nuclear fuel which includes any self-sustaining process of nuclear fission.

- Participation or attempted participation by any Insured Party in any of the following:
  - Defence force, police force, medical rescue service, firefighting service, correctional services facility or the disarming of explosives;
  - Aviation activities where any medical expense incurred in relation to such activities are insured by any other party (excludes fare-paying passengers in a licensed passenger carrying aircraft);
  - Hazardous Sport, regardless of whether activities are performed privately, socially, during practice sessions, while participating in organised events, as an amateur or a professional;
- Any acts or attempted acts, including participation or attempted participation by any Insured Party, of any of the following:
  - Civil commotion, labour disturbances, riot, strike, lock-out or public disorder or any activity which is calculated or directed to bring about any of the following:
    - War, invasion, act of a foreign enemy, hostilities, civil war or warlike operations (regardless of whether war is declared or not);
    - Mutiny, military rising or usurped power, martial law or state of siege, or any other event or cause which determines the proclamation or maintenance of martial law or state of siege, insurrection, rebellion or revolution;
    - Any act (whether on behalf of an organisation, body, person or group of persons) calculated or directed to overthrow or influence any state or government or any provincial, local or tribal authority with force or using fear, terrorism or violence;
    - Any act calculated or directed to bring about loss or damage to further any political aim, objective or cause, or to bring about any social or economic change, or in protest against any state or government, or any provincial, local or tribal authority, or for inspiring fear in the public, or any section thereof;
    - Terrorism. An act of terrorism means the use or threat of violence for political, religious, personal or ideological reasons. This may or may not include an act that is harmful to human life. It could be committed by any person or group of persons, acting alone, on behalf of or with any organisation or government. It includes any act committed to influence any government or inspire fear in the public;
    - The act of any lawfully established authority in controlling, preventing, suppressing or in any other way dealing with any event referred to above.
- Any claim that is excluded or rejected by the Insured Party's Medical Scheme.
- Any claim that does not form part of the registered benefits of the Insured Party's Medical Scheme but has been paid on an ex gratia basis.
- The following procedures, items, services, service providers or events:
  - External prosthesis;
  - Any appliances including, but not limited to, wheelchairs, beds or convalescing equipment;
  - All specialised dental procedures including, but not limited to, crowns, bridges, dental implant related procedures, orthognathic surgery, temporomandibular joint ("TMJ") surgery,

labial frenectomy, bone augmentations, bone or tissue regeneration. The definition does not include Basic Dentistry, this exclusion does not apply to the Dental Reconstruction Benefit in this Policy.
  - Harvesting and/or preserving of human tissues, including but not limited to stem cell regeneration;
  - Breast enlargement;
  - Gastroplasty, lipectomy or otoplasty;
  - Gender reversal procedures;
  - Therapeutic massage therapists;
  - Institutions that primarily care for persons who are mentally disabled, blind, deaf, mute or in any other way physically disabled;
  - Nursing homes or homes for the elderly;
  - Places of rest or recuperation;
  - Rehabilitation (drug addiction, alcoholism, eating disorders or any other form of addictive behaviour), frail care or hospice services;
  - Health hydro or alternative therapy clinics;
  - Step-Down facilities;
  - TTO (To-Take-Out) medicines.
- Any expenses incurred as a result of an injury in a motor vehicle accident that are subsequently recoverable by the relevant Insured Party from the Road Accident Fund.
- Any expenses incurred as a result of an injury on duty that are subsequently recoverable by the relevant Insured Party from the Workman's Compensation Fund.
- Any co-payment or deductible applied by the Insured Party's Medical Scheme against the benefits to be received or paid out from the Medical Scheme, other than those specifically listed in the Benefit Schedule outlined in this Policy.
- Any Penalty, applied by the Insured Party's Medical Scheme.
- Any fee charged by a Medical Practitioner, Hospital or other healthcare providers that constitutes Split Billing in this Policy. This exclusion does not apply to Balance Billing in this Policy.
- Any criminal act or attempted criminal act by an Insured Party which includes the submission of any fraudulent information or the use of any fraudulent means to obtain any Benefit under this Policy.
- Any Treatment or Medical Procedure for infertility.
- Expenses incurred for transport charges or for services rendered whilst being transported in any vehicle, vessel or craft whether or not such vehicle, vessel or craft is specifically designed for medical emergency transport.
- Any act by an Insured Party that wilfully exposed the Insured Party to danger (except where such an act is to save human life).
- Any Treatment or Medical Procedure that, in the sole opinion of the Insurer is of such a nature that it is not considered to be medically necessary, or where alternative conservative Treatment would provide a similar outcome or is of such a nature that there is no likely improvement in the medical condition of the Insured Party.
- Any Hospital Episode, Treatment or Medical Procedure relating to the Insured Event which begins after the cancellation of this Policy.
- Any Treatment or Medical Procedure that occurred outside of the period of cover.
- A Deductible or Co-payment that is specified by the Insured Party's Medical Scheme as a percentage of costs. This does not apply to the 20% oncology Co-payment as per the oncology Co-payments or Penalty Co-payments in this Policy.
- Any outpatient Treatment unless otherwise specified in this Policy.

