ambledown
FINANCIAL SERVICES (PTY) LTD
Ambledown is an Authorised Financial Services Provider, No. 10287

GUARDRISK
TAILORED RISK SOLUTIONS
Guardrisk Insurance Company Limited,
a licensed non-life Insurer and an authorised financial services provider (No.75)

Gap Plus & Extend

Master Policy Wording

Master Policy Wording No.: GICL/PLUSEXTEND/2024

This Policy covers the shortfall between what a health practitioner charges and the amount your Medical Aid pays for in-hospital treatment and define out-patient procedures subject to the terms and conditions of this contract.

Operative Clause

In consideration of and conditional upon the prior payment of the premium by or on behalf of the Insured and the acceptance thereof by or on behalf of Guardrisk Insurance Company Limited (the Company) and subject to the Terms, Conditions, and General Endorsements to the policy, the Company agrees to pay the Principal Insured Person for a Defined Event occurring during the period of insurance up to the limit of indemnity stated and benefit as stated in the Policy. The application form and declaration completed by the Insured Person and/or Principal Insured Person form part of this policy as well as the policy schedule and any endorsement to the policy.

Important Notes:

Please note that 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.

a. Cover under this Policy is subject to the Insured Person having a medical aid cover with a registered medical aid scheme.
b. No benefit shall be payable in respect of any medical or surgical treatment unless such treatment occurred during the period of hospital confinement as an in-patient or during chemotherapy or radiotherapy as an out-patient for the treatment of cancer or during treatment as an out-patient for the necessity of kidney dialysis.
c. The minimum entry age for the Principal Insured Person is age 18 (eighteen) and the maximum entry age is age 65 (sixty-five).

Definitions

In this policy all words and expressions signifying the singular shall include the plural and vice versa. Words and expressions which denote any gender includes the other genders. The following words and expressions shall have the following meanings:

1. "Accident" means bodily injury caused by an external, violent, unexpected and visible event.

2. "Company" means Guardrisk Insurance Company Limited, a licensed non-life insurer and an authorised financial services provider (FSP No. 75) Reg No. 1992/001639/06.

3. "Co-Payment" means a stated amount imposed as a co-payment or deductible by a medical scheme. A co-payment or deductible must be indicated in the rules of the medical scheme as approved by the Council for Medical Schemes.

4. "Eligible Child" means a child who is by way of natural/ biological child born of or stepchild or legally adopted child placed under

the foster care of the Principal Insured Person and who has not attained the age of twenty one (21) and who is not already insured under this policy or any other insurance issued by a company providing similar cover.

This age may be extended in respect of an unmarried child who is a dependant on the Principal Insured Person's Medical Scheme, who has not attained the age of twenty six (26).

There will be no age restriction for children who are either mentally or physically incapacitated from maintaining themselves, always provided that the children are wholly dependent on the Principal Insured Person for support and maintenance. A child shall only be accepted for cover if such child is covered by a registered medical aid scheme.

5. "Eligible Spouse" means the spouse of the Principal Insured Person who is not already insured under this section or any other policy issued by a company providing similar cover. A spouse shall only be accepted for cover in terms of this policy if such spouse is covered by a registered medical aid scheme.

   For the purpose of the Policy "Eligible Spouse" shall include a party to any union acceptable according to South African Law.

   Where a person shares an abode with a Principal Insured Person and has done so for at least six (6) months and lives together in the manner of a legally married couple the person shall be regarded as a spouse.

   Should a Principal Insured Person have more than one spouse who could qualify as an Eligible Spouse then that Principal Insured Person must make an irrevocable nomination of one Eligible Spouse to whom the benefits provided by this policy are to apply.

   No benefits will be paid in respect of an Eligible Spouse if more than one person qualifies as such and no nomination has been made by the Principal Insured Person.

6. "Emergency" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or death.

   The determination of an Emergency will be done through diagnosis (through classification by the attending Medical Practitioner and/or the Casualty Unit) and not on symptoms presented.

7. "Family" means the Principal Insured Person, Eligible Spouse and Eligible Children (as defined) provided that the Eligible Spouse and Eligible Child are Insured Persons.

