Dis-Chem

HEALTH

your care covered

2023 Base Policy

INSURED BY

CENTRIQ INSURANCE

A LICENSED NON-LIFE INSURER

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.

Dis-Chem HEALTH your care covered

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Contents

Disclaimer

This Policy replaces all previous versions of your Dis-Chem Health Gap Policy. All terms and conditions in this Policy are applicable to all Insured Parties on the Policy.

All definitions throughout the Policy are indicated with the first letter of each word capitalised. Important points are indicated with a bold font type.

Processing of insurance information is done in accordance 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. The cover provided is always subject to all the terms and conditions explained throughout your Policy.

Section B: Your Underwriting Manager

Your Underwriting Manager is responsible for all administrative matters relating to your Policy which include:

- Issuing of your Policy.
- Processing of your Claims.
- Collection of your Premium.

This product is administered by Kaelo Risk (Pty) Ltd, registration number 2008/019335/07, an authorised Financial Services Provider (FSP 36931). You can reach Kaelo on 0861 029 892 or email dischemgap@kaelo.co.za.

Section C: Definitions

Any words and expressions used in this Policy can refer to either singular or plural and to either gender.

The words and expressions utilised are defined as follows:

Number	Definition	Meaning
C1	Accidental Harm	"Accidental Harm": bodily injury caused by violent, unintentional, external and physical means.
C2	Balance Billing	"Balance 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 (or Procedures) and is billed together on one statement or invoice and is not considered as a refundable Benefit by a Medical Scheme.
C3	Basic Dentistry	"Basic Dentistry": is defined as 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	"Benefit" or "Benefits": the Benefit amount payable to the Insured Party in relation to an Insured Event, as calculated in terms of the Benefit Schedule.
C5	Benefit Schedule	Benefit Schedule: the cover and Benefits detailed in this Policy under Addendum A.
C6	Condition-Specific Waiting Period	"Condition-Specific Waiting Period": a period in which an Insured Party is not entitled to claim Policy Benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within a 12-month period prior to the cover Inception Date.
C7	Core Benefits	'"Core Benefits" are the 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	"Deductible" or "Co-payment": the fixed, defined Rand amount that is deducted from the Insured Party's overall Medical Scheme Benefit entitlement by the Insured Party's Medical Scheme.
C9	Designated Service Provider or DSP	"Designated Service Provider" or "DSP": a medical service provider designated by a Medical Scheme as one of their preferred suppliers.
C10	Eligible Child	"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. In the event that 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 30 days of doing so, the Eligible Child may take up a new Policy in their own capacity without any additional waiting periods or exclusions being applied. The age limitation will not be applicable to a Special Needs Child.
C11	Eligible Special Dependant	"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 an eligible dependant on the Policyholder's Medical Scheme and has been explicitly accepted

Number	Definition	Meaning
		by the Insurer for such cover under this Policy. In the event that no such explicit acceptance is provided by the Insurer, such special dependants are not covered even though they are dependants on the Policyholder's Medical Scheme.
C12	Eligible Spouse	"Eligible Spouse": • the partner of the Policyholder with whom a spousal union exists, whether by virtue of South African law or religious tenet. • the partner that shares a home with the Policyholder in a common law spousal union and has done so for at least six months.
C13	Emergency	"Emergency": a serious, unexpected, and dangerous situation requiring immediate action
C14	Family	"Family": collectively the Policyholder, Eligible Spouse, Eligible Children, Special Needs Child and/or Eligible Special Dependants as defined in the Policy Schedule
C15	General Waiting Period	"General Waiting Period": the period in which an Insured Party may not claim any Policy Benefits, except for Benefits directly arising from Accidental Harm.
C16	Hazardous Sport	"Hazardous Sport": 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.
C17	Hospital	"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 aforementioned facilities. • Is not an institution that primarily cares for persons who are mentally handicapped, blind, deaf, mute or in any other way physically handicapped. • Is not a convalescent 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 establishments. • Is not a step-down facility.
C18	Hospital Episode	"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.