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BENEFIT SCHEDULE

Addendum A: Detailed Benefits

Benefits	Description	Limit
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.		
Core Benefits		
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 • Oncology First-Time Diagnosis • 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.	Core Benefit Limit: The Overall Annual Limit applied to all Core Benefits is R 198 660 per Insured Party Per Annum.
Tariff Shortfalls	Benefits will be paid in respect of services occurring during a Hospital Episode that are rendered and charged for by a 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' Treatment costs. The Medical Scheme rate for a total colonoscopy is R2 000 (100%) which means that the maximum that the Medical Scheme will pay is R2 000 (100%). The specialist performing the procedure charged R12 000 which is six times the Medical Scheme Tariff (600%). The maximum Benefit payable by this Policy for this procedure is therefore: • R12 000 – Fee charged by the specialist • LESS R2 000 – Benefit paid by Medical Scheme • = R10 000 – The gap cover Benefit.	The Benefit provided is for charges above the Medical Scheme Tariff limited to an additional six times (600%) that of the Medical Scheme Tariff, subject to the Overall Annual Limit.
Co-Payments and Deductibles	Benefits payable are for a standard Co-payment or an upfront Deductible amount for the cost of a Medical Procedure. 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. This Benefit excludes any Deductible or Co-payment that is specified by the Insured Party's Medical Scheme as a percentage of costs and not a specified rand amount.	Subject to the Overall Annual Limit.

Benefits	Description	Limit
Shortfalls from Sub-Limits	This Benefit will apply for services provided during a Hospital Episode, where the charges relating to the service supplied are greater than 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, and subject to the Benefit limit.	Limit: R 64 500.
Oncology Tariff Shortfalls	Benefits will be paid in respect of oncology and related Treatment, that has been approved by the Insured Party's Medical Scheme, for 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 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%) of the Medical Scheme Tariff, subject to the Overall Annual Limit
Oncology Sub Limits	Benefits will be paid in respect of oncology and related Treatment, that has been approved by the Insured Party's Medical Scheme, for treating cancer (malignant neoplasm) and which occurs during an Insured Event. Benefits will be paid in respect of services, where the charges relating to the services supplied, are greater than 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 Overall Annual Limit.
Oncology Co-Payments	Benefits are payable in respect of oncology and related Treatment, that has been approved by the Insured Party's Medical Scheme, for 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 Insured Party's Medical Scheme.	The maximum Benefit payable is limited to a 20% Co-Payment, subject to the Overall Annual Limit.

