

SIRAGO

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CORPORATE GAP COVER SOLUTIONS 2021

INTRODUCTION

Sirago Underwriting Managers (Pty) Ltd is a registered Financial Services Provider (FSP 4710) and underwritten by GENRIC Insurance Company Limited (FSP 43638), an Authorised Financial Services Provider and Registered Short-term Insurer. Sirago offers a variety of Gap Cover solutions tailored for the unique requirements of the South African healthcare market.

Our competitive products are unparalleled in the market. They are the essential complement for companies as part of their employee healthcare solutions, or for an individual, as part of their personal healthcare portfolio.

Sirago Corporate was designed specifically to meet the needs of the corporate market. We have a highly specialised service team to ensure our brokers, employers and policyholders receive focused responses.

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

OUR PARTNERSHIP WITH YOU

At Sirago we form loyal partnerships with our brokers and policyholders based on empathy and efficiency, resulting in the best customer service experience.

WHY CHOOSE SIRAGO?

- Personalised customer service.
- Gap Cover solutions tailored to supplement corporate healthcare solutions, or an individual's healthcare portfolio.
- Shortfall cover for both in and out of hospital.
- Shortfall cover for day to day consultations at specialists.
- Emergency Room cover for accident and trauma, and emergency illness for children under 8, as well as shortfall cover on general illness for an emergency.
- No maximum entry age unless specified.
- No benefit categories cease at age 65.
- Cover as a family, irrespective of whether or not you are all on the same medical scheme.
- Claims are reimbursed to the policyholder and/or the service provider.
- Weekly claim runs.

Disclaimer:

Gap cover is not a substitute for a medical scheme membership and the cover is not the same as that of a medical scheme. This is a short-term insurance accident and health policy in terms of the Short-term Insurance Act 18 of 2017. The policy wording supersedes any marketing documentation and all benefits will be payable against the Policy Terms and Conditions only.

WHO IS COVERED BY THIS POLICY?

Sirago makes two options available for Corporate employer groups, Corporate Comprehensive and Corporate Starter Gap.

Corporate Comprehensive Gap

Membership is available to employees as part of a group, whether your company offers it on a compulsory or voluntary basis, with a minimum group participation of 20 paying policyholders. Premium payments for these groups must be via employer payroll. We appreciate that every group is unique, therefore we premium rate each group using the actuarially designed Sirago Rating Tool. The benchmark for premium determination is based on whether you join as an individual, or as a family, and the prospective policyholder's age at the inception of the policy according to the following age bands:

- 64 and under
- 65 and over

Corporate Starter Gap

Membership is available to employees as part of a group, whether your company offers it on a compulsory or voluntary basis, with a minimum group participation of 50 paying policyholders. Premium payments for these groups must be via employer payroll. We appreciate that every group is unique, therefore we premium rate each group using the actuarially designed Sirago Rating Tool. The benchmark for premium determination is based on whether you join as an individual, or as a family, and the prospective policyholder's age at the inception of the policy according to the following age band*:

- 44 and under*

*Regardless of entry age on any possible previous cover, the maximum entry age on the Corporate Starter Gap option is strictly 44 years.

We will cover you and all the dependants registered on your medical scheme on one policy. If you belong to different medical schemes, or medical scheme options, we will cover two adults (i.e the policyholder and one other adult dependant, if applicable) and three child dependants on one policy.

A child is considered to be a child dependant up to the age of 21, however cover can be extended to the age of 27 for full-time students. Documented proof of full-time studies is required to verify a dependent over the age of 21, or by providing the Certificate of Membership from your medical scheme confirming that the dependant is still on the same medical scheme.

"The first wealth is health."

Ralph Waldo Emerson



0 - 64



65+

Corporate premiums are determined by algorithms based on certain variables and criteria.

IN-HOSPITAL BENEFITS

Gap Cover

The Gap Cover benefit covers the difference between the medical scheme rate and the rate that service providers charge. We cover an additional 500% above the medical scheme rate. Claims related to robotic surgery shortfalls on the hospital account are covered up to R30 000 per policy, limited to R12 000 per claim. 2 Claims per beneficiary per annum.

Co-payment Cover

Co-payment Cover is for the co-payments, excesses or deductibles imposed by a medical scheme for specified procedures, cover for hospital admission fees, scans, or surgical procedures. Co-payments related to cancer are catered for in the Cancer Benefit.