8. "Hospital" means any institution in the territory of the Republic of South Africa which in the opinion of the Company meets each of the following criteria:

   a. Has diagnostic and therapeutic facilities for surgical and medical diagnosis treatment and care of insured and sick persons by or under the supervision of a staff of medical practitioners.
   b. Provides nursing service supervised by registered nurses or nurses with equivalent qualifications.
   c. Is not other than incidentally either a mental institution, a convalescent home, lodging facility or ward, rehabilitation or stepdown facility.
   d. Is not a place of rest for the aged or a place for drug addicts or alcoholics or a health hydro or natural cure clinic or similar establishment.
   e. Is not an institution providing long-term care for the blind, deaf, uncommunicative or other handicapped persons.

9. "Hospital Confinement" means admission to a hospital ward, other than a lodging ward.

10. "Illness" means any one somatic Illness or disease which manifests itself during the period of insurance and includes premature senile degenerative changes, but not an Illness which is of such a nature as to be incapable of diagnosis by objective evidence or which though capable of diagnosis by such evidence has not been so diagnosed.

11. "Insured Incident" means any one Accident or Illness which causes an Insured Person to be confined to hospital and to undergo certain medical or surgical procedures and/or operations.

12. "Insured Person" means

    a. A Principal Insured Person or an Eligible Spouse of a Principal Insured Person or an Eligible Child of a Principal Insured Person. Such persons must be covered by a registered medical aid scheme and who is not already insured under this section or any other policy issued by a company providing similar cover and
    b. Such other person as the Company may from time to time deem eligible.

13. "Medical practitioner" means a legally qualified medical practitioner registered by the Board of Health Care Funders (BHF).

14. "Medical Aid Scheme Option" means the Medical Aid Scheme Option of the Principal Insured Person immediately prior to the Defined Event.

15. "Medical Scheme Option Reimbursement Rate" means the multiple of the Medical Scheme Tariff as indicated by the rules of the Medical Scheme.

16. "Medical Scheme Tariff" means the rate equal to the Insured Person's Medical Scheme Rate.

17. "Principal Insured Person" means the Insured as detailed in the Schedule and accepted by the Company as eligible for participation in the insurance provided by this policy.

18. "Schedule" means the Schedule of Insurance attaching to and forming part of this Policy.

19. "Split Billing" means an amount charged by a Medical Practitioner or Hospital equal to the difference between the amount charged to the Medical Aid Scheme and the amount charged to the Insured Person.

20. "Sub-Limitation" means a sub-limitation indicated in the rules of the medical scheme as approved by the Council for Medical Schemes.

21. "Treatment" means any form of investigation or examination by or consultation with or treatment by a medical practitioner for the purpose of treating or monitoring an Insured Person's medical condition arising out of an Insured Incident.

22. "Underwriting Manager" means Ambledown Financial Services (Pty) Ltd, Reg. No. 2004/006271/07, FSP No. 10287.

01 Description of Benefits

The Benefits provided under this policy are detailed below:

a. Gap Cover - A benefit equal to actual cost limited to six (6) times the Medical Scheme Tariff less the higher of the Medical Scheme Tariff or Medical Scheme Option Reimbursement Rate for treatment received whilst as an in-patient and/or outpatient (as stated in the Defined Event).

b. Co-payment Cover - A benefit equal to the charges in the form of a co-payment or deductable applied for treatment received

whilst as an in-patient and/or outpatient (as stated in the Defined Event).

This benefit shall include any costs incurred from the penalty imposed by the medical scheme for the use of a non-network hospital or a hospital that is not listed as a designated service provider. This for such penalties is only payable once per family per annum.

c. Sub-limitation Cover - A benefit equal to charges above any sub-limitation imposed by the medical scheme for treatment received whilst as an in-patient and/or outpatient (as stated in the Defined Event).

d. Casualty Cover - The cost of a medical or a surgical procedure performed in a casualty ward of a Hospital following an Emergency and where such costs were not met by the medical scheme.

Defined Events

In the event of an Insured Person suffering an Insured Incident (as defined) which necessitates the Insured Person:

1. Being confined to Hospital (but excluding ward fees, theatre fees, medicines, material expenses / costs and any other hospital expenses).