Benefits	Description	Limit
Out-of-Hospital Tariff Shortfalls	This Benefit provides additional cover of up to 500% of the Medical Scheme rate for outpatient procedures, subject to the costs being funded from the risk/hospital benefit by the Insured Party's Medical Scheme. **Out-of-Hospital Tariff Shortfalls Example:** Mr V is on a Medical Scheme – plan C which covers him to a maximum of 100% of the Medical Scheme rate. This means that the Medical Scheme will pay all expenses at the defined Medical Scheme rate towards Mr V's Treatment costs. Mr V has opted to undergo an arthroscopy of his shoulder out of Hospital. The Medical Scheme rate for a total arthroscopy is R2000 (100%). This means that the maximum that the Medical Scheme will pay is R2000 (100%). The specialist performing the procedure charged R10 000 which is five times the Medical Scheme Tariff (500%). The maximum Benefit payable for this procedure is therefore: • R10 000 – Fee charged by the specialist for the arthroscopy • LESS R2 000 – Benefit paid by Medical Scheme • =R8 000 – Your gap cover Benefit.	The Benefit provided is for charges above the Medical Scheme Tariff, limited to five times (500%) of the Medical Scheme Tariff, and subject to the Overall Annual Limit.
Penalty Co-Payment	Notwithstanding the exclusion relating to penalties, this Benefit will pay a fixed value Penalty Co-payment or Deductible, or a percentage penalty Co-payment up to a maximum of 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, that is not a fixed value Penalty Co-payment defined in the rules of the Insured Party's Medical Scheme, remains an exclusion.	Subject to two events per Family Per Annum and a maximum of R18 550 per event and subject to the Overall Annual Limit.
Innovative Oncology Medicines	Benefits will be paid in respect of defined Innovative Oncology Medicines approved by the Insured Party's Medical Scheme.	The Benefit payable is equal to the total cost of the Innovative Oncology Medicine less the amount paid by the Medical Scheme from the Insured Party's hospital/risk benefit up to a maximum value equal to the lesser of 25% of the total cost or R13 780.
Dental Reconstruction Benefit	Benefits are only payable in respect of dental reconstruction surgery being required as a direct result of Accidental Injury or from oncology Treatment/s or Medical Procedure/s that occurred after the Insured Party›s Effective Date of cover. 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:** Mr X is involved in a motor vehicle accident which damaged his teeth. Mr X is required to have dental reconstruction as a result of this. Mr X was admitted to Hospital for his surgery. The total cost for Mr X's Treatment was R10 500. Mr. X's Medical Scheme paid R3 000 toward the dental surgeon's account from his hospital benefit. Kaelo Gap will calculate the Benefit payable to Mr X as: • R10 500 (Charged Amount) • Less R3 000 (Paid by Medical Scheme) • = R7 500	Subject to two events per Family Per Annum and a maximum amount of R49 900 Per Annum and subject to the Overall Annual Limit.

Benefits	Description	Limit
Benefits Extenders		
Family Booster	A lump sum Benefit is payable when a Premature Birth occurs.	The lump sum Benefit is R15 900.
Casualty Child Illness	Benefits 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-hours are Mondays to Fridays between 18:00 and 08:00 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 refund that too.	Subject to two events Per Annum and a maximum of R2 860 per event. The Benefit only applies to children under age 12.
Accidental Casualty	Benefits will be paid in respect of emergency outpatient 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 refund that too. No Benefit is payable for services that are related to an Illness or that are not delivered within a casualty ward of a Hospital.	Subject to a maximum of R18 450 per event.
Hospital Booster	The following daily lump sum Benefit is payable where an Insured Party is admitted to a Hospital, and such an Insured Event occurred as a direct result of either Accidental Injury or Premature Birth. For the purposes of the Benefit calculation, the first day is defined as beginning at the time of admission to Hospital and ending 24 hours later. All subsequent days are defined as beginning and ending on the same start and end times as the first day. The following Benefit limitations apply: If more than one Insured Party in the Family is hospitalised as a result of the same event, only the Insured Party with the longest Hospital Episode will receive a Benefit. No Benefit is payable after day 30 of any Hospital Episode.	A maximum of two Hospital Episodes per Family are covered under this Benefit Per Annum, limited to R29 300 per Insured Party Per Annum. The Benefit is payable from day one of the Hospital Episode: • 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).
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.

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Benefits	Description	Limit
Oncology First- Time Diagnosis	A lump sum Benefit for first-time diagnosis of cancer to the medical equivalent of stage 2 or higher form of cancer. The Benefit is only payable during an Insured Event. The Benefit is subject to one claim per Insured Party for the lifetime of the Policy. It excludes any form of cancer that was previously identified or required Treatment. It excludes cancer diagnosed prior to 2024	Limit: R15 000
Medical Scheme 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. In the event of death, this Benefit 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.	The Benefit payable is subject to an overall limit of R35 500
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. In the event of death, the Benefit will only apply (become payable) where the Policyholder is the principal member of the Medical Scheme and only if there are dependants 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 of event. This Benefit is limited to one event over the Policy lifetime.
Road Accident Fund Claims	An end-to-end legal service is provided by the nominated Service Provider of Kaelo to assist Insured Parties with legitimate claims against the Road Accident Fund. Service Providers are contracted to Kaelo and not to the Insurer: Centriq Insurance Company Limited.	Included.