Co-payments Charged as a Percentage

If your medical scheme defines a co-payment as a percentage of the claim, the amount covered will be limited to R16 000 per claim.

Penalty Fee Co-payments

This benefit covers the Penalty Fee co-payment or deductible charged by your medical scheme for the voluntary use of a non-designated service provider/network hospital, or the use of a partial-cover network hospital. We cover up to R11 500 per claim, and 3 claims per policy, irrespective of whether a rand amount or percentage penalty fee is charged by the medical scheme.

Day Hospital/Clinic and/or In Room Surgical Procedures Cover

We settle the Gap portion of claims.

Prescribed Minimum Benefit (PMB) Cover

The PMB benefit covers the gap portion for the voluntary use of a non-designated service provider for planned PMB procedures, except in the event of an emergency.

Hospital Account Shortfalls

The Hospital Account Shortfall benefit will cover any charges on the hospital account that the medical scheme has not paid, for example items like consumables and private wards. We pay up to R5 000 per policy at maximum of R1 250 per claim, and 3 claims per beneficiary.

Sub-limit Enhancer

The Sub-limit Enhancer benefit covers the shortfall on MRI scans, CT scans, intraocular lenses and internal prosthesis. We pay up to R25 000 per claim, R100 000 per policy. 2 claims per beneficiary and 4 claims per policy.

Step-down Benefit

The Step-down benefit provides cover for ongoing treatment after an accident, stroke or cancer treatment when the benefit limit of the medical scheme has been reached. Rehabilitation must be provided as an in-patient in a step-down/sub-acute facility by the resident healthcare practitioners during your recovery, for ongoing treatment. We will cover up to R9 000 per policy.

OUT-OF-HOSPITAL BENEFITS

Emergency Room Cover

This benefit covers immediate medical treatment due to an accident, trauma, or illness at any registered emergency facility. All costs related to the accidental event will be covered and paid to a maximum of R12 000 per policy for the following events:

- **Accident and Trauma Benefit:** All costs related to the accidental event will be covered and paid to a maximum value of the sub-limit available, whether you are liable to pay the costs related to the emergency event out of your own pocket, or if your medical scheme pays from your savings account.
- **Illness Benefit:** For visits to an emergency room because of illness in a medical emergency, we will cover the amount above the medical scheme rate when the medical scheme pays their portion.
- **Child Emergency Illness Benefit:** This benefit is applicable to children under the age of 8, who require emergency illness treatment outside of normal consultation hours. All costs related to the event will be covered and paid to a maximum value of the sub-limit available, whether you are liable to pay the costs related to the emergency event out of your own pocket, or if your medical scheme pays from your savings account.

Day-to-day Specialist Consultation Fee

The Day-to-day Specialist Consultation Fee benefit covers the difference between the medical scheme rate and the rate which the specialist charges for the cost of the consultation only. We cover R6 500 per policy at R1 350 per claim for the cost above the medical scheme rate only. 4 claims per beneficiary.

Appliance Benefit

The Appliance Benefit will cover the difference between the medical aid benefit amount and the charge by the service provider for claims for any of the following appliances if there is a benefit on your medical scheme option: hearing aids; wheelchairs; C-pap machine; humidifiers; insulin pump; glucometer; nebuliser and the Mirena device. We will pay up to R6 600 per policy.

The benefits below aggregate to the Overall Annual Limit (OAL) of R174 000 per beneficiary per annum from 1 April 2021. Benefit categories are either per beneficiary, or per policy per annum, unless otherwise stated.

Primary Care Consultation Benefit

Subject to a sub-limit of R4 500 per policy per annum, and R400 per claim. Applicable to the following: dental consultations; alternative therapist consultations (this applies to any alternative therapists recognised and paid for by the medical scheme option you are on); and GP consultations. This applies to the difference between the medical scheme rate and provider rate of the consultation charge only and depends on your medical scheme option: hospital plan, savings plan, and/or traditional medical scheme option.