2. Undergoing Medical and Surgical procedures and/or operations or Treatment (as defined) whilst in hospital, including:

    a. The necessity for chemotherapy or radiotherapy for the treatment of cancer on an out-patient basis,
    b. The necessity for kidney dialysis on an out-patient basis

3. The necessity for outpatient treatment for the following procedures:

I. General Surgery	i. Surgical biopsy of breast lump ii. Needle biopsy of breast lump iii. Vacuum biopsy of the breast (X-ray stereotactic mamoraphy – biopsy) iv. Hernia repairs ▪ Inguinal hernia ▪ Femoral hernia ▪ Umbilical hernia ▪ Epigastric hernia ▪ Spigelian hernia v. Varicose veins in the rooms (if paid from scheme's risk) vi. Ischio-rectal abscess drainage vii. Closure of colostomy viii. Surgical haemorrhoidectomy (excluding sclerotherapy or band ligation) ix. Non-invasive haemorrhoidectomy (inclusive of Sclerotheraphy and band ligation) x. Lymph node biopsy xi. Endoscopy xii. Excision of skin lesions (melanoma and other malignant neoplasms of the skin)
II. Urology	i. Vasectomy

		ii. Cystoscopy iii. Orchidopexy iv. Prostate biopsy v. Urethrostomy vi. Stent placement and reconstruction vii. Urethral Dilation viii. Circumcision
III.	Opthalmology	i. Cataract removal ii. Pterygium removal iii. Trabeculectomy
IV.	ENT Surgery	i. Direct laryngoscopy ii. Tonsillectomy iii. Laser ENT Surgery iv. Conventional ENT Surgery v. Nasal surgery (Turbinectomy and Septoplasty) vi. Sinus surgery (FESS) vii. Myringotomy viii. Grommets
V.	Orthopaedic	i. Arthroscopy ii. Carpal Tunnel Release iii. Ganglion surgery iv. Bunionectomy
VI.	Paediatric surgery	i. Orchidopexy
VII.	Hepatobiliary surgery	i. Needle biopsy of the liver
VIII.	Cardiothoracic surgery	i. Bronchoscopy
IX.	General medical cardiology	i. Coronary angioplasty ii. Coronary angiogram
X.	Neurology	i. 24-hour halter EEG
XI.	Immunology	i. Plasmapheresis
XII.	Gastroenterology	i. Oesophagoscopy ii. Gastroscopy iii. Colonoscopy iv. ERCP
XIII.	Diagnostic radiology	i. Myelogram ii. Bronchography iii. Angiograms ▪ Carotid ▪ Cerebral ▪ Coronary ▪ Peripheral

XIV. Obstetrics & gynaecology	i. Tubal ligation ii. Childbirth in a non-hospital setting iii. Incision and drainage of Bartholin's cyst iv. Marsupialisation of Bartholin's cyst v. Cervical laser ablation vi. Hysteroscopy vii. Phototherapy viii. Dilation and curettage
XV. Hyperbaric oxygen treatment for:	i. Radionecrosis ii. Malunion of major fractures iii. Avascular leg ulcers iv. Decompression sickness v. Chronic osteitis vi. Serious anaerobic infections
XVI. Skin conditions **Excision of the following non-neoplastic naevi:**	i. Araneus ii. Spider iii. Stellar

4. The necessity for outpatient diagnostic radiology limited to:

   a. Magnetic Resonance Imaging (MRI)
   b. Computed Tomography Scans (CT Scans)
   c. Positron Emission Tomography (PET Scans)
   d. Nuclear Scans (limited to the mapping of Cancer)

5. The treatment received in a casualty unit of a Hospital provided that such treatment is not for routine physical treatment or any other medical examination or treatment other than Emergency medical treatment.

The Company will pay to the Principal Insured Person a benefit in accordance with the Description of Benefits subject to the limitations.

General Exceptions

The Company shall not be liable for costs and expenses resulting from:

1. An Insured Incident for which the Insured Person received treatment or advice twelve (12) months prior to the inception of this policy. This exclusion only applies to the first twelve (12) months of an Insured Person's cover.

2. Nuclear weapons or nuclear material or by ionising 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.

3. Investigations, treatment, surgery for obesity or any medical treatment directly or indirectly caused by or related to any condition that is a consequence of obesity.

4. Cosmetic surgery or surgery directly or indirectly caused by or related to or in consequence of cosmetic surgery.

5. Routine physical or any procedure of a purely diagnostic nature or any other examination where there is no objective indication of impairment in normal health and laboratory diagnostic or X-ray examinations except in the course of a disability established by prior call or attendance of a physician.

6. Suicide, attempted suicide or intentional self-injury.

7. The taking of any drug or narcotic unless prescribed by and taken in accordance with the instructions of a registered medical practitioner (other than the Insured Person) or any Illness caused by the use of alcohol.

8. Drug addiction.

9. An event directly attributable to the Insured Person where the alcohol content in the blood exceeds the legal level permitted by law.