Number	Definition	Meaning
C19	Hospital Network	"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.
C20	Illness	"Illness": any physical disease or sickness which manifests in an Insured Party but is not a disease or sickness which is of such a nature as to be incapable of diagnosis by objective evidence or which, even though capable of diagnosis by such evidence, has not been diagnosed as such. In other words, it must be capable of diagnosis and have been diagnosed.
C21	Inception Date	"Inception Date": the first day of the month on which cover commences for the Insured Party as noted in the Policy Schedule.
C22	Innovative Oncology Medicines	"Innovative Oncology Medicines": medicines as defined by the Insured Party's underlying Medical Scheme's oncology innovative benefit. Cover not included on Base plan.
C23	Insurer	"Insurer": Centriq Insurance Company Limited, registration number 1998/007558/06 (FSP 3417)
C24	Insured or Insured Party	"Insured or Insured Party": the Policyholder, Eligible Spouse, Eligible Child or Eligible Special Dependant, as defined in this Policy and also referred to as you or your in this Policy.
C25	Insured Event	"Insured Event": any one or more of the following: • Accidental Harm, 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 the purposes of treating a tumour, growth or other body tissue that has cancer (malignant neoplasm). Cover not included on the Base plan. • An Insured Party receives kidney dialysis for the treatment of acute or chronic renal failure. Accidental Harm that directly causes an Insured Party to receive Emergency medical Treatment at the out-patient casualty or Trauma ward of a Hospital.
C26	Kaelo	"Kaelo": Kaelo Risk (Pty) Ltd (registration no: 2008/019335/07), hereinafter 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	"Medical Expense Shortfall Policy": means 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	"Medical Practitioner": a person who is suitably qualified and registered with the Health Professions Council of South Africa to practice medicine.
C29	Medical Procedure	"Medical Procedure": any procedure defined under the National Health Reference Price List (NHRPL). If the procedure is not defined, the Insurer will calculate, at their sole discretion, an appropriate Benefit to be paid to the Policyholder.

Number	Definition	Meaning
C30	Medical Scheme	"Medical Scheme": a Medical Scheme as registered under the Medical Schemes Act.
C31	Medical Schemes Act	"Medical Schemes Act": the Medical Schemes Act No. 131 of 1998.
C32	National Health Reference Price List	"National Health Reference Price List" or "NHRPL": the benefit tariff set annually by the Department of Health as a guideline for charges by healthcare service providers or any replacement of the NHRPL effected by a change in law or statute or the generally accepted industry equivalent thereof.
C33	Overall Annual Limit	"Overall Annual Limit" is the maximum amount payable per Insured Party Per Annum in respect of Core Benefits.
C34	Penalty	"Penalty": any Co-payment, Deductible, exclusion or reduction, applied against the Benefits of an Insured Party's Medical Scheme, that would otherwise not have been applied had the authorisation rules of that Medical Scheme been adhered to or the Benefits had been attained from the Designated Service Provider or Hospital Network of that Medical Scheme plan type.
C35	Per Annum	"Per Annum" the period from 1 January to 31 December of any year.
C36	Permanent Disability	"Permanent Disability": any Accidental Harm 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.
C37	Policy	"Policy": this policy as well as the Benefit Schedule and the Policy Schedule.
C38	Policy Exclusions	"Policy Exclusions": the list of services, conditions or events detailed in the "Policy Exclusions" section of this Policy that are excluded from cover at all times.
C39	Policy Schedule	"Policy Schedule": the schedule attaching to and forming part of this Policy that defines the product option, cover type, Inception Date, Waiting Periods and monthly Premium and other information that pertains to the cover provided under this Policy.
C40	Policyholder	"Policyholder": is the owner of this Policy, the person that is responsible for paying the Premiums and the person that can make adjustments to this Policy.
C41	Premature Birth	"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.
C42	Premium or Premiums	"Premium": the monthly amount due to the Insurer payable by, or on behalf of, the Policyholder.
C43	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.
C44	Special Needs Child	"Special Needs Child": any child, including a legally adopted child or stepchild of the Policyholder, who by virtue of either a physical or mental disability, is unable to financially support him/herself and remains reliant on the Policyholder for support and care.

Number	Definition	Meaning
C45	Split Billing	"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 (or Procedures) 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.
C46	Tariff	"Tariff": either the NHRPL Tariff or a specific Tariff registered by a Medical Scheme to determine the rate at which its Benefits are payable.
C47	Trauma	"Trauma": Accidental Harm to an Insured Party that gives rise to an Insured Event.
C48	Treatment	"Treatment": any form of medical advice, diagnosis, care or treatment provided by a Medical Practitioner for the purpose of treating or monitoring the medical condition of an Insured Party.