Preventative Care Cover

R8 000 sub-limit per policy. R1 200 per claim. Applies when your medical scheme option makes provision for these benefits and pays for it, or whether it is self-funded. Maximum 3 claims per beneficiary per annum. Defined as pap smears, cholesterol tests, blood glucose tests, flu vaccinations, childhood immunisations, bone density scans, prostate specific antigen tests, mammograms, and contraceptive implantation (excludes cost of device). Covers the difference between that rate that the service provider charges and the benefit amount on your medical scheme option for the listed procedures only.

Trauma Counselling

A sub-limit of R5 000 per policy per annum. Limited to R750 per claim. This benefit covers you for trauma counselling with a registered medical professional within the first 6 months after a traumatic incident, not limited to dread disease, hijacking, and/or violent crimes, at the discretion of the insurer, on the provision of supporting documentation.

CANCER BENEFITS

These benefits are available in the event that the cancer treatment does not form part of the legislative PMB framework.

Cancer Co-payment Benefit

The Cancer Co-payment Benefit incorporates co-payments for ongoing cancer related treatments and biological drugs. The benefit is applied once your medical scheme's cancer benefit has been exhausted and a percentage co-payment is imposed for further treatment on the on the medical scheme's registered treatment plan. Subject to OAL.

Cancer Boost Benefit

The Cancer Boost benefit is applicable to policyholders whose medical scheme option has a defined rand limit for cancer treatment and the rand limit on the medical scheme has been reached. We will cover the costs of the ongoing treatment as per the medical scheme's registered treatment plan, subject to OAL.

Cancer Breast Reconstruction Benefit

The Cancer Breast Reconstruction benefit covers up to 300% of the medical scheme rate for breast reconstruction of the affected breast post-mastectomy, if the medical scheme approves the reconstructive surgery. We will also cover up to R25 000 for the reconstruction of the non-affected breast should the medical scheme not cover this at all. This benefit is available within the first 18 months of the initial mastectomy provided the beneficiary was a member of Sirago at the time of the mastectomy and has retained their cover with Sirago since that event. Subject to OAL.

VALUE ADDED BENEFITS

These do not form part of the aggregated OAL of R174 000.

Gap Cover Premium Waiver

A Premium Waiver benefit may be claimed by the surviving spouse/adult dependent on the current Sirago policy in the event of the death or total permanent disability of the policyholder on the Sirago policy, irrespective of source of payment of the gap premium. We hold the premium of the policy as a credit against the policy for 12 months if the medical scheme membership is maintained.

Medical Scheme Premium Waiver

Payable in event of death or total permanent disability of the policyholder of the Sirago policy and where all beneficiaries are linked to a single medical scheme. In the event of dual medical scheme membership, this benefit is only payable in the event of death or total permanent disability of the policyholder. Sirago will pay a claim for the medical scheme premium to the nominated beneficiary for the upkeep of medical scheme contributions up to a sub-limit of R4 500 per month for up to 6 months.

Accidental Death

The Accidental Death benefit will pay the nominated beneficiary for the accidental death of members on the Sirago policy at R15 000 for the policyholder, R10 000 for the adult dependant and R5 000 per child dependant.

Cancer Cover (Initial Diagnosis)

This benefit will pay out a lump sum of R22 500 upon the initial diagnosis of malignant cancer from stage 1, and excludes any incidence of cancer/pre-cancer prior to inception of the policy.

Sirago Baby

An instruction to add a new-born to the policy must be submitted within 31 days of the birth of the child. After confirmation of pregnancy, this benefit has a R2 000 sub-limit for claims for prenatal scans, childhood immunisations or pre-and post-birth tests (to limit) per child. In the event of twins, the benefit will be doubled, and in the event of triplets, the benefit will be tripled.

Sirago policy has an Overall Annual Limit (OAL) of R164 000 per beneficiary until 31 March 2021, adapted to R174 000 per beneficiary per annum from 1 April 2021.



0 - 44

Age Limit:
44**OAL per beneficiary per annum: R174 000**

R119



R169

IN-HOSPITAL BENEFITS

Gap Cover

Gap Cover will settle claims up to 200% above your medical scheme plan/option rate, to a maximum of 300%, or at the scheme stated benefit value as determined within your scheme policy.

Co-payments

The excesses imposed by your medical scheme payable to a maximum rand limit for specified procedures or tests. Cover for co-payments imposed by medical schemes for hospital admissions, scans and surgical procedures. Co-payment benefits are subject to a sub-limit of R12 000 per policy per annum, limited to R6 000 per claim.