10. Participation in

    a. Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers.
    b. Aviation other than as a passenger, pilot, or crew of a commercial operated airline.
    c. Any form of race or speed test (other than on foot or involving any non-mechanically propelled vehicle vessel craft or aircraft).

11. Benefits which are covered or payable by the Insured's medical aid scheme such as Prescribed Minimum Benefits, will not be covered.

12. No benefits shall be payable due to the Insured Person's failure to comply with the medical scheme rules regarding the failure to make use of a Hospital that is a designated service provider, preferred service provider, associated Hospital or network Hospital. This exclusion does not apply to:

    a. Radiotherapy or chemotherapy included in the benefit Private Care for Cancer Treatment Cover if such Designated Service Provider is Public Hospitals or Public Clinics; or
    b. A once-off benefit per family per annum applicable to a penalty imposed by the medical scheme for the use of a non-network hospital.

13. No benefits for Computed Tomography Scans (CT Scans) where the scan is used for guidance during a procedure to administer pain relief, draining of bodily fluids, biopsies or any other medical procedure.

14. No benefits for ward fees, theatre fees, medicines, material expenses / costs and any other hospital expenses.

15. Any medical / surgical procedure not covered, declined or paid as an exception by the medical scheme.

16. Investigations, treatment or surgery for artificial insemination or hormone treatment for infertility.

17. Depression, insanity, mental or mental stress, psychotic / psychoneurotic disorders, behavioural and neurodevelopmental disorders.

18. No benefits shall be payable in the event of a fraudulent submission by the claimant.

19. Sub-Limitations imposed by a medical scheme as a result of an agreement between a member and a medical scheme will not qualify for benefits in terms of this Policy.

20. A Co-Payment or deductible as a result of an agreement between a member and a medical scheme will not qualify for benefits in terms of this Policy.

21. Split Billing.

Specific Limitations

a. The maximum benefit payable for cost incurred from the penalty imposed by the medical scheme for the use of a non-network Hospital or a Hospital that is not listed as a designated service provider is R15,000 per family per annum.

b. Treatment in a casualty unit of a Hospital shall be limited to R11,000 in the aggregate per Insured Person per annum.

Overall Limitations

The following Policy benefits are subject to an overall benefit limitation of R198,660.42, or any higher amount which may be published by the Regulator, in the aggregate per Insured Person per annum:

a. Gap Cover

b. Co-payment Cover

c. Non-DSP Penalty Cover

d. Sub-limitation Cover

e. Casualty Cover

General Conditions

1. Cooling-Off Period

The Insured is entitled to cancel this Policy in writing to the Administrator within 14 days after the date of receipt of the Policy documentation or from the reasonably determined date on which the Policy documentation was received. Please note that the Insured may only cancel this Policy within 14 days where no benefit has yet been paid or claimed or the event insured against under this Policy has not yet occurred. All premiums that were paid up to the date that the Administrator receives the written notice of cancellation will be refunded to the Insured, subject to the deduction of the cost of any risk cover the Insured may have enjoyed. The request for cancellation shall be completed by the Administrator by no later than 60 days after the Administrator receives the cancellation notice.

2. Claims

a. Following an Insured Incident the Principal Insured Person shall at his own expense:

i. As soon as possible notify the Underwriting Manager of any claim in writing (email to claims@ambledown.co.za) but

not later than one hundred and eighty (180) days from the first day of treatment for such Insured Incident.

ii. Supply in writing any such proof or other information as the Company may reasonably request, which shall at least include the following documents relating to the claim:
   - Hospital account,
   - Doctors' account, and
   - Medical aid statement

iii. Where necessary, provide authority for the Company to inspect all current and/or past medical or other information including the results of any blood tests and submit to medical examination on behalf of and at the expense of the Company.

iv. Where the Insured Person is not a Principal Insured Person the Principal Insured Person shall provide or obtain the necessary permission or consent to comply with this condition failing which all benefits in respect of any claims subject to this condition shall be avoidable.

b. Any claim in terms of this policy will prescribe after twelve (12) calendar months from the date of occurrence of the Insured Incident if the claim is outstanding and not a subject of a then pending court case.

c. Any benefit payable in respect of treatment received while confined in hospital shall only become due at the end of a period of such confinement. However payment may be made to the Principal Insured Person at the end of a thirty (30) day period of treatment during hospital confinement at the discretion of the Company.

d. The Company will negotiate with and request the Insured Person's Medical Scheme to re-assess any claim, negotiate any discount with the relevant service providers and pay the benefit payable in terms of this policy directly to the service provider, should a discount be negotiated.

e. All benefits payable shall be paid to the Principal Insured Person, his legal representative or the medical practitioner whose receipt shall in every case be a full discharge to the Company.

f. No benefit payable shall carry interest.