Section D: Claims

Following an Insured Event**,** the Insured Party or the Policyholder, as the case may be, will at his own expense:

- 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 end of the Insured Event are excluded from cover.
- 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.
- Provide authority for 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.
- Where the Insured Party is not the Policyholder, the Policyholder will provide or obtain the necessary 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 such time as the requisite permissions or consents 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 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 Benefit (PMB) medical procedures or claims with high values may be investigated with your Medical Scheme or discussed with your service provider for possible discount negotiation. PMBs 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 respect of 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 the Policyholder after a **31-day** period during an Insured Event**.**

All Benefits payable will be paid to the Policyholder or his legal representative whose receipt of the Benefits will in every case be a full discharge of liability.

In the event of the death of the Policyholder, 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 the Policyholder's estate.

No Benefit payable will carry interest.

Any discount accrued by an Insured Party, against the amount owing by the Insured to any Medical Provider, will be factored into 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 make representation to the Insurer, challenging this decision. If the Insurer persists in rejecting the claim or disputing the quantum, the Insured Party has to 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 is conditional on the Insured Party supplying such medical evidence as is required by the Insurer to adequately 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

- All Premiums are payable *monthly in advance, on your chosen debit order strike date.* 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 arrear Premiums (i.e. do a double deduction) 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.**
- If the arrear Premiums are still not received after the attempt to do a double deduction, then you have another **30-day grace period** after which we will automatically deduct the arrear Premiums (i.e. do a triple deduction) from the same account to ensure continuous cover.
- Should your Premium remain **outstanding after the third month** your cover will be **cancelled at midnight on the last day of the month** for which Premium has been received.
- 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**. In the event that 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 thereafter.
- 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 adjust the** Premiums **by giving at least 31 days written notice** thereof to the Policyholder.

Section F: General Terms and Conditions

Jurisdiction and Currency

This Policy is subject to the jurisdiction of the courts of the **Republic of South Africa** and **South African law will apply**. The payment of all Premiums and Benefits must be made in the currency of the Republic of South Africa.

Commencement of Cover

Cover will commence on the **first day of the calendar month** for which the Premium has been paid by or on behalf of the Policyholder, 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 Insured Parties 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 the Policyholder, the Policyholder's application for insurance, and any written or spoken statement made by the Policyholder or on his/her behalf, forms the contract between the Policyholder and the Insurer.
- The Insurer **may alter the Policy Exclusions**, **Benefits** or the basis upon which Benefits are calculated under this Policy by giving **31 days written notice** thereof.

General

Once the Policyholder has paid the Premium in accordance with Policy guidelines and on or before the Inception Date or renewal date, Insured Parties are **covered for an Insured Event up to the limits stated in the Policy or any attached schedules** subject to applicable terms, conditions, exclusions and provisions as stated in the Policy.

Eligible Spouse

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

On the death of the Policyholder, the nominated Eligible Spouse may transfer the Policy of cover into their own capacity within 30 days without any additional waiting periods or exclusions being applied.

Section G: Termination of Cover

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

In the event that 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 to institute legal proceedings against the relevant party to recover any losses.

In the event that 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 is entitled to reject any claim under this Policy and/or to void this Policy from the Policy Start Date.

Section H: Waiting Periods

The Insurer will apply Waiting Periods to the cover of an Insured Party as outlined 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.

The above Waiting Periods will be applied to the cover of the relevant Insured Party, from the time that such Insured Party's cover commences under this Policy.

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

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 be applied to the dependant.

The Insurer reserves the right to waive the Waiting Periods for the Insured Parties. Any such waiver applied will be indicated on the Policy Schedule.

Section I: Policy Exclusions

The Insurer will not be liable for any claim caused by or related to, whether such cause or related cause is as a direct or indirect consequence of 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 Trauma or other essential non-elective Treatment or Medical Procedure.
- Suicide, attempted suicide or wilful injury to oneself.
- Abortion, attempted abortion or any complications related thereto unless Treatment is, in the sole opinion of the Insurer, of a non-elective nature.
- Any procedure or examination where there is no objective indication of impairment in normal health.
- The consumption of any drug or narcotic, whether legal or illegal, unless legally prescribed by and taken in accordance with 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 Harm, 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 Harm or event directly or indirectly attributable to the Insured Party having a blood alcohol content exceeding thirty milligrams per one hundred millilitres of blood.
- Nuclear weapons, nuclear material, ionising radiations or contamination by radioactivity from any nuclear fuel, or from 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 as defined, regardless 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 act or activity which is calculated or directed to bring about any of the above;
    - 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 by means of 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 the purpose of 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 with the intention 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, temporo-mandibular joint ("TMJ") surgery, labial frenectomy, bone augmentations, bone or tissue regeneration. The above definition does not include **Basic Dentistry**, as defined in this Policy; this exclusion is not applicable to the Dental Reconstruction Benefit in this policy.
  - Harvesting and/or preserving of human tissues, including but not limited to stem cell regeneration;
  - Breast augmentation;
  - Gastroplasty, lipectomy or otoplasty;
  - Gender reversal procedures;
  - Therapeutic massage therapists;
  - Institutions that primarily care for persons who are mentally handicapped, blind, deaf, mute or in any other way physically handicapped;
  - Convalescent 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 medical service 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 the purposes of medical emergency transport.
- Any act by an Insured Party that wilfully exposed the Insured Party to danger (except where such an act was necessitated in order 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 commences after the date of cancellation of this Policy.
- Any Treatment or Medical Procedure where such Treatment 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. Oncology cover is not included in the Base plan.
- Any Out-patient Treatment unless otherwise specified in this Policy.