Day Hospital/Clinic and/or In Room Surgical Procedures Cover

Will settle the Gap portion of claims.

PMB Cover

This benefit will cover your Gap portion for the voluntary use of a non-designated service provider for planned procedures, except in the event of an emergency. Subject to a R30 000 sub-limit per policy per annum. Paid to a maximum of R15 000 per claim. Subject to OAL.



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DID YOU KNOW?

You are under no obligation to divulge any information about your personal insurance portfolio to any provider or outside party, even if the hospital or specialist requests it.

ENTHUSIASM IS COMMON
RESILIENCE IS RARE **#FUTUREBUILT**



HOW TO CLAIM

We care that the claims process is seamless. If you need any assistance submitting your claim or any advice, please call our friendly customer service consultants. Should you be incapacitated and not be able to make contact, you may get someone to contact us on your behalf. Please always consult your broker if in doubt.

Submitting your Claim

Claims related to the health event need to be submitted within 180 days after the event date.

Documents Required:

- Sirago Corporate claim form completed and signed by the policyholder.
- Hospital and related accounts substantiating your claim.
- Medical scheme statement reflecting all the payments made by your medical scheme for the treatment dates of the health event.
- Completed medical reports substantiating the clinical information or any other documentation if requested by our claims team.
- Pre-authorisation letter from your medical scheme for co-payment claims.
- Value Added Benefit claims: documentation and certification which may include a death certificate or a report from a registered medical practitioner confirming total permanent disability.
- Initial Cancer Diagnosis: we require a histology report.

POLICY SPECIFIC EXCLUSIONS

No benefits are payable for:

- Any claims not authorised by your medical scheme unless it's part of the benefit entitlement.
- Claims that exceed the utilisation or benefit limit per annum.
- Out-patient treatment other than defined as covered under this policy.
- Any and all experimental treatments and medication both in- and out-of-hospital.

GENERAL POLICY EXCLUSIONS

- An event not covered that falls outside of the policy's intention.
- Any pre-existing condition, disease, disorder or illness, for 10 months.
- Any pre-existing cancer condition, disease, disorder or illness, for 12 months.
- Claims for regular or routine medical treatment of a diagnostic nature.
- Illness or injury resulting from alcohol or drug abuse.
- Any psychiatric or psychological condition.
- Suicide or attempted suicide.
- Medication, drugs, prescriptions, consumables and equipment used, unless it forms part of the benefit entitlement of this policy.
- Cosmetic surgery unless defined as part of the benefit entitlement of this policy.

- Elective procedures.
- Diagnostic investigations, treatment or surgery related to eating disorders, obesity or weight management.
- Investigations, treatment, medication or surgery related to any condition where the policyholder seeks advice, diagnosis and/or treatments outside the borders of South Africa.
- Body Mass Index (BMI), unless defined as part of the benefit entitlement of this policy.
- Diagnostic investigations, treatment or surgery relating to any form of assisted reproduction.
- Participation in any form of race or speed test involving mechanically propelled vehicles or crafts, participation as a professional sports person, or any hobby defined as dangerous in the Policy Terms and Conditions.

STANDARD SHORT-TERM POLICY EXCLUSIONS

No benefits will be paid for claims arising from:

- Participation in war, invasion, act of a foreign enemy, hostilities, civil war, rebellion, revolution, insurrection or political risk of any kind, terrorism or violence.
- Any riot, strike, public or domestic disorder, civil commotion, labour disturbances or lock-out.
- Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers.
- Preventing authorities from dealing or controlling any of the above activities.
- Compensation in terms of the War Damage Insurance Act 85 of 1976.
- Nuclear weapons, nuclear material or ionizing radiation.
- Committing unlawful activities in the Republic of South Africa.
- Loss arising from any contractual liability.
- Consequential loss or damage.

The above is a summary of Policy Terms and Conditions. For a concise list please refer to our website or speak to your broker.

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BROKER DETAILS

Sirago Underwriting Managers (Pty) Ltd is an Authorised Financial Services Provider (FSP: 4710) underwritten by GENRIC Insurance Company Limited (FSP: 43638). GENRIC is an Authorised Financial Services Provider and licensed non-life insurer.