3. Time Bar

In the event of your claim being rejected and a claim rejection letter being sent to you, you have a period of 90 days in which to make a representation directly to the Company. Should you make a representation within the 90-day period, the Company has within 45 days of receiving the representation, to notify you of their final decision after reviewing the representation. Should you be dissatisfied with the Company's decision, you have a period of 6 months in which to institute legal action. You may lodge a complaint with the Ombudsman for Short Term Insurance on the details below.

The Insured's representation must be submitted in writing to:

The Complaints Officer	The Compliance Officer
Guardrisk Insurance Company Limited Tel: 0860 333 361 Email: complaints@guardrisk.co.za	Guardrisk Insurance Company Limited Tel: 011 699 1000 Email: compliance@guardrisk.co.za

Alternatively, the Principal Insured may contact:

The Ombudsman for Short-Term Insurance		
PO Box 32334 Braamfontein 2017	Tel: 011 726 8900 / Share call: 0860 726 890 Fax: 011 726 5501	Email: Info@osti.co.za www.osti.co.za

FAIS Ombudsman		
PO Box 41 Menlyn Park 0010	Tel: 012 762 5000 / 086 066 3274	Email: Info@faisombud.co.za www.faisombud.co.za

4. Premiums

a. The premium is due by the first (1st) day of the month that the premium relates to. The premium must be paid by the premium payment date as set out in the policy schedule.

b. If the premium is not paid by the premium payment date, the Company will allow a fifteen (15) day grace period from the last day of the month of cover.

c. If the outstanding premium is not paid within the grace period, then this Policy shall be deemed to have been cancelled at midnight on the last day of the month for which the last premium was received.

d. The Company may offer terms of reinstatement, but is not obliged to do so or to reinstate the Insured Person's policy.

e. The Company is not obliged to accept premium tendered to it after the grace period or after the period of insurance detailed in the schedule.

f. The Company will not consider any claim that arises during the grace period unless the Company receives the full outstanding premium before the end of the grace period.

g. A full month's premium is due in respect of any Insured Person whose cover commences or ceases during a calendar month if such person enjoyed cover for fifteen (15) days or more in that particular month.

5. Termination of cover

a. An Insured Incident will only qualify for benefits if the hospitalisation caused by such Insured Incident commences before the date of cancellation in which case all outstanding claims must be submitted to the Company within three (3) months after the date of cancellation.

b. Cover terminates on the death of the Principal Insured Person. However, on the death of the Principal Insured Person the cover of the Eligible Spouse under this policy may be continued should such spouse elect to do so within sixty (60) days of the death of the Principal Insured Person.

c. Cover will be terminated immediately where the Insured files a claim that is fraudulent or uses any fraudulent or improper means to get any benefit under this Policy.

d. No Premium refund shall be due in the case of cancellation by the Insured Person, or termination of cover due to fraud.

6. **Medical evidence**

Payment of any benefit is conditional on

a. The Insured Person supplying such medical evidence as is required; and

b. If requested by the Company, an Insured Person undergoing any medical examination at the Company's expense.

7. **Jurisdiction and Currency**

The Policy is valid only within the territorial limits of South Africa. All payments will be made in the currency of South Africa. Your Policy will be governed by the laws of the Republic of South Africa whose courts will have jurisdiction in any dispute arising under your Policy.

8. **Dual Insurance**

Should the Insured have other policies covering, or partial covering, the same event covered by this Policy the Company is only liable to contribute a pro-rata proportion of such loss or event.

9. **Commencement of cover**

Cover in terms of this Policy commences on the first (1st) day of the calendar month for which the premium has been paid by or for the Insured Person.

10. **Cancellations and Policy Amendments**

a. The Insured is entitled to cancel this Policy by providing 31 days' notice in writing to the Company.

b. This Policy may be cancelled by the company by providing thirty one (31) days' notice in writing to the Insured due to fraud and cancellation of a product line.

a. Policy Amendments

i. This Policy may be amended or endorsed by the Company by providing 31 days' notice in writing to the Insured, by issuing a written endorsement to the Policy and shall apply from the date as advised in the notice given to the Insured.

ii. The Insured may request amendments to the Policy during the period of the Policy. Any such amendments shall be evidenced by the Company by issuing an updated Policy Schedule to the Insured.