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2023 Detailed Benefits

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CENTRIQ INSURANCE

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Benefit Schedule
Addendum A: Detailed Benefits

2023 Benefits	Description	Dis-Chem HealthGap Base 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 • Shortfalls from Sub-Limits • Out-of-Hospital Tariff Shortfalls • Dental Reconstruction Benefit Prescribed Minimum Benefits (PMB) 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 is R195 498 per Insured Party Per Annum. which is the maximum combined Benefit payable by the Insurer for all Core Benefit clauses.
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'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 R10 000 which is five times the Medical Scheme tariff (500%). The maximum Benefit payable by this Policy for this procedure is therefore: R10 000 – Fee charged by the specialist LESS	The Benefit provided is for charges above the Medical Scheme Tariff limited to an additional five times (500%) that of the Medical Scheme Tariff, subject to the Overall Annual Limit.

2023 Benefits	Description	Dis-Chem HealthGap Base Limit
	R2 000 – Benefit paid by Medical Scheme = R8 000 – The gap cover Benefit.	
Shortfalls from Sub-Limits	This benefit will apply for services provided during a Hospital Episode, where the charges relating to the service supplied have exceeded the Sub-limit benefit paid by the Insured Party's Medical Scheme. The Benefit payable is equal to the charged amount, less the amount paid by the Insured Party's Medical Scheme, and subject to the benefit limit.	Limit: R30 700.
Out-of-Hospital Tariff Shortfalls	This benefit provides additional cover of up to 500% of the Medical Scheme rate for out-patient procedures, subject to the costs being funded from the risk/hospital benefit by the Insured Party's Medical Scheme. **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 by this Policy for this procedure is therefore: R10 000 – Fee charged by the specialist for the Arthroscopy	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.

2023 Benefits	Description	Dis-Chem HealthGap Base Limit
	LESS R2 000 – Benefit paid by Medical Scheme =R8 000 – Your gap cover Benefit.	
Dental Reconstruction Benefit	Benefits are only payable in respect of Dental Reconstruction Surgery being required as a direct result of Accidental Harm or from Oncology Treatment that occurred after the Inception Date. The Benefit payable is equal to the total cost of treatment less the amount paid by the Medical Scheme from your hospital/risk benefit. The benefit is 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. Dis-Chem Health 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 R45 700 Per Annum and subject to the Overall Annual Limit
Benefit Extenders		
Hospital Booster	The following daily lump sum Benefits are payable where an Insured Party is admitted to a Hospital, and such an Insured Event occurred as a direct result of either Accidental Harm or Premature Birth, as defined, in your	A maximum of two Hospital Episodes per Family are covered under this Benefit Per Annum, limited to R28 500 per Insured

2023 Benefits	Description	Dis-Chem HealthGap Base Limit
	Policy. For the purposes of the above Benefit calculation, the first day is defined as commencing at the time of admission to Hospital and ending 24 hours later. All subsequent days are defined as commencing and ending on the same start and end times as the first day. The following Benefit limitations apply to this clause: 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 attract a Benefit under this clause. No Benefit is payable under this clause after day 30 of any Hospital Episode.	Party Per Annum. The Benefit is payable from day one of the Hospital Episode: R412 per day from the 1st to the 13th day (inclusive). R803 per day from the 14th to the 20th day (inclusive). R1555 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 Harm.	Limited as follows: Children below six years: R20 000. All other Insured Parties: R28 000.
Medical Scheme Contribution Waiver	A lump sum Benefit is payable upon the death or Permanent Disability of the Policyholder due to Accidental Harm 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 maximum limit of R35 500

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2023 Benefits	Description	Dis-Chem HealthGap Base Limit
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 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.